

ORIGINAL

IN THE SUPREME COURT OF OHIO

<p>ProMedica Health System and The Toledo Hospital,</p> <p style="text-align: right;">Appellants,</p> <p>v.</p> <p>Virginia King,</p> <p style="text-align: right;">Appellee.</p>	<p>Supreme Court Case No. 2010-1236</p> <p>On Appeal From The Lucas County Court of Appeals Sixth Appellate District</p> <p>Court of Appeals Case No. L-09-1282</p>
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**REPLY BRIEF OF *AMICI CURIAE*, MERCY HEALTH PARTNERS AND CATHOLIC
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I. Preliminary Statement:

Setting aside all of the inflammatory rhetoric included in the briefs, this Court must focus specifically on the issues upon which the Court has accepted jurisdiction, namely Proposition of Law II, as follows:

Proposition Of Law II: Revised Code §1751.60(A) Applies Only When The Insurance Coverage Provided By An Insured Patient's Health Insuring Corporation Is The Only Coverage Available To An Insured Patient, And It Does Not Supersede Ohio's Law On The Coordination Of Benefits

Proposition of Law II basically involves two (2) separate issues for this Court to decide: (1) whether Revised Code §1751.60(A) only applies in circumstances where a patient's only insurance coverage is provided by the patient's health insuring corporation; and, (2) whether Revised Code §1751.60 supersedes Ohio's law on the coordination of benefits.

The undersigned *amici curiae* and Appellants assert that Revised Code §1751.60(A) is not applicable in circumstances where a patient has insurance coverage from another source in addition to the patient's health insuring corporation. Revised Code §1751.60 is applicable and governs only the situation where an individual's only available medical benefits come from the patient's health insuring corporation. Neither the undersigned *amici curiae* nor Appellants contend that a medical provider should be free to bill whoever they want, as erroneously asserted by Appellee and her *amicus curiae*. Instead, this *amici curiae* and Appellants are seeking this Court's guidance and interpretation of a statute that is clearly subject to more than one reasonable interpretation, thereby rendering the statute ambiguous and in conflict with Ohio's law on the coordination of benefits, which warrants a closer review, analysis and application of the subject statute by this Court.

Similarly, the undersigned *amici curiae* and Appellants assert that Revised Code §1751.60(A), as interpreted and applied by the Sixth District Court of Appeals in its Decision

and Judgment dated June 4, 2010 in the underlying action, clearly conflicts with Ohio's law on the coordination of benefits. It is clear that Ohio's law on the coordination of benefits is *in pari materia* with Revised Code §1751.60(A), as the statutes relate to the same matter or subject and, accordingly, the statutes must be construed together. The undersigned *amici curiae* and Appellants assert that Revised Code §1751.60(A), when construed together with Ohio's laws on the coordination of benefits, cannot be interpreted and applied as set forth by the Sixth District Court of Appeals in the underlying action.

The undersigned *amici curiae* respectfully request this Court to hold that Revised Code §1751.60(A) must be narrowly construed to only prohibit medical providers from seeking compensation directly from an individual enrollee and/or subscriber for anything other than co-payments and deductibles in the limited circumstances where an individual's only available medical benefits come from the individual's health insuring corporation. On its face and when construed together with statutes that are *in pari materia*, Revised Code §1751.60(A) contains no other prohibitions or restrictions on medical providers and clearly does not restrict a medical provider from billing a third party payor who is a responsible primary party under Ohio's law on the coordination of benefits. Accordingly, the interpretation and application of Revised Code §1751.60(A) by the Sixth District Court of Appeals in the underlying action is erroneous and the undersigned *amici curiae* respectfully request this Court for guidance on the proper interpretation and application of Revised Code §1751.60(A), as set forth hererin.

II. Statement of Facts

The Ohio Supreme Court has accepted discretionary jurisdiction on an important proposition of law in order to properly interpret, construct and apply an ambiguous Ohio Statute, Revised Code §1751.60(A), utilizing well-delineated canons of statutory interpretation. The

proper interpretation and construction of Revised Code §1751.60(A) significantly impacts medical providers, health insuring corporations, other insurance carriers, and individual patients throughout the State of Ohio, and further ensures that the legislative intent of the General Assembly when Revised Code §1751.60(A) was enacted is preserved and followed. *Amici Curiae*, Mercy Health Partners and Catholic Healthcare Partners, defer to the Statement of Facts provided within the Merit Brief of Appellants, ProMedica Health System and The Toledo Hospital.

Nevertheless, at the outset, the undersigned *amici curiae* feel compelled to clarify a significant misconception that has been advanced by and permeates the merit briefs filed by Appellee and her *amicus curiae*; i.e., that medical providers charge more for medical services depending on who is receiving the bill. Rather, the charges remain the same regardless of the recipient of the bill. Medical providers merely adjust what they will accept as payment in full for the same charges depending on whether or not the payor has an applicable preferred provider agreement in place with the medical provider. Contrary to the repeated unsubstantiated assertions, medical providers do not utilize “inflated top-line billing” rates when sending a bill to automobile or other insurance carriers. *See Appellee Merit Brief at p.4.*

In addition, Appellee further contends that the undersigned *amici curiae* admit to uniformly billing car accident victims as if they were Medicare patients¹, yet nowhere within the record or the Merit Brief of the undersigned *amici curiae* is any such admission found.

Futhermore, the merit brief filed by *amicus curiae* Ohio Association of Justice is replete with factual assertions containing no authority in support thereof and which are not properly part of any record established at either the trial court or appellate court levels in the underlying case.

¹ Appellee Merit Brief at p.30 (citing *Mercy Health Partners Brief at p.20*).

Whether or not the health insuring corporation would be considered the primary insurer under Ohio's coordination of benefits statutes in the underlying action is not at issue before this Court. Instead, the issues accepted for review by this Court are whether Revised Code §1751.60(A) is only applicable when the insurance coverage provided by a patient's health insuring corporation is the only coverage available to the patient, and whether Revised Code §1751.60 supersedes Ohio's law on the coordination of benefits. *See Proposition of Law II.*

III. Law and Argument

Proposition Of Law II: Revised Code §1751.60(A) Applies Only When The Insurance Coverage Provided By An Insured Patient's Health Insuring Corporation Is The Only Coverage Available To An Insured Patient, And It Does Not Supersede Ohio's Law On The Coordination Of Benefits

Contrary to any other assertion, this Court's review of the underlying action is limited to two (2) very narrow and specified issues, as follows: (1) whether Revised Code §1751.60(A) only applies in circumstances where a patient's only insurance coverage is provided by the patient's health insuring corporation; and, (2) whether Revised Code §1751.60 supersedes Ohio's law on the coordination of benefits. These two (2) issues are contained within Proposition of Law II upon which this Court accepted jurisdiction.

A. Revised Code §1751.60(A) only applies when the insurance coverage provided by a patient's health insuring corporation is the only insurance coverage available.

The only prohibition expressly stated within the language of Revised Code 1751.60(A), titled "Provider or Facility to Seek Compensation for Covered Services Solely from Health Insuring Corporation," is the prohibition against seeking compensation directly from individual enrollees and subscribers of a health insuring corporation. Specifically, Revised Code §1751.60(A) states as follows:

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.

Revised Code §1751.60(A) does not, through any express language included in the statute, prohibit a provider or health care facility from seeking compensation from a third-party payor, such as an automobile liability insurance carrier, automobile medical payment carrier, and/or homeowners insurance carrier. When you strictly analyze the language utilized within the statute, such language clearly reveals no prohibition against seeking compensation from a third-party payor.

Contrary to the assertions of Appellee and her *amicus curiae*, the Ohio Department of Insurance, in Bulletin 2010-06, clearly supports the position set forth by Appellants and their *amici curiae*; i.e., that Revised Code §1751.60(A) is only applicable when an individual only has medical benefits available from a health insuring corporation. In Bulletin 2010-06 entitled "*Guidance Governing Interpretation of R.C. 1751.60*" effective November 9, 2010², which by its own language rescinds, replaces and supersedes Bulletin 2010-03, the Ohio Department of Insurance, clarified the Department's authority and provided "guidance to insurance companies, health insuring corporations (sometimes called HMOs), health care providers and health care facilities regarding interpretation of Section 1751.60 of the Revised Code...". See *Ohio Department of Insurance Bulletin 2010-06*. As further expounded upon by the Ohio Department of Insurance within Bulletin 2010-06, "[t]he Department is seeking to clarify the meaning of the statute in the context of R.C. Chapter 1751 in order to avoid confusion regarding the statute and

² Bulletin 2010-06 was issued on November 9, 2010 and has been placed in the record before this Court. A copy of Bulletin 2010-06 may be found at:
<http://www/insurance.ohio.gov/Legal/Bulletins/Pages/BulletinIndex.aspx>

the Department's authority." See *Ohio Department of Insurance Bulletin 2010-06*. The Ohio Department of Insurance, within Bulletin 2010-06, continues, as follows:

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. The term "health insuring corporation" is specifically defined in R.C. 1751.01(P). R.C. 1751.60 only applies to provider contracts involving health insuring corporations. **It does not apply to providers in relation to coverage offered by sickness and accident insurers licensed under R.C. Title 39, self-insured health benefit plans, or third-party administrators or carriers that administer self insured plans on "administrative services only" basis.**

R.C. 1751.60 requires that a contract between a health insuring corporation and a health care provider or health care facility include a provision that holds harmless the health 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 (*emphasis added*). See *Ohio Department of Insurance Bulletin 2010-06*.

This language and interpretation by the Ohio Department of Insurance, the agency which is statutorily responsible for the regulation of the insurance industry, is completely ignored by counsel for Appellee and her *amicus curiae*.

This avoidance on the part of counsel is understandable, as it is clear that the Ohio Department of Insurance interprets Revised Code §1751.60(A) as not being applicable in those circumstances where an individual has medical benefits provided under a sickness and accident policy, self-insured health benefit plans, or a third-party administrator plan. See *Bulletin 2010-06*. This interpretation and application of Revised Code §1751.60(A) is the identical argument and assertion being made by Appellants and their *amici curiae*, including the undersigned *amici curiae*, in the underlying action. Accordingly, the agency authorized by the General Assembly with the responsibility for regulating the insurance industry, the Ohio Department of Insurance, has reviewed and analyzed the statute at issue in the *Virginia King* case, Revised Code §1751.60,

and determined the correct and proper interpretation, construction and application of the statute. This correct and proper interpretation, construction and application of Revised Code §1751.60 is reasonable and is consistent with the position being advanced by Appellants and the undersigned *amici curiae* in the *Virginia King* case.

Courts are required to give due deference to an administrative interpretation formulated by an agency that has accumulated substantial expertise and to which a legislative body has delegated such responsibility, when interpreting statutes. *Weiss v. Public Utility Commission* (2000), 90 Ohio St.3d 15, 17-18. See also, *Northwestern Ohio Bldg. and Construction Trades Council v. Conrad* (2001), 92 Ohio St.3d 282, 750 N.E.2d 130; and, *Jones Metal Products Co. v. Walker* (1972), 29 Ohio St.2d 173. This Court in *Northwestern Ohio Bldg. and Construction Trades Council v. Conrad* went on to hold that a court must give due deference to the agency's reasonable interpretation of the legislative scheme that provides the authority for the agency to act. *Northwestern, supra* at 287.

This Court further cemented the importance of giving due deference in *State ex rel. Clark v. Great Lakes Construction Co.* (2003), 99 Ohio St.3d 320, 321. In that case, this Court held that "an agency's interpretation of a statute that it has the duty to enforce will not be overturned unless the interpretation is unreasonable." *State ex rel. Clark, supra* at 321.

The construction placed upon a statute by executive departments or bureaus is not only persuasive,³ but is also entitled to great weight,⁴ great respect,⁵ and is not to be disregarded or set

³ *State ex rel. Hunt v. Fronizer*, 2 Ohio N.P. (n.s.) 373 (C.P. 1904).

⁴ *Miami Conservancy Dist. v. Bucher*, 87 Ohio App. 390, 95 N.E.2d 226 (2nd Dist., Montgomery Cty. 1949); *National Petroleum Pub. Co. v. Bowers*, 56 Ohio Op. 133 (B.T.A. 1954); and, *Jones v. Bd. of Ed. Cleveland City School Dist.*, 474 F.2d 1232, 68 Ohio Op.2d 286 (6th Cir. 1973).

⁵ *Emerson v. Forest City Ry.*, 4 Ohio N.P. (n.s.) 493 (C.P. 1906), *aff'd*, 18 Ohio C.D. 683 (Ohio Cir. Ct. 1906), *aff'd*, 77 Ohio St. 596 (1907).

aside unless judicial construction makes it imperative to do so.⁶ In the *Virginia King* case, the interpretation, construction and application of Revised Code §1751.60(A) by the Ohio Department of Insurance, as evidenced by Bulletin 2010-06, as clarification from the administrative agency responsible for regulation of the insurance industry, must be considered by this Court as persuasive and is, accordingly, entitled to great weight and great respect by this Court.

Here, due deference and great weight and respect must be given to the interpretation, construction and application of Revised Code §1751.60 by the Ohio Department of Insurance. The Ohio Department of Insurance has extensive longstanding knowledge of and expertise in regulating the insurance industry and in developing, implementing and enforcing rules and regulations governing all aspects of insurance throughout Ohio. Accordingly, Bulletin 2010-06, which sets forth the Department's interpretation, construction and application of Revised Code §1751.60, clearly constitutes a reasonable interpretation of the statute at issue in the *Virginia King* case.

It is now clear that, based upon the Decision and Judgment from the Sixth District Court of Appeals in the underlying action, an ambiguity exists in connection with the interpretation and application of Revised Code §1751.60(A). It is well-established under Ohio law that a statute is ambiguous when its language is subject to more than one reasonable interpretation. *Family Medicine Foundation, Inc. v. Bright* (2002), 96 Ohio St.3d 183, 2002-Ohio-4034, at ¶8 (citing *State v. Jordan* (2000), 89 Ohio St.3d 488, 492). See also, *Clark v. Scarpelli* (2001), 91 Ohio St.3d 271; *Christie v. GMS Mgt. Co., Inc.* (2000), 88 Ohio St.3d 376; and, *Forbes v. Bolton*, 20 Ohio N.P. (n.s.) 449 (C.P. 1918).

⁶ *Wadsworth v. Dambach*, 99 Ohio App. 269 (6th Dist., Ottawa Cty. 1954); and, *National Petroleum Pub. Co. v. Bowers*, 56 Ohio Op. 133 (B.T.A. 1954).

Stated another way, as was set forth in pertinent part by this Court in Inglis v. Pontius, Superintendent of Banks, in determining that the statute at issue in the case was in fact ambiguous, “[v]ery few statutes are so perfectly framed and so carefully worded as to be free from criticisms when analyzed and expounded by able and ingenious counsel...”. Inglis v. Pontius, Superintendent of Banks (1921), 102 Ohio St. 140, 151, 131 N.E. 509. The underlying action has clearly established that Revised Code §1751.60(A) is ambiguous at best, as the statute has been interpreted in two (2) distinct and reasonable manners, by the Ohio Department of Insurance and by the Sixth District Court of Appeals for Lucas County, Ohio. Because Revised Code §1751.60(A) is clearly ambiguous, utilization of the well-established canons of statutory interpretation and construction are warranted and, as set forth previously in the merit brief filed by Appellants and their *amici curiae*, mandate that Revised Code §1751.60(A) is not applicable in circumstances where a patient has insurance coverage from another source in addition to the patient’s health insuring corporation. This Court, in the underlying action involving Virginia King, is faced with just such a situation.

Having established that the statute at issue, Revised Code §1751.60, is ambiguous, it becomes the duty and responsibility of this Court to determine the proper interpretation, construction and application of the statute by first determining the legislative intent of the General Assembly when the statute was enacted, utilizing the factors described under Revised Code §1.49. For the sake of brevity, the undersigned *amici curiae* will not reiterate the well-established canons of statutory interpretation or apply each such canon to Revised Code §1751.60. Rather, this Court is directed to the merit briefs previously filed on behalf of Appellants and their *amici curiae* for a detailed review of the canons and application of same to the statute at issue.

Not only does the Decision and Judgment from the Sixth District Court of Appeals clerly highlight the ambiguity contained within the language of Revised Code §1751.60(A), it further creates a conflict by superseding Ohio's laws on the coordination of benefits. This conflict between statutes involving the same subject matter must be resolved in order to arrive at a meaningful and workable interpretation of Revised Code §1751.60(A).

B. Revised Code §1751.60(A), as interpreted and applied by the Sixth District Court of Appeals in the underlying action, is in conflict with Ohio's laws on the coordination of benefits.

Because Revised Code §1751.60(A) relates to the same matter or subject as Ohio's law on the coordination of benefits, such statutes must be construed together in order to ascertain the intent of the General Assembly. It is well established under Ohio law that statutes relating to the same matter or subject, although passed at different times and making no reference to each other, are *in pari materia*. See D.A.B.E., Inc. v. Toledo-Lucas Cty. Bd. of Health (2002), 96 Ohio St.3d 250; State ex rel. Gains v. Rossi (1999), 86 Ohio St.3d 620; Yonkings v. Wilkinson (1999), 86 Ohio St.3d 225; and, Cater v. City of Cleveland (1998), 83 Ohio St.3d 24. It is also a fundamental rule of statutory construction that sections and acts that are *in pari materia* should be construed together. See State ex rel. Pratt v. Weygandt (1956), 164 Ohio St. 463; Suez Co. v. Young, 118 Ohio App. 415, 195 N.E.2d 117 (6th Dist., Lucas Cty. 1963); Volan v. Keller, 20 Ohio App.2d 204, 253 N.E.2d 309 (7th Dist., Jefferson Cty. 1969); and, Cook v. Village of Paulding, 4 Ohio Misc. 111, 207 N.E.2d 405 (C.P. 1965).

Here, the statute at issue, Revised Code §1751.60(A), clearly relates to the same matter or subject as Revised Code §§3902.11, *et seq.*, Ohio's statutes and regulations on the coordination of benefits. Accordingly, these statutes are *in pari materia* and this Court, in determining the

proper interpretation and application of Revised Code §1751.60(A), must reference and take into account Ohio's statutes on the coordination of benefits.

When the statute at issue, Revised Code §1751.60(A), as interpreted and applied by the Sixth District Court of Appeals in the underlying action, is construed in relation to Ohio's laws on the coordination of benefits, Revised Code §§3902.11, *et seq.*, it becomes clear that a conflict exists. Specifically, the interpretation and application of Revised Code §1751.60(A) in the underlying action cannot be reconciled with the provisions contained within Ohio's laws on the coordination of benefits.

Specifically, the Sixth District Court of Appeals for Lucas County in the *Virginia King* appeal held as follows:

Given the preferred provider contract in place between appellant's healthcare insurer and the healthcare provider from whom treatment was received, the billing activity in connection to the treatment were subject to the statutory limitations established by R.C. 1751.60(A). The crux of R.C. 1751.60(A) is that in preferred provider scenarios, compensation, and therefore billing, may solely be pursued from the contracting health insurer." *See Decision and Judgment dated June 4, 2010 from the Sixth District Court of Appeals for Lucas County, Ohio, ¶5.*

* * *

The key, determinative word utilized in R.C. 1751.60(A) is 'solely.' The commonly understood meaning of the term is reflected in the definition set forth in Black's Law Dictionary (6 Ed. 1991) which defines sole as, "Without another or others." In applying that unambiguous term to the instant case, we find that the term 'solely' clearly and plainly means to the exclusion of others." *See Decision and Judgment dated June 4, 2010 from the Sixth District Court of Appeals for Lucas County, Ohio, ¶12.*

* * *

"Based upon the foregoing, the plain and unambiguous meaning of R.C. 1751.60(A) is that health care providers and facilities who execute preferred provider agreements with health insurance corporations can solely bill the health insurance corporation subject to the agreement for covered services furnished to enrollees or subscribers covered by the agreement to the exclusion of any and all other potential payors. As such, we interpret R.C. 1751.60(A) consistent with *Hayberg* and contrary to the mistaken, non-exclusive payor interpretation proffered by appellees." *See Decision and Judgment dated June 4, 2010 from the Sixth District Court of Appeals for Lucas County, Ohio, ¶13.*

The statutory interpretation and application of Revised Code §1751.60(A) by the Sixth District Court of Appeals in the underlying action lacks sufficient and adequate analysis and further leaves Revised Code §1751.60 in conflict with other Ohio statutes involving the same subject matter. The Sixth District Court of Appeals' construction and interpretation of Revised Code §1751.60 further ignores the clear intent of the statute to provide protection for individual enrollees and subscribers, fails to perceive the ambiguity present within the statute, rejects the fundamental inconsistency between its decision and other Ohio statutes including Revised Code §3902.11, focuses myopically on the single word "solely" within the statute, and cites for authority only the 11th District Court of Appeals' decision in the Hayberg v. Physicians Emergency Serv. Inc. case⁷, which is clearly not controlling precedent⁸, and the secondary authority of *Black's Law Dictionary*. The decision from the Sixth District Court of Appeals mandating that medical providers seek compensation only from the health insuring corporation subject to a contract for covered services and expressly prohibiting medical providers from seeking compensation from any other potentially responsible entity is in inherent conflict with Ohio's coordination of benefits statutes.

Moreover, if "solely means solely" as asserted repeatedly by Appellee, then the second portion ("and not under any circumstances from the enrollee or subscriber") of the statute is not necessary and is, in fact, redundant. If a medical provider is prohibited from billing any entity other than a health insuring corporation, as stated by Appellee and her *amicus curiae*, that same

⁷ 2008-Ohio-6180 (11th Dist. CA Portage Cty. 2008), appeal not accepted for review (2009), 121 Ohio St.3d 1442, 2009-Ohio-1638.

⁸ As an opinion of one judge with a concurrence in judgment only and not as to the opinion by another judge and a dissenting opinion by the third judge, the decision rendered is entitled to no precedential value beyond the parties involved therein. See, People v. Petros, 198 Mich.App. 401, 499 N.W.2d 784 (1993); Hester by Scott v. Rymer, 717 S.W.2d 251 (Mo. Ct. App. S.D. 1986); and, Northern Indiana Public Service Co. v. Citizens Action Coalition of Indiana, Inc., 548 N.E.2d 153 (Ind. 1989).

medical provider could never bill the individual enrollee or subscriber. The Ohio General Assembly is clearly not in the business of adding unnecessary and redundant language to a statute.

This disconnect, and in fact conflict, between the statute at issue and *in pari materia* statutes under Ohio law, clearly demonstrate that the interpretation, construction and application of Revised Code §1751.60(A) being asserted by Appellees and adopted by the Sixth District Court of Appeals for Lucas County in the *Virginia King* case is erroneous.

“An error that is manifest beyond doubt, either on the face of the statute or when read in connection with other statutes *in pari materia*, may be corrected by a court if the true intention of the legislature can be ascertained.” *Stanton v. Frankel Brothers Realty Co.* (1927), 117 Ohio St. 345, 158 N.E. 868. See also, *Brim v. Rice*, 20 Ohio App.2d 293, 253 N.E.2d 820 (1st Dist., Hamilton Cty. 1969); and, *State v. Reineke*, 27 Ohio App.3d 382, 501 N.E.2d 683 (10th Dist., Franklin Cty. 1986).

As was held by this Court in *State v. Wilson*, “a court should not pick out one sentence and disassociate it from the context but, rather, should look at the four corners of the enactment and determine the intent of the enacting body.” *State v. Wilson* (1997), 77 Ohio St.3d 334, 673 N.E.2d 1347. This principle was further expanded by this Court and by the United States Supreme Court the following year. See *Textron Lycoming Reciprocating Engine Div., Avco Corp. v. United Auto., Aerospace, Agricultural Implement Workers of America, International Union* (1998), 523 U.S. 653, 657, 118 S. Ct. 1626 (“More basically, however, it is a fundamental principle of statutory construction (and, indeed, of language itself) that the meaning of a word cannot be determined in isolation, but must be drawn from the context in which it is used.” citing *Deal v. United States*, 508 U.S. 129, 132 (1993)); and, *State ex rel.*

Thompson v. Spon (1998), 83 Ohio St.3d 551, 554, 700 N.E.2d 1281 (“In reviewing a statute, a court cannot pick out one sentence and disassociate it from the context, but must look to the four corners of the enactment to determine the intent of the enacting body.” citing *State v. Wilson* (1997), 77 Ohio St.3d 334, 336, 673 N.E.2d 1347; *MacDonald v. Bernard* (1982), 1 Ohio St.3d 85, 89, 438 N.E.2d 410).

In addition, it is clear from case precedent from the Sixth District Court of Appeals that too much emphasis ought not be given to particular words used within a statute and that an entire statute must be considered in determining the spirit and meaning of the statute. See *Suez Co. v. Young*, 118 Ohio App. 415, 195 N.E.2d 117 (6th Dist., Lucas Cty. 1963). As stated by the court in *In re Clark's Estate*, “to overemphasize one word or phrase of a statute at the expense of the others would be to give the statute a stunted meaning.” *In re Clark's Estate*, 74 Ohio L. Abs. 460, 141 N.E.2d 259 (Prob. Ct. 1955), judgment aff'd, 102 Ohio App. 200 (4th Dist., Ross Cty. 1956).

As stated very simply by the United States Supreme Court in *Holloway v. United States*, 526 U.S. 1, 119 S. Ct. 966 (1999), “the meaning of statutory language, plain or not, depends on context.” Stated another way by this Court in *Blackwell v. Bowman* (1948), 150 Ohio St. 34, 80 N.E.2d 493, “an act under consideration should be construed in its entirety.” See also, *Muth v. Maxton*, 53 Ohio Op. 263, 119 N.E.2d 162 (C.P. 1954). In the *Virginia King* case, not only did the Sixth District Court of Appeals for Lucas County focus entirely on a single provision of the statute, the Court of Appeals specifically focused on a single word (“solely”) found within that sentence in making its determination of the meaning of the entire statute. Such focus is clearly not mandated and, in fact, has been specifically criticized by this Court.

It is well established that a court must examine a statute in its entirety rather than focusing on an isolated word or phrase within the statute. See *Massillon City School Dist. Bd. of*

Ed. v. Massillon (2004), 104 Ohio St.3d 518, 2004-Ohio-6775, at ¶37. A court should not “pick out one sentence and disassociate it from the context, but must look at the four corners of the enactment to determine the intent of the enacting body.” *State v. Jackson* (2004), 102 Ohio St.3d 380, 2004-Ohio-3206, at ¶34. In contrast, the Sixth District Court of Appeals for Lucas County merely examined and defined a single word from Ohio Revised Code §1751.60 within its Decision and Judgment dated June 4, 2010, and then extrapolated an interpretation of the entire statute from that word.

As stated by this Court in *Sarmiento v. Grange Mut. Cas. Co.* (2005), 106 Ohio St.3d 403, 2005-Ohio-5410, at ¶25, “... none of the language employed in a statute should be disregarded.” However, a simple review of the statutory interpretation of Revised Code §1751.60(A) found within the decision of the Sixth District Court of Appeals reveals that the court clearly disregarded the remaining language of the statute when it myopically focused on the single term “solely” and utilized *Black’s Law Dictionary* (6th Ed. 1991), a secondary source, for its definition.

Whatever the Supreme Court ultimately decides is the correct interpretation and application of Revised Code §1751.60, it is undeniable that the General Assembly, at the time of the passage and enactment of the statute, did not anticipate the situations with which the courts are faced in the cases involving Virginia King, Dorothy Streeter, and Annette Hayberg. In addition, it is equally clear that the General Assembly did not intend such a significant impact on medical providers, health insuring corporations, other insurance carriers, and individual patients throughout the State of Ohio through the enactment and passage of Revised Code §1751.60(A).

As a result of the decision from the Sixth District Court of Appeals, medical providers throughout the State of Ohio have been placed in a position of great uncertainty regarding the

ability to continue established and uniform billing practices and procedures⁹ for seeking compensation for medical services provided to patients. Medical providers are also left with a significant quandary regarding the interplay between various Revised Code statutes, including Revised Code §1751.60 and Ohio's coordination of benefits statutes, Revised Code §3902.11, *et seq.* Health insuring corporations doing business within the State of Ohio are left with potentially significant increases in the number of claims presented by medical providers, as the health insuring corporations become the only entities from whom the medical providers may seek compensation. In contrast, insurance carriers, such as automobile insurance carriers, who have accepted premiums and written policies containing primary medical payment coverage, are now insulated from having to remit payment to the medical providers for medical services provided to their insured. Finally and most importantly, patients throughout the State of Ohio are left with significant changes to the medical care benefits available to the patient and to the manner in which the individual patient can navigate the health care benefits available.

In summary, the interpretation of Revised Code §1751.60 contained within the Decision and Judgment dated June 4, 2010 from the Sixth District Court of Appeals leaves all of Ohio in a climate of confusion regarding the ability of medical providers to seek compensation for covered medical services provided to patients. The interpretation and application of Revised Code §1751.60(A) by the Sixth District Court of Appeals clearly conflicts with Ohio's statutes on the

⁹ Appellee and her *amicus curiae* contend that these billing practices and procedures are recent creations of medical providers (*Appellee Merit Brief at p.4; Amicus Curiae Merit Brief at p.19*), yet the factual assertions within the Complaint establish otherwise. Specifically, the Complaint alleges that the billing practices and procedures of Appellants has been affecting individuals from 2007, the date of Virginia King's automobile accident, to the present time. *See ¶12 of the Complaint with Class Action Allegations.* Further, the Complaint describes the potential class as containing "over one million persons". *See ¶21 of the Complaint with Class Action Allegations.* It is axiomatic that on a motion to dismiss, the factual allegations contained within the Complaint are taken as true. Accordingly, by the admission of Appellee, the billing practices and procedures at issue in this action have been in place since at least 2007.

coordination of benefits. At the very least, this Court should provide guidance to medical providers throughout the entire State of Ohio regarding the proper interpretation and application of Revised Code §1751.60(A), as the statute is undeniably ambiguous.

IV. Conclusion

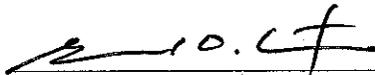
This Court should disregard all of the inflammatory rhetoric set forth in the briefs and focus instead on the two (2) issues contained within Proposition of Law II; i.e., whether Revised Code §1751.60(A) only applies in circumstances where a patient's only available insurance coverage is provided by the patient's health insuring corporation, and whether Revised Code §1751.60 supersedes Ohio's law on the coordination of benefits.

The undersigned *amici curiae* and Appellants assert that Revised Code §1751.60(A) is not applicable in circumstances where a patient has insurance coverage from another source in addition to the patient's health insuring corporation. The only time that Revised Code §1751.60 is applicable and governs the situation is where an individual's only available medical benefits come from the patient's health insuring corporation. In those situations where a patient has insurance coverage available from another source in addition to the patient's health insuring corporation, Ohio's laws on the coordination of benefits, Revised Code §§3902.11, *et seq.*, are applicable and determine the entities that are responsible for the payment of such medical bills. It is undeniable that Revised Code §1751.60(A), as interpreted and applied by the Sixth District Court of Appeals in its Decision and Judgment dated June 4, 2010 in the underlying action, clearly conflicts with Ohio's laws on the coordination of benefits and with the interpretation and application of Revised Code 1751.60(A) by the Ohio Department of Insurance within Bulletin 2010-06. At the very least, due to the ambiguity contained within the language of Revised Code

1751.60(A), guidance from this Court on the proper interpretation and application of Revised Code 1751.60(A) is warranted, as requested by the undersigned *amici curiae* and Appellants.

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CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing **Reply Merit Brief of *Amici Curiae*** **Mercy Health Partners and Catholic Healthcare Partners in Support of Jurisdiction** was served via regular U.S. mail, postage prepaid, on this 11th day of March, 2011, on the following:

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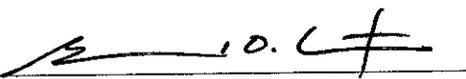
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