

ORIGINAL

IN THE SUPREME COURT OF OHIO

Virginia King

Plaintiff-Appellee

-vs-

ProMedica Health System and
The Toledo Hospital

Defendants-Appellants

Supreme Court
Case No. 10-1236

On Appeal from the Lucas County
Court of Appeals, Sixth Appellate
District

C.A. No. L-09-1282

**BRIEF OF AMICI CURIAE
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TABLE OF CONTENTS

	Page
Table of Authorities	v
Identification and Position of <i>Amicus Curiae</i>	
Ohio Association for Justice	1
Statement of the Case and Facts	2
Argument and Analysis	
I. This Court Needs Only to Apply Basic Rules of Statutory Construction.	4
1. Interpretation of the Statute with the Guidance of the Department of Insurance	8
2. Contract Issues and Public Policy.	10
3. To Permit ProMedica’s Billing Practice is to Undermine Longstanding and Fundamental Freedom of Contract Principles.	13
4. The Decision and Direction by a Patient to Exhaust His/Her Automobile Policy Medical Payment Benefits Should be a Knowing, Voluntary, and Sound Election.	15
5. Appellants’ Claims of Financial Consideration	19
Conclusion.	21
Certification	22
APPENDIX.	viii
Sample of Promedica Consent for Treatment	16
<i>Most Toledo Area Hospitals Post Gains in 2010</i> <u>Toledo Blade</u> December 19, 2010	19

TABLE OF AUTHORITIES

	Page
CASES:	
<i>Akron General Medical Center v. Welms</i> (Portage C.P. 2010), 160 Ohio Misc.2d 1, 937 N.E.2d 1106.	11
<i>Blount v. Smith</i> (1967), 12 Ohio St.2d 41, 41 O.O.2d 250, 231 N.E.2d 301.	13
<i>Cincinnati v. Berretta U.S.A. Corp.</i> (2002), 95 Ohio St.3d 416, 768 N.E.2d 1136.	2
<i>Cincinnati Indemn. Co. v. Martin</i> (1999), 85 Ohio St.3d 604, 608, 710 N.E.2d 677	6
<i>Cleveland Mobile Radio Sales, Inc. v. Verizon Wireless</i> (2007), 113 Ohio St.3d 394, 865 N.E.2d 1275.	7
<i>Discount Cellular, Inc., v. PUCO</i> 112 Ohio St.3d 360, 859 N.E.2d 957.	6
<i>Elyria Foundry Co. v. Pub Util. Comm.</i> (2008), 118 Ohio St.3d 269, 888 N.E.2d 1055, 2008 Ohio 2230.	9
<i>Grandview/Southview Hospitals v. Monie</i> (2 nd Dist. 2005), 2005 Ohio 1574, ¶10, 2005 WL 737393.	8
<i>Hayberg v. Physicians Emergency Services, Inc.</i> (2008), 2008 WL 5052744, ¶26, 2008 Ohio 6180 (11 Dist).	11
<i>Jacques v. Manton</i> (2010), 125 Ohio St.3d 342, 928 N.E.2d 434.	12,13
<i>Love v. Motorists Mut. Ins. Co.</i> (1993), 86 Ohio App.3d 394, 620 N.E.2d 987 (4 Dist).	5
<i>McArthur v. Randall</i> (2006), 166 Ohio App.3d 546, 549, 852 N.E.2d 198 (2 Dist)	8

<i>Mitchell v. Lawson Milk Co.</i> (1991) 60 Ohio St.3d 143, 573 N.E.2d 1063.	2
<i>N. Buckeye Edn. Council Group v. Lawson</i> (2004), 103 Ohio St.3d 188, 814 N.E.2d 1210.	13
<i>Northwestern Ohio Bldg. & Constr. Trades Council v. Conrad</i> (2001), 92 Ohio St3d 282, 287, 750 N.E.2d 130, 135	9,10
<i>Pennsylvania Co. v. Thatcher</i> (1908), 78 Ohio St. 175, 85 N.E. 55.	16
<i>Phung v. Waste Management, Inc.</i> (1986), 23 Ohio St.3d 100, 102, 23 OBR 260, 262, 491 N.E.2d 1114, 1116.	13
<i>Robinson v. Bates</i> (2006), 112 Ohio St.3d 17, 857 N.E.2d 1195.	12
<i>Sheet Metal Workers' International Association, Local Union Number 33 v. Gene's Refrigeration, Heating & Air Conditioning, Inc.</i> (2009), 122 Ohio St.3d 248, 253, 910 N.E.2d 444.	7
<i>Shell v. Ohio Veterinary Med. Licensing Bd.</i> 105 Ohio St.3d 420, 2006-Ohio-2423 at ¶ 34.	10
<i>State ex rel. Alford v. Willoughby Civ. Serv. Comm.</i> (1979), 58 Ohio St.2d 221, 223, 12 O.O.3d 229, 229-230, 390 N.E.2d 782, 784-785	2
<i>State ex rel. Bowman v. Columbiana Cty. Bd. of Commrs.</i> (1997), 77 Ohio St.3d 398, 674 N.E.2d 694	5
<i>State ex rel. Murphy v. Athens County Board of Elections</i> (1941), 138 Ohio St. 432, 35 N.E.2d 574	5
<i>Vought Industries, Inc. v. Tracy</i> (1995), 72 Ohio St.3d 261, 648 N.E.2d 1364	5
<i>West Broad Chiropractic v. American Family Insurance</i> (2009), 122 Ohio St.3d 497, 912 N.E.2d 1093.	16,17,18

STATUTES AND OTHER AUTHORITIES:

Civ.R. 12(B)(6).....	2
R.C. 1.11.....	6
R.C. 1.47 (C).....	6
R.C. 1.49.....	7
R.C. 1751.01(P).....	9
R.C. 1751.60.....	1,6,8,9,10,11, 14
R.C. 1751.60(A).....	2,4,5,6,8,20
Department of Insurance Bulletin 2010-03.....	8
Department of Insurance Bulletin 2010-06.....	8
S.B. 67 Final Bill Analysis, 1997.....	6,7

Identification and Position of *Amicus Curiae* Ohio Association for Justice

This *Amicus Curiae* brief is submitted by the Ohio Association for Justice (“OAJ”). The OAJ is an association of Ohio attorneys whose purpose is to advance “the cause of those who are damaged in person or property and who must seek redress therefore.” As part of this mission, our members are dedicated to preserving the rights of private litigants and consumers, as well as promoting public confidence in the legal system.

The reversal of the Sixth District’s decision in this case would deprive Virginia King, and others like her, a bargained for benefit of her auto insurance contract, while at the same depriving her of the benefits to which she is entitled under her health insurance contract. The reversal of the Sixth District’s decision in her favor would not only deprive Virginia King of her bargained-for benefits, but it would vacate the pronouncements of other Ohio appellate courts which have interpreted R.C. 1751.60 similarly.

A reversal of the Sixth District’s decision would cause a windfall to hospitals and healthcare providers across the state, at the expense of victims of automobile accidents who have had the foresight to purchase multiple layers of insurance.

A reversal of the Sixth District’s decision would go against the Ohio Constitution’s Separation of Powers by negating the General Assembly’s authority to make laws and set forth public policy for the citizens of this state. Because the healthcare provider receives the full “list price” of the medical services from the auto policy provider, and not a pre-negotiated (reduced) rate as would be paid by a Health Insuring Corporation (“HIC”), this reduces the amount of medical expenses a patient can pay for with his or her available insurance benefits. This means more money out of the consumer’s pocket. To allow the insured to recover his or her full

medical expenses does not create a windfall for the patient, as the HIC has the right of subrogation to recover any expenses it pays out, and allows for the plaintiff to be fully compensated for her injuries, which is what insurance policies are designed to do.

OAJ opposes ProMedica's billing practice and believes the insured should have an informed choice of how his or her automobile insurance medpay benefits are used. Therefore, the OAJ supports Virginia King in her opposition to Appellant's proposed interpretation of R.C. § 1751.60(A).

Statement of the Case and Facts

Amicus Curiae OAJ agrees with and concurs in the Statement of Factual Background as set forth in Appellee Virginia King's briefs, which points out that because the trial court disposed of this case on a Motion to Dismiss under Civ. R. 12(B)(6), the factual allegations in King's Complaint must be construed in her favor. See *Cincinnati v. Berretta U.S.A. Corp.* (2002), 95 Ohio St.3d 416, 768 N.E.2d 1136, ¶ 5, quoting *Mitchell v. Lawson Milk Co.* (1991) 60 Ohio St.3d 143, 573 N.E.2d 1063 (“[i]n construing a complaint upon a motion to dismiss for failure to state a claim, we must presume that all factual allegations of the complaint are true and make all reasonable inferences in favor of the non-moving party.”). An Appellate court reviewing a Motion to Dismiss is thus confined to the allegations in the complaint. See, e.g., *State ex rel. Alford v. Willoughby Civ. Serv. Comm.* (1979), 58 Ohio St.2d 221, 223, 12 O.O.3d 229, 229-230, 390 N.E.2d 782, 784-785. Though it is tempting to indulge in the factual liberties taken by Amici supporting Appellants, this Court must accept as true that ProMedica billed King's auto carrier – not at King's request – but as part of ProMedica's new billing policy.

Had this case been allowed to proceed beyond the stage at which it was dismissed, or if this Court sees fit to remand this case for further proceedings, a proper factual record could have been – or could be -- developed. Such factual determinations may likely center around the following issues:

1. Whether ProMedica's policy of billing its patients' auto carriers and thus depleting their medical payments benefits, is a longstanding practice; or if it is a practice with a recent vintage. Amici who support ProMedica contend without any proof that the practice is longstanding and would constitute a hardship to force them to change it. OAJ asserts that this practice has only come into vogue within the past few years, with front-line providers across the state now employing extremely aggressive billing practices not previously seen. OAJ further asserts that the cost incurred for an aggressive and illegitimate practice is not a sufficient reason to decline to recognize its unlawfulness.
2. Whether ProMedica's practice of billing a patient's auto carrier is a knowing and voluntary request by the patient – meaning that the patient knows and understands that his or her medical payment benefits will be depleted by the first Emergency Room visit, and therefore unavailable for other medical bills, co-pays and deductibles.
3. Whether ProMedica's practice of billing a patient's auto carrier is truly at the request of the patient, or performed by the admission/billing clerk that obtains such information from the patient upon checking into the hospital shortly after a traumatic event. And whether the clerk fully informs the patient the purpose of his/her request.
4. Whether ProMedica informs the patient that its services would be covered under a

separate policy of insurance which contains service rates that have been negotiated in advance between two knowledgeable and informed entities with equal bargaining power.

5. Whether ProMedica permits the patient a meaningful opportunity to see the rates for the services it charges, or an opportunity for the patient to negotiate those rates in a meaningful way.
6. The true financial impact of ProMedica's billing practice on the patient, versus the financial impact on ProMedica if the Sixth District's decision in this case is upheld.

Argument and Analysis

I. This Court Needs Only to Apply Basic Rules of Statutory Construction:

The Sixth District properly interpreted R.C. 1751.60(A), using basic rules of statutory interpretation. R.C. 1751.60(A) reads:

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 statute is not ambiguous as Appellants and their *amici* suggest, as there is no conflicting language, nor does a reading of the statute suggest the General Assembly intended for it to only be applicable when the patient has a Health Insuring Company. Had that been the case, the General Assembly could have simply drafted the statute to reflect its intentions. Or it could have tied the billing prohibition to the coordination of benefits scheme by indicating that other insurers could be billed. However, the General Assembly did not draft the statute in that manner,

thus R.C. 1751.60(A) is to be applied to *all* individuals who receive healthcare services from a healthcare provider who contracts with the patient's HIC, whether or not medpay benefits are available to the patient through a separate auto policy.

Because the term "solely" is not defined, courts must resort to basic rules of statutory interpretation. When interpreting an undefined term, courts must use the normal and customary meaning for those words. *State ex rel. Bowman v. Columbiana Cty. Bd. of Commrs.* (1997), 77 Ohio St.3d 398, 674 N.E.2d 694. While interpreting a statute, the court may not enlarge or add to a statute, or delete or insert words from it. *Vought Industries, Inc. v. Tracy* (1995), 72 Ohio St.3d 261, 648 N.E.2d 1364; *Love v. Motorists Mut. Ins. Co.* (1993), 86 Ohio App.3d 394, 620 N.E.2d 987 (4 Dist). In this case, this Court should not add any sort of language such as "when covered *only* by a health insuring corporation." To do so would be contrary to the basic rules of statutory interpretation, as it would enlarge R.C. 1751.60(A). Using the normal and customary meaning of "solely," there is only one interpretation of R.C. 1751.60(A): that the provider must bill **only** the HIC.

Appellant and its supporting amici contend that this statute may be interpreted using the title of the section, citing *State ex rel. Murphy v. Athens County Board of Elections* (1941), 138 Ohio St. 432, 35 N.E.2d 574. However, as that case makes clear, the title should only be used when the meaning of the statute is in question: "It is true that the heading or title given by a legislative body to a statute must be accorded consideration, but it may not be employed to alter the meaning of language that is unambiguous." *Id.* at 435. Because the statute is not ambiguous, the title should not be used to determine the General Assembly's intent or to change the meaning and purpose of the statute.

One Amicus brief filed in support of Appellant's position asserts that the statute should be interpreted to bring about a just result. (Amicus OHA Merit Brief, 13, citing R.C. 1.47(C); *Discount Cellular, Inc., v. PUCO*, 112 Ohio St.3d 360, 859 N.E.2d 957). As will be discussed below, interpreting the statute in favor of the Appellants will result in an **unjust** outcome to Ms. King and all others who are covered by both an automobile policy and HIC policy.

R.C. 1751.60 is a remedial statute, designed to protect the interests of the insured. As such, it needs to be liberally construed in favor of effectuating the General Assembly's intended result. R.C. 1.11; See e.g. *Cincinnati Indemn. Co. v. Martin* (1999), 85 Ohio St.3d 604, 608, 710 N.E.2d 677. The General Assembly's intent can be seen in the Final Bill Analysis, 1997 S.B. 67: **"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." (emphasis added). As such, the statute should be construed in favor of Ms. King, in order to protect her, as the General Assembly intended to do when drafting this remedial statute.

Appellant ProMedica even recognizes this fact, "In short, all of the available sources demonstrate that the purpose of R.C. 1751.60(A) is to insulate *insureds* from liability." (Merit Brief at 3). However, the practical effect of Appellant's interpretation of R.C. 1751.60 is to allow health care providers to unbind themselves from negotiated rates, and avail themselves of the non-negotiated, list price, leaving the insured open to financial liability as a result of the accident. Finally, with the HIC and the auto carrier both having rights of subrogation, there is no windfall to the insured; on the contrary, there are higher subrogated amounts to re-pay, as well as more uncovered medical bills, co-pays and deductibles.

Appellant ProMedica contends that the statute is ambiguous in scope; in other words, that it may not apply to the present situation, and that this Court needs to determine the statute's applicability to Ms. King, before interpreting the statute's meaning. (*See e.g.* ProMedica Merit Brief, 12). The tools of interpreting a statute's ambiguous scope are the same as the ordinary tools of statutory interpretation: looking to the intent of the General Assembly, the language of the statute, and possible outcomes in determining the intent of the General Assembly. *Sheet Metal Workers' International Association, Local Union Number 33 v. Gene's Refrigeration, Heating & Air Conditioning, Inc.* (2009), 122 Ohio St.3d 248, 253, 910 N.E.2d 444; citing R.C. 1.49 and *Cleveland Mobile Radio Sales, Inc. v. Verizon Wireless* (2007), 113 Ohio St.3d 394, 865 N.E.2d 1275. In *Sheet Metal*, this Court was tasked with determining whether a worker was entitled to be paid a prevailing wage. However, before it could make that determination, this Court found that the statute in question was ambiguous in scope, and after resolving the ambiguity, decided that the statute did not apply to the worker's situation. *Id.* This Court found that the prevailing wage statute was ambiguous in scope because it did not specify that it applied to off-site work, as was the worker's contention. *Id.* at 255.

Applying these same tools of statutory interpretation, the statute clearly applies to Ms. King's situation. Again, looking at the Final Bill Analysis, 1997 S.B. 67, "several provisions focusing on protections for subscribers and enrollees..." it is clear that this statute is designed to look out for the best interests of the subscribers. Therefore, the scope of this statute should be construed as applying in this situation, in order to protect Ms. King and the millions of other insureds in Ohio.

Appellants and their *amici* argue that resolution in favor of Ms. King would prevent a healthcare provider from *ever* being able to collect from an auto policy, even if the HIC denied the claim. However, R.C. 1751.60(A) only applies to **covered services**, and just as a healthcare provider is able to directly bill a patient for an uncovered service without violating R.C. 1751.60, in this situation, the provider could also bill the auto carrier if it chose to do so. In refuting this theory -- that an auto carrier could never be billed in under Appellee's interpretation -- the Second District recognized that R.C. 1751.60(A) imposes a mandatory requirement for providers to bill HICs only if they are in contract. *Grandview/Southview Hospitals v. Monie* (2nd Dist. 2005), 2005 Ohio 1574, ¶10, 2005 WL 737393. "In other words, if [the provider] is an Anthem provider, he cannot seek payment from [the insured], an Anthem insured, for anything other than approved copayments or noncovered services." *McArthur v. Randall* (2006), 166 Ohio App.3d 546, 549, 852 N.E.2d 198 (2 Dist).

1. Interpretation of the Statute with the Guidance of the Department of Insurance:

While Appellant is correct in asserting that an administrative agency's expertise should be followed in certain circumstances (Appellant's Memorandum in Support of Jurisdiction, at 11), the Department of Insurance Bulletin 2010-03 is probably of little salvation to its position. As a primary matter, this bulletin was superseded less than four months later by Bulletin 2010-06, which made clear, "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 and casualty insurer, and is not intended to overturn any court decisions."

Be that as it may, as Appellant points out, and as this Court has recognized, "It is axiomatic that if a statute prescribes specific authority for an administrative agency to perform a

specific act, but does not provide the details by which the act should be performed, the agency is to perform the act in a reasonable manner based upon a reasonable interpretation of the statutory scheme.” See, *Northwestern Ohio Bldg. & Constr. Trades Council v. Conrad* (2001), 92 Ohio St3d 282, 287, 750 N.E.2d 130, 135. In that instance, this Court gives deference to the agency’s interpretation of the legislation. *Id.*; *Elyria Foundry Co. v. Pub Util. Comm.* (2008), 118 Ohio St.3d 269, 888 N.E.2d 1055, 2008 Ohio 2230.

The clarification offered by the Department of Insurance in these bulletins, while unnecessary, is simply a restatement of the obvious – that the statute “only applies to provider contracts involving health insuring corporations.” Such is the case with ProMedica and Virginia King. It is alleged in King’s complaint that ProMedica had a provider contract with King’s HIC. (King Complaint ¶ 14). According to the Bulletins then, ProMedica is subject to R.C. 1751.60, and is thus prohibited “from balance billing, or seeking compensation from, a subscriber except for approved copayments and deductibles.”

The Bulletin also specifies that R.C. 1751.60 is not applicable to insurance policies issued under title 39 of the Revised Code, namely sickness and accident policies, and only applies to “health insuring corporations” as defined in R.C. 1751.01(P). If the statute is not applicable to auto insurance policies, then auto insurance policies should not figure into the equation when interpreting the healthcare providers’ responsibilities under R.C. 1751.60, meaning the hospital is required to bill the HIC **solely** as determined by the Sixth District Court of Appeals.

It is likewise axiomatic that an administrative agencies’ decisions and expertise should be relied upon when enacting legislation is lacking, as noted in *Conrad*, supra., or to clear up an ambiguous statutes. *Shell v. Ohio Veterinary Med. Licensing Bd.*, 105 Ohio St.3d 420, 2006-

Ohio-2423 at ¶ 34. Where a statute is not ambiguous, as is the case with R.C. 1751.60, the statute should be applied as written. *Id.*

OAJ believes that the General Assembly's intent and the plain language of the statute is clear and definite, and as such there is no need to look beyond it.

2. Contract Issues and Public Policy

Automobile policies with medical payment provisions have coverage maximums, typically \$5000; if the healthcare provider bills the auto insurer directly, the patient's ability to collect is diminished by the amount of the provider's bill. This is especially so if the entity performing this practice is the emergency room immediately after an injury is sustained. Allowing the provider to bill the auto insurer directly is an end-run around the providers' obligations under the HIC contract. The terms, rates, and amounts in the HIC contract are negotiated in advance between two entities of equal bargaining power. The bill the providers send to the insured's auto carrier is not based on negotiated rates, but rather the rates set unilaterally by the provider. In short, the healthcare provider hopes to be paid the full amount of its bill by the medpay insurer, and not the reduced, negotiated rate that the HIC has agreed to pay the healthcare provider for its services, which further limits the amount the insured can collect from the auto insurer.

The Eleventh District observed that such a practice results in a windfall for the healthcare providers, not the patient:

Here, appellee billed and accepted \$2,566.06 more than it was entitled to from Nationwide in violation of R.C. 1751.60. Under the statute, appellee was required to seek compensation for covered services solely from Anthem and was only permitted to seek approved co-payments and deductibles (which in this case was nothing) from Nationwide.

Hayberg v. Physicians Emergency Services, Inc. (2008), 2008 WL 5052744, ¶26, 2008 Ohio 6180 (11 Dist), appeal not accepted for review, 121 Ohio St.3d 1442, 903 N.E.2d 1224. In *Hayberg*, because Nationwide Insurance Company paid \$2,566.06 more for the same covered services than what Anthem had negotiated, this resulted in a reduction of the fixed available funds under Mr. Hayberg's automobile contract with Nationwide. ¶ 41. This difference, the Eleventh District determined, was a direct benefit to the healthcare provider—money that it would not be able to collect from billing the HIC, as R.C. 1751.60 requires the provider to do.

At least one court has recognized the unfairness of providers charging a higher rate to the uninsured. *Akron General Medical Center v. Welms* (Portage C.P. 2010), 160 Ohio Misc.2d 1, 937 N.E.2d 1106. In *Welms*, the trial court denied the hospital's request for summary judgment on unpaid medical bills incurred by the plaintiff, finding there to be a question of fact as to the value of the services rendered. The hospital provided medical services to an uninsured patient, and he was billed the full list-price of the services by the hospital. The patient received similar services from the hospital shortly afterward, at which point he had health insurance. Noting that the hospital adjusted its bill in accordance with the health insurance company contract, the trial court called into question whether the non-negotiated rates for the first services were reasonable:

It seems that Akron General grants substantive reductions to patients who are paying their bill through an insurer, but refuses reductions to those patients who pay out of their own pockets. This circumstance raises a **real question as to the reasonable value** of the medical treatment provided to Welms during his August 2006 hospital stay.

Id. at ¶12 (emphasis added).

Notably in this context, two recent cases decided by this Court are instructive on the issue of negotiated hospital rates: *Jacques v. Manton* (2010), 125 Ohio St.3d 342, 928 N.E.2d 434, and *Robinson v. Bates* (2006), 112 Ohio St.3d 17, 857 N.E.2d 1195. In *Robinson*, this Court observed that the amount originally billed by the provider may not reflect the “reasonable value” of the medical services:

{¶ 17} To avoid the creation of separate categories of plaintiffs based on individual insurance coverage, we decline to adopt a categorical rule. Because different insurance arrangements exist, the fairest approach is to make the defendant liable for the reasonable value of plaintiff's medical treatment. Due to the realities of today's insurance and reimbursement system, in any given case, that determination is not necessarily the amount of the original bill or the amount paid. Instead, the reasonable value of medical services is a matter for the jury to determine from all relevant evidence. Both the original medical bill rendered and the amount accepted as full payment are admissible to prove the reasonableness and necessity of charges rendered for medical and hospital care.

{¶ 18} The jury may decide that the reasonable value of medical care is the amount originally billed, the amount the medical provider accepted as payment, or some amount in between. Any difference between the original amount of a medical bill and the amount accepted as the bill's full payment is not a “benefit” under the collateral-source rule because it is not a payment, but both the original bill and the amount accepted are evidence relevant to the reasonable value of medical expenses.

{¶ 19} It may well be that the collateral-source rule itself is out of sync with today's economic realities of managed care and insurance reimbursement for medical expenses. However, whether plaintiffs should be allowed to seek recovery for medical expenses as they are originally billed or only for the amount negotiated and paid by insurance is for the General Assembly to determine.

Thus, this Court held in *Robinson* that “both the original bill and the amount accepted are evidence relevant to the reasonable value of medical expenses.” *Robinson* at Syl. 1.

Following up that decision, this Court more recently observed that a negotiated rate for a medical service should be introduced at trial because it “allows the fact-finder to determine the actual amount of medical expenses incurred.” *Jacques* at ¶ 12 (emphasis added). Had the billed,

non-negotiated rate for medical services been considered reasonable, no tortfeasor would be able to rebut the original bills, and would be liable for the full billed amount.

Appellant's practice of billing its patient's auto carriers, even though it is under contract with the patient's health insurer, allows it to escape the "economic realities" of rates negotiated between two informed entities with equal bargaining positions, while at the same time allowing the HIC to escape its obligation (to pay the medical expenses of its insured, with the option of seeking subrogation at a later point). This practice should not be permitted.

3. To Permit ProMedica's Billing Practice is to Undermine Longstanding and Fundamental Freedom of Contract Principles:

As this Court has repeatedly recognized, the concept of "freedom of contract" is fundamental to our society. *Blount v. Smith* (1967), 12 Ohio St.2d 41, 41 O.O.2d 250, 231 N.E.2d 301. "[P]arties to a contractual relationship should have complete freedom to fashion whatever relationship they so desire." *Phung v. Waste Management, Inc.* (1986), 23 Ohio St.3d 100, 102, 23 OBR 260, 262, 491 N.E.2d 1114, 1116. And as this Court reiterated in *N. Buckeye Edn. Council Group v. Lawson* (2004), 103 Ohio St.3d 188, 814 N.E.2d 1210, even a bad bargain must still be enforced:

"Cases of contractual interpretation should not be decided on the basis of what is 'just' or equitable. This concept is applicable even where a party has made a bad bargain, contracted away all his rights, and has been left in the position of doing the work while another may benefit from the work. Where various written documents exist, it is the court's duty to interpret their meaning, and reach a decision by using the usual tools of contractual interpretation (*e.g.*, the written documents, the intent of the parties, and the acts of the parties) and not by a determination of what is fair, equitable, or just.") *Lawson* at ¶ 20.

ProMedica entered into a contract with Virginia King's HIC, and Virginia King is an intended third party beneficiary of that contract. These contracts require the provider to render

medical treatment to the insured, bill the HIC for services rendered, and accept the rate for these services that the provider and HIC have agreed upon. The providers have freely entered into these contracts with the healthcare providers, and know and understand the terms. The providers' incentive for entering into these contracts include an expected volume of patients, and prompt guaranteed payment for the services rendered to those patients. However, the healthcare providers are choosing to break their agreements with the HIC, in order to collect a higher sum of money for the same services from the patient's automobile insurer. The providers should be held to their negotiated contracts with the HICs, in order to protect the insured and prevent the healthcare providers from taking advantage of the insured's foresight to have purchased insurance, designed to protect the insured, not the healthcare providers.

Auto insurance policies are contracts, and are between the auto insurer and the driver. The insurer has contractually agreed to provide the driver with benefits up to the policy maximum, but has no agreement or duty to reimburse the healthcare provider. These benefits are often used by injured parties to pay for ever rising co-pays and deductibles, and ever-increasing excluded treatment (i.e., chiropractic care, massage therapy, and other excluded services). By billing the auto insurer directly, the provider is interfering with the insurance contract between the insurer and insured. To follow Appellant's proposed interpretation of R.C. 1751.60, this Court would be relieving the health care provider of its statutory and contractual obligation to bill the HIC and honor its negotiated rates. At the same time it would deprive the driver of the benefit of his or her bargain with the auto insurance company.

The auto insurer has no particular interest to protect here, as most situations will result in their same level of payout whether the auto insurer pays the insured, or the provider directly.

It is not hard to imagine a situation where the healthcare provider bills for at least \$5,000 in medical care, and the auto insurer pays the \$5,000-the policy maximum. The insured is then unable to recover another cent from his or her auto insurer, even though if the healthcare provider billed the HIC, the plaintiff would still be able to collect the *full \$5,000* from the auto insurer, which could be applied toward other services not covered by her health insurance policy. In this age of high insurance deductible plans, 20% co-pays, and excluded services, medpay benefits are integral to help cover the ever-growing gaps in medical coverage. ProMedica's practice therefore deprives Ms. King, and others like her, of the benefits of the multiple policy premiums that she pays, in order to protect herself in the event of an accident.

Amicus OHA ignores the financial loss that results from this practice when trying to claim that Ms. King's claim is barred, saying that Ms. King "has suffered no actual injury." (*OHA* Merit Brief, 12, n. 10). However, Appellant's billing of Ms. King's auto insurance has directly reduced the amount she can collect from her automobile carrier. These funds are ones that she may have intended to use for expenses that are not covered by her HIC, such as massage therapy, chiropractic care, dental care, or eyeglasses, which *would* be payable from the auto liability carrier medpay funds. Instead, Ms. King is now **forced to pay out of pocket** for these expenses, as these are not covered services by her HIC, and she can no longer collect from her liability coverage, as it has already been claimed.

4. The Decision and Direction by a Patient to Exhaust His/Her Automobile Policy Medical Payment Benefits Should be a Knowing, Voluntary, and Sound Election:

Another important aspect of public policy is the **insured's choice**. Most members of the public do not even know of their available medpay coverage—and once the provider bills the

automobile carrier, the medpay benefits are quickly exhausted. Appellant ProMedica and its supporting Amici claim that the insured chooses to allow this type of billing, and in particular that Appellee Virginia King authorized this. There is no evidence in the record to show this, and this point is specifically disputed by her counsel.

In reality, such elections are often buried in the Consent for Treatment that a patient quickly signs upon admission to a medical facility such as ProMedica (see exemplar attached hereto at Appendix A). Often times these forms are presented shortly after a traumatic event and are among a series of consent forms that must be executed before needed medical treatment is rendered. In such circumstance the injured patient is unlikely to realize that they are waiving their rights, especially in a time of great distress, pain, and worry following an accident with serious injuries. When a provider is conducting an intake interview, asking questions about the source of the injury and about their insurance, they are doing so for purposes of seeking out this auto policy coverage, and not for treatment reasons—and the patient is not aware of it. This practice should not be allowed to occur without the **express and informed consent** of the patient.

Moreover, an Assignment of benefits as set forth in the exemplar attached hereto as Appendix A is of dubious value. As this Court has repeatedly determined, an injured person cannot assign his or her rights to a third party if liability has not yet been established. *West Broad Chiropractic v. American Family Insurance* (2009), 122 Ohio St.3d 497, 912 N.E.2d 1093; *Pennsylvania Co. v. Thatcher* (1908), 78 Ohio St. 175, 85 N.E. 55. The insured-assignor in *West Broad* was injured in a car accident and sought treatment from the assignee-provider. The provider had the insured sign an “Assignment of Right to Receive Benefits and/or Proceeds of

Settlement or Judgment,” in exchange for her treatment. *West Broad*, at 497-99. This court, in relying on long-standing public policy, found such an assignment to be void:

A chiropractor or other assignee expects full payment and lacks interest in negotiating the amount of the debt. Likewise, the third-party insurer lacks the ability to dispute the amount or reasonableness of the charges. The insurer must take these factors into account when settling the claim, and the result may be less to the injured party, forcing him or her to litigate in hopes of obtaining a greater recovery. Attorneys may therefore be deterred from taking smaller claims when the proceeds are taken by assignees, **leaving little to no funds for the injured party or the attorney's fee.**

Furthermore, if an injured person executes multiple assignments to a variety of creditors, the third-party insurer may be faced with determining the priority of assignments and how to distribute settlement proceeds pro rata among numerous assignees if the debt exceeds the amount of the settlement. Generally, the injured person is represented by counsel, who receives the settlement funds and who may negotiate a lesser payment with his client's creditors. *West Broad's* proposition, however, places the obligation on the insurer to identify and locate each assignee at the time of settlement to determine the current liability and may subject the insurer to multiple lawsuits.

Upholding the legality of such assignments opens the door for other creditors to seek debt protection through assignments: the pharmacy, the automobile repair shop, other medical providers. If the injured person executes an assignment to satisfy a debt that is not related to the accident, i.e., a landlord or consumer debt, the insurer would be thrust into a credit situation that is completely unrelated to the underlying accident, and the unrelated third party becomes a de facto collection agent that must prioritize and pay debts to avoid personal liability.

Id. at 501 (emphasis added). The holding in *West Broad* raises many important public policy points that apply to all cases of providers claiming limited medpay benefits. For example, in seeking treatment after a car accident, the insured may be taken to the hospital via ambulance, treated in the emergency room, discharged, sent for follow up outpatient care with a physician, physical therapist, occupational therapist, pain management physician, chiropractic physician, and so forth. Many of these types of services are either excluded or capped under most health insurance plans. By having medical payments available under an auto policy, an injured party can

still obtain these services and pay for them using the med pay benefits. To uphold Appellant's proposed interpretation would simply create a race among the providers to deplete the limited pool of medpay benefits, all without the insured's full knowledge and consent.

And in that scenario, as this Court pointed out, "[T]he third-party insurer may be faced with determining the priority of assignments and how to distribute settlement proceeds pro rata among numerous assignees if the debt exceeds the amount of the settlement." *Id.* at 501. This Court recognized, such a stampede could deprive the injured claimant of discounts which could otherwise be negotiated by claimant's counsel:

Generally, the injured person is represented by counsel, who receives the settlement funds and who may negotiate a lesser payment with his client's creditors. West Broad's proposition, however, places the obligation on the insurer to identify and locate each assignee at the time of settlement to determine the current liability and may subject the insurer to multiple lawsuits.

{¶ 24} Upholding the legality of such assignments opens the door for other creditors to seek debt protection through assignments: the pharmacy, the automobile repair shop, other medical providers. If the injured person executes an assignment to satisfy a debt that is not related to the accident, i.e., a landlord or consumer debt, the insurer would be thrust into a credit situation that is completely unrelated to the underlying accident, and the unrelated third party becomes a de facto collection agent that must prioritize and pay debts to avoid personal liability.

By permitting Appellant to bypass its obligations under its agreement with the HIC, and to give credence to assignments executed in its emergency rooms, would be to uphold the type of assignments which this Court declared to be unenforceable in *West Broad Chiropractic*. OAJ respectfully asserts that this Court should decline to uphold ProMedica's billing practice for the same reasons.

5. Appellants' Claims of Financial Consideration:

Throughout their pleadings, Appellant ProMedica and *amicus* OHA attempt to use financial reasons to justify their attempts to have this Court uphold their current billing practices.

Appellants and their *amici* claim that one reason this change would be so costly is that this is a longstanding practice, something they have “historically done under Ohio law.” (See *e.g.* OHA Merit Brief, 1). However, OAJ asserts that this practice is of more recent vintage. Providers have historically billed the HIC for these services, which the HIC then exercised their right of subrogation. An informal survey of OAJ members indicates that this is a practice that providers have recently started, within the last couple of years.

Appellants and their *amici* claim they will lose millions of dollars in revenue, and assert that they will incur substantial costs to reverse their billing practices. (OHA Merit Brief, 17-18; ProMedica Merit Brief, 24-26). The providers are concerned with losing the difference between the HIC negotiated rate and the full non-negotiated unilaterally set rate. While ProMedica is crying poor, it appears to be doing well financially. The ProMedica system, despite the worst economy since the Great Depression, posted a 3.5% overall operating profit in its most recent accounting period, with one of its member hospitals posting a 12.93% profit. In fact, seven out of eight hospitals in the same market had positive operating margins for the second straight year. (*Most Toledo Area Hospitals Post Gains in 2010*, Toledo Blade December 19, 2010; Attached as Appendix B).

Leaving aside for the moment the claim that hospitals are struggling financially-- even if the cost to reverse billing practices is significant, this should not be used as justification to uphold Appellant’s skirting of the law. As discussed above, the providers only recently began this unfair billing practice. In doing so, they voluntarily incurred costs to change their practices.

Any costs that they incurred were done so knowing that the practice could be found to be illegal and contrary to law. Additionally, incurring a cost to change an illegal practice is not a reason to uphold it.

Imagine a mining company that claims it should not be ordered to comply with safe mining practices because it would be too costly; or a factory that disposes of its toxic waste into the state's rivers claiming that it would be too costly to comply with the Clean Water Act; or a bill collector that invests in an expensive robo-call program that dials debtors' homes repeatedly throughout the night in violation of Fair Debt Collection laws. A hospital that violates a statute governing billing practices should not be above the law because it has invested money into a new billing program.

Likewise, the arguments citing charitable care are no less absurd – just because someone or some entity contributes its ill-gotten profits to charity does not absolve them from following the law in the other aspects of their business. While a hospital may perform the laudable task of providing charity care to the uninsured, such charity should not be shifted onto the backs of patients with the foresight to obtain multiple types of insurance. It is unfair of the providers to claim on one hand that they need this money, and then turn and use it to provider care to others; indeed, Bernie Madoff was very generous with other people's money too.

Conclusion

The OAJ supports the position of Appellee Virginia King and urges this court to reject Appellant's Proposition of Law, and to uphold the Sixth District's interpretation of R.C. 1751.60(A).

Respectfully submitted,



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CERTIFICATION

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by placing same in ordinary U.S. mail, this 21st day of February, 2011.



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APPENDIX INDEX

Appendix Pg.

1.	Sample of Promedica Consent for Treatment	1
2.	<i>Most Toledo Area Hospitals Post Gains in 2010</i> <u>Toledo Blade</u> December 19, 2010	2

CONSENT FOR TREATMENT

I hereby consent to the rendering of healthcare, which may include routine diagnostic procedures and such medical treatment as is determined necessary by the treating physician, his/her assistants, his/her associates, designees or consultants, and authorized representatives of this healthcare entity. I further consent to and authorize the administration of any anesthetic and/or the performing of any surgical or medical procedure(s) the treating physician, his/her assistants, his/her associates, designees or consultants may determine necessary for my diagnosis and/or treatment. I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that this healthcare entity will retain ownership rights to these images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or as outlined in this organization's policy. Images that identify me will be released and/or used outside the organization only upon written authorization from me or my legal representative. I understand that many of the physicians who render professional services in the healthcare entity are independent contractors and are NOT employees or agents of the healthcare entity. The healthcare entity is NOT responsible for the acts and/or omissions of physicians who are not directed or controlled by the healthcare entity.

PAYMENT OF BENEFITS AND CLAIMS: I hereby assign to the health care entity my right to payment for healthcare services and supplies I receive from health care entity, and I direct anyone paying or receiving money for services or supplies I receive to pay the money to ProMedica Health System, their designee or my treating physician for payment of my bill. I understand that the healthcare services I receive may not be covered or paid for, or may only be partially covered or paid for, by my insurance company or any other third party payer. In the event that the billed charges for the healthcare services I receive are not covered or paid for on my behalf, or are only partially covered or paid, I understand and agree that I am responsible for the payment of the billed charges or the remaining balance of billed charges for any such services or, if the health care entity has a contractual payment arrangement with my insurance company or my third party payer, I will be responsible for the payment of any co-payments, deductibles, and co-insurance for covered services and billed charges for any non-covered services.

I certify that I have received the Medicare Bill of Rights _____ initial (in-house patients only)

PERSONAL VALUABLES: The healthcare entity is not responsible for money, jewelry, clothes or other valuables I have brought with me during my visit.

I certify that I have read this Consent for Treatment, I understand it, and agree that by signing it I am

Signature of Patient/Legally Authorized Representative _____ Date _____

Relationship to Patient _____ Witness(es) _____

Patient unable to sign because _____ (Reason) _____ (Signature)

Privacy Notice Received _____ Initial _____

Unable to obtain acknowledgment of receipt of Privacy Notice because _____

Reason _____ Signature _____

Privacy Status: In Facility Directory _____ Not in Facility Directory _____ On Clergy List _____



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December 19, 2010

Most area hospitals post gains in 2010

Julie M. McKinnon

The Blade, Toledo, Ohio

Dec. 19--**St. Luke's** Hospital continued to bleed financially last year, and while the Maumee hospital since has become part of **ProMedica** Health System, federal regulators are scrutinizing whether the match violates competition laws before granting their blessing -- and opening the way for **operative** changes.

Hospital officials, however, are looking at ways to **meld St. Luke's operations** into **ProMedica**, a process aimed at improving efficiencies that takes all of the system's Toledo-area hospitals into account.

A consultant is working with officials, and members of the hospital's medical staff, board, and community will weigh in, Gary Akenberger, **ProMedica's** senior vice president for finance, said.

It could be some time before any consolidation strategy is finalized, Kathleen Hanley, **ProMedica's** chief financial officer, said.

"We want to move as rapidly as possible, but we want to do it methodically," Ms. Hanley said.

Improving efficiency is a priority for all hospitals nationwide as they reduce overtime, pull back on capital spending, and make other moves, David Koepke, lead scientist for Thomson Reuters' health-care and science business, said.

"Hospitals have done a pretty good job of cost control," Mr. Koepke said.

"They're more careful about acquiring supplies. They're more careful about staffing."

Mr. Koepke added, "Of all industries, health care has managed to weather the recession and the subsequent time pretty well."

The Blade annually examines how Toledo-area hospitals are doing financially by obtaining the most recent Internal Revenue Service forms, called 990s, filed by the non-profit entities.

As a public institution, the University of Toledo Medical Center, formerly the Medical College of Ohio Hospital, doesn't file the same annual IRS forms as the other hospitals, but it keeps public financial records.

All that information plus other statistics from **St. Luke's**, **ProMedica**, Mercy, and the former MCO are compared.

Even though none of the Toledo-area hospitals is a for-profit entity, each must generate enough revenue to reinvest in facilities and equipment.

Another component the hospitals report is executive compensation.

ProMedica's Alan Brass, who retired last year as chief executive, regained his status as the highest-paid hospital executive in the Toledo area, receiving a compensation package worth nearly \$3.5 million.

ProMedica's Flower Hospital, meanwhile, again last year had the best financial result among all Toledo-area hospitals based on revenues received for the business of caring for patients.

Flower in 2009 had an **operating** profit of nearly \$23.7 million, giving it an **operating** margin of nearly 13 percent and contributing to **ProMedica's** **operating** profit of nearly \$56.6 million, a 3.5 percent margin.

At UTMC, **operating** profit and margin for the fiscal year that ended June 30 were higher than budgeted. The hospital had nearly \$10.3 million in **operating** profit and a margin of 3.9 percent.

UTMC did better than expected with profitable services, such as orthopedics and heart care, and negotiated better contracts with many suppliers to cut expenses, said Scott Scarborough, interim executive director of UTMC and the university's senior vice president for finance and administration.

St. Luke's last year was the only Toledo-area hospital with an **operating** loss, which totaled more than \$15 million. The hospital officially became part of **ProMedica** in September and was added to its Paramount Health Care network, solving some of **St. Luke's** problems of being shut out of lucrative insurance contracts.

The Federal Trade Commission continues to evaluate the match, a process that could wrap up early next year, Ms. Hanley of **ProMedica** said. The FTC does not comment on investigations.

ProMedica expects its hospitals will fare financially about the same this year as last, Ms. Hanley said. **St. Luke's** performance could improve slightly, although it still will have an **operating** loss this year, she said.

Mercy **St. Anne** Hospital was the only other hospital that came near negative financial territory last year with an **operating** profit of \$629,002.

St. Anne's **operating** margin was just 0.6 percent, and insurance issues also affected -- but does not endanger -- that hospital, said Todd Warner, chief financial officer for Mercy and other Catholic Health Partners hospitals in Lima, Ohio, and Lorain.

Last year, Mercy overall had a 2.7 percent margin and an **operating** profit of \$22.9 million, with Mercy **St. Charles** having the best performance among the system's local hospitals with a 4.3 percent **operating** margin.

The system also provides a high level of community benefit, such as free hospital care, totaling 9.7 percent of its total expenses, Mercy officials say.

This year, Mercy through November has a 3.8 percent **operating** margin, even though patient volumes are lower than expected, Mr. Warner said.

Attempts to improve efficiencies have made a difference, he said.

Mercy **St. Vincent** Medical Center, for example, has been able to decrease the length of time patients need to be in the hospital, Mr. Warner said. That not only makes patients happier, but it allows Mercy to save \$500 a day with insurance programs that pay by the type of case instead of length of stay and increases the hospital's capacity, he said.

Nearly two years ago, **St. Vincent** implemented a care-coordination center, where nurses electronically schedule and track every patient's admission, unit placement, tests, and other information. Each hospital unit has electronic boards showing the status of patients, who are told from the start each step in their care plans.

"It seems so logical, and it seems so simple," Mindy Ward, vice president of finance and northern Ohio division controller for Catholic Health Partners, said. "But it really is making a big difference."

Kim Mullins, clinical nurse manager for the care coordination center and orthopedics unit at St. Vincent, said 90 percent of patients transferred from other hospitals have a room assignment within 10 minutes. "I think everyone would agree it was hard to get used to, but I don't know how we could live without it now," she said.

St. Vincent's is serving as a model for other hospitals.

Officials from Baptist Medical Center South in Montgomery, Ala., visited St. Vincent in August, 2009, and they started using the electronic "hub" system in mid-September.

One benefit is more collaboration among departments, Vanessa Stacks, an administrative director at Baptist, said. "It just helps streamline the process," Ms. Stacks said. "It's definitely had an impact."

Nationwide, well-run hospitals are tightening their belts and working to improve efficiencies, and utilizing technology plays into that effort, Sheila Schweitzer, senior vice president at Ingenix, a health information and consulting firm, said.

This year's operating margins nationally should be better than last year's, although they will stay in the low single digits on average, she said.

"Hospitals are paying a lot more attention to the revenue cycle," Ms. Schweitzer said.

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--- Index References ---

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