

ORIGINAL

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 and)	Appellate Case No.: L-09-1282
The Toledo Hospital,)	
)	
Appellants.)	

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I. INTRODUCTION

The delivery of health care services to patients in 21st-century America is complicated. This much goes without saying. Patients, providers, insurers and regulators navigate a bewildering array of complex interactions and interrelationships. Because patients rarely bargain directly for medical services, “price” is uniquely opaque to consumers: the “price” of a particular medical service can vary considerably depending on who is paying the bill. This variation can be significant even if the same provider renders identical services to the same patient on the same day.

Patients purchase insurance in order to secure medical services at an affordable price. A consumer/patient pays heavily for her health coverage, either individually or through her employer. Health insurers, in turn, negotiate rates and prices with providers. The insurer and provider, not the patient, generally bargain about the price of medical services.

This case is about a consumer’s challenge to a medical provider’s effort to exploit the complexity inherent in medical billing to enrich itself at the expense of other providers, liability insurers and its own patients, despite a clear statutory prohibition.

Like all contracts, a preferred provider arrangement is essentially a trade-off: the provider gains access to a large pool of paying patients in exchange for an agreement to accept reasonable compensation for treatment rendered to subscribers and enrollees. Providers enter these arrangements voluntarily and reap their benefits in the form of larger patient volume and more reliable and prompt payment. In turn, patients obtain a lower price for medical services, but must tolerate restrictions on the number of doctors and hospitals that will “accept” their plan. Patients should reasonably expect that health

care providers will abide by their agreements to “accept” health plans. Although this system of indirect payment is controversial and the subject of much political debate, patients, providers and insurers must live with it every day.

Because patients rarely even see the “price” of medical services before treatment, let alone negotiate with the provider, the preferred provider arrangement is invariably the only real market check on the cost of medical services to patients with private health insurance.

Ohio law protects the bargain struck as part of the “preferred provider” system. After agreeing to accept a realistic price for a particular service from a patient’s medical insurer, the provider may not stick its hand back into the patient’s own pocket for an additional amount. This policy is codified in a number of places in the Revised Code, including R.C. § 1751.60(A), which provides: “every provider or health care facility that contracts with a health insuring corporation to provide health care services *** shall seek compensation for covered services solely from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers.” The Sixth District, like the other appellate courts to review the issue, concluded that the statute means what it says. “Solely” means solely.

Appellants, ProMedica Health Systems and The Toledo Hospital (collectively “ProMedica”) urge a construction that limits that application of R.C. § 1751.60 to situations in which the “health insuring corporation” and the patient herself are the only actors involved. Beyond allowing ProMedica to continue targeting patients with alternate payment sources, this construction has little to recommend it. Neither ProMedica nor its

amici,¹ offer a coherent alternative to the Sixth District's construction of R.C. § 1751.60 and leave important issues unresolved.

What conduct, exactly, is prohibited by R.C. § 1751.60, a statute that has been indisputably duly enacted by the legislature? ProMedica and its *amici* offer alternative and conflicting proposals.

ProMedica suggests that Ohio's rule for the "coordination of benefits" between multiple insurance plans conflict with, or are even "superseded" by, the prevailing construction of R.C. § 1751.60. ProMedica does not, however, explain how the two sets of regulations fit together into a coherent whole and allow it to continue indiscriminate billing. Instead, ProMedica baldly suggests that the existence of the rules for coordination alone remove any multi-payer situation from the "scope" of R.C. § 1751.60. Under ProMedica's proposal, the mere possibility of multiple payers equates to a license to bill anyone and everyone.

Finally, ProMedica and its *amici* complain vigorously about the cost and burden of complying with the appellate courts' interpretation of R.C. § 1751.60. They tell less than half the story. In recent years, large health care providers have apparently invested considerable resources to develop strategies for capturing insurance benefits available to the victims of an automobile or other accidents. In stark contrast to the picture painted by ProMedica and its *amici*, the conduct challenged here is an outgrowth of providers pushing their billing practices to the edge of the envelope. It is ProMedica and its *amici*,

¹ For the sake of simplicity, *amici* will refer to both briefs submitted in support of ProMedica's position. The brief of Mercy Health Partners and Catholic Healthcare Partners will be referenced as the "Mercy *amici*" and the brief of the Ohio Hospital Association, Ohio State Medical Association, the Ohio Osteopathic Association and the Ohio Association of Health Plans will be referenced as the "OHA *amici*."

not patients, that have recently upset the longstanding status quo. Until recently, providers rarely directly sought med-pay benefits available under automobile policies.

As set forth below, ProMedica and other providers are depriving patients such as King of an asset for which they have paid (med-pay benefits under automobile policies) and using it for a purpose that does not provide them with any meaningful benefit. Instead of being applied to King's copayments, deductibles and non-covered services, ProMedica is redirecting her med-pay benefits towards its own inflated top-line billing rate. As a result, King is effectively stripped of her the benefits available under her automobile policy.

None of the reasons advanced by ProMedica warrant overturning the view prevailing in Ohio's appellate courts. Pursuant to R.C. § 1751.60, a provider entering into an agreement with a health insuring corporation must seek compensation solely from that entity, to the exclusion of liability and other insurers. To do otherwise would allow ProMedica completely to deprive its patients of an asset for which they have paid a premium.

II. STATEMENT OF FACTUAL BACKGROUND

This case involves a consumer challenge to a hospital's practice of capitalizing on insurance proceeds available to victims of automobile and other accidents. Because the trial court originally dismissed this case pursuant to Civ.R. 12(B)(6), the operative facts must be taken from King's complaint.

- A. After King was injured in an automobile accident, ProMedica declined to bill her health insurer, instead collecting med-pay benefits directly from her automobile insurer.**

As alleged in King's complaint, the facts here are fairly straightforward. King was injured in a car accident and sought treatment at the Toledo Hospital, which is operated by ProMedica. (Cmplt. at ¶¶ 12-13). King was covered under a health insurance plan issued by Aetna Insurance Company ("Aetna"), a health insuring corporation. (Cmplt. at ¶ 14). At the time of her admission, King provided ProMedica's staff with all information necessary to submit a claim to Aetna. (Cmplt. at ¶ 14). Instead of billing Aetna, ProMedica directly billed King's automobile insurer for the med-pay benefits available under that policy. (Cmplt. at ¶ 16). King alleges, and ProMedica has not yet disputed, that the provider makes a practice of collecting directly from automobile insurers. (Cmplt. at ¶ 17).

Like many providers, ProMedica has negotiated a "preferred provider" agreements with major health insuring corporations. (Cmplt. at ¶ 17). As part of these contracts, ProMedica has agreed to accept less than its top-line "retail," or non-preferred, rates for services rendered to Aetna enrollees. (Cmplt. at ¶ 17). By submitting bills directly to an alternate third-party payer, ProMedica hopes and expects to collect more money for the same services. (Cmplt. at ¶ 17). This practice deprives patients of resources that would otherwise be available to them to meet other needs following an accident, particularly deductibles, co-pays and medical expenses that are not covered by the health insuring corporation. In personal injury cases, the practice also leads to a larger subrogation claim at the time of settlement or judgment. Instead of reimbursing her health insurer at the preferred provider rates, the patient is required to reimburse her automobile insurer at the inflated top-line rates extracted by the provider. (Cmplt. at ¶¶

14-19). Thus, at the end of the day, ProMedica is effectively seizing a resource that would otherwise have gone to King.

King challenges the practice because, among other reasons, it violates R.C. § 1751.60(A), which provides:

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. The Lucas County Court of Common Pleas dismisses King's complaint pursuant to Civ.R. 12(B)(6).

King originally filed an action against ProMedica in the United States District Court in November 2008.² King voluntarily dismissed the federal case before any substantive issues were resolved because of questions about whether federal subject matter jurisdiction was proper.

In April 2009, King re-filed substantially the same claim in the Lucas County Court of Common Pleas. Instead of answering King's complaint, ProMedica filed a motion to dismiss pursuant to Civ.R. 12(B)(6) arguing, *inter alia*, that R.C. § 1751.60 is inapplicable here because ProMedica billed King's automobile insurer, but not King directly. Adopting this reasoning, the trial court granted ProMedica's motion in October 2009. When it dismissed King's claims, the trial court explicitly rejected the only other published decision on the topic, the Eleventh District's opinion in *Hayberg v. Physicians Emergency Serv., Inc.*, 11th Dist. No. 2008-P-0010, 2008-Ohio-6180. See Lucas County Common Pleas Court Case No. 200903599, Judgment Entry (Oct. 6, 2009) at pp. 4-6.

² N.D. Ohio docket no. 3:08-cv-2619, dismissed March 2009.

C. The trial court's dismissal leaves significant factual issues unaddressed.

Whatever its merits, the trial court's dismissal made a significant practical impact on the course of this litigation. Although the parties raised additional arguments in the trial court, the appeal to the Sixth District, and the proposition of law accepted by this Court, focused on the relatively narrow issue of whether R.C. § 1751.60 prohibits ProMedica from billing King's automobile insurer for her med-pay benefits. Most importantly, this case reaches the Supreme Court without a factual record. The parties twice³ began to exchange paper discovery, but the process was never completed. No witnesses were deposed. As a result, two important factual issues remain undeveloped.

1. Neither the trial court nor the Court of Appeals made any determination regarding the priority of King's insurance policies under Ohio's coordination of benefits scheme.

First, the relevant contracts are not in the record. The policies issued by King's health insuring corporation (Aetna) and her automobile insurer (Safeco) are not available for review. Likewise, the negotiated "preferred provider" agreement between ProMedica and Aetna is unavailable. As a result, for reasons set forth below, no court can determine which policy is "primary" under the coordination of benefits scheme cited by ProMedica based on the current record.

The record is also silent about whether ProMedica was aware of the terms of the Aetna and Safeco policies at the time that it made the decision to directly bill the automobile insurer. Further, there is no information about whether ProMedica maintains

³ First in the U.S. District Court before King's voluntary dismissal and later in the Common Pleas Court before the trial court granted a motion to dismiss. As a result of this discovery, both parties possess a sort of half-knowledge about the facts surrounding King's claim. The parties have discovered more than what was known at the time the complaint was filed, but have not yet had the opportunity to rigorously challenge each other's position.

procedures to determine whether a particular policy is “primary” under the coordination of benefits scheme.

If this case is remanded to the trial court, the facts could ultimately support any number of possibilities, including: 1) before billing, ProMedica investigated and correctly determined that the Safeco policy is “primary;” 2) ProMedica investigated and determined that the Safeco policy was “primary,” but turned out to be mistaken; 3) ProMedica routinely bills some potential payers; 4) ProMedica bills all potential payers; 5) ProMedica accepts payment from the first entity that pays the bill; 6) ProMedica accepts payment from the entity that pays the greatest amount; 7) ProMedica accepts payment from multiple entities and refunds (or does not refund) one or more of them; and/or, 8) ProMedica did not actually investigate, but billed the automobile insurer with the hope that it would receive additional money compared to what was available from Aetna.

This last possibility is set forth in King’s complaint. (Cmplt. at ¶ 17). This Court should view any attempt by ProMedica to offer an alternative description of its billing practices with some skepticism. At minimum, these are unilateral and self-serving explanations that have not been challenged through the litigation process. When ProMedica represents that it “issues billing statements to companies that have historically been primary as a means of expediting the payment process,” it may or may not be painting a complete picture. (See ProMedica Merit Brief at p. 25).

The entire question of which policy is primary was never addressed below. To be clear, ProMedica is arguing that it is entitled to bill Safeco based on the mere possibility that it may ultimately be responsible for payment.

2. Details surrounding billing and payment for King's treatment are unknown from the present record.

Before she filed suit, King and her counsel wrote to, and spoke with, ProMedica about the propriety of directly billing her automobile insurer. Both provider and patient also had some contact with Safeco and Aetna. As a result, the parties had a significant course of dealing that is not in the record and not directly relevant to this appeal. Questions about whether King consented, objected, or was silent in the face of ProMedica's decision to bill Safeco must be resolved in the first instance by the trial court. To its credit, ProMedica itself appears to acknowledge this principle of fairness.

ProMedica's *amici*, the Ohio Hospital Association, *et. al.* take inappropriate and inaccurate liberties with the limited factual information available. (See OHA *amici* brief at p. 3-4). The OHA *amici* use snippets from the course of dealing between King,⁴ ProMedica and the insurers to create the impression that King herself had the idea to submit a bill to Safeco. King vigorously disputes this version of the facts. If this case is remanded to the trial court, a complete record will show that King cooperated with ProMedica and truthfully responded to its inquiries about her medical condition and available insurance benefits. King never "requested" or "directed" ProMedica to bill anyone. To the contrary, upon learning that ProMedica seized her med-pay benefits, King's counsel asked ProMedica to refund Safeco and bill Aetna in compliance with the R.C. § 1751.60(A). ProMedica refused to do so, despite the explicit instructions from King.

⁴ King does not dispute that the correspondence cited by the OHA *amici* are genuine. Instead, King notes that the cited material is only a portion of that exchanged in discovery. A complete version of these facts is not available because this case arrives at the Supreme Court on a motion to dismiss.

D. The Sixth District Court of Appeals holds that “solely” means solely.

The Sixth District reversed the trial court, holding that ProMedica’s billing practices violated the unambiguous terms of the statute. The Court of Appeals relied on three major factors in reaching its conclusion. First, ProMedica’s duty to comply with the statute is triggered by the existence of a “preferred provider” contract between the provider and a “health insuring corporation.” *King v. ProMedica Health Systems, Inc.*, 6th Dist. No. L-09-1282, 2010-Ohio-2578 at ¶ 5. Second, when the statute applies, the phrase “seek compensation solely from the health insuring corporation” unambiguously prohibits ProMedica from billing alternate payers. *Id.* at ¶¶ 12-13. Finally, although limited, Ohio appellate authority on the subject is unanimous. In the *Hayberg* case, the Eleventh District concluded that R.C. § 1751.60 prohibits substantially the same conduct. *Id.* at ¶ 11.

This Court is now exercising discretionary jurisdiction to determine whether the prevailing construction of R.C. § 1751.60 conflicts with Ohio’s scheme for coordinating payment between multiple insurance policies.

E. The Ohio Department of Insurance reverses its position on whether R.C. § 1751.60(A) allows providers to bill third-party payers.

In the time since the Sixth District’s decision, the Ohio Department of Insurance has issued two policy bulletins concerning R.C. § 1751.60.

The Department issued Policy Bulletin 2010-03 in July 2010, which addressed two general topics. First, the Department notes that the statutory command of R.C. § 1751.60 applies only to contracts involving “health insuring corporations” as specifically defined by R.C. § 1751.01(P). Second, in Bulletin 2010-03 the Department appeared to endorse the construction of R.C. § 1751.60(A) advocated by ProMedica in this action.

Only four months later, perhaps after considering the full ramifications of its initial pronouncement, the Department rescinded Bulletin 2010-03 and replaced it with Bulletin 2010-06. In the new bulletin, the Department maintains its position that R.C. § 1751.60 applies only to “health insuring corporations.” However, the Department reversed itself with respect to billing alternate payers. In Bulletin 2010-06, the Department notes that the bulletin “is not intended to promote or encourage any practice involving a health care facility seeking payment directly from a property & casualty insurer.***” Thus, even when its official position is viewed in the light most favorable to ProMedica, the Department does not support its position regarding the direct billing of automobile insurers.

III. LAW AND ARGUMENT

Proposition of Law II: R.C. § 1751.60(A) applies only when the insurance 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.

A. King’s med-pay benefits from her automobile insurer belong to King. ProMedica has no independent right to these funds.

One matter must be clarified at the outset. ProMedica, on its own, does not have a legal right to King’s medical payment benefits. Any such right flows, if at all, from King herself. In other words, unless King submits a claim to her automobile insurer for med-pay benefits, ProMedica is not entitled to the money. King’s med-pay benefits are an asset belonging to her.

King purchased her automobile policy from Safeco, including her med-pay benefits. King’s automobile policy is a contract between herself and Safeco. This Court has “long held that an insurance policy is a *contract* between the insurer and the insured.”

Pilkington N.A., Inc. v. Travelers Cas. & Sur. Co., 112 Ohio St.3d 482, 2006-Ohio-6551 at ¶ 23, citing *Ohayon v. Safeco Ins. Co. of Illinois* (2001), 91 Ohio St. 3d 474, 478 (emphasis in the original). ProMedica is not a party to King's automobile insurance contract. A non-party to a contract is not entitled to enforce its terms absent evidence that it is an intended beneficiary. *TRINOVA Corp. v. Pilkington Bros., P.L.C.* (1994), 70 Ohio St.3d 271, 277-78. No such evidence exists in this case and there is no rational reason to suppose that King or Safeco intended the insurance contract to benefit ProMedica.

Although ProMedica is clearly entitled to be compensated for medical services provided to King, it is not automatically entitled to be paid from a particular source. King's medical health insurance benefits and the med-pay benefits available to her under her automobile insurance policy belong to her. As a general matter, she must take some action, such as submitting a claim to Safeco or complying with the "evidence of coverage"⁵ concerning her Aetna plan, before her automobile insurer would consider making payments on her behalf. When she presented herself to the Toledo Hospital for treatment, King was not obligated to identify her automobile insurer to the admission clerk or even inform ProMedica that she was injured in a car accident.

ProMedica and its *amici* leave the impression that King's med-pay benefits are the exclusive property of health care providers and "well-recognized, and critical, source of reimbursement" for hospitals, going so far as to raise the specter of insolvency. (See OHA *amici* brief at p. 17). As set forth in the Ohio Association for Justice's amicus

⁵ Specifically defined by R.C. § 1751.01(L) as, "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." That is, the proscribed method of submitting a claim to, and the services covered by, a health insuring corporation.

brief, the state's hospitals are doing reasonably well. Fears of their imminent demise are greatly exaggerated. No one disputes that doctors and hospitals provide invaluable, even lifesaving services to Ohioans. No one disputes that, within the framework of the applicable law, hospitals and doctors are entitled to be compensated for the reasonable value of these services. No one disputes that the applicable legal framework can be complex and perhaps even contradictory. This is the system within which everyone must live. Neither the trial court nor the Court of Appeals attempted to rationalize Ohio's health care system, only interpret the statute placed before them. Neither should this Court.

As set forth below, R.C. § 1751.60(A) applies only to 1) patients with a policy issued by a "health insuring corporation" as specifically defined by Ohio law; 2) the providers have contracted with the same health insuring corporation. ProMedica and its *amici* virtually ignore the voluntary nature of the second factor. Because this case only deals with insured patients, ProMedica will be paid for treatment rendered to King and other enrollees and subscribers covered by the statute under King's medical insurance policy. The questions here are: By whom and in what amount?

ProMedica would like to directly bill King's automobile insurer because doing so allows it to collect the exorbitant rate that it unilaterally sets for its services. Because patients rarely see this rate beforehand, it is not the subject to any negotiation or market discipline. King would prefer that the bill be submitted to her health insurer because doing so will allow her to use her med-pay benefits for copayments, deductibles and services that are not covered by her major medical plan.

King paid for both policies and they belong to her. Absent King's submission of a claim under the automobile policy, ProMedica has no independent right to these particular funds, only a right to be reimbursed for its services in a manner otherwise allowed by law. Like all Ohioans, ProMedica must comply with the law, whether convenient or not.

B. R.C. § 1751.60(A) unambiguously prohibits ProMedica from billing King's automobile insurer.

Before this Court can even turn to the principles of statutory interpretation advocated by ProMedica, it must necessarily arrive at a conclusion that no Ohio appellate court has ever reached: R.C. § 1751.60(A) is ambiguous on its face. If this Court cannot do so, then the statute must be enforced as written.

To date, all of the Ohio appellate courts to consider the issue have concluded that R.C. § 1751.60(A) is unambiguous. In circumstances in which the statute applies, the provider must seek compensation "solely" from the health insuring corporation, to the exclusion of the patient and other potential payers. In addition to the Sixth District in this case, the Eleventh District reached an identical conclusion in *Hayberg*, 2008-Ohio-6180.

In that case, the Eleventh District held that R.C. § 1751.60(A) required a provider to bill the patient's health insurer for covered services, including a prohibition against billing other third-party payers. *Hayberg*, 2008-Ohio-6180 at ¶ 26. In *Hayberg*, Robinson Memorial Hospital initially billed a patient's health insurer (Anthem) a total of \$11,295.39 for a patient's treatment. *Id.* at ¶ 3. Upon learning that the patient's⁶ auto

⁶ Hayberg was injured while a passenger in a car operated by her husband. The *Hayberg* court was faced with a somewhat anomalous situation because the tortfeasor's liability insurance policy was also Hayberg's own policy. In *Hayberg*, the parties disputed

insurer (Nationwide) was responsible for her medical bills, the hospital billed Nationwide \$13,861.45 for the same services and provided Anthem a refund. *Id.* at ¶¶ 3-4. The *Hayberg* court concluded that the hospital “billed and accepted \$2,566.06 more than it was entitled to from Nationwide in violation of R.C. § 1751.60. Under the statute [the hospital] was required to seek compensation solely from Anthem and was only permitted to seek approved co-payments and deductibles... from Nationwide.” *Id.* at ¶ 26.

The *Hayberg* court noted that the “clear legislative purpose of R.C. § 1751.60 is to make sure that individuals who are covered under health plans realize the benefits of those plans and are not forced to pay any amount in excess of the copayments and deductibles they are required to pay under the contracts between health care facilities and health insuring corporations.” *Id.* at ¶ 25. The court observed that the hospital, by collecting \$2,566.06 more from Nationwide than it would have received under its contract with Anthem, reduced the amount available to the patient/insured under the Nationwide policy. *Id.* at ¶ 43. In other words, the provider took \$2,566.06 directly out of its patient’s pocket in violation of R.C. § 1751.60.

In *dicta*, the Second District agreed, holding that R.C. § 1751.60 prohibited a chiropractor from billing an Anthem enrollee⁷ for anything other than approved co-payments or uncovered services. *McArthur v. Randall*, 166 Ohio App.3d 546, 2006-Ohio-777 at ¶ 14. The *McArthur* court reached this conclusion despite the chiropractor’s testimony that he bypassed the health insurer, in part, because he believed that an

whether the provider was entitled to bill this insurer. See *Hayberg*, 2008-Ohio-6180 at ¶¶ 2-4.

⁷ In *McArthur*, the parties were primarily disputing whether the chiropractor was or was not an Anthem preferred provider at the time of treatment.

automobile insurer would ultimately be responsible for the patient's medical bills. *McArthur*, 2006-Ohio-777 at ¶¶ 5-6.

As two Ohio appellate courts have held, and another has concluded in *dicta*, R.C. § 1751.60(A) is unambiguous with respect to both its command and its scope. No appellate court has held otherwise.

1. The Sixth District properly relied on the words actually enacted by the legislature itself when it concluded that “solely” means solely.

The various alternative interpretations of R.C. § 1751.60 advocated by ProMedica and its *amici* simply cannot be reconciled with the words of the statute without disregarding the phrase “seek compensation for covered services solely from the health insuring corporation.” This result would be contrary to the well-established rules for interpreting statutes.

When construing a statute, a court's paramount concern is the legislature's intent in enacting it. See, e.g., *State ex rel. Cincinnati Enquirer v. Jones-Kelly*, 118 Ohio St.3d 81, 2008-Ohio-1770 at ¶ 17; *State ex. Rel. Russell v. Thornton*, 111 Ohio St.3d 409, 2006-Ohio-5858 at ¶ 11. “The court must look to the statute itself to determine legislative intent, and if such intent is clearly expressed therein, the statute may not be restricted, constricted, qualified, narrowed, enlarged or abridged; significance and effect should, if possible, be accorded to every word, phrase, sentence and part of an act.” *State ex. rel. McGraw v. Gorman* (1985), 17 Ohio St.3d 147, 149, quoting *State ex. rel. McGraw v. Gorman* (1985), 17 Ohio St.3d 147, 149, paragraph five of the syllabus. “In construing the terms of a particular statute, words must be given their usual, normal, and/or customary meanings.” *Proctor v. Kardassilaris*, 115 Ohio St.3d 71, 2007-Ohio-4838 at ¶ 12.

A court cannot turn to other principles of statutory interpretation until it exhausts the plain meaning of the words actually in the statute. When the plain language is clear and has a definite meaning, there is no need to apply rules of statutory construction. *Id.*; see also *Cline v. Ohio Bur. of Motor Vehicles* (1991), 61 Ohio St.3d 93, 96. The Court must “give effect to the words used, not * * * delete words used or * * * insert words not used.” *State v. Horner*, 126 Ohio St.3d 466, 2010-Ohio-466 at ¶ 22, quoting *Columbus-Suburban Coach Lines, Inc. v. Pub. Utilities Comm.* (1969), 20 Ohio St.2d 125, 127. If the words of a statute itself convey a clear and definite meaning, the interpretive effort is at an end and the Court must enforce it as written. *Provident Bank v. Wood* (1973), 36 Ohio St.2d 101, 105-106.

Without looking further, this fundamental principle of statutory construction compels the conclusion adopted by the Sixth and Eleventh Districts: R.C. § 1751.60 prohibits a health care provider from seeking compensation from entities other than the patient’s health insurer. To do otherwise would render portions of the statute meaningless. The Sixth District properly found that the phrase “shall seek compensation for covered service solely from the health insuring corporation” could not be clearer. If a health care facility provides covered services to an enrollee/subscriber, it must seek compensation “solely” from the health insurer, as opposed to all others. *King*, 2010-Ohio-2578 at ¶ 12.

ProMedica oddly argues the command to bill “solely the health insuring corporation” is contradicted or rendered ambiguous by the phrase “and not, under any circumstances, for the enrollees or subscribers.” The provider goes so far as to suggest that the Sixth District’s construction would render the second phrase “superfluous.” (See

ProMedica Merit Brief at p. 15). Not so. Under Sixth District’s construction a provider may seek compensation “solely from the health insuring corporation” and also “not under any circumstances from the enrollee/subscriber”. A provider may follow both commands and both phrases are given effect. In contrast, under ProMedica’s view, a provider apparently may not seek compensation “under any circumstances” from the subscriber herself, but need not follow the command to seek compensation “solely from the health insuring corporation.” Under the provider’s construction, one phrase is given effect and the other discarded. Doing so violates the first principle of statutory construction: the words of the statute must be given effect. For this reason alone, the Sixth District must be affirmed.

2. R.C. § 1751.60(A) unambiguously sets forth its own “scope.”

Dissatisfied with the plain-language construction of R.C. § 1751.60(A) adopted by the Sixth District, ProMedica makes much of the alleged “scope” of the statute. That is, the hospital argues that its practice of directly billing automobile policies falls entirely outside of the statute’s command. The difficulty for ProMedica is that the statute itself is clear as to its “scope,” or the circumstances under which it applies.

The section is part of Chapter 1751 of the Revised Code, which contains an extensive definition section, which specifically defines many of the words and phrases appearing in R.C. § 1751.60(A), including:

- “provider” (R.C. § 1751.01(AA));
- “health care facility” (R.C. § 1751.01(M)), a definition that undisputedly includes ProMedica and The Toledo Hospital;

- “health care services” (R.C. § 1751.01(N)), a definition that undisputedly includes the treatment provided to King;
- “health insuring corporation” (R.C. § 1751.01(P)), no party has disputed that King’s Aetna policy qualifies under this definition;
- “compensation” (R.C. § 1751.01(G)), a definition that unquestionably includes the money sought from King’s automobile insurer;
- “enrollee” (R.C. § 1751.01(K));
- “subscriber” (R.C. § 1751.01(DD)).

King unquestionably qualifies as an “enrollee” or “subscriber” to the Aetna plan. Once these specific statutory definitions are considered, the “scope” of R.C. § 1751.60 becomes crystal clear.

R.C. § 1751.60(A) begins with two exceptions to its general command. Pursuant to R.C. § 1751.60(F), the section does not apply to health care services provided during times that the contract between the health insuring corporation and the subscriber is not in effect. R.C. § 1751.60(E) allows the Superintendent of Insurance to exempt providers from these requirements under certain circumstances. No party has argued that either provision is applicable in this case.

The next phrase of R.C. § 1751.60(A) is both critical to the “scope” of the section and completely neglected by ProMedica: “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.”

The “scope” of the statute could not be clearer. As the Sixth District held, “[g]iven the preferred provider contract in place between [King’s] healthcare insurer and

the healthcare provider from whom treatment was received, the billing activities in connection to the treatment were subject to *** R.C. § 1751.60(A)”. *King*, 2010-Ohio-2578 at ¶ 5. This case “is rooted in the existence of the preferred provider contract.” *Id* at ¶ 12. Thus, billing activity is governed by R.C. § 1751.60(A) when there are four conditions precedent: a provider/health care facility; a health insuring corporation; an enrollee/subscriber; and a preferred provider contract.

ProMedica and its *amici* totally and completely fail to mention or note this final condition. The section does not apply to all providers or all health insuring corporations. Instead, the section only applies when the provider has contracted to treat a particular enrollee/subscriber at a particular price.

ProMedica’s practice of directly billing automobile insurers is so vexing precisely because of the preferred provider arrangement that it would prefer not to mention.

ProMedica and its *amici* would like the Court to believe that the amount that it bills for medical services is something like the price of gasoline at the pump: clearly posted and instantly comparable to the price offered at the station across the street. Of course, this conception vastly oversimplifies the situation. At best, the amount appearing on the face of ProMedica’s bill is comparable to the sticker price on a used car lot, more a top-line starting point for negotiations than a bottom-line price. Worse, in the case of medical providers, the sticker price is often unseen by patients prior to their treatment. A sufficiently sick or injured patient may well lack even the capacity to bargain over price. By and large, patients rely on third parties such as health insuring corporations to negotiate on their behalf.

As this Court is certainly aware, the amount billed and the amount ultimately accepted by health care providers can vary considerably. See *Robinson v. Bates*, 112 Ohio St.3d 17, 2006-Ohio-6362 at paragraph one of the syllabus (the face amount of a medical bill and the amount accepted from a health insurer are both evidence of the reasonable value of the medical services provided). The preferred provider rate can be less than half of the amount billed. *Jaques v. Manton*, 125 Ohio St.3d 342, 2010-Ohio-1838 at ¶ 19 (provider accepted \$7483.91 in satisfaction of a \$21,874.80 bill). The difference is at the heart of this case.

Here, ProMedica agreed to accept a particular amount in compensation for services provided to King from her health insurer. This amount was reached as part of an arms-length negotiation between parties of approximately equal bargaining power. In contrast, a patient thinking she is covered by health insurance may not even see or question the amount billed, expecting the treatment to be covered by her health insurer. The top-line amount on ProMedica's bill can be as high as ProMedica desires because few patients actually see it, let alone expect to pay it. The negotiating power rests with the provider and the health insuring corporation.

Thus, although ProMedica agreed to accept the preferred provider rate from a third party, King did not agree to pay the top-line amount to anyone. In this sense, King is simply asking ProMedica to honor its contractual commitment. It is this commitment that triggers the "scope" of R.C. § 1751.60. ProMedica could easily place itself outside of the "scope" of the statute by simply declining to enter into a preferred provider contract with Aetna. Instead, ProMedica has freely chosen to trade its right to collect its inflated top-line amount in exchange for the patient flow, reliable and prompt payment

source and other benefits that come with being an Aetna preferred provider. ProMedica has placed itself within the “scope” of R.C. § 1751.60 and must therefore follow its command.

C. The “coordination of benefits” rules cited by ProMedica do not conflict with R.C. § 1751.60(A)

ProMedica relies heavily on Ohio’s scheme for coordinating benefits between multiple “health plans” to justify its billing practices and remove this case from the “scope” of R.C. § 1751.60(A). In essence, ProMedica argues as follows:

Step 1: Ohio has detailed rules for multiple “plan[s] of health coverage” to determine among themselves which one is ultimately responsible for a particular bill; and

Step 2: Med-pay benefits under automobile insurance policies can be “plans” subject to coordination according to regulations promulgated by Ohio Department of Insurance; therefore,

Step 3: ProMedica is entitled to bill to the automobile insurer simply because it may be subject to coordination.

Despite the superficial appeal of this argument, it is flawed for three major reasons.

First, R.C. § 1751.60(A) and the coordination benefits rules address different topics and regulate separate entities. Neither the statutes themselves, nor for that matter any argument advanced by ProMedica, offer a clear explanation of how the two sets of regulations can be coherently reconciled in a manner that allows ProMedica to continue billing med-pay insurers.

Second, even if R.C. § 1751.60(A) is ambiguous on its face and only susceptible to construction if read *in pari materia* with other portions of the Revised Code, the relevant sections are not limited to the coordination of benefits rules cited by ProMedica.

Ohio also has a strong policy against this type of balance billing. If the legislature intended to allow providers to bill alternative payment sources because they are “primary,” it could have easily done so. In fact, it did. A similar prohibition against balance billing of Medicare patients explicitly authorizes the provider to bill “primary” payment sources first. See R.C. § 4767.01(B). The fact that R.C. § 1751.60(A) make no reference other “primary” payment sources is strong evidence that the legislature had no such intention here.

Finally, by attempting to distinguish this case from *Hayberg* on the basis that med-pay benefits are different than liability coverage under the same automobile insurance policy, ProMedica appears to be engaged in a bait-and-switch. The Court needs to look no further than ProMedica’s *amici* to see that providers are regularly billing both sources, even if ProMedica itself now claims that third-party liability policies are not subject to coordination.

1. R.C. § 1751.60 and Ohio’s scheme for coordination of benefits address distinct topics.

Despite ProMedica’s assertions to the contrary, Ohio’s coordination of benefits rules do not meaningfully conflict with R.C. § 1751.60(A). The coordination of benefits scheme does not direct ProMedica to bill an entity other than King’s health insuring corporation, and the provider will not run afoul of any part of the coordination rules if did not do so.

The coordination of benefits rules apply to health insurers and health insurance plans, not health care facilities and providers. As ProMedica acknowledges, R.C. § 3902.13(A) directs that “plan[s] of health coverage determines its order of benefits.” The

coordination of benefits statute vests the plans themselves, not providers such as ProMedica, with the responsibility to determine priority of payment.

There is a sound policy reason for placing the responsibility for coordination with the plans. Even a cursory review of the order of payment shows that detailed knowledge of the terms of all respective plans is required to accurately determine which one is “primary.” According to R.C. § 3902.13(B)(1) the first factor to consider is that, “[a] plan that does not coordinate with other plans is always the primary plan.” Right away, proper application of coordination rules requires the knowledge of whether an insurance policy contains a particular provision. Although ProMedica argues that “[a]uto insurer medical expense benefits typically do not coordinate,⁸” this statement is not necessarily true in every case.⁹ One needs access to the actual terms of the contract to know for certain.

Even complete copies of the terms of all relevant contracts may not be sufficient. Accurate coordination sometimes requires information about: whether the patient is a beneficiary or dependant (R.C. § 3902.13(B)(2)); if the patient is a child, the birthdates of his or her parents (R.C. § 3902.13(B)(3)); which parent currently has legal custody of a child (R.C. § 3902.13(B)(4)); and even whether the patient is currently working or recently laid off (R.C. § 3902.13(B)(5)). Clearly, the coordination process contemplated

⁸ See ProMedica Merit Brief at p. 20

⁹ The coordination of benefits statutes themselves seem somewhat inconsistent on this point. R.C. § 3902.11(B) requires a contract to contain a coordination of benefits provision to be a “plan of health coverage” subject to coordination. R.C. § 3902.13(A)(1) states that a “plan” that does not coordinate is “always the primary plan.” This issue is for another day because the record is silent about whether King’s Safeco plan contains a coordination of benefits provision.

by R.C. § 3902.13 contemplates fairly detailed knowledge about both the plan and the patient.

Coordination also clearly requires a substantial investment of time and effort on the part of the plans doing the coordination. When an automobile policy or other liability is involved things get even more complicated. Issues of liability and causation can lurk for years after the treatment is rendered.

ProMedica and its *amici* systematically reject any responsibility for correctly executing the coordination of benefits scheme. Rather, the providers are offering the rules as a fig leaf to continue essentially indiscriminate billing. ProMedica and its *amici* hope to quickly reach the med-pay benefits, be paid at their exorbitant top-line rate and leave others to sort out the consequences.

For a moment, accept for the sake of argument that ProMedica is correct: the coordination of benefits rules play a role in determining whether it is entitled to bill King's automobile insurer. ProMedica fails to explain what that role is. In fact, ProMedica's position raises more questions than answers.

Is ProMedica entitled to bill only the primary payer under the coordination of benefits scheme? What steps must it take to identify that plan? In the case of an automobile policy, the primary plan may be unknown until issues of liability and causation are resolved months or years later. Is the patient's statement that a particular injury was caused by an automobile accident sufficient, or must ProMedica wait until the plans (or the courts) apportion responsibility? What happens if ProMedica gets it wrong and mistakenly (or intentionally) bills a secondary plan? Is ProMedica obligated to keep

all insurers completely informed about who it is billing? That is, must ProMedica inform Aetna that it is also billing Safeco?

May ProMedica bill multiple plans? If so, must ProMedica bill all possible plans or may it pick and choose? Does it have to accept the first payment it receives, or may it wait for a better offer from another plan? Must ProMedica follow its patient's instructions or may it do as it pleases? What happens if the patient gives instructions that contradict the terms of her plan? Does ProMedica's knowledge of the terms of the respective plan, or lack thereof, factor in? How? What if the plans themselves dispute priority? If ProMedica disagrees with a plan's decision not to pay, may it then bill the patient directly? For that matter, may ProMedica simply bill the patient directly in a multi-payer situation? ProMedica seems to argue that it may because such scenario is beyond the "scope" of R.C. § 1751.60(A).

ProMedica counters all of these questions with exactly one of their own: What happens if a provider complies with R.C. § 1751.60(A) and submits a bill to a health insuring corporation, but that insurer refuses to pay because it determines that some other insurer is primary? ProMedica predicts all manner of chaos if this situation plays out. In fact, there is a simple answer. R.C. § 1751.60(D) states:

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.

If the health insuring corporation will not pay for whatever reason, the services are not covered. ProMedica may then bill the enrollee or subscriber. Although this may cause delays, it does not completely deprive ProMedica of payments or lead to an absurd result.

2. R.C. § 1751.60 is only one of several sections of the Revised Code evidencing Ohio's strong public policy against balance billing.

R.C. § 1751.60 governs billing activity directed toward patients covered by "health insuring corporations." If the Court finds that resort to principles of statutory interpretation are necessary, sections of the Revised Code governing billing of patients covered by other types of insurers shed at least as much light on the meaning of R.C. § 1751.60 as the coordination of benefits scheme cited by ProMedica.

a. Patients covered under several types of insurance plans are entitled to take advantage of the preferred provider rates, even of the contracting insurer is not ultimately responsible for payment.

When an insured patient is required to pay for health care services out of her own pocket, she may not be charged more than the preferred provider rate. R.C. § 3923.81(A) provides:

If a person is covered by a health benefit plan issued by a sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement and the person is required to pay for health care costs out-of-pocket ***, the amount the person is required to pay to a health care provider or pharmacy shall not exceed the amount the sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement would pay under applicable reimbursement rates negotiated with the provider or pharmacy. This division does not preclude a person from reaching an agreement with a health care provider or pharmacy on terms that are more favorable to the person than negotiated reimbursement rates that otherwise would apply *** The requirements of this division do not apply to amounts owed to a provider or pharmacy with whom the sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement has no applicable negotiated reimbursement rate. (emphasis added).

From this section two things are immediately apparent. First, when read in conjunction with R.C. § 1751.60 and other sections of the Revised Code addressed below, it is clear that Ohio has a strong policy of protecting insured patients from being gouged when they are required to pay for health care out of their own pockets. Under R.C. § 3923.81(A),

the customer may negotiate to pay less than the preferred provider rate, but a hospital may not charge the patient more.

Second, R.C. § 3923.81(A) provides a slightly different protection to consumers than R.C. § 1751.60(A). The former governs the amount that a patient can be charged, while the latter governs the parties that may be billed. However, both sections make clear that the preferred provider contract is at the heart of the protection afforded. The negotiated rate between the patient's provider and insurer is extended to payments not actually made by the insurer itself. This fact alone undermines ProMedica's argument that the prevailing construction of R.C. § 1751.60 leads to absurd results because the legislature would have supposedly never intended to extend the preferred provider rates to payments other than those made by the contracting health insurer. In the instance of R.C. § 3923.81(A), the legislature clearly intended the preferred provider rate negotiated between an insurer and a provider to be passed on to patients, even if the payments are not actually made by the contracting insurer.

- b. Unlike R.C. § 1751.60(A), Ohio's prohibition on balance billing Medicare recipients explicitly allows providers to identify and bill other primary payers.

If the legislature intended for providers to refer to a coordination of benefits scheme when deciding whether to bill an alternate payer, it could have said so. In the context of Medicare patients, it did. The fact that the legislature declined to do the same in the context of health insuring corporations can be viewed as strong evidence that it did exempt multiple payer situations from the command of R.C. § 1751.60.

Ohio prohibits medical providers from "balance billing" Medicare beneficiaries for health care services and equipment. R.C. § 4769.02. "Balance billing" means

charging or collecting an amount in excess of the established Medicare reimbursement rate. R.C. § 4769.01(B). Notably, there is no prohibition on balance billing in this context when Medicare is the secondary insurer. R.C. § 4769.01(B) provides:

*** When medicare is the secondary insurer, the health care practitioner may pursue full reimbursement under the terms and conditions of the primary coverage and, if applicable, the charge allowed under the terms and conditions of the appropriate provider contract, from the primary insurer, but the medicare beneficiary cannot be balance billed above the medicare reimbursement rate for a medicare-covered service or supply. "Balance billing" does not include charging or collecting deductibles or coinsurance required by the program.

In other words, when a patient is covered by Medicare, she may not be balance billed, but her primary insurer may be.

In a few short sentences, the General Assembly clearly enacted the precise rule for Medicare patients that ProMedica and its *amici* advocate here. Of course, the Court must take several dubious steps of statutory interpretation to transfer the Medicare rule to patients covered by health insuring corporations. First, the Court must reach the unprecedented conclusion that R.C. § 1751.60 is ambiguous on its face. Second, the Court must look to the coordination of benefits scheme cited by ProMedica to the exclusion of all other sections of the Revised Code. Finally, the Court must conclude that the only way to reconcile these two regulatory schemes is to allow ProMedica to bill any and all plans subject to coordination. None of these inferences is obvious from the text of any statute. One must wonder why, when the legislature so easily articulated ProMedica's rule in the Medicare context, so many gymnastics are required here to reach the same result.

3. The Court need look no farther than ProMedica's *amici* to see that the coordination of benefits scheme does not actually play a controlling role in providers' billing practices.

ProMedica's argues that this case is distinguishable from *Hayberg* because the med-pay benefits here are different under the coordination of benefits scheme than the liability policy in that case. One need look no further than ProMedica's *amici* to see that this contention is, at best, the reddest of the herrings. Ohio providers are using the possibility of virtually type time of automobile coverage as a reason to refuse to accept a preferred provider rate from a major medical provider.

The Mercy *amici* admit that they uniformly bill car accident victims as if they were Medicare patients.¹⁰ As set forth above, Ohio specifically allows billing an insurer that is primary relative to Medicare, but does not in other circumstances. Contrary to the picture painted by Mercy, Ohio's framework is entirely consistent with the federal statute. Pursuant to 42 U.S.C. § 1395y(b)(2)(A)(ii), Medicare is secondary even to third-party liability policies, including self-insured plans. The federal statute prioritizes plans according to general types, whereas Ohio looks to factors such as which plan has covered the patient for the longest period.

Although the Mercy *amici* claim that the currently stayed *Dorothy Streeter v. Mercy Health Partners* matter is "virtually identical" to those raised here, significant difference exist.¹¹ Namely, in the *Streeter* case the provider allegedly declined to submit the bill to the plaintiff's health insurer turned her over to collections because she had an alternate payment source. That is, Streeter was allegedly subject to phone calls and other

¹⁰ See Mercy Health Partners brief at p. 20.

¹¹ Lucas County Court of Common Pleas Case No. CI 20093601

collection harassment activity solely because the provider knew she had been involved in a car accident and thought she might have another means of paying the bill.¹²

Mercy's one-size-fits all approach to medical billing illustrates two points. First, as a practical matter, providers are not limiting their violations of R.C. § 1751.60 to med-pay coverage because it may be subject to coordination. Rather, providers are grabbing all types of alternative coverage, with little regard for any coordination scheme.

Second, a ruling in favor of ProMedica in this case will encourage providers to continue to push their billing practices to the edge of the envelope. In coming years, this Court will likely see cases involving providers who seize underinsured motorist coverage or the proceeds of liability settlements. Neither the financial incentives for providers to seek alternate payment sources, nor the harm to patients by allowing the practices to continue can be ignored.

D. The additional statutory interpretation factors cited by ProMedica are unpersuasive.

1. The legislative history surrounding R.C. § 1751.60(A) does not particularly support ProMedica.

King and ProMedica agree that R.C. § 1751.60(A) was originally enacted as part of Am. Sub. S.B. 67, a sweeping bill that repealed and replaced prior portions of the Revised Code governing “prepaid dental plan organizations, medical care corporations, health care corporations, dental care corporations, and health maintenance organizations.” See *Ohio Legislative Services Commission, Final Bill Analysis, Am. Sub. S.B. 67, 122d*

¹² To be fair, the *Streeter* case remains in the pleading stages at this point because it has been stayed pending the outcome of this case. The facts contained herein are taken from the complaint in *Streeter*.

*General Assembly.*¹³ Going forward, these diverse entities would be governed under a single regulatory scheme addressing “health insuring corporations.” *Id.*

Am. Sub. S.B. 67 addressed a wide variety of topics such as requiring that individuals and entities operating “health insuring corporations” to obtain a certificate of authority authorizing them to do so, file certain reports with the Department of Insurance and to comply with certain solvency standards. According to the Legislative Services Commission’s Final bill, Am. Sub. S.B. 67 is explicitly intended “to provide uniform regulation of providers of managed care services.” *Id.* Notably, the term “provider” is specially defined by R.C. § 1751.01(AA) to mean doctors and hospitals such as ProMedica, not insurers.

This fact should cast significant doubt on ProMedica’s suggestion that Am. Sub. S.B. 67 was “primarily” or “mostly” concerned with the regulation of “health insuring corporations,” or enacted in response to problems associated with their insolvency. According to the available legislative history, the bill was also enacted to reach conduct by providers such as ProMedica. There can really be no dispute that R.C. § 1751.60(A) issues a direct command to providers regarding their billing practices.

Similarly, the available legislative history of Am. Sub. S.B. 67 surrounding R.C. § 1751.60 itself does not contain a clear statement on ProMedica’s practice of billing automobile insurers. With respect to several sections of Am. Sub. S.B. 67, the Legislative Services Commission states:

¹³ Available at:
<http://lsc.state.oh.us/coderev/fnl122.nsf/All%20Bills%20and%20Resolutions/AB4AB723FF697E2185256598006664AE>

The act also contains several provisions focusing on protections for subscribers and enrollees, including: anti-discrimination provisions; a requirement to provide notice of restrictions on the choice of providers; providing access to applications, filings, and reports of health insuring corporations; providing confidential status to diagnoses and other health information pertaining to enrollees; and restricting the authority of providers and health care facilities to seek compensation for covered services from enrollees.

At best, this statement is neutral with respect to ProMedica's position. This statement manifests a strong legislative intention to protect enrollees and subscribers from abusive billing practices, an intention unquestionably consistent with the Sixth District's interpretation of the statute. Under the prevailing construction of R.C. § 1751.60 protects an asset belonging to the insured: the med-pay benefits for which she has paid.

2. The Ohio Department of Insurance does not endorse ProMedica's billing practices.

ProMedica argues that the Ohio Department of Insurance's administrative interpretation of R.C. § 1751.60 should be afforded deference. Unfortunately for the provider, the Department's two official statements on the subject do not really support its position. In fact, the Department explicitly does not "promote or encourage"¹⁴ the billing practices at issue.

Even if the Department's two bulletins can be understood, even indirectly, as evidence that R.C. § 1751.60 allows bills to be submitted to possible alternate third party payers, the Department lacks authority to contravene an unambiguous statute.

a. The Department first appeared to endorse ProMedica's position, and then rescinded that support.

¹⁴ See Bulletin 2010-6

In the time since the Sixth District opinion in this case, the Department has twice issued Policy Bulletins regarding R.C. § 1751.60. Taken together, these two Bulletins cannot be understood to support ProMedica.

Effective July 16, 2010, the Department issued Bulletin 2010-03.¹⁵ In broad terms, Bulletin 2010-03 addresses two topics. First, the Department notes that the protections afforded by R.C. § 1751.60 apply only to policies and plans issued by “health insuring corporations” governed by Chapter 17 of the Revised Code. As set forth above, the term “health insuring corporation” is afforded a specific statutory definition in R.C. § 1751.01(P). Bulletin 2010-03 expressed the Department’s position that R.C. § 1751.60 does not apply to other types of insurance policies, including “coverage offered by sickness and accident insurers licensed under Title 39 of the Revised Code, self-insured health benefit plans, or third party administrators***.”¹⁶

This issue is not disputed here. King has alleged, and to date no party has disputed, that her Aetna policy involves a “health insuring corporation” as defined by R.C. § 1751.01(P). (Cmplt. at ¶¶ 14-16).

Second, the Department largely adopted the construction of R.C. § 1751.60 advocated by ProMedica in Bulletin 2010-03. The Bulletin explicitly refers to two recent decisions by the Sixth and Eleventh Appellate Districts¹⁷ holding that “a health care provider may not bill a third party *** for more than the provider would receive under the negotiated terms of a first party health insuring corporation contract.” In its first

¹⁵ “Guidance Governing Interpretation of R.C. § 1751.60”

¹⁶ As set forth above, billing activities with respect to many of these policies are nonetheless governed by R.C. § 3923.81.

¹⁷ The *King* and *Hayberg* decisions.

policy bulletin, at least with respect to third party liability policies, the Department basically adopted ProMedica's position:

“Section 1751.60 does not prohibit a health care provider or health care facility from seeking and receiving full payment from a third party's liability insurer which may be liable for the debt.”

With respect to third-party liability policies, the Department could not be clearer than it was in Bulletin 2010-03. Nonetheless, even under the now-rescinded version of its Bulletin, the Department never construed R.C. § 1751.60 to allow the billing of med-pay insurers.

On November 9, 2010, the Department rescinded and retracted Bulletin 2010-03 and replaced it with Bulletin 2010-06.¹⁸ The Department maintains its earlier position with respect to the types of policies affected by R.C. § 1751.60. The statute governs only billing activity associated with “health insuring corporations” as defined by statute.

The Department rescinded the language of the earlier Bulletin most favorable to ProMedica's position through Bulletin 2010-06: the Department now says nothing about whether R.C. § 1751.60 reaches billing activity directed toward any alternative payers. Notably, the Department has removed any reference to the billing alternate third-party payers. There is no language about billing liability or any other insurers.

Even when viewed in the light most favorable to ProMedica, the new Bulletin is neutral to its position. More objectively, the Department's new position is closer to King's than ProMedica's. The Department notes that Bulletin 2010-06 “is not intended to promote or encourage any practice involving a health care facility seeking payment

¹⁸ Also titled, “Guidance Governing Interpretation of R.C. § 1751.60”

directly from a property & casualty liability insurer, and is not intended to overturn any court decisions.” This revision is a stark contrast with the earlier Bulletin.

The change in the Department’s position cannot be ignored. The fact that the Department explicitly retracted its support for ProMedica’s position should be taken as strong evidence that it no longer holds that view. Although the reasons for the Department’s shift cannot be known, it is probable that the Department more closely considered the full implications of its initial statement. When considered in their entirety, the Department’s bulletins cannot be understood as evidence that it construes R.C. § 1751.60(A) as allowing ProMedica to bill King’s automobile insurer.

b. The Department cannot contravene unambiguous statute.

ProMedica correctly observes that courts generally give deference to statutory interpretations promulgated by an administrative agency with enforcement responsibility in a particular field. *Weiss v. Pub. Util. Comm.* (2000), 90 Ohio St.3d 15, 17-18. ProMedica failed to note, however, that this deference is particularly great when the relevant administrative interpretation is “longstanding.” *Id.* citing *Cleveland v. Pub. Util. Comm.* (1981), 67 Ohio St.3d 446, 451.

Here, the Department of Insurance did not issue any guidance regarding the interpretation of R.C. § 1751.60 until July 2010, after the Sixth District’s opinion in this case. Not only that, as set forth above, the Department issued a substantially revised interpretation five months later, effectively reversing itself.

Even in the face of a “longstanding” administrative interpretation of a particular statute, “[i]f the meaning of the statute is unambiguous and definite, then it must be applied as written and no further interpretation is necessary.” *Shell v. Ohio Veterinary*

Med. Licensing Bd., 105 Ohio St.3d 420, 2006-Ohio-2423 at ¶ 34, citing *State ex rel. Herman v. Klopfliesch*, (1995), 72 Ohio St.3d 581, 584. Here, ProMedica is requesting that the Court favor its spin on a four-month old administrative interpretation of a statute over the words actually enacted by the legislature.

3. ProMedica and other providers are responsible for upsetting the longstanding practice in this industry.

In attempting to limit the scope of R.C. § 1751.60, ProMedica relies heavily on this Court's reasoning in *Sheet Metal Workers' Int'l Ass'n v. Gene's Refrigeration Heating & Air Conditioning, Inc.*, 122 Ohio St.3d 248, 2009-Ohio-2747. The *Sheet Metal Workers'* case involved R.C. § 4115.05, which required workers to be paid the prevailing wage for work "performed on any material to be used in connection with a public work." *Id.* at ¶ 33. The parties disputed whether the prevailing wage must be paid to workers who are working on materials to be utilized on a public work, but are not actually working on the jobsite itself. This Court concluded that the prevailing wage need not be paid to such workers. *Id.* at ¶ 43.

After finding that the statutory language did not convey a clear meaning, this Court turned to other principles of interpretation. Specifically, this Court relied heavily on the history of the prevailing wage law and the industry practice and custom in the area. *Id.* at ¶¶ 30-32, 39. The relevant section of the prevailing wage law was enacted in 1935 and has remained largely unchanged in the intervening 70 years. *Id.* at ¶ 32. Several *amici* on both sides of the *Sheet Metal Workers'* case acknowledged that, during these seven decades, the prevailing wage law was universally understood to apply only to the work performed on the job site. *Id.* at ¶ 39. This Court noted, "[i]f the General Assembly had intended to legislatively *** expand the scope of the prevailing-wage

mandates more than 70 years ago, the applicability of the law would surely have been challenged before now.” *Id.*

More than anything else, ProMedica and its *amici* work to create the impression that they have always maintained the same billing procedures and practices and that this case is about an innovative plaintiffs attempt to upset longstanding and universally observed practices. Nothing could be farther from reality. It is difficult to imagine a field more unsettled in today’s environment than billing and payment related to health care services. There is simply no decades-long practice to guide the Court here.

ProMedica and its *amici* repeatedly note that, if the Sixth District is affirmed, they would be required to make significant and costly changes to their billing procedures. In a backhanded way, the providers are acknowledging what is really going on here. In recent years, the providers have apparently invested considerable resources in information systems, admissions protocols, collection departments and other areas intended to identify possible payment sources and ensure the maximum possible payment.

Providers are simply far more aggressive in this area than they were even five years ago. In the undersigned counsel’s experience, prior to approximately 2007-2008, providers would rarely directly collect med-pay benefits in the manner alleged here. Now they will do so even over the patient’s explicit objection. Of course there is nothing inherently wrong with providers looking after themselves. However, ProMedica and its *amici* are shading the truth when they paint the picture that “things have always been this way.” The providers themselves have done much to upset the status quo in recent years.

ProMedica’s argument in this area perfectly captures the danger of disregarding the language enacted by the legislature in favor of flexible factors such as “industry

practice.” First, the parties significantly disagree about what the “industry practice” is and has been over time. Second, such an approach opens the door to what happened here: the widespread adoption of a questionable activity, followed by a defense on the grounds that it has become “industry practice.”

E. The balance of public policy favors the prevailing construction of R.C. § 1751.60.

ProMedica and its *amici* suggest that the balance of Ohio public policy favors its position because, under some circumstances, providers may have difficulty securing timely payment. In particular, they complain that, if the health insuring corporation does not immediately pay the provider’s bill, obtaining reimbursement is more difficult. Of course, the providers completely ignore the “real world” impact on patient and other actors of their decision to disregard R.C. § 1751.60(A).

1. ProMedica’s practice effectively deprives patients of their med-pay benefits.

In order to understand the harm that is being visited upon Ohio’s patients and consumers by ProMedica’s billing practices, one must first understand the distinct roles played by major medical plans as compared to automobile med-pay benefits. Health plans offered by companies such as Aetna provide the insured with a large pool of benefits. In theory, the insured could be entitled to perhaps a few million dollars of benefits over her lifetime. However, these benefits typically come with significant restrictions, limitations, deductibles and co-payments. For example, coverage for dental, vision and prescription medication is not always fully covered by major medical plans. In addition, enrollees and subscribers may be required make co-payments or meet deductibles under their health plans. It is not unusual for these costs to reach into the

hundreds or even thousands of dollars per year. For the typical Ohio family, co-payments and deductibles can be quite burdensome.

Moreover, patients with insurance are often steered toward “preferred providers” who have agreed to accept their health plan. That is, a patient is directed to doctors and hospitals who have contracted to accept a certain price in exchange for health care services.

A patient such as King can reasonably expect her health insuring corporation to meet the bulk of her medical expenses, whether or not the treatment is related to a car accident. However, major medical coverage comes with significant restrictions. Not all services are covered and not all providers are eligible.

Med-pay benefits under automobile policies are more flexible, but provide far less coverage. The policies have few restrictions on how the benefits are applied, as long as the treatment is the result of a car accident. Med-pay policies also typically cover multiple individuals (passengers, family members, etc.), who may not otherwise have medical coverage or may have less generous coverage. An insured can use her med-pay benefits to meet a variety of medical bills, including expenses not normally covered by major medical insurance such as dental bills, prescription medication, copayments and deductibles. Often, med-pay benefits are made directly to the insured to meet short-term medical expenses following an accident. *Macejko v. Ortiz*, 7th Dist. No. 06 MA 150, 2008-Ohio-1188 at ¶¶ 2-3; *Garrett v. Ohio Farmers Ins. Co.*, 11th Dist. No. 2003-L-182, 2005-Ohio-413 at ¶¶ 2, 3 and 8. The amount of med-pay benefits available is normally relatively small, usually a few thousand dollars. As a result, med-pay benefits alone are

rarely sufficient to pay all of the medical bills arising from even a moderately serious car accident, nor are they intended to.

By evading their statutory obligation under R.C. § 1751.60 and billing automobile insurers directly, ProMedica and its *amici* are harming patients at two distinct times. First, immediately after her car accident, ProMedica is depriving King of the most flexible available source of funds for meeting short-term needs. If ProMedica's position is adopted, all of King's med-pay benefits will be seized by the first provider to reach them and applied to the inflated top-line amount that providers bill, but rarely actually receive, for medical services.

But-for ProMedica's conduct, King would be able to apply her med-pay benefits to medical expenses not covered by her Aetna policy: co-payments, deductibles and non-covered services. Instead, King must reach into her pocket to pay these expenses. By definition, King will never receive reimbursement from Aetna because the expenses are not covered under that plan. Reimbursement will come, if at all, after the question of liability for the car accident is decided in her favor.

Second, ProMedica is harming its patients at the time she recovers for her personal injury claim, whether by settlement or through a judgment. For the reasons set forth above, the provider is avoiding its agreement to accept a discounted payment from Aetna. That is, ProMedica expects to receive a greater payment for the same services from Kings' med-pay benefits than from her health insurer. The difference in price usually comes directly out of the patient's pocket. Whichever insurer initially pays King's medical bills generally retains a right of subrogation in the event that King recovers from a third party tortfeasor. The right to subrogation is equal to the amount

paid. If Safeco pays more than Aetna, King must ultimately satisfy a higher subrogation lien.

2. Patients and consumers are not the only interests harmed by ProMedica's unlawful billing practices.

Leaving aside the harm caused to the patient herself, ProMedica's billing practices hurts other actors in the system. Liability insurers, honest health care providers and the public at large are all negatively impacted.

As set forth above, ProMedica's ability to extract an inflated amount from King's med-pay carrier at the outset creates a larger subrogation lien down the road. This necessarily tends to increase the amount of any recovery to which is entitled to from the responsible tortfeasor. If the tortfeasor has sufficient liability insurance, his or her liability insurer will be required to pay more. Aggregated together, this conduct has the knock-on effect of increased premiums for liability insurance.

If the tortfeasor has inadequate liability coverage, as is often the case when serious injuries are involved, the loss is distributed between the other parties: King, the tortfeasor, King's underinsured motorist carrier and other subrogation lienholders, many of which are also health care providers. In the present day, the settlement of a personal injury takes on many characteristics of insolvency proceedings: distributing inadequate insurance proceeds among a series of equally dissatisfied claimants. In part, ProMedica hopes to avoid precisely this give and take of settlement. If ProMedica has its way, it will have already pocketed King's med-pay benefits and applied them to its opening top-line demand.

Perhaps this race to the bottom is the most insidious effect of ProMedica's billing practice. The provider that reaches the med-pay policy first gets paid an inflated amount

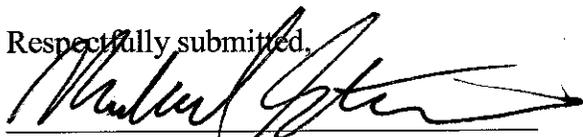
from that policy. All others will have to take a place in line for the co-payments, deductibles and services not covered by the health insuring corporation. This situation creates a powerful incentive to be first to reach the med-pay benefits and providers who follow the patient-friendly command of R.C. § 1751.60 will be disadvantaged.

Finally, in a broad sense, ProMedica's conduct here contributes in its own way to the skyrocketing costs of health care. The need to negotiate with health insurers over the price of medical services is the only force imposing any market discipline on providers. As set forth above, the top-line amount on ProMedica's billing statement is not particularly connected to price in any real sense. The consumer does rarely see, and even more rarely pays this amount. The amount billed is more a statement of what ProMedica wishes to be paid than an amount that it reasonably expects to actually collect. Remember, this is not a case about whether a provider does or does not get paid for its services. This case is about whether ProMedica accepts the previously agreed preferred provider amount or is permitted to continue to game the system for something more. When a provider is permitted to impose its unilateral price on an unsuspecting consumer, everyone loses.

IV. CONCLUSION

For the reasons set forth above, the judgment of the Sixth District Court of Appeals should be affirmed. R.C. § 1751.60(A) prohibits a doctor or hospital that has entered into a preferred provider contract with a health insuring corporation from billing another entity. Solely means solely.

Respectfully submitted,



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*** CURRENT THROUGH LEGISLATION PASSED BY THE 128TH OHIO GENERAL ASSEMBLY AND FILED
WITH THE SECRETARY OF STATE THROUGH FILE 58 ***
*** ANNOTATIONS CURRENT THROUGH OCTOBER 1, 2010 ***
*** OPINIONS OF ATTORNEY GENERAL CURRENT THROUGH OCTOBER 1, 2010 ***

TITLE 39. INSURANCE
CHAPTER 3923. SICKNESS AND ACCIDENT INSURANCE
MISCELLANEOUS

Go to the Ohio Code Archive Directory

ORC Ann. 3923.81 (2011)

§ 3923.81. Reimbursement rate for health benefit plan deductibles; system for providing information regarding potential out of pocket costs for services provided by in-network providers

(A) If a person is covered by a health benefit plan issued by a sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement and the person is required to pay for health care costs out-of-pocket or with funds from a savings account, the amount the person is required to pay to a health care provider or pharmacy shall not exceed the amount the sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement would pay under applicable reimbursement rates negotiated with the provider or pharmacy. This division does not preclude a person from reaching an agreement with a health care provider or pharmacy on terms that are more favorable to the person than negotiated reimbursement rates that otherwise would apply as long as the claim submitted reflects the alternative amount negotiated, except that a health care provider or pharmacy shall not waive all or part of a copay or deductible if prohibited by any other provision of the Revised Code. The requirements of this division do not apply to amounts owed to a provider or pharmacy with whom the sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement has no applicable negotiated reimbursement rate.

(B) Each sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement shall establish and maintain a system whereby a person covered by a health benefit plan may obtain information regarding potential out of pocket costs for services provided by in-network providers.

(C) As used in this section:

(1) "Health benefit plan" means any policy of sickness and accident insurance or any policy, contract, or agreement covering one or more "basic health care services," "supplemental health care services," or "specialty health

care services," as defined in section 1751.01 of the Revised Code, offered or provided by a health insuring corporation or by a sickness and accident insurer or multiple employer welfare arrangement.

(2) "Reimbursement rates" means any rates that apply to a payment made by a sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement for charges covered by a health benefit plan.

(3) "Savings account" includes health savings accounts, health reimbursement arrangements, flexible savings accounts, medical savings accounts, and similar accounts and arrangements.

HISTORY:

151 v S 5, § 1, eff. 3-23-07.

NOTES:

Section Notes

The provisions of § 3 of 151 v S 5 read as follows:

SECTION 3. Section 3923.81 of the Revised Code, as enacted by this act, takes effect on the effective date of this act; however, the amendment of division (B) of that section does not apply to any facts occurring before six months after the effective date of this act.



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TITLE 47. OCCUPATIONS -- PROFESSIONS
 CHAPTER 4769. BALANCE BILLING OF MEDICARE BENEFICIARIES

Go to the Ohio Code Archive Directory

ORC Ann. 4769.01 (2011)

§ 4769.01. Definitions

As used in this chapter:

(A) "Medicare" means the program established by Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended.

(B) "Balance billing" means charging or collecting from a medicare beneficiary an amount in excess of the medicare reimbursement rate for medicare-covered services or supplies provided to a medicare beneficiary, except when medicare is the secondary insurer. When medicare is the secondary insurer, the health care practitioner may pursue full reimbursement under the terms and conditions of the primary coverage and, if applicable, the charge allowed under the terms and conditions of the appropriate provider contract, from the primary insurer, but the medicare beneficiary cannot be balance billed above the medicare reimbursement rate for a medicare-covered service or supply. "Balance billing" does not include charging or collecting deductibles or coinsurance required by the program.

(C) "Health care practitioner" means all of the following:

- (1) A dentist or dental hygienist licensed under Chapter 4715. of the Revised Code;
- (2) A registered or licensed practical nurse licensed under Chapter 4723. of the Revised Code;
- (3) An optometrist licensed under Chapter 4725. of the Revised Code;
- (4) A dispensing optician, spectacle dispensing optician, contact lens dispensing optician, or spectacle-contact lens dispensing optician licensed under Chapter 4725. of the Revised Code;

- (5) A pharmacist licensed under Chapter 4729. of the Revised Code;
- (6) A physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatry;
- (7) A physician assistant authorized under Chapter 4730. of the Revised Code to practice as a physician assistant;
- (8) A practitioner of a limited branch of medicine issued a certificate under Chapter 4731. of the Revised Code;
- (9) A psychologist licensed under Chapter 4732. of the Revised Code;
- (10) A chiropractor licensed under Chapter 4734. of the Revised Code;
- (11) A hearing aid dealer or fitter licensed under Chapter 4747. of the Revised Code;
- (12) A speech-language pathologist or audiologist licensed under Chapter 4753. of the Revised Code;
- (13) An occupational therapist or occupational therapy assistant licensed under Chapter 4755. of the Revised Code;
- (14) A physical therapist or physical therapy assistant licensed under Chapter 4755. of the Revised Code;
- (15) A professional clinical counselor, professional counselor, social worker, or independent social worker licensed, or a social work assistant registered, under Chapter 4757. of the Revised Code;
- (16) A dietitian licensed under Chapter 4759. of the Revised Code;
- (17) A respiratory care professional licensed under Chapter 4761. of the Revised Code;
- (18) An emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic certified under Chapter 4765. of the Revised Code.

HISTORY:

144 v H 478 (Eff 1-14-93); 146 v S 150 (Eff 11-24-95); 146 v S 143 (Eff 3-5-96); 146 v S 223. Eff 3-18-97.

NOTES:

ALR

Power of administrative agency, in investigation of nonjudicial nature, to issue subpoenas against persons not subject to agency's regulatory jurisdiction. 27 ALR2d 1208.

Case Notes & OAGs

ANALYSIS Federal preemption Summary judgment

FEDERAL PREEMPTION.

Ohio statutes prohibiting the balance billing of Medicare beneficiaries are not preempted by the Medicare Act: Downhour v. Somani, 85 F.3d 261, 1996 U.S. App. LEXIS 13564 (6th Cir. 1996).

SUMMARY JUDGMENT.

Court erred in awarding summary judgment to a widow in an action by an ambulance flight company to collect a balance due for transporting the widow's husband; because Medicare provided no coverage at all for the services that the flight company attempted to collect on, the flight company did not engage in balance billing as defined in Ohio Rev. Code Ann. § 4769.01(B). *Med Flight, Inc. v. Whites*, 2004 Ohio App. LEXIS 3645, 2004 Ohio 4005, (2004).



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TITLE 47. OCCUPATIONS -- PROFESSIONS
CHAPTER 4769. BALANCE BILLING OF MEDICARE BENEFICIARIES

Go to the Ohio Code Archive Directory

ORC Ann. 4769.02 (2011)

§ 4769.02. Balance billing of medicare beneficiaries prohibited

No health care practitioner, and no person that employs any health care practitioner, shall balance bill for any supplies or service provided to a medicare beneficiary.

HISTORY:

144 v H 478 (Eff 1-14-93); 146 v S 150. Eff 11-24-95.

NOTES:

Related Statutes & Rules

Cross-References to Related Statutes

Civil action to enforce repayment order, RC § 4769.10.

Complaints alleging violations; sanctions, RC § 4769.03.

Inspection of records, RC § 4769.05.

Investigatory powers, RC § 4769.06.

Losing party may be required to pay costs of investigation and adjudication, RC § 4769.08.

Practice Manuals & Treatises

Anderson's Ohio Elder Law Practice Manual § 7.12 Benefits

ALR

Power of administrative agency, in investigation of nonjudicial nature, to issue subpoenas against persons not subject to agency's regulatory jurisdiction. 27 ALR2d 1208.

Case Notes & OAGs

Ohio statutes prohibiting the balance billing of Medicare beneficiaries are not preempted by the Medicare Act: *Downhour v. Somani*, 85 F.3d 261, 1996 U.S. App. LEXIS 13564 (6th Cir. 1996).

**OHIO DEPARTMENT OF INSURANCE
STATE OF OHIO**

BULLETIN 2010-03

**GUIDANCE GOVERNING INTERPRETATION OF O.R.C. 1751.60
Effective July 16, 2010**

The purpose of this Bulletin is to provide guidance to insurance companies and health care providers regarding interpretation of O.R.C. 1751.60, 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.

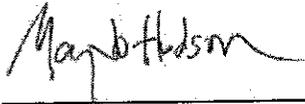
In two recent decisions, the 11th and 6th Appellate District Courts interpreted Section 1751.60 to mean that a health care provider or health care facility may not bill an independent third party, or its insurer, for more than the provider would receive under the negotiated terms of a first party health insuring corporation contract. The Department is seeking to clarify the meaning of the statute in the context of Chapter 1751 of the Ohio Revised Code in order to avoid confusion regarding the statute and the Department's authority.

Chapter 1751 of the Ohio Revised Code governs the licensure and operation of health insuring corporations, including contracting between health insuring corporations and health care providers. Section 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 Title 39 of the Revised Code, self-insured health benefit plans, or third party administrators or carriers that administer self insured plans on an "administrative services only" basis.

Section 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 insurance 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.

Section 1751.60 does not prohibit a health care provider or health care facility from seeking and receiving full payment from a third party or a third party's liability insurer which may be liable for the debt. Rather, Section 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 Chapter 1751, nor Section 1751.60, references a private right of action.



Mary Jo Hudson
Superintendent of Insurance