

**ORIGINAL**

**IN THE SUPREME COURT OF OHIO**

**ProMedica Health System and  
The Toledo Hospital,**

**Appellants,**

**v.**

**Virginia King,**

**Appellee.**

**Case No. 2010-1236**

**On Appeal From the  
Lucas County Court Of Appeals  
Sixth Appellate District**

**Appellate Case No. L-09-1282**

---

**REPLY BRIEF OF APPELLANTS PROMEDICA HEALTH SYSTEM  
AND THE TOLEDO HOSPITAL**

---

Patrick F. McCartan (0024623)  
(Counsel of Record)  
Marc L. Swartzbaugh (0020656)  
Jones Day  
North Point, 901 Lakeside Avenue  
Cleveland, OH 44114-1190  
Telephone: (216) 586-3939  
Facsimile: (216) 579-0212  
pmccartan@jonesday.com  
mswartzbaugh@jonesday.com

Douglas R. Cole (0070665)  
Alexis J. Zouhary (0085680)  
Jones Day  
325 John H. McConnell Boulevard  
Suite 600  
Columbus, OH 43216-5017  
Telephone: (614) 469-3939  
Facsimile: (614) 461-4198  
drcole@jonesday.com  
azouhary@jonesday.com

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

Counsel for Appellants ProMedica Health System  
and The Toledo Hospital

John T Murray, Esq. (0008793)  
(Counsel of Record)  
Leslie O. Murray, Esq. (0081496)  
Murray & Murray Co., L.P.A.  
111 East Shoreline Drive  
Sandusky, OH 44870  
Telephone: (419) 624-3000  
Facsimile: (419) 624-0707  
jotm@murrayandmurray.com

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

Counsel for Appellee  
Virginia King

**FILED**  
**MAR 14 2011**  
**CLERK OF COURT**  
**SUPREME COURT OF OHIO**

**TABLE OF CONTENTS**

	<b>Page</b>
TABLE OF AUTHORITIES .....	ii
ARGUMENT .....	1
A.    King’s Argument That The Statutory Language Is Unambiguous Misses The Point; The Key Question Here Is The Statute’s Appropriate Scope .....	3
1.    The Statutory Scope Is Limited To Preventing Efforts To Bill <i>Insureds</i> And Does Not Address Efforts To Bill <i>Other Insurers</i> .....	3
2.    King’s Attacks On ProMedica’s Billing Practices Are Irrelevant To The Question Of The Scope Of R.C. 1751.60(A) .....	7
B.    The Legislative History Of R.C. 1751.60 Supports ProMedica’s, Not King’s, Understanding Of The Statute’s Scope .....	9
C.    King’s Reading Of R.C. 1751.60(A) Would Put That Statutory Provision In Direct Conflict With Ohio’s Coordination-Of-Benefits Rules.....	11
D.    King’s Argument That ProMedica Is “Upsetting The Longstanding Practice In This Industry” Relies On Evidence Outside The Record And Is Factually Inaccurate .....	15
E.    The ODI Bulletins Confirm That R.C. 1751.60(A) Does Not Apply On The Facts Here .....	16
CONCLUSION.....	19
CERTIFICATE OF SERVICE	

**TABLE OF AUTHORITIES**

**Page**

**CASES**

*Beneficial Ohio, Inc., v. Ellis,*  
121 Ohio St. 3d 89, 2009-Ohio-311.....4

*Hayberg v. Physicians Emergency Serv. Inc.,*  
11th Dist. No. 2008-P-0010, 2008-Ohio-6180 .....6, 7

*McArthur v. Randall,*  
(2006), 166 Ohio App. 3d 546 .....6

*Sheet Metal Workers' Int'l Ass'n v. Gene's Refrigeration,*  
*Heating & Air Conditioning, Inc.,*  
122 Ohio St. 3d 248, 2009-Ohio-2747.....4

**STATUTES AND ADMINISTRATIVE PROVISIONS**

R.C. 1751.01(AA).....10

R.C. 1751.60 ..... passim

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

R.C. 1751.60(C).....17, 18

R.C. 1751.60(E).....18

R.C. 3901.011 .....17

R.C. 3902.11(B)(2) .....6

R.C. 3902.13 .....6

R.C. 3902.13(F) .....13

R.C. 3902.13(G).....14

R.C. 3923.81(A).....14

R.C. 4769.01(B).....14

Ohio Adm. Code 3901-8-01.....8, 12

**TABLE OF AUTHORITIES**  
**(continued)**

**Page**

**OTHER**

Ohio Department of Insurance, Bulletin 2010-06, <i>Guidance Governing Interpretation of R.C. 1751.60</i> .....	3, 17, 18
--	-----------

## ARGUMENT

Contrary to King's claims, this case is *not* about a health care provider "stick[ing] its hand back into the patient's own pocket for an additional amount." King Br. at 2. King's Complaint does not allege, nor does she assert in her brief, that ProMedica has billed her *at all*. Rather, the issue in this case is whether Ohio Revised Code § 1751.60(A)—the statute on which King relies for her lawsuit—prohibits ProMedica from billing, not King, but a potentially responsible insurer other than her health insuring corporation. It does not.

As ProMedica showed in its opening brief, R.C. 1751.60(A) is designed to prevent health care providers and facilities from seeking to shift payment obligations from the health insurer *to the patient*. In that context, the statute's command is clear and unambiguous—health care providers and facilities shall seek reimbursement "solely from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers." That language does not apply, however, when the provider is seeking payment, not from the "enrollee or subscriber," but rather from *a different insurer*.

Allocation between multiple insurers is governed by Ohio's coordination-of-benefits statutes and rules, not R.C. 1751.60(A). King claims that is not true, asserting that the scope of the statute "could not be clearer," King Br. at 19, and includes the multi-insurer setting. But the statutory language she cites actually supports ProMedica. *See infra* at 4-5. And, in any event, her real argument appears to be that King's care should have been billed at the lower preferred-provider rate, an argument that (in addition to being wrong) has nothing to do with the only question that this appeal raises—whether the hospital can bill a different insurer.

ProMedica also showed that applying R.C. 1751.60(A) outside its proper scope and using it to prevent providers and facilities from sending bills to other potentially responsible insurers would put the statute in direct conflict with the coordination-of-benefits provisions. King admits

that the coordination-of-benefits rules are quite complex. *See* King Br. at 23-25. And she provides no good reason for this Court to impose an overly broad reading of R.C. 1751.60(A) that will upset that carefully crafted apple cart. Indeed, King admits that the responsibility for performing the coordination analysis lies with the insurers (not the health care providers or facilities), and that the analysis requires “detailed knowledge of the terms of all respective plans,” King Br. at 24, as well as “detailed knowledge about . . . the patient,” *id.* at 25. She fails to offer any explanation, however, as to how that complex analysis can occur if the provider or facility is not allowed even to send the bill to all potentially responsible insurers. Nor does King fare any better in trying to explain away the conflicts that applying R.C. 1751.60(A) in the multiple-insurer setting would create.

King’s remaining arguments likewise do little to advance her case. For example, she cites the “strong policy of protecting insured patients from being gouged when they are required to pay for health care out of their own pockets.” King Br. at 27. But here, of course, there is no allegation that King was required to pay anything. Likewise, her references to other statutes that are designed to prevent a provider from passing costs “on to patients,” *see, e.g., id.* at 28, actually support ProMedica, as they show that the legislature’s principal policy concerns in this arena relate to the billing *of patients*, not the billing *of other insurers*.

Similarly, King has no good answer for the Department of Insurance Bulletins that support ProMedica’s understanding of the statute. She admits that Bulletin 2010-03 “largely adopted the construction of R.C. 1751.60 advocated by ProMedica.” King Br. at 34. She attempts to overcome that by asserting that the Ohio Department of Insurance (“ODI”) “rescinded” that understanding in Bulletin 2010-06. But King cannot deny that even this latter bulletin concludes that “R.C. 1751.60 applies to compensation sought from a subscriber.” *See*

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

1751.60. That is, of course, exactly ProMedica's point: the statute is designed to prevent billing *patients*, not other insurers.

The bottom line is that the decision below and King's argument here directly threaten Ohio's coordination-of-benefits process. As King admits, she would prefer that her health insurer pay ProMedica's bill so that her med-pay benefits will remain in reserve for other expenses. But questions regarding which policy pays first lie at the heart of the coordination-of-benefits process, and King should not be allowed to use a misreading of R.C. 1751.60(A) to thwart that process. Especially at a time when health care providers are undergoing fundamental challenges and tectonic market shifts, there is no reason to add to that burden by adopting an overbroad statutory construction that would displace well-settled, industry-wide billing practices, practices that are fully consistent with Ohio's longstanding coordination-of-benefits rules.

**A. King's Argument That The Statutory Language Is Unambiguous Misses The Point; The Key Question Here Is The Statute's Appropriate Scope.**

**1. The Statutory Scope Is Limited To Preventing Efforts To Bill Insureds And Does Not Address Efforts To Bill Other Insurers.**

Fully a third of all the cases that King cites in her brief relate to a single unremarkable legal proposition: where the statutory language is unambiguous, that language controls. *See* King Br. at 16. That proposition is clearly correct, but irrelevant to any disputed issue here. ProMedica agrees that, within the statute's appropriate scope, the language of R.C. 1751.60(A) is unambiguous. Where the court below erred was not in interpreting the substance of the statutory command, but in failing to even consider the question of statutory scope. As ProMedica demonstrated in its opening brief, R.C. 1751.60(A) simply does not apply as between multiple different insurers, and King has failed to show otherwise.

This Court has acknowledged that the first step in a case involving a statute is to determine whether the statute even applies to the facts at hand. *See ProMedica Br.* at 10 (citing *Beneficial Ohio, Inc., v. Ellis*, 121 Ohio St. 3d 89, 2009-Ohio-311; *Sheet Metal Workers' Int'l Ass'n v. Gene's Refrigeration, Heating & Air Conditioning, Inc.*, 122 Ohio St. 3d 248, 2009-Ohio-2747). Where a statute does not apply, the substance of the statutory command is irrelevant. The court below failed to consider this important first step.

Because King has no good answer to the case law requiring courts to consider questions of statutory scope, she is left to argue, without citation to a single case, that R.C. 1751.60(A) “unambiguously sets forth its own ‘scope’” and that this scope includes the “practice of directly billing automobile policies.” *King Br.* at 18. King is wrong. As ProMedica showed in its opening brief, the statute is directed solely to precluding provider attempts to bill *the insured*. The statutory language does not even *mention* other insurers. *See ProMedica Br.* at 14-16. The Chapter in which the statute appears is directed exclusively to “Health Insuring Corporations,” a category that does not include auto insurer med-pay coverage. *Id.* And the legislative history (as discussed more fully below, *see infra* at 9-11) reveals that concerns about *billing patients*, not concerns about billing other insurers, prompted the legislature to enact R.C. 1751.60. *See also ProMedica Br.* at 17-18. Reading the statute in context, then, the scope of R.C. 1751.60(A) is clear: where a health care provider or facility has agreed that it will look to a health insuring corporation for reimbursement, it cannot seek to shift that liability to the patient. That principle simply is not implicated here.

King tries to overcome these undisputed facts regarding statutory context by pointing to exactly one passage in R.C. 1751.60(A): “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." See King Br. at 19. According to King, this passage means that the statute applies whenever there is a preferred provider contract between a health care provider or facility and the health care insurer that covers the subscriber. But that reading distorts the statute. Placing the snippet that King cites in context, the statute reads:

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.

R.C. 1751.60(A). The "every provider" language on which King relies does not define the statute's scope, but merely creates a *threshold*, a necessary precondition. Unless there is a provider contract in place, the statute does not even prevent billing subscribers. But the fact that this threshold is met provides no insight on the entirely separate question of the scope of provider or facility conduct that the statute reaches or, in other words, whether the statute prevents providers or facilities from billing *other insurers*. As noted above, there is no reason to think that it does, and a whole host of reasons to conclude that it does not.

Nor is King correct that under ProMedica's reading "one phrase [i.e., the prohibition on billing a subscriber] is given effect and the other [requiring the provider or facility to seek recovery solely from the health insuring corporation] is discarded." King Br. at 18. Rather, as ProMedica explained in its opening brief, ProMedica's reading gives effect to both phrases, in that the phrases work together to define the scope within which the statute applies. The provider or facility (1) must bill the health insuring corporation (2) to the exclusion of the subscribers. It is King's reading that discards statutory language. For, if the requirement to seek compensation "solely from the health insurer" means, as King suggests, to the exclusion of *all* others, then why does the statute go on to say "and not, under any circumstances, from the enrollees or

subscribers”? Under King’s reading, the latter command (regarding enrollees or subscribers) would be entirely subsumed within the former.

King is likewise incorrect to claim that ProMedica has failed to “offer a coherent alternative to the Sixth District’s construction of R.C. §1751.60.” King Br. at 3. Under ProMedica’s view, R.C. 1751.60 applies in the circumstance specifically addressed in the statute, that is, when the only insurance coverage available to the insured is that provided by her health insuring corporation. When other insurance is potentially available, Ohio’s law on the coordination of insurance benefits applies, and the insurance companies are allowed to determine among themselves their relative priorities and their respective payment obligations. Thus, ProMedica’s construction gives full effect to all applicable statutes. The Sixth District’s, by contrast, does not. Indeed, the Sixth District’s construction of the statute ignores the fact that insurance provided by health insuring corporations is specifically made subject to Ohio’s coordination-of-benefits rules. *See, e.g.*, R.C. 3902.11(B)(2); 3902.13.

King similarly fails to improve her position through her claim that “all of the Ohio appellate courts to consider the issue have concluded that R.C. § 1751.60(A) is unambiguous.” King Br. at 14. First, her reference to “all of the Ohio appellate courts to consider the issue” constitutes exactly two courts, the decision below and the unreported decision in *Hayberg v. Physicians Emergency Serv. Inc.*, 11th Dist. No. 2008-P-0010, 2008-Ohio-6180. (While she identifies one other court, *McArthur v. Randall* (2006), 166 Ohio App. 3d 546, she concedes that the court’s passing treatment of this issue was dicta. *See* King Br. at 15. In any event, that case involved a provider’s attempt to bill *the patient*, and thus clearly fell within the statute’s scope of operation.)

Whether or not *Hayberg* was wrongly decided on its own facts, the case is inapposite here because it did not involve coordination-of-benefits issues. In *Hayberg*, the insured was not covered by two “plans,” but rather was covered under her health insurance policy and *someone else’s* liability policy, a situation not covered by coordination-of-benefits rules. Even King concedes that *Hayberg* involved “a somewhat anomalous situation.” King Br. at 14, n.6. Thus, the case carries little or no persuasive value. Moreover, even if the case were factually on point, neither the *Hayberg* court (nor the court below) ever considered the question of *statutory scope*—the dispositive issue here.

**2. King’s Attacks On ProMedica’s Billing Practices Are Irrelevant To The Question Of The Scope Of R.C. 1751.60(A).**

King tries to buttress her argument by claiming that ProMedica’s billing practices are designed to allow it to collect an improperly inflated rate, *see* King Br. at 21, a charge she raises in various flavors throughout her brief. Indeed, King spends much of her brief painting ProMedica’s billing practices as an attempt to “enrich itself at the expense of other providers, liability insurers and its own patients.” *Id.* at 1. She asserts that ProMedica and other providers have “push[ed] their billing practices to the edge of the envelope,” *id.* at 3, and that ProMedica is doing so to “collect the exorbitant rate that it unilaterally sets for services.” *Id.* at 13. Similarly, she claims that ProMedica has “redirect[ed] the med-pay benefits toward its own inflated top-line billing rate,” thereby “effectively stripping [King] of . . . the benefits available under her auto policy.” *Id.* at 14. Such assertions, however, are irrelevant to the only question before this Court, namely, whether the scope of R.C. 1751.60(A) extends to prohibiting health care providers or facilities from billing other potentially responsible insurers.

To be sure, King is correct that ProMedica bills different insurers at different rates, depending on the terms of the contract that governs each insurer’s obligations. But there is

nothing untoward about that practice. Health insuring corporations typically have a large number of subscribers in a single geographic area who will receive medical care that is reimbursable from the health insuring corporation. Relying on the leverage that this large potential patient population creates, they are able to negotiate very favorable rates. Auto insurers, by contrast, typically have policyholders spread across a wide geographic area, and these policyholders may be injured in an even broader set of geographic locations. Given the wide variety of hospitals in which their policyholders may receive care, automobile insurers do not have the same incentives, or the same leverage, to negotiate volume rates with particular hospitals. Thus, auto insurers typically pay “reasonable and customary” rates. There is no reason, and King has offered none, to require health care facilities to pass along negotiated “volume rates” to insurance companies that have not negotiated those rates. Certainly there is no reason to manipulate the meaning of R.C. 1751.60(A) to arrive at that result.

Indeed, the ODI’s coordination-of-benefits provisions expressly contemplate that different insurers may be charged different amounts for the same services. For example, the coordination-of-benefits policy language that the ODI requires specifically notes that where multiple insurers bear responsibility for the same medical treatment, some of those insurers may be billed “on the basis of usual or customary fees,” while others are billed “on the basis of negotiated fees.” OAC 3901-8-01, App. A.<sup>1</sup> See also 3901-8-04(F)(1)(a) (providing coordination rules for “[w]hen plans have differing allowable expenses”). In other words, the

<sup>1</sup> The provision states that: If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan’s payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits. OAC 3901-8-01, App. A.

ODI expressly acknowledges that different insurers may be billed at different rates, and provides coordination-of-benefits rules covering that very situation. Put simply, there is nothing wrong with ProMedica using different rate schedules depending on the contract it has with a particular insurer, and King is mistaken to suggest otherwise.

In any event, complaints about differential rates are irrelevant to the claim at issue here. The only question before this Court is whether R.C. 1751.60(A) prevents ProMedica from billing insurers other than the health insuring corporation. There is nothing in the statutory language that suggests that the answer to that question in any way turns on whether ProMedica bills those other insurers at a higher rate than it bills the health insuring corporation. Nor does the fact that ProMedica might bill other insurers at a higher rate deprive King of any of the statutory protections that R.C. 1751.60(A) provides. ProMedica agrees that the statute would apply to any attempt *to bill King herself* for the care that she received; the statute thus limits her potential liability to “copayments and deductibles.” And here, it bears remembering, King has not alleged that she was billed *at all*. But the bottom line is that this statute simply does not address questions relating to billing *other insurers*, and King has failed to show otherwise.

**B. The Legislative History Of R.C. 1751.60 Supports ProMedica’s, Not King’s, Understanding Of The Statute’s Scope.**

In its opening brief, ProMedica showed that the legislative history surrounding the enactment of R.C. 1751.60(A) confirms that the statutory provision is not designed to prevent a health care provider or facility from billing multiple separate *insurers*, but rather to limit the provider’s ability to bill *patients*. See ProMedica Br. at 17-18. While King seeks to “cast significant doubt on ProMedica’s suggestion[s],” King Br. at 32, regarding the meaning of this legislative history, the only passages of actual legislative history she cites confirm ProMedica’s understanding.

In one of the two passages on which King relies, the Legislative Service Commission notes that the bill contains “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*.” King Br. at 33. Although King claims this statement is “neutral with respect to ProMedica’s position,” even she ultimately concedes that the statement “manifests a strong legislative intention *to protect enrollees and subscribers* from abusive billing practices.” *Id.* As ProMedica has noted repeatedly, here there is no allegation that ProMedica has billed King *at all*, let alone that it has billed her in an “abusive” manner.

Second, King argues that the legislative history does not “particularly” support ProMedica’s “suggestion” that the bill was concerned primarily with regulation of health insuring corporations. *See* King Br. at 31-32. This is so, she says, because the Legislative Service Commission’s choice of language in the final bill analysis of Am. Sub. S.B. 67 states that the bill “is explicitly intended ‘to provide uniform regulation of *providers* of managed care services.’” *Id.* at 32. She asserts that the term “provider” is “specially defined by § 1751.01(AA) to mean doctors and hospitals such as ProMedica, not insurers.” *Id.* But that argument is wrong on two fronts. First, the Legislative Service Commission report (like both King and ProMedica at many places in their briefs and like the ODI in its Bulletins) is using the term “provider” here in a generic, nonstatutory sense simply to refer to those who “provide” managed care services, such as HMOs. Second, ProMedica is not a “provider” within the statutory definition in any event. “Provider” is limited to natural persons, partnerships of natural persons, and Chapter 1785 professional associations. *See* R.C. 1751.01(AA). ProMedica, as King acknowledges in her brief, *see* King Br. at 18, is a “health care facility.” Thus, contrary to

King's claim, the reference to regulating "providers" does not show that the bill was intended to provide uniform regulation of hospitals.

Moreover, if further evidence were needed to underscore that the thrust of the legislation was to protect Ohio insureds through comprehensive regulation of health insuring corporations, not hospitals, uncodified section 9 of Am. Sub. S.B. 67 provides it. The General Assembly there set forth the reason why the bill was passed as an emergency measure—to protect the "substantial numbers of Ohio citizens" insured by "currently unregulated forms *of managed care corporations*":

In order to protect the public health and safety of the citizens of this state, the Superintendent [of Insurance] must have the immediate authority to regulate these currently unregulated forms of managed care corporations and to strengthen the financial regulation of all corporations engaged in managed care in Ohio.

In short, the legislative history confirms that this statute was designed to protect Ohio insureds by limiting attempts to hold those insureds responsible for health care bills if their health insuring corporation fails to pay. The statute was not intended to, and does not, regulate either the allocation of payment responsibility among multiple potentially responsible insurers, or a health care facility's efforts to ensure that all such insurers have access to the necessary information to participate in that allocation process.

**C. King's Reading Of R.C. 1751.60(A) Would Put That Statutory Provision In Direct Conflict With Ohio's Coordination-Of-Benefits Rules.**

In its opening brief, ProMedica explained that adopting the understanding of R.C. 1751.60(A) that King proposes—whereby the statute is transformed into a broad prohibition on billing other insurers—would place the statute in direct conflict with Ohio's coordination-of-benefits rules. King claims that ProMedica's conflict argument is "flawed for three major

reasons,” King Br. at 22, but none of those purported “reasons” in fact do anything to cure the conflicts that ProMedica identified.

Ohio’s coordination-of-benefits statutes provide that when two or more insurers both have responsibility under their policies for a given health care expense, the insurers are required to coordinate benefits. King does not dispute, nor could she, that the med-pay benefits under her auto insurance policy are a “plan” that is subject to coordination-of-benefits rules. See OAC 3901-8-01(C)(11)(c) (“plan” includes “medical benefits coverage” under automobile insurance). Under the coordination-of-benefits process, one insurer is “primary” and has the original obligation to handle the bill, while the other is secondary, and has obligations only to the extent that the primary insurer does not provide complete coverage for the expense. As King acknowledges, Ohio law requires insurers to perform the coordination analysis, and provides a complex, factually-intensive set of rules for performing that analysis in a given case. King has not alleged, nor could she, that ProMedica’s billing practices are in any way inconsistent with those rules.

King does not dispute that the coordination-of-benefits rules often make auto insurer med-pay coverage primary. Yet, under King’s proposed reading, the provider would not even be able to send the bill to the auto insurer. How would the coordination-of-benefits analysis—an analysis that King admits is *the insurers’ responsibility*—even take place? And, if the coordination-of-benefits analysis would show that the auto insurer is primary, how, under King’s reading, would the auto insurer even learn of its obligation? Nor does King offer any explanation as to how her understanding of R.C. 1751.60(A) could work in the face of multiple potentially responsible health insuring plans, such as, for example, where a dependent is covered under both of her parents’ policies. The short answer is that using R.C. 1751.60(A) to prohibit

providers from billing *different insurers* would throw a wrench in the carefully constructed coordination-of-benefits framework. Indeed, Ohio law expressly provides insurers with the right to “obtain any fact and information necessary to apply the [coordination-of-benefits] provisions,” even if that occurs “without the consent of the beneficiary.” R.C. 3902.13(F). Surely a provider’s or facility’s bills are “necessary” to the coordination-of-benefits process.

King mounts three attacks on the conflict issue, but each fails. First, she claims that R.C. 1751.60(A) and the coordination-of-benefits provisions “address distinct topics.” *See King Br.* at 23. She makes the point that it is insurers, not providers, who are required to engage in the coordination analysis. Exactly so—which is why all of the insurers need the billing information, so that they can determine among themselves who has the primary obligation, and what that obligation entails. In fact, King goes on at great length detailing the complex factual inquiry that is necessary to complete the analysis. *See King Br.* at 24-25. That analysis can work only if the various responsible insurers all have access to the information they need to make the coordination-of-benefits determination, as Ohio law recognizes. *See R.C. 3902.13(F).*

Second, King points to a supposed “strong public policy against balance billing.” *See King Br.* at 27. But, as she notes, this policy (to the extent it exists) is directed at “protecting insured patients from being gouged when they are required to pay for health care out of their own pockets,” *id.*, a policy that simply is not implicated where, as here, King has not even *alleged* that she has paid a dime out of her own pocket. Nor does she fare any better in trying to subtly warp this “public policy” into a rule that one who pays a provider’s bill is entitled to claim the benefit of the lower rate that the health insuring corporation has negotiated with the provider. *King Br.* at 28 (“The negotiated rate between the patient’s provider and insurer is extended to payments not actually made by the insurer itself.”). The statute that King cites in support of this

argument, R.C. 3923.81(A), provides no assistance. *See* King Br. at 28. It at most requires a provider to offer the preferred rate *when billing a subscriber*. *See* R.C. 3923.81(A). The statute says nothing about the amounts that *other insurers* should be charged. King's reference to Ohio's Medicare statutes, *see* R.C. 4769.01(B), is similarly inapposite. King Br. at 29. Just because this statute provides that there is no prohibition on billing a second insurer in the Medicare context does not imply that such a prohibition does exist outside the Medicare context. The argument is a *non sequitur*.

Finally, King's third contention, that allowing health care providers to bill other insurers will "encourage providers to push their billing practices to the edge of the envelope," is also misplaced. *See* King Br. at 31. In billing the med-pay coverage, ProMedica is not "pushing the edge" of any "envelope." Rather, it is seeking reimbursement from a potentially responsible insurer, and providing the information necessary for that insurer to participate in the coordination-of-benefits process.<sup>2</sup>

King's real agenda on the coordination-of-benefits front is clear elsewhere in her brief. She wants the ability to substitute her own priority of payment scheme between the two insurers who have responsibility to cover the medical expenses here. King "would prefer that the bill be submitted to her health insurer," King Br. at 13, so that her med-pay benefits will be available to her for other uses such as co-pays and deductibles. But that is just another way of saying that

<sup>2</sup> Moreover, issuing a bill to an insurer does not guarantee that the insurer is going to pay. Issuing the bill is only the first step. The insurer must determine under its claim language whether the cost is covered, and also must engage in the statutorily mandated coordination-of-benefits analysis. The insurer pays only if its policy language and the coordination-of-benefits rules require it to do so. If King believes Safeco was wrong in either of those determinations (i.e., as to whether her hospital expenses were covered costs under the Safeco policy, or whether under the coordination-of-benefits rules Safeco had the obligation to pay), she should take that up with Safeco. And, if Safeco paid in error, the insurer (not King) has a right under Ohio law to reimbursement. *See* R.C. 3902.13(G) ("If the amount of payments made by any plan is more than should have been paid, the plan may recover the excess from whichever party received the excess payment.").

King wants her health insurer to be primary (i.e., to pay first), with her med-pay benefits left untapped until after the health insurer has paid. The short answer to that argument is that Ohio law, not King's preferences, determines which insurer is primary and which is secondary. If the health insurer is primary, then it will pay first, with the med-pay benefits held in reserve for other costs, as King would like. If, on the other hand, the med-pay benefits are primary under the coordination-of-benefits statutes and the Department of Insurance rules, then those benefits will pay first, King's preferences notwithstanding.

In sum, the ordering between the two insurers is determined by the coordination-of-benefits rules. King should not be allowed to subvert those rules by misinterpreting R.C. 1751.60(A) to prevent one of the responsible insurers from receiving the bill in the first instance.

**D. King's Argument That ProMedica Is "Upsetting The Longstanding Practice In This Industry" Relies On Evidence Outside The Record And Is Factually Inaccurate.**

King tries to distinguish *Sheet Metal Workers*, in which the Court affirmed the need to consider statutory scope, on the grounds that there the Court was adopting longstanding industry practices, while here ProMedica is allegedly asking the Court to ignore longstanding practices. *See King Br.* at 37-38. That is not only wrong as a factual matter, but the "evidence" on which King relies for this argument is totally outside the record.

It is somewhat ironic that King even chooses to press this argument. Earlier in her brief, she takes amici to task for relying on a letter that was attached to the motion to dismiss, because the letter is not properly part of the record on appeal (although she "does not dispute that the correspondence cited by the OHA amici are genuine," *King Br.* at 9, n.2). Having chastised others for allegedly relying on non-record evidence, however, King relies, as support for her "longstanding practices" argument, on her "undersigned counsel's experience," which is that providers have become "far more aggressive" in their billing practices since "approximately

2007-2008.” *Id.* at 38. *See also id.* at 4 (making unsubstantiated factual assertion, which appears nowhere in her Complaint, that “[u]ntil recently, providers rarely directly sought med-pay benefits available under automobile policies”). It should go without saying that such anecdotal and conclusory “evidence” from King’s attorneys is not part of the record before this Court, and is entitled to no weight in deciding this case.

Moreover, as a factual matter, King is wrong in asserting that ProMedica is asking this Court to ignore longstanding billing practices, or in claiming that ProMedica’s billing practices “upset the longstanding status quo.” King Br. at 4. In fact, King did not allege, nor could she, that ProMedica’s billing practices are in any way contrary to the coordination-of-benefits statute, which was enacted in 1988, or that those practices have recently changed. In short, King’s unfounded assertions in her brief about supposed changes in billing practices provide no basis for applying R.C. 1751.60(A) outside its intended scope.

**E. The ODI Bulletins Confirm That R.C. 1751.60(A) Does Not Apply On The Facts Here.**

As ProMedica explained in its brief, the ODI has issued two bulletins relating to the proper understanding of R.C. 1751.60(A). Both of those bulletins confirm that the trial court (and ProMedica) has the proper understanding of the statutory provision’s scope. Indeed, even King admits that the first of the two bulletins supports ProMedica. And, while King argues that the second bulletin favors her, those arguments are flawed.

In the first bulletin, 2010-03, the Department expressly stated that R.C. 1751.60(A) does not prohibit billing third-party liability insurers:

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

Ohio Department of Insurance, Bulletin 2010-03, *Guidance Governing Interpretation of R.C. 1751.60*. As King admits, in this bulletin, “the Department basically adopted ProMedica’s position.” King Br. at 35.

But King claims that the later bulletin, 2010-06, changes the Department’s view and actually supports her position. See King Br. at 35-36. It does not. Nowhere does the Bulletin say that providers or facilities *cannot* bill third party insurers; it merely states that the Bulletin is not intended to “promote or encourage” such practice. As King herself puts it, “the Department now says nothing about whether R.C. § 1751.60 reaches billing activity directed toward any alternative payers”; rather, “[t]he Department maintains its earlier position” that “[t]he statute governs *only* billing activity associated with ‘health insuring corporations’ as defined by statute.” King Br. at 35 (emphasis added). Exactly so.

Nor does the other language that she cites, that the Bulletin is “not intended to overturn any court decision,” help her. *Id.* The language is better understood as merely reflecting the entirely appropriate principle that the ODI does not have authority to review or overturn court decisions.

While the ODI lacks authority to overturn court decisions, it does have the ability, indeed the responsibility, to interpret and apply insurance laws. See R.C. 3901.011 (granting the Superintendent of the Department of Insurance the responsibility to “see that the laws relating to insurance are executed and enforced”). That authority is particularly strong with regard to R.C. 1751.60, as the statutory provision expressly gives the Superintendent of the Department the ability to review and approve the policy language by which health insuring corporations implement the commands of R.C. 1751.60(A):

every contract between a health insuring corporation and provider or health care facility shall contain *a provision approved by the*

*superintendent of insurance* requiring the provider or health care facility to seek compensation solely from the health insuring corporation and not, under any circumstances, from the subscriber or enrollee, except for approved copayments and deductibles

R.C. 1751.60(C) (emphasis added). Moreover, the statute also grants the Superintendent the authority to “waive the requirements of division[] A” when certain requirements are met, *see* R.C. 1751.60(E), further confirming the importance of the Department’s role in defining the contours of the statutory provision.

The Department’s view of those contours, as expressed in the later Bulletin, clearly supports ProMedica’s position. In particular, the later bulletin reinforces three points that bear special emphasis here: (1) the statute “only applies to provider contracts involving health insuring corporations,” (2) the statute “does not apply to providers in relation to coverage offered by sickness and accident insurers,” and (3) “R.C. 1751.60 applies to compensation *sought from a subscriber* and provides the Department with authority to take action if a violation with respect to a subscriber occurs.” Ohio Department of Insurance, Bulletin 2010-06, *Guidance Governing Interpretation of R.C. 1751.60* (emphasis added). Taken together, these three points confirm ProMedica’s position: the statutory scope simply does not include questions relating to the appropriate way to allocate liability between multiple potentially responsible insurers. Rather, the statute “applies to compensation sought from a subscriber,” i.e., it is limited to the question of whether, and to what extent, a health care provider or facility may bill *the insured*.

King cannot avoid this result by claiming that the interpretation is not “longstanding” or that it contradicts the statutory language. *See* King Br. at 36-37. First, as noted above, the Department has a special responsibility to review and approve the policy language by which a health insuring corporation implements the statutory rule. Thus, the Superintendent’s understanding of what those requirements entail is of particular significance. Second, the

Superintendent's interpretation does not seek to overturn the statutory language. Again, the key question in this case is not, as King claims, "what does 'solely' mean?", but rather, "under what circumstances does the statutory language apply?" The Bulletin confirms that the statute applies to efforts to bill subscribers, not other insurers. In defining the scope in this manner, the Bulletin adopts not only a reasonable understanding of the statutory language, but the very understanding that the overall statutory context compels.

### **CONCLUSION**

The trial court got it right. For all the foregoing reasons, R.C. 1751.60(A) simply is not designed to, and does not, prohibit a health care provider or facility from billing another insurer. Accordingly, ProMedica respectfully urges this Court to reverse the decision below.

Dated: March 14, 2011

Respectfully submitted,

*Pat McCartan / by Douglas R. Cole*

Patrick F. McCartan (0024623) (007-665)

(Counsel of Record)

Marc L. Swartzbaugh (0020656)

Jones Day

North Point, 901 Lakeside Avenue

Cleveland, OH 44114-1190

Telephone: (216) 586-3939

Facsimile: (216) 579-0212

pmccartan@jonesday.com

mswartzbaugh@jonesday.com

Douglas R. Cole (0070665)

Alexis J. Zouhary (0085680)

Jones Day

325 John H. McConnell Boulevard,

Suite 600

Columbus, OH 43216-5017

Telephone: (614) 469-3939

Facsimile: (614) 461-4198

drcole@jonesday.com

azouhary@jonesday.com

Marshall A. Bennett, Jr. (0015845)

Jennifer J. Dawson (0033707)

Marshall & Melhorn, LLC

Four SeaGate, Eighth Floor

Toledo, OH 43604

Telephone: (419) 249-7100

Facsimile: (419) 249-7151

bennett@marshall-melhorn.com

dawson@marshall-melhorn.com

Counsel for Appellants

ProMedica Health System and

The Toledo Hospital

**CERTIFICATE OF SERVICE**

I certify that a copy of this Reply Brief was sent by ordinary U.S. mail on this 14<sup>th</sup> day of

March, 2011, to:

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

John L. Huffman, Esq.  
528 Spitzer Building  
Toledo, OH 43604

Counsel for Appellee  
Virginia King

Daniel R. Michel, Esq.  
Jennifer N. Brown, Esq.  
Arthur, O'Neil, Mertz, Michel &  
Brown, Co., L.P.A.  
901 Ralston Ave.  
P.O. Box 781  
Defiance, OH 43512

Counsel for Amici Curiae  
Ohio Association for Justice

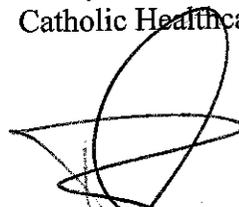
Anne Marie Sferra  
Bridget Purdue Riddell  
Bricker & Eckler LLP  
100 South Third Street  
Columbus, OH 43215

Counsel for Amici Curiae  
Ohio Hospital Association,  
Ohio State Medical Association, and  
Ohio Osteopathic Association

Garrick O. White  
Richard F. Ellenberger  
Anspach Meeks Ellenberger LLP  
300 Madison Avenue, Suite 1600  
Toledo, OH 43604-2633

Barry F. Hudgin  
Vice President & General Counsel  
Mercy Health Partners  
2200 Jefferson Avenue  
Toledo, OH 43604

Counsel for Amici Curiae  
Mercy Health Partners and  
Catholic Healthcare Partners



---

Counsel for Appellants  
ProMedica Health System and  
The Toledo Hospital