

IN THE SUPREME COURT OF OHIO

CITY OF AKRON, et al.)	Case No. 2014-0738
)	
vs.)	
)	On Appeal from the Franklin County
OHIO STATE DEPARTMENT OF)	Court of Appeals, Tenth Appellate
INSURANCE, et al.,)	District
)	
)	Court of Appeals Case Nos.
)	13-AP-473, 13-AP-484, 13-AP-496

**MERIT BRIEF OF APPELLANTS
TIMOTHY METCALFE AND WILLIAM BIASELLA**

LARRY D. SHENISE (0068461)
P.O. Box 471
Tallmadge, Ohio 44278
(330) 472-5622.
Fax (330) 294-0044
ldsheniselaw@gmail.com

COUNSEL FOR APPELLANTS
TIMOTHY METCALFE &

WILLIAM BIASELLA

PAUL L. JACKSON (0040198)
Roetzel & Andress, LPA
222 S. Main Street
Akron, Ohio 44308

*COUNSEL FOR APPELLEE
CITY OF AKRON*

JENNIFER M. CROSKY (0072379)

Assistant Attorney General
State Office Tower, 26th Floor
30 East Broad Street
Columbus, Ohio 43215-3428

COUNSEL FOR APPELLEE OP&F

MICHAEL E. SMITH (0042372)
Frantz Ward LLP
2500 Key Center
127 Public Square
Cleveland, Ohio 44114-1230

COUNSEL FOR APPELLEE MMO

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES.....	iii
STATEMENT OF CASE AND FACTS.....	1
INTRODUCTION.....	4
ARGUMENT.....	5

Proposition of Law No. I:

A complaint falls within the Ohio Department of Insurance's exclusive jurisdiction if that agency is vested by the legislature with the sole authority to resolve the issue.....	5
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Proposition of Law No. II:

The City of Akron’s and OP&F’s group health plans are uninsured agreements and/or group type contracts subject to the jurisdiction of the superintendent of insurance pursuant to O.A.C. 3901-8-01 and its predecessor O.A.C. 3901-1-56	7
--	----------

Proposition of Law No. III:

For the purposes of Title 39, a person is defined as any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, fraternal benefit society, title guarantee and trust company, health insuring corporation, and any other legal entity as stated in R. C. 3901.04(A)(2) and/or R.C. 3901.19.....	15
--	-----------

Proposition of Law No. IV:

Akron, OP&F, and Medical Mutual of Ohio are all third-party payers as defined in R.C. 3902.11 and R.C. 3901.38(F) and subject to Ohio’s coordination of benefits laws as relating to unfair and deceptive acts as specifically defined in R.C. 3902.13(K).....	16
---	-----------

Proposition of Law No. V

The appellate court decision has created an issue of denial of due of and either intentionally or inadvertently created a private cause of action contrary to Ohio law.....	20
--	-----------

CONCLUSION.....	22
PROOF OF SERVICE.....	23
APPENDIX	Appendix Page
Notice of Appeal to the Ohio Supreme Court (May 9, 2004).....	1
Judgment Entry of the Franklin County Court of Appeals (January 14, 2014).....	3
Opinion of the Franklin County Court of Appeals (January 14, 2014).....	6
Judgment Entry Franklin County Court of Appeals on Motion for Reconsideration (March 25, 2014).....	27
Opinion of the Franklin County Court of Appeals on Motion for Reconsideration (March 25, 2014).....	30
Ohio Revised Code 3901.04.....	39
Ohio Revised Code 3901.041.....	41
Ohio Revised Code 3902.11.....	42
Ohio Revised Code 3902.13.....	43
Ohio Revised Code 3902.14.....	45
Ohio Revised Code 3901.19.....	46
Ohio Revised Code 3901.38.....	47
O.A.C. 3901-8-01.....	48

TABLE OF AUTHORITIES

	Page
Cases	
<i>Accord McClelland v. Clemson Trucking Company, Inc.</i> 1998 WL 904909 (1998).....	14
<i>Adams v. Thompson Newspapers, Inc.</i> 1996 WL 689128 (1996)	14
<i>Fort Halifax Packing Co., Inc. v. Coyne</i> , 482 U.S. 1, 11, 107 S.Ct. 2211, 2217, 96 L.Ed.2d 1 (1987).....	11
<i>Ingersoll-Rand Co. v. McClendon</i> , 498 U.S. 133, 142, 111 S.Ct. 478 (1990).....	11
<i>Keystone Chapter, Associated Builders and Contractors, Inc. v. Foley</i> , 37 F.3d 945, 954 (3d Cir.1994), cert. denied, 514 U.S. 1032, 115 S.Ct. 1393	11
<i>McGurl v. Trucking Employees of New Jersey Welfare Fund</i> , 124 F.3d 471 (3 rd Cir. 1997).....	10
<i>New York State Conference of Blue Cross & Blue Shield Plans, et al. v. Travelers et at. Insurance Co.</i> 514 U.S. 645, 115 S. Ct. 1671 (1995).....	9
<i>Ohio Valley Associated Builders and Contractors v. Industrial Power Systems, Inc.</i> , 190 Ohio App.3d 273, 941, 2010-Ohio-4930, N.E.2d 849	17
<i>Physicians Insurances Company of Ohio v. Grandview Hospital and Medical Center</i> , 44 Ohio App.3d 157 (1988).....	4
<i>Pilot Life Ins. Co. v. Dedeaux</i> , 481 U.S. 41, 46-47, 107 S.Ct. 1549 (1987).....	11
<i>Sears v. Weimer</i> , 143 Ohio St. 312, 55 N.E.2d 413 (1944)	18
<i>Shaw v. Delta Air Lines, Inc.</i> , 463 U.S. 85, 99, 103 S. Ct. 2890, 2901.....	11
<i>State ex rel. Blue Cross and Blue Shield Mutual of Northern Ohio v. Carrol</i> , 21 Ohio App. 3d 263, 487, N.E. 2d 576 (8 th Dist. 1985).....	13
<i>Strack v. Westfield Cos.</i> , 33 Ohio App.3d 336, 337, 515 N.E.2d 1005(9 th Dist. 1986)	12
Statutes	
29 U.S.C. §1003(a).....	9
29 U.S.C §1003(b).....	9
29 U.S.C. §1144(b)(2)(A).....	9
R.C. 1.42.....	17
R.C. 1.59(C).....	5

R.C. 9.833.....	15
R.C. 119.....	3
R.C. 1751.01.....	18, 19
R.C. 1751.08.....	15
R.C. 1751.56.....	7
R.C. 1753.....	15
R.C. 2744.081.....	14, 15
Revised Code Title 39.....	5, 6, 10, 16
R.C. 3901.04.....	6, 15
R.C. 3901.041.....	6
R.C. 3901.19.....	15, 16
R.C. 3901.20.....	8, 13
R.C. 3901.38.....	5, 10, 16, 17, 18, 19
R.C. 3902.11.....	6, 16, 17, 18
R.C. 3902.13.....	2, 3, 10, 12, 13, 16, 20
R.C. 3902.14.....	6
R.C. 3923.37.....	7
R.C. 3959.01.....	18
R.C. 3959.16.....	18
R.C. 4117.....	1, 21
R.C. 4717.31.....	15
R.C. 4717.31.....	15
R.C. 4717.33.....	15
R.C. 4717.34.....	15
R.C. 4717.35.....	15
R.C. 4717.37.....	15
O.A.C. 3901-1-56.....	3, 7
O.A.C. 3901-8-01.....	3, 6, 7, 8

STATEMENT OF THE CASE AND FACTS

Procedurally this case has been ongoing ten years. Timothy Metcalfe, a retired Akron firefighter, and William Biasella, a retired Akron police officer, filed their action for themselves and on behalf of a class of an estimated 900 Akron safety force retirees and their widows in the Summit County Court of Common Pleas. The complaint presented two counts: that the City of Akron (Akron), the Ohio Police & Fire Pension Fund (OP&F) and Medical Mutual of Ohio (MMO) had violated state law with regards to the coordination of benefits and had engaged in a civil conspiracy. (Supp. 1) The issue of a civil conspiracy was never before the Ohio Department of Insurance (ODI) or in any way involved in the course of the appeals.

It is important to note that the retirees did not file suit under R.C. Chapter 4117, which governs public employees collective bargaining, because as retirees, they cannot bring suit under that section as they are not considered bargaining unit members. The above fact is important because the Court of Appeals specifically stated contrary to the argument of the Appellants they are left with a remedy through the collective bargaining process. (Appx. 24)

However, the remedy the Court suggests is simply not available to retirees and in addition is not available to other employees covered under self funded plans whose jobs have no union representation. The Court states that the unions can bargain for coordination of benefits provisions in their contracts and then use the grievance procedure if the terms of the contract are violated. Neither class of employee listed above has that right.

All three Defendants, who are now the Appellees before this Court filed similar motions asking the common pleas court to dismiss the case arguing that the court lacked subject matter jurisdiction stating exclusive initial and primary jurisdiction rested with the Superintendent of Insurance. (Supp. 17) The City of Akron's motion actually argued that the Plaintiffs had failed to

exhaust their administrative remedies at the Department of Insurance conferred by Revised Code Section 3902.13 and that the exclusive remedy for Plaintiffs' claims was administrative proceedings through the Ohio Superintendent of Insurance. (Supp. 10) They now argue that the Superintendent lacks jurisdiction.

Upon the filing of the motion to dismiss in the common pleas court, Appellee OP&F also filed a motion to stay the proceedings, as did Appellants. The Common Pleas Court issued a stay based on the written motions and an agreement reached between all parties including the Attorney General's Office representing the Ohio Department of Insurance (ODI) staying the proceedings until as the Court stated "such time as the Department of Insurance rules on the questions presented in this matter or until such time as the Superintendent of Insurance declines jurisdiction in this matter." (Supp. 25)

A formal complaint by Metcalfe and Biasella on behalf of themselves and the class members was made to the Department of Insurance.

Ultimately, ODI issued a Notice of Opportunity for Hearing asserting its jurisdiction, specifically noting Akron's and the Ohio Police and Fire Pension Fund's (OP&F) admission as to the Department's primary jurisdiction over the parties and the subject matter. (Supp. 27)

The matter then proceeded to ODI, where Akron filed a Motion to Dismiss. Neither OP&F nor the third Defendant, Medical Mutual of Ohio, who acted as the third-party administrator for both Akron and OP&F contested the issue of jurisdiction.

The administrative Hearing Officer assigned to the case ruled against the motion to dismiss and the matter proceeded forward. Ultimately, it was decided after a series of pre-trials that the issue would be handled through the submission of briefs and that no oral hearing would

be held. Akron openly admits that they do not follow the coordination of benefit rules as outlined in Ohio Administrative Code (O.A.C.) 3901-1-56, as they existed when the case was first filed, nor as they exist now pursuant to O.A.C. 3901-8-01 (Appx. 48-59), which replaced O.A.C. 3901-1-56 in 2008, when ODI revised several rules.

The final decision of the Staff Hearing Officer in his Report and Recommendation found that Akron had violated the coordination of benefits and committed an unfair and deceptive insurance act pursuant to R.C. 3902.13. (Supp. 38) After all the parties had an opportunity to file objections the Superintendent issued the final order in the matter. (Supp. 41) As a result the Superintendent issued a cease and desist order to Akron, OP&F and MMO and also ordered an accounting of all claims that should have been coordinated in her final order (Supp. 52)

Each of the Defendants appealed the administrative ruling to the Franklin County Court of Common Pleas pursuant to R.C. 119. Initially the Common Pleas Court attempted to transfer jurisdiction to Summit County based on language contained in the Superintendent's Order that the Order be "directed to the Summit County Court of Common Pleas for further application in the case of *Metcalf, et al. v. City of Akron, et al.*, Case No. 2005-11-6527." (Supp. 52) After a joint appeal of all parties, the 10th District Court of Appeals returned the case to Franklin County Common Pleas for an administrative appeal. That Court ultimately found ODI lacked jurisdiction over the Defendants based on a holding that self-funded plans were not insurance.

The Complainants and ODI both appealed to the Tenth District Court of Appeals arguing that jurisdiction was proper with ODI. The court of appeals has upheld the lower court ruling actually vastly expanding on the reasoning that court. Appellants' Motion for Reconsideration was denied. (Appx. 27)

The argument of the Complainants and ODI has never been that the ODI jurisdiction extended to the plan itself, but only to the coordination of benefits provision inserted in the plan. As ODI has previously argued, it is the conduct that is regulated by state ordinance, and the legislature has granted the superintendent specific authority to regulate that conduct. Simply put a self-funded plan does not have to include a COB provision, but if it chooses to do so and then uses that provision to coordinate with other plans, including fully insured plans to its advantage, then it should be subject to the same rules and regulations as the insured plans.

In support of their position on these issues, the Appellants present the following argument.

INTRODUCTION

The Appellees in this case have done a masterful job to this point of confusing the appellate courts as to what this case is about. First and foremost, this case is not about insurance or the business of insurance. Appellants agree with any findings that Akron and OP&F administer self-funded/self-insured governmental group health benefit plans. They are plans that do not purchase policies from insurance companies to satisfy their obligations for medical benefits. As the Franklin County Common Pleas Court called those plans in citing to *Physicians Insurances Company of Ohio v. Grandview Hospital and Medical Center*, 44 Ohio App.3d 157, 542 N.E.2d 706 (3rd Dist.1988), they are actually the “antithesis of insurance.” (Supp. 63) This case is also not about whether ODI has jurisdiction over the entire plan of either Appellee. That has never from day one been a contention of the Appellants or the Department of Insurance. The limited issue in this case is do the statutes as contained within Ohio Revised Code Title 39 provide ODI jurisdiction with regards to the coordination of benefits provisions contained in each of those plans and thus also jurisdiction as to the unfair and deceptive practice claims that

flow directly from the violations related to those provisions. Neither issue has anything to do with Akron or OP&F engaging in the business of insurance. In fact, the point that both the Akron plan and the OP&F plan are *uninsured agreements* is what forms in part the basis for the jurisdiction of the Ohio Department of Insurance through the Superintendent of Insurance.

In order to demonstrate the obvious errors of the Appellate Court it must be said upfront that the Court appears to go out of its way to find a reason to uphold the decision of the Common Pleas Court, instead of making the legal analysis needed. For example, instead of using the definition of a person used throughout Title 39, which clearly included both the City of Akron and the Ohio Police & Fire Pension Fund as legal entities, the Court reached back to the general statutory definition of a person as it is found in R.C. 1.59(C), which should be noted was last updated over 10 years ago. Also in that that same statute it states that the general statutory definition shall apply “unless another definition is provided in that statute or a related statute.” Title 39 contains related statutes which the Court chose to ignore in favor of the general statutory definition. The Court then used the general definition to disqualify the City of Akron and the Ohio Police & Fire Pension Fund as third party payers under R.C. 3901.38(F)(8). (Appx. 47) A more detailed argument is contained within.

The Court also states that “although Akron is technically an employer, R.C. 3901.38(F) distinguishes between employers and self-insured employers.” Nowhere in R.C. 3901.38 is there a definition of self-insured employer. (Appx. 47)

ARGUMENT IN SUPPORT OF PROPOSITIONS OF LAW

Proposition of Law No. I:

A complaint falls within the Ohio Department of Insurance's exclusive jurisdiction if that agency is vested by the legislature with the sole authority to resolve the issue.

- A. R.C. 3901.04 defines the specific powers granted to the Superintendent of insurance and defines "Laws of this state relating to insurance" and specifically includes Title 39. (Appx. 39)

The legislature has vested the Superintendent of Insurance with the sole authority pursuant to R.C. 3901.04 to enforce the laws of the State of Ohio relating to insurance, as they are defined within Title 39. The issue of the coordination of benefits relates to insurance. The decision of the Court of Appeals has taken that authority from the Superintendent and although maybe not intentionally, created a private right of action for at least some individuals, a position the Courts of Ohio have consistently ruled against. More importantly others have been left with no remedy if an issue arises regarding a coordination of benefit issue involving a governmental self-funded plan.

- B. **R.C. 3901.041 establishes the rule-making and adjudicating powers of the superintendent and states the superintendent of insurance shall adopt, amend, and rescind rules and make adjudications, necessary to discharge the superintendent's duties and exercise the superintendent's powers, including, but not limited to, the superintendent's duties and powers under Title XXXIX [39] of the Revised Code.**

Those rules are found in the Ohio Administrative Code, including but not limited to Chapter 3901. Specific among those rules is O.A.C. 3901-08-01 (Coordination of Benefits) which states:

(A) Authority

This rule is promulgated pursuant to section 3901.041 of the Revised Code, providing that the superintendent of insurance shall adopt, amend and rescind rules and make adjudications necessary to discharge his duties and exercise his powers under Title 39 of the Revised Code; and section 3902.14 of the Revised Code, providing that the superintendent may adopt rules to carry out the purposes of sections 3902.11 to 3902.14 of the Revised Code.

(C)(11)(c) Plan includes:

(ii) An *uninsured arrangement of group or group-type coverage*

(iv) *Group-type contracts*

(C)(11)(d) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56 ; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

The doctrine of expression unius est exclusion alterius is applicable. Since governmental self-insurance plans are not excluded from the definition of health care plans subject to R.C. 3901-8-01 then they are automatically included.

Prior to the adoption of O.A.C. 3901-8-01 in 2008, O.A.C. 3901-1-56 was the rule in effect governing the coordination of benefits. Subject to both O.A.C. 3901-8-01 and O.A.C. 3901-56 the superintendent of insurance has jurisdiction over both uninsured arrangements and group-type contracts.

Proposition of Law No. II:

The City of Akron's and OP&F's group health plans are uninsured agreements and/or group type contracts subject to the jurisdiction of the superintendent of insurance pursuant to O.A.C. 3901-8-01 and its predecessor O.A.C. 3901-1-56

A. The Decision of the Franklin County Common Pleas Court

The sole basis for the decision of the Franklin County Court of Common Pleas in overturning the Administrative Order of the Superintendent of ODI was that the Superintendent lacked jurisdiction over all the Appellees because the self-funded plans of Akron and OP&F were not insurance. (Supp. 63) Thus if the plans are not insurance they are nothing more than

uninsured arrangements between Akron and its employee and OP&F and its members as defined in O.A.C. 3901-8-01(C)(11)(c)(ii). (Appx. 50)

That Court also stated that the decision of ODI was based on the incorrect determination by the staff hearing officer that the self-funded plan of the COA was insurance and subject to the insurance laws of the State of Ohio pursuant to Ohio Revised Code § 3901.20. That statement was made at paragraph 25 of the Hearing Officer's decision on the motion of Akron to dismiss.

The issue in this case has been totally lost in the courts' emphasis on the term insurance. That emphasis has caused the courts to lose sight of what this case is about. The issue before the Court is did the Superintendent of Insurance have the authority to decide whether the Appellees were in violation of the coordination of benefits statutes as defined by the Ohio Revised Code. The Franklin County Court of Common Pleas in jumping on the statement of the hearing officer with regards to the self-funded plan of Akron being insurance chose to ignore the well-reasoned argument of the hearing officer contained in his Report and Recommendation that supports the fact that the jurisdiction of the Superintendent is defined by statute, not by the single term insurance as is (Supp. 30-40)

In ruling on Complainants Motion for Reconsideration the Court states "Initially we note that the complainants did not present any argument regarding Ohio Adm. Code 3901-8-01 in their appeal to this court." (Appx. 6). However the Appellants raised the issue starting at P. 7 of their original brief.

Both the Akron and the OP&F plans are group type coverage and consist of uninsured agreements and when read in conjunction with the rest of the law concerning coordination of benefits it is clear the plans were meant to come under the jurisdiction of the Department of Insurance.

B. The City of Akron and OP&F Have Argued Throughout That They Are Self-funded Plans

The decision of the Franklin County Common Pleas Court states “ The City of Akron, the OP&F, and Medical Mutual of Ohio base their argument on Ohio jurisprudence holding that health benefits provided pursuant to contract (a self-funded plan) are not insurance, but are the antithesis of insurance.” As stated earlier Appellants do not disagree with the fact that the self-insured/self-funded governmental plans of Akron and OP&F are not insurance, because no policies are purchased to cover the benefits offered, however the jurisdiction of ODI is not based around the plans being designated insurance.

C. ERISA v. Non-ERISA plans

1. ERISA exempts private employee benefit plans from state insurance regulation

The Employment Retirement Income Security Act, commonly known as ERISA specifically excludes *private* employee benefit plans, including private self-funded plans from regulation under the rules any of state department of insurance. See 29 U.S.C. §1003(a). Pursuant to 29 U.S.C. §1144(b)(2)(A), under what has become known as the “Deemer Clause” it states that a self-funded plan shall not ‘be deemed to be an insurance company or other insurer... or to be engaged in the business of insurance... for the purposes of any law of any state.”

2. Governmental plans are excluded from ERISA coverage

However pursuant to 29 U.S.C §1003(b) governmental and church plans are excluded from ERISA coverage. Thus governmental plans are open to regulation by the state. In *New York State Conference of Blue Cross & Blue Shield Plans, et al. V. Travelers Insurance Co.* et at. 514 U.S. 645, 115 S. Ct. 1671 (1995) the Court began to carve out an insurance

exception which has allowed state insurance regulation over certain aspects of private group health plans which the Court held had “only an indirect economic effect on the relative costs of various health insurance packages in a given State” and were not "conflicting directives" from which Congress meant to apply ERISA’s preemption. This has allowed State Departments of Insurance to impose limited regulations on private group health plans including self-funded plans. This is an extremely important point as it goes to the Appellate Court’s reasoning where it states “Construing R.C. 3902.13 and 3901.38(F) in pari materia with the other statutes in Chapter 39 which expressly regulate self-insurance, it is apparent that the General Assembly intentionally choose not to make self-insured health care plans subject to the coordination of benefits laws.” (Appx. 23) The other statutes in Chapter 39 the Court refers to are the limited exceptions that ERISA allows the State to regulate with regard to private plans, which includes self-funded plans. It appears the Court did not consider the implications of ERISA and the fact that the General Assembly has no right to enact any legislation with regards to the coordination of benefits as it pertains to *private* self-funded health plans as they fall under the exclusive jurisdiction of the federal government as decided by the federal courts.

3. The intent is to uniformly regulate coordination of benefits between plans

Despite the fact that ERISA specifically excludes regulation by any state department of insurance, federal courts determined the need for a unified coordination of benefits system. In deciding cases under ERISA, where no specific federal provision existed, the federal courts weighed the option of using state insurance regulations where the controversy existed.

However, in *McGurl v. Trucking Employees of New Jersey Welfare Fund*, 124 F.3d 471 (3rd Cir. 1997) the court stated “It is not difficult to foresee the complications and considerable

inefficiencies that would arise from having a patchwork scheme of differing state coordination of benefits rules.” citing *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 11, 107 S.Ct. 2211, 2217, 96 L.Ed.2d 1 (1987); *Keystone Chapter, Associated Builders and Contractors, Inc. v. Foley*, 37 F.3d 945, 954 (3d Cir.1994), cert. denied, 514 U.S. 1032, 115 S.Ct. 1393. In upholding the lower court’s fashioning of a uniform coordination of benefits rule to settle a dispute between two competing self-funded plans both claiming to be secondary, that “ERISA’s statutory mandate is to impose uniformity and predictability for the administration of self-insured plans so that beneficiaries can be guaranteed their expected benefits and so that administrators are not subject to “conflicting or inconsistent State and local regulation of employee benefit plans.”” *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99, 103 S. Ct. 2890, 2901

In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142, 111 S.Ct. 478 (1990) the court held the purpose of ERISA is purpose of ensuring that benefit plans are not subject to divergent regulatory schemes in different states; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46-47, 107 S.Ct. 1549 (1987).

Common sense dictates that the General Assembly took the same approach in fashioning Ohio’s laws to ensure uniformity among those plans that are insured and those governmental and church plans that are self-funded or self-insured. The decision of the Appellate Court in this matter has created just the opposite and actually raised the disparity one step further for the State of Ohio. The decision creates two totally separate sets of rules, one for fully insured health plans where health coverage is purchased by the employer through an insurance carrier and self-funded plans where according to the Court they are subject to no regulation whatsoever. It openly creates a due process issue for those beneficiaries of the plans who have no recourse in disputes with regards to coordination of benefits. Simply put that is absurd. Someone has to be able to

settle disputes. Otherwise the bottom line would be a system of chaos, if self-funded Non-ERISA plans are free to act as they please with no control.

The action of the federal courts demonstrate the intent that coordination of benefit clauses be regulated. Since ERISA specifically excludes governmental plans that regulation is left to the state and the system for that regulation is already well established under the laws of the State of Ohio as enforced by ODI and the Superintendent of Insurance who has the expertise on the issue.

4. The City of Akron, OP&F and Medical Mutual all argued for dismissal of of the Summit County Common Pleas Complaint based on a premise that the Superintendent of Insurance had sole jurisdiction and/or primary administrative jurisdiction

After the filing of the initial; civil complaint in Summit County Common Pleas Court, the City of Akron, OP&F and Medical Mutual all moved for dismissal under the theory that no private cause of action could be brought under the insurance laws of the State of Ohio.

The City of Akron's motion stated "Ohio's insurance laws give the Superintendent of Insurance the sole authority to oversee insurance issues and enforce insurance laws." (Supp. 12) In support of its position Akron cited to *Strack v. Westfield Cos.*, 33 Ohio App.3d 336, 337, 515 N.E.2d 1005(9th Dist. 1986) stating that holding made clear the "intent of the legislature was to allow only an administrative remedy." (Supp. 12) This specific language was cited by Akron from that case:

The Department of Insurance was established in order to Determine what insurance practices were unfair or deceptive and how to best control them. The combination of administrative remedies and civil penalties reflects the *legislative solution* to a problem perceived by it. This court will not substitute its judgment for that of the legislature, which could have easily expressly provided for such a remedy. (Supp. 13)

In its motion, OP&F stated that “the Ohio Superintendent of Insurance has initial and primary jurisdiction over the Plaintiffs’ allegations concerning violations of Ohio insurance rules.” (Supp. 17) In the same motion OP&F wrote R.C. 3902.13(A), (K) and (J) *evidence a clear legislative intent* that the Superintendent of Insurance should make the initial determination of any claim that the requirements for coordination of benefits have been violated.” (Supp. 22)

In support of its position to dismiss, OP&F cited *State ex rel. Blue Cross and Blue Shield Mutual of Northern Ohio v. Carrol*, 21 Ohio App. 3d 263, 487, N.E. 2d 576 (8th Dist. 1985) which deprived a common pleas court of jurisdiction in a case pursuant to R.C. 3901.20, which defines other unfair and deceptive insurance practices. In citing that case, OP&F stated “Since R.C. 3902.13(A) is subject to the same regulatory hearing process as those violations described in R.C. 3901.20, it too deprives a court of jurisdiction to hear a claim regarding coordination of benefits when insured are covered by more than one plan.” (Supp. 21)

The Appellees will surely argue that they did not mean that the Superintendent had jurisdiction over the coordination of benefit provisions within their plans. However, Appellants then ask this Court to consider one question. What was their intent? Did they really not mean what they argued to the Common Pleas Court? Or more importantly did they know they were attempting to deceive the Common Pleas Court just to get Appellants case dismissed? If they answer yes to any of those three scenarios then that raises an ethical issue. Appellants only make that point to emphasize that Appellees knew they were making the proper argument in the Common Pleas Court.

In the case of OP&F they never made a challenge to the jurisdiction of the Superintendent until after receiving a dis-favorable ruling from the Department of Insurance.

Further evidence of both Akron's and OP&F's intent for Department of Insurance involvement can be found in their individual health plans. Within the Akron health plan under "Claim Review" is the following language:

"If MMO denied, reduced or terminated coverage for a Health care benefit not covered under your certificate you Have a right to request a review by the Ohio Department\ of Insurance." (Supp. 57)

The language goes on to allow the Department to make the final determination. This is a significant point in that Akron is saying that its members have a right to seek review on a specific claim issue within a plan. As Appellant's stated earlier with, it has never been their intent to argue that the Department of Insurance has jurisdiction over the entire plan of Akron or OP&F, however the above language demonstrates the voluntary grant of authority to the Department of Insurance on an issue that all of Akron's arguments would be far more applicable to, as it would relate to individualized health care decisions.

4. The City of Akron's and OP&F's self-funded plans are not part of a joint risk insurance pool

In its Memorandum in Opposition to Jurisdiction filed with this Court the City of Akron states "Courts have held time and time again that self-funded plans or programs are not subject to Ohio Insurance law and cites to *Accord McClelland v. Clemson Trucking Company, Inc.* 1998 WL 904909 (1998) and *Adams v. Thompson Newspapers, Inc.* 1996 WL 689128 (1996) in support of its position. Both those cases involve joint insurance pools established pursuant to R.C. 2744.081. That statute states in pertinent part states:

"[A] political subdivision may, pursuant to a written agreement, and to the extent that it considers necessary, join with other political subdivisions in establishing and maintaining a joint self-insurance pool to provide for the payment of judgments, settlement of claims, expense, loss, and damage that arises, or is claimed to have arisen, from an act or

omission of the political subdivision or any of its employees in connection with a governmental or proprietary function and to indemnify or hold harmless the subdivision's employees against such loss or damage. ***." R.C. 2744.081(A).

The plain wording of the statute demonstrates that the only purpose of the joint risk pool is to cover potential loss due to acts of negligence on the part of an employee of a political subdivision. Neither case has any bearing on the matter before this Court.

Akron has also raised the argument in the lower Courts that it should, by analogy be treated the same as joint self-insurance pool formed pursuant to R.C. 9.833. That argument has no merit. Akron is not a joint self-insurance plan and instead is a single entity municipal plan and therefore, not governed by R.C. 9.833(C)(10).

Proposition of Law No. III:

For the purposes of Title 39, a person is defined as any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, fraternal benefit society, title guarantee and trust company, health insuring corporation, and any other legal entity as stated in R. C. 3901.04(A)(2) and/or R.C. 3901.19

R.C. 3901.04 titled Superintendent - specific powers states:

(A) As used in this section:

- (1) "Laws of this state relating to insurance" include but are not limited to Chapter 1751, notwithstanding section 1751.08 , Chapter 1753, **Title XXXIX**, sections 5725.18 to 5725.25 , and Chapter 5729. of the Revised Code. Sections 4717.31, 4717.33 , 4717.34 , 4717.35 , and 4717.37 of the Revised Code are "laws of this state relating to insurance" to the extent those sections apply to insurance companies or insurance agents.
- (2) "Person" has the meaning defined in division (A) of section 3901.19 of the Revised Code.

The Appellate Court in its Decision on Appellant's Motion for Reconsideration stated "There is no indication in R.C. 3901.04 that R.C. 3901.19(A) definition of the term "person" is applicable to every section in Title 39 of the Revised Code."

However the definition is listed within the same statute that defines the specific powers of the Superintendent *as to all of Title 39*.

R.C. 3901.19(B) states:

Whenever it appears to the superintendent of insurance, from the superintendent's files, upon complaint or otherwise, that any person has engaged in, is engaged in, or is about to engage in any act or practice declared to be illegal or prohibited by the laws of this state relating to insurance, or defined as unfair or deceptive by such laws, or when the superintendent believes it to be in the best interest of the public and necessary for the protection of the people in this state, the superintendent or anyone designated by the superintendent under the superintendent's official seal may do any one or more of the following:

Thus the definition is not only listed within the context of the Superintendent's general authority as granted by the legislature, it is also contained within the context of the Superintendent's powers to deal with acts defined as unfair or deceptive by the laws, which is what this case has been about since its inception, the intentional violation of coordination of benefit statutes. The Court is asked to keep in mind the dictates of R.C.

Legal interpretation aside, common sense dictates that the legislature meant for the definition applied to the word "person" in R.C. 3109.19(A)(2) to be applied to all the laws of insurance subject to specific exceptions such as that mentioned by the Court of Appeals as discussed below. The Court of Appeals reasoning is the exception not the rule.

Proposition of Law No. 4:

Akron, OP&F, and Medical Mutual of Ohio are all third-party payers as defined in R.C. 3902.11 and R.C. 3901.38(F) and subject to Ohio's Coordination of Benefits Laws as Relating to Unfair and Deceptive Acts as Specifically Defined In R.C. 3902.13(K)

A. R.C. 3902.11

R.C. 3902.11 titled Coordination of benefits definitions defines the following:

- (B) “Plan of Health Coverage means any of the following if the policy, contract or *agreement* contains a coordination of benefits provision.
- (3) Any other individual or group policy or *agreement* under which a third-party payer provides for hospital, dental, surgical, or medical services.

The following statement was made by the Appellate Court with regards to the Akron and OP& F plans qualifying as a plan of health coverage pursuant to R.C 3902.11. “The self-funded health care plans offered by Akron and OP&F contain coordination of benefits provisions.” (Appx. 20) “According, ODI and complainants contend that Akron and OP&F offer plans of health coverage under R.C. 3902.11(B)(3).” The Court then goes on to say “R.C. 3902.11(B)(3), however, is only applicable to a third party payer.” (Appx. 20) While the Court disagrees about the definition of a third-party payer, that language indicates the acceptance that the plan itself meets the definition of R.C. 3902.11(B)(3).

B. R.C. 3901.38(F)

The important to point to be made here is that had the Court found that Akron and OP&F were third party payers both would have immediately been subject to the jurisdiction of the superintendent of insurance. All the other arguments about coordination of benefits and plans would not have to have even been considered. Instead as the argument below shows the Court went out of its way to find that neither Akron of OP&F was a third party payer despite the clear language of the statute. Words used in a statute are to be taken in their usual, normal, and customary meaning. R.C. 1.42. “If those words are plain and unambiguous, we cannot engage in statutory interpretation.” *Ohio Valley Associated Builders and Contractors v. Industrial Power*

Systems, Inc., 190 Ohio App.3d 273, 941, 2010-Ohio-4930, N.E.2d 849, citing *Sears v. Weimer*, 143 Ohio St. 312, 55 N.E.2d 413 (1944) paragraph five of the syllabus

R.C. 3902.11 states "Beneficiary" and "third-party payer" have the same meanings as in section 3901.38 of the Revised Code. R.C. 3901.38 states:

- (F) "Third-party payer" means any of the following:
 - (1) An insurance company;
 - (2) A health insuring corporation;
 - (3) A labor organization;
 - (4) An employer;
 - (5) An intermediary organization, as defined in section 1751.01 of the Revised Code, that is not a health delivery network contracting solely with self-insured employers;
 - (6) An administrator subject to sections 3959.01 to 3959.16 of the Revised Code;
 - (7) A health delivery network, as defined in section 1751.01 of the Revised Code;
 - (8) Any other person that is obligated pursuant to a benefits contract to reimburse for covered health care services rendered to beneficiaries under such contract.

1. The City of Akron qualifies as a third-party payer pursuant to R.C. 3901.08(F)(4) an employer and R.C. 3901.38(F)(8) as any other person under such contract

The City of Akron is an employer pursuant to R.C. 3901.38(F)(4). The Appellate Court states in its decision Akron is technically an employer, it doesn't qualify as one under the statute because 3901.38(F) distinguishes between employers and self-insured employers. (Appx. 21). As indicated earlier in the introduction nowhere in the statute is there a distinction made between employers and self-insured employers. The only mention of self-insured employers in R.C.

3901.38 is found in R.C. 3901.38(F)(5) where the term “intermediary organization” is defined.

R.C. 3901.38(F)(5) in defining another example of a third-party payer as being:

An intermediary organization, as defined in section 1751.01 of the Revised Code, that is not a health delivery network contracting solely with self-insured employers

The definition is solely with regards to an intermediary organization and part of that definition includes its interaction with self-insured employers. By no means does it in anyway define a self-insured employer.

The Court then uses it’s reasoning as to why Akron doesn’t qualify as an employer to justify finding that Akron is not a third party payer, because to make that finding would put Akron under the jurisdiction of ODI with regards to the coordination of benefits. (Appx. 38)

2. OP&F qualifies as a third-party payer pursuant to R.C. 3901.08(F)(3) A labor organization and R.C. 3901.38(F)(8) as any other person under such contract

Appellants in their brief to the 10th District Court of Appeals raised the issue that OP&F in addition to qualifying as a third-party payer as a person, qualified as a labor organization. The same issue was raised in Appellants Memorandum in Support of Jurisdiction to this Court. On neither occasion has OP&F challenged that definition.

More critical to the same issue the Appellate Court never addressed the issue.

3. Medical Mutual of Ohio qualifies as a third-party payer pursuant to R.C. 3901.38(F)(1) as being an insurance company and R.C. 3901.38(F)(8) as any other person

The Court failed to even consider the role of Medical Mutual as a third-party administrator to both OP&F. There should be no question that Medical Mutual qualifies as a third-party payer as an insurance company, licensed and regulated under the insurance laws of

the State of Ohio. Apparently the appellate court has decided that Medical Mutual gets a free pass for its un-defensible violation of R.C. 3902.13(K)(1), which states:

“No-third party payer shall knowingly fail to comply with the order of benefits as set forth in division (A) of this section.”

Medical Mutual has no jurisdictional argument to make and it cannot argue that its contract with Akron relieves it of the responsibility under insurance law. In other words it can't argue that it is Akron that made me do it, because they choose the order of benefits. A basic tenet of contract law is that you can't enter an illegal contract. As noted by the Superintendent of Insurance in her final order:

“Since at least 2004, both OP&F and medical Mutual of Ohio have Expressed concerns to Akron over Akron's position that it is always secondary and that the coordination of benefits provision of Akron's plan was in-Applicable. Akron has always rejected those concerns and demanded that its plan must be administered secondary to the OP&F plan and any other plans in which its retirees were enrolled.” (Supp. 33)

Proposition of Law No. V

The appellate court decision has created an issue of denial of due of and either intentionally or inadvertently created a private cause of action contrary to Ohio

 Akron in its Memorandum in Opposition to Jurisdiction contended that the Appellate Courts ruling is limited in scope to a “lone political subdivision”

 “As the general Assembly did not make the coordination of benefits law applicable to self-insured entities, when it has made other insurance laws applicable to self-insured entities, we conclude that the coordination of benefits law in R.C. 3902.13 is inapplicable to self-insured health care plans.” (Appx. 23)

 Nowhere it that statement does it say that this decision shall effect the self-insured health care plan of the City of Akron only. Every Non-ERISA plan is directly affected by the decision.

Retired members and non-union members on Non-ERISA governmental and church plans are denied due process by the appellate decision.

While active members of collective bargaining units may have access to to enforce provisions of the collective bargaining agreement as suggested by the Court through grievances and arbitration, retirees have no such right. As noted in the introduction the original suit in Common Pleas Court was not filed pursuant to R.C. 4117 because as retirees, they cannot bring suit under that section as they are not considered bargaining unit members. Their rights are limited to any vested benefits under common law contract principles and thus to resolve a dispute they must file a lawsuit. They have no administrative remedies.

The situation becomes even more desperate for those employees of self-insured Non-ERISA employers who are not members, nor were members of a union. They have absolutely no recourse to redress issues.

CONCLUSION

The decision below is fundamentally wrong in its reasoning and interpretation of existing law under Title 39 of the Ohio Revised Code and has created an unacceptable dual set of rules, one for those of employers who purchase medical coverage for their employees through an insurance carrier and a separate one, which is actually no rule at all, for Non-ERISA self-funded plans such as the two plans in this case. Self-funded plans hold all the cards when it comes to coordination with traditional plans, Traditional plans, where insurance is purchased must follow the coordination of benefits rules while self-funded plans are free to decide in any manner they wish.

The decision below must be reversed and the Department of Insurance Order re-instated. A reversal will result in the elimination of the patchwork scheme of differing coordination of

benefit rules that the federal government sought to prevent when it established ERISA, but left the actual regulation of governmental and church plans to the states.

Respectfully submitted,

/s/ Larry D. Shenise
Larry D. Shenise #0068461
P.O. Box 471
Tallmadge, Ohio 44278
(330) 472-5622
Fax 330-294-0044
ldsheniselaw@gmail.com

Counsel for Appellants

CERTIFICATE OF SERVICE

This is to certify that a true copy of Appellants' Merit Brief was sent by regular U.S. Mail, postage prepaid, this 16th day of November 2014 to the following:

Paul L. Jackson, Esq.,
Roetzel & Address, LPA
222 S. Main Street
Akron, Ohio 44308

Counsel for Appellant City of Akron

Jennifer M. Croskey
Assistant Attorney General
State Office Tower
26th Floor
30 East Broad Street
Columbus, Ohio 43215-3428

*Counsel for Appellant Ohio Police &
Fire Pension Fund*

Michael E. Smith, Esq.
FRANTZ WARD LLP
2500 Key Center
127 Public Square
Cleveland, Ohio 44114-1230

Counsel for Appellant MMO

/s/ Larry D. Shenise
Larry D. Shenise #0068461

APPENDIX

IN THE SUPREME COURT OF OHIO

14-0738

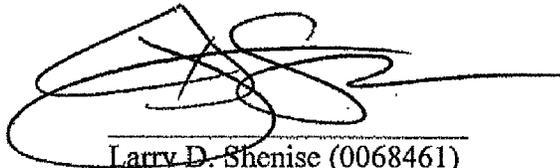
TIMOTHY METCALFE, *et al.*,)
)
 Appellants,)
)
 -vs.-)
)
 THE CITY OF AKRON, *et al*)
)
 Appellees.)

On Appeal from the Franklin County
 Court of Appeals, Tenth Appellate
 District
 Court of Appeals Case Nos.
 13-AP-473, 13-AP-484, 13-496

NOTICE OF APPEAL OF APPELLANTS TIMOTHY METCALFE, *et al.*

Appellants, Timothy Metcalfe and William Biasella, hereby gives notice of appeal to the Supreme Court of Ohio from the judgment of the Franklin County Court of Appeals, Tenth Appellate District, entered January 14, 2014 and from the judgment entered March 25, 2014 denying Appellants timely filed Motion for Reconsideration. This case is one of public or great general interest.

Respectfully submitted,



Larry D. Shenise (0068461)
 P.O. Box 471
 Tallmadge, Ohio
 330-472-5622
 Fax 330-294-0044
 ldsheniselaw@gmail.com

FILED
 MAY 09 2014
 CLERK OF COURT
 SUPREME COURT OF OHIO

Counsel for Appellants

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 May 12 1:56 PM-13AP0000473

CERTIFICATE OF SERVICE

This is to certify that a true copy of Appellants' Notice of Appeal was sent by regular

U.S. Mail, postage prepaid, this 9th day of May 2014 to the following:

Paul L. Jackson, Esq.,
Roetzel & Andress, LPA
222 S. Main Street
Akron, Ohio 44308

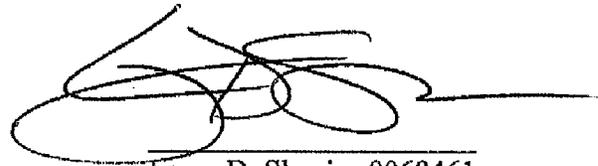
Counsel for Appellant City of Akron

Jennifer M. Croskey
Assistant Attorney General
State Office Tower
26th Floor
30 East Broad Street
Columbus, Ohio 43215-3428

Counsel for Appellant Ohio Police &
Fire Pension Fund

Michael E. Smith, Esq.
FRANTZ WARD LLP
2500 Key Center
127 Public Square
Cleveland, Ohio 44114-1230

Counsel for Appellant MMO



Larry D. Shenise 0068461
Counsel for Appellants

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

City of Akron,	:	
	:	
Appellant-Appellee,	:	
	:	
v.	:	Nos. 13AP-473
	:	and 13AP-486
	:	(C.P.C. No. 10CVF-08-11258)
Ohio Department of Insurance et al.,	:	
	:	(REGULAR CALENDAR)
	:	
Appellees-Appellants,	:	
	:	
[Timothy Metcalf & William Biasella,	:	
	:	
Appellees-Appellants].	:	
	:	
	:	
Ohio Police & Fire Pension Fund,	:	
	:	
Appellee-Appellee,	:	
	:	
v.	:	Nos. 13AP-483
	:	and 13AP-496
	:	(C.P.C. No. 10CVF-08-11426)
Ohio Department of Insurance et al.,	:	
	:	(REGULAR CALENDAR)
Appellees-Appellants.	:	
	:	
	:	
Medical Mutual of Ohio,	:	
	:	
Appellant-Appellee,	:	
	:	
v.	:	Nos. 13AP-484
	:	and 13AP-495
	:	(C.P.C. No. 10CVF-08-11513)
Ohio Department of Insurance et al.,	:	
	:	(REGULAR CALENDAR)
Appellants-Appellants,	:	
	:	
[Timothy Metcalf & William Biasella,	:	
	:	
Appellants-Appellants.]	:	
	:	

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 Jan 14 2:16 PM-13AP000473

JUDGMENT ENTRY

For the reasons stated in the decision of this court rendered herein on January 14, 2014, the Ohio Department of Insurance's assignments of error are overruled, and Timothy Metcalf and William Biasella's assignments of error are overruled. It is the judgment and order of this court that the judgment of the Franklin County Court of Common Pleas is affirmed. Costs shall be assessed against appellants.

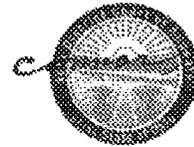
CONNOR, J., BROWN and KLATT, JJ.

/s/ _____
Judge John A. Connor

Tenth District Court of Appeals

Date: 01-14-2014
Case Title: AKRON CITY -VS- OHIO STATE DEPARTMENT INSURANCE
Case Number: 13AP000473
Type: JEJ - JUDGMENT ENTRY

So Ordered



/s/ Judge John A. Connor

Electronically signed on 2014-Jan-14 page 3 of 3

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

City of Akron,	:	
Appellant-Appellee,	:	
v.	:	Nos. 13AP-473
	:	and 13AP-486
Ohio Department of Insurance et al.,	:	(C.P.C. No. 10CVF-08-11258)
	:	(REGULAR CALENDAR)
Appellees-Appellants,	:	
[Timothy Metcalf & William Biasella,	:	
Appellees-Appellants].	:	
	:	
Ohio Police & Fire Pension Fund,	:	
Appellee-Appellee,	:	
v.	:	Nos. 13AP-483
	:	and 13AP-496
Ohio Department of Insurance et al.,	:	(C.P.C. No. 10CVF-08-11426)
	:	(REGULAR CALENDAR)
Appellees-Appellants.	:	
	:	
Medical Mutual of Ohio,	:	
Appellant-Appellee,	:	
v.	:	Nos. 13AP-484
	:	and 13AP-495
Ohio Department of Insurance et al.,	:	(C.P.C. No. 10CVF-08-11513)
	:	(REGULAR CALENDAR)
Appellants-Appellants,	:	
[Timothy Metcalf & William Biasella,	:	
Appellants-Appellants.]	:	

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 Jan 14 12:51 PM-13AP000473

D E C I S I O N

Rendered on January 14, 2014

Roetzel Andress, LPA, Paul L. Jackson, and Karen D. Adinolfi; Cheri B. Cunningham, Director of Law, and Tammy Kalail, for City of Akron.

Michael DeWine, Attorney General, and W. Scott Myers, for Ohio Department of Insurance.

Larry D. Shenise, and Joel D. Reed, for Timothy Metcalfe and William Biasella.

Frantz Ward LLP, and Michael E. Smith, for Medical Mutual of Ohio.

Michael DeWine, Attorney General, and Jennifer S.M. Croskey, for Ohio Police & Fire Pension Fund.

APPEALS from the Franklin County Court of Common Pleas

CONNOR, J.

{¶ 1} Appellants, Mary Taylor, in her capacity as the Superintendent of the Ohio Department of Insurance ("ODI"), and Timothy Metcalfe and William Biasella ("complainants"), appeal from a judgment of the Franklin County Court of Common Pleas dismissing the administrative appeal at issue for lack of jurisdiction. Because ODI lacked jurisdiction over the self-funded retiree health care plans sponsored by appellees, the City of Akron ("Akron") and the Ohio Police & Fire Pension Fund ("OP&F"), and administered by appellee Medical Mutual of Ohio ("MMO"), we affirm.

I. FACTS AND PROCEDURAL HISTORY

{¶ 2} On August 2, 2010, Akron appealed an order issued by ODI on July 20, 2010 to the Franklin County Court of Common Pleas. In the July 20, 2010 order, ODI ordered Akron, MMO and OP&F to cease and desist from further violating Ohio's coordination of benefits law, and ordered appellees to coordinate the benefits of their members pursuant to the terms of their plans and consistent with Ohio law.

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 Jan 14 12:51 PM-13AP000473

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496

3

{¶ 3} The facts underlying ODI's July 20, 2010 cease and desist order arise from a dispute between Akron and Akron's retired police officers and firefighters regarding the retirees' health care coverage. The dispute has spawned several legal actions in the Summit County Court of Common Pleas and the Ninth District Court of Appeals. In *Fraternal Order of Police, Akron Lodge No. 7 v. Akron*, 9th Dist. No. 23332, 2007-Ohio-958, an action related to the instant dispute, the Ninth District Court of Appeals explained the underlying facts as follows:

Members of the FOP include both current and retired police officers in the City of Akron. These members have primary health insurance through the Ohio Police and Fire Pension Fund ("OP & F") and secondary coverage through the City of Akron. The City has always required retirees to enroll in OP & F's health plan as a condition of participating in the City's secondary plan. Traditionally, members of the FOP were not required to pay for their health insurance. OP & F changed this policy in the early 1990's, when it notified its members that they would have to start paying a premium for health insurance. In 2003, OP & F announced a significant increase in its premiums. Shortly thereafter, FOP member and retired officer Rick Grochowski sought health insurance from the City. The City denied Grochowski's request, informing him that they would no longer provide him with secondary health care because OP & F was no longer his principal health insurance provider. As a result, in February of 2004, retired police officers and retired firefighters ("the retirees") filed a class action lawsuit ("*Metcalfe I*"), seeking recovery on a common law breach of contract claim. See *Metcalfe v. Akron*, Summit Cty. No.2 [REDACTED]. The retirees filed five claims including a claim for declaratory judgment and a claim for breach of contract. In their declaratory judgment action, the retirees alleged that City of Akron ordinances entitled them to payment of their insurance premiums and that the retirees are not required to enroll in OP & F. The retirees also filed a breach of contract claim alleging that the City's failure to pay insurance premiums constituted a "breach of the various CBA's". The City filed a motion for summary judgment on May 9, 2005. On January 12, 2006, the trial court granted summary judgment in favor of the City, finding that the City did not breach its various CBAs with the Union and was not required to provide retirees with fully-paid primary health coverage under the City's ordinances. This Court affirmed the trial court's ruling on

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496

4

August 30, 2006. See *Metcalfe v. Akron*, 9th Dist. No. 23068, 2006-Ohio-4470.

In March of 2004, the FOP brought a grievance against the City for violating the parties' CBA by increasing premiums, requiring retirees to maintain OP & F as their primary coverage and ceasing to provide secondary coverage to certain retirees. The grievance was brought on behalf of the FOP's membership, including "current, former, retired, active members, as well as retired officer Rick Grochowski and all other effected officers who have served or are serving on the Akron Police Department."

The same class of plaintiffs from *Metcalfe I* filed a second lawsuit ("*Metcalfe II*") against the City, OP & F, and Medical Mutual of Ohio ("MMO") on November 4, 2005. See *Metcalfe v. Akron, Summit Cty.* No. 2 [REDACTED]. In the second action, the retirees alleged that they are entitled to payment of health insurance claims by the various defendants in compliance with R.C. 3902.13 and Ohio insurance regulations as they relate to the coordination of benefits. The trial court granted stay of *Metcalfe II* pending review by the Ohio Department of Insurance.

Id. at ¶ 3-5.

{¶ 4} The matter currently before this court concerns *Metcalfe v. Akron*, Summit C.P. No. 2 [REDACTED] ("*Metcalfe II*"), which the Summit County Court of Common Pleas referred to ODI. The stay order issued by the Summit County Court of Common Pleas indicated that the court would stay the action until ODI ruled on the questions presented by the litigation, or until ODI determined that it lacked jurisdiction in the matter. On February 14, 2006, the complainants submitted a complaint to ODI, asserting that Akron, OP&F and MMO had violated Ohio's coordination of benefits law.

{¶ 5} ODI issued a notice of opportunity for a hearing to Akron, OP&F and MMO on March 12, 2008. ODI noted that Akron and OP&F both operated non-Employee Retirement Income Security Act ("ERISA"), self-funded health care plans, and that MMO acted as the administrator for both plans. In the notice, ODI concluded that, as Akron, OP&F and MMO satisfied the definition of "person" in R.C. 3901.19, they were prohibited from engaging in unfair or deceptive acts or practices in the business of insurance. As R.C. 3902.13 deemed a knowing violation of Ohio's coordination of

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496 5

benefits provisions to be an unfair or deceptive insurance act or practice, ODI concluded it possessed jurisdiction and that a R.C. 3901.22 hearing was necessary and justified.

{¶ 6} On September 29, 2008, Akron filed a motion to dismiss the action pending before ODI. Akron asserted that ODI did not possess jurisdiction over Akron's self-funded health care plan, as the self-funded plan did not constitute insurance. In support of its contention, Akron attached several letters issued by ODI employees, wherein ODI explained that it did not possess jurisdiction to regulate self-funded health care plans. One such letter, issued on August 18, 2008, was issued in response to a citizen's concern over OP&F's health care plan and the rising cost of healthcare premiums under that plan. ODI provided the following response to the citizen's inquiry:

Allow me to clarify the role and function of the Ohio Department of Insurance. Our responsibility is to enforce insurance laws and regulations as applicable to insurance companies in accordance with Title 39 of the Ohio Revised Code (ORC). Entities that are "self-funded;" generally large employers such as hospitals or manufacturers and most, if not all public employee or government-sponsored retiree plans, fall into the category of "self-funded." The funding of the benefit plan, whether by the employer, group, or another party, generally exempts it from the obligations and requirements of ORC. As such, any complaints against OP&F would not fall under the regulatory authority of this agency. This is not only the case with your plan, but the other retiree plans (State Teachers' Retirement System (STRS), Public Employee Retirement System (PERS), private-employer retiree plans) as well. Please understand; this is not to suggest that a "self-funded" plan is not required to comply with any law; there may be applicable Federal regulations. However, these plans do not fall under the jurisdiction of *state* insurance law.

(Emphasis sic.) (Hearing Officer's Record, 11; Akron's Motion to Dismiss, exhibit B.)

{¶ 7} Relying on these letters, Akron asserted that ODI could not now attempt to claim that it possessed jurisdiction over Akron's self-funded health care plan.¹ Akron also asserted that, as the "retiree medical benefit plans have arisen out of collective

¹ The other letters were issued on March 28, 2008; March 10, 2008; March 7, 2008; January 14, 2008; October 1, 2007; August 15, 2007; August 22, 2007; August 29, 2007; April 5, 2007; and December 20, 2006. The letters all indicate that ODI does not possess jurisdiction to regulate self-funded or self-insured plans.

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496

6

bargaining agreements between the City and the unions representing its safety forces," any alleged violations of the obligations under the union contracts could be addressed through the grievance procedures called for under those collective bargaining agreements. (Hearing Officer's Record, 11; Akron's Motion to Dismiss, 8.)

{¶ 8} Akron supported its motion to dismiss with the affidavit of Mark McLeod, Akron's employee benefits manager, and Akron's group insurance plan for retirees. McLeod explained that Akron sponsored two self-funded medical plans: one for its active police officers and firefighters and one for its retired police officers and firefighters. McLeod also explained that Akron had, "for decades, made contributions throughout the careers of all of its active police officers and firefighters to the Ohio Police and Fire Pension Fund," which in turn provided pension benefits and health care coverage to all retired police officers and firefighters in Ohio. (Hearing Officer's Record, 11; Akron's Motion to Dismiss, exhibit A; McLeod Affidavit, ¶ 5.) McLeod stated that "Akron's retiree medical plan, through its contract with MMO, [was] secondary or supplemental to the OP&F retiree medical insurance plan." (Hearing Officer's Record, 11; Akron's Motion to Dismiss, exhibit A; McLeod Affidavit, ¶ 9.) Akron administers its retiree medical benefits plan "in such a way that medical claims for police and fire retirees and their dependents cannot be processed unless they have first been processed under the OP&F plan as the primary plan." (Hearing Officer's Record, 11; Akron's Motion to Dismiss, exhibit A; McLeod Affidavit, ¶ 10.)

{¶ 9} Akron's group insurance plan for retirees provides for the coordination of benefits between it and any other plan under which a retiree receives health care coverage. The order of benefits determination rules expressly state that payment under the plan will be reduced to the extent that an eligible member is paid or entitled to be paid "by any medical care plan which has been established by: * * * the Police and Firemen's Disability and Pension Fund of Ohio; provided you and your Dependents are eligible to enroll in any of these plans." (Hearing Officer's Record, 11; Akron's Motion to Dismiss, exhibit A; McLeod Affidavit, exhibit No. 2; Akron's Group Insurance Plan, 37.) The remaining order of benefits determination rules contained in Akron's plan substantively mirror the order of benefit determination rules found in Ohio's coordination of benefits law, R.C. 3902.13. The OP&F health care plan also contains a

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496

7

coordination of benefits provision, which provides that the order of benefits determination rules shall be determined pursuant to the rules outlined by ODI. (See Hearing Officer's Record, 43; ODI's exhibit L; Ohio Police & Fire Pension Fund, Amended and Restated Health Care Plan, Section 7.2.) MMO's contract with Akron states that "[i]n administering coordination of benefits under this agreement, Medical Mutual will assume that the City's plan is secondary for all retirees and survivors." (Hearing Officer's Record, 43; ODI's exhibit C1; Medical Mutual Services Group Contract, Section 8.4.)

{¶ 10} An ODI hearing officer overruled Akron's motion to dismiss on April 28, 2009. The hearing officer determined that Akron's self-funded retiree health care plan was a legal entity, and thus a person, under R.C. 3901.19(A). The hearing officer further concluded that Akron's self-funded medical plan was an organization under R.C. 3901.19(D), and constituted a plan of health coverage under R.C. 3902.11(B)(3). The hearing officer concluded that Akron's "self-insured insurance fund provided for its police and fire retirees" was "insurance provided within the State of Ohio and [was] subject to the insurance laws of this state pursuant to" R.C. 3901.20. (Hearing Officer's Record, 18; Hearing Officer's Ruling on Motion to Dismiss, ¶ 25.) The hearing officer also found "a colorable claim" that Akron had violated R.C. 3902.13(K).

{¶ 11} The hearing officer issued a report and recommendation, including findings of fact and conclusions of law on April 7, 2010. The hearing officer found that the complainants became eligible for the Akron retiree health care plan and the OP&F health care plan on the same day: the day of their respective retirements. The hearing officer noted that while the complainants paid no premiums for their coverage under Akron's self-funded retiree health care plan, they paid premiums of approximately \$300 and \$566 per month, respectively, for their coverage under OP&F. Pursuant to McLeod's affidavit, the hearing officer found that retired Akron police officers and firefighters must enroll in OP&F's insurance plan as a condition precedent to receiving any coverage under Akron's plan.

{¶ 12} The hearing officer concluded that "Akron's knowing failure to apply legally appropriate coordination of benefits provisions of its self-insured program constitutes a violation of [R.C.] 3902.13(K)(1), and is, therefore, deemed an unfair and

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496 8

deceptive practice as a matter of law." (Hearing Officer's Record, 78; Hearing Officer's Report and Recommendation, ¶ 39.) The hearing officer also determined that Akron violated R.C. 3902.13(K)(2), by requiring the retirees to enroll in OP&F as a condition precedent to coverage under Akron's plan. Accordingly, the hearing officer concluded that Akron's actions constituted an unfair or deceptive act or practice under R.C. 3901.20, and recommended that ODI issue a cease and desist order.

{¶ 13} On July 20, 2010, ODI issued an order adopting the hearing officer's report and recommendation, with only minor modifications. Following the hearing officer's recommendation, ODI ordered that Akron, OP&F and MMO cease and desist from further violations of Ohio's coordination of benefits laws, and that they coordinate the benefits of their members pursuant to the terms of their plans and consistent with Ohio law. ODI further ordered that Akron immediately cease and desist from further violations of R.C. 3902.13(K)(1) and (2), and that Akron make an accounting of the complainants' past healthcare claims which were subject to coordination. ODI lastly ordered that its order be "directed to the Summit County Court of Common Pleas for further application in the case of *Metcalfe, et al.*, Case No. 2 [REDACTED]." (ODI's July 20, 2010 Order, 12.)

{¶ 14} Akron, OP&F and MMO each appealed ODI's July 20, 2010 order to the Franklin County Court of Common Pleas. The trial court consolidated the cases into one action. On October 12, 2010, the trial court granted Akron's motion to suspend enforcement of the July 20, 2010 order during the pendency of the case.

{¶ 15} On September 28, 2011, the trial court issued an entry ordering that the case be transferred to the Summit County Court of Common Pleas. The court noted that the July 20, 2010 order specified that the order should be directed to the Summit County Court of Common Pleas for application in *Metcalfe II*. Akron, OP&F and MMO jointly appealed the transfer order. On April 25, 2012, this court issued a journal entry reflecting the parties' agreement to remand the case to the trial court, so that the trial court could address the appeal pursuant to R.C. 119.12. On February 1, 2013, the trial court reactivated the case.

{¶ 16} On May 9, 2013, the trial court issued an order dismissing the administrative appeal for lack of subject-matter jurisdiction. The court noted that the

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496 9

health care plans offered by Akron and OP&F were not insurance, but merely a risk of loss retention fund. The court explained that such a funding mechanism was not insurance, but "the antithesis of insurance." (Final Judgment Entry, 3.) The court noted ODI's assertion that it was merely regulating the market-place conduct of a plan of health coverage under R.C. 3902.11(B). While the trial court found that this argument held "superficial appeal," it determined the argument failed because ODI had expressly concluded that Akron's self-funded insurance plan was insurance and subject to the insurance laws of this state. (Final Judgment Entry, 3.) The court further noted that R.C. 3901.20 prohibited unfair and/or deceptive acts or practices in the business of insurance, and thus could not "reach beyond persons engaged in the business of insurance." (Final Judgment Entry, 3-4.) Thus, because Akron and OP&F were engaged in conduct which was the antithesis of insurance, the court concluded that ODI's July 20, 2010 order was void for lack of subject-matter jurisdiction.

II. ASSIGNMENTS OF ERROR

{¶ 17} ODI appeals, assigning the following errors:

[I.] The common pleas court erred by holding that the Department lacked subject matter jurisdiction to enforce Akron and OP&F's use of a coordination of benefit provision in their plans of health coverage.

[II.] The common pleas court's rationale supporting its ultimate decision is so flawed and internally inconsistent that it alone constitutes reversible error.

[III.] The Common Pleas Court Erred by Failing to Acknowledge or Address the Department Jurisdiction Under the Doctrine of Primary Administrative Jurisdiction.

{¶ 18} The complainants appeal, assigning the following errors:

I. THE TRIAL COURT ERRED IN HOLDING THAT THE CITY OF AKRON AND THE OHIO POLICE & FIRE PENSION FUND DO NOT OFFER INSURANCE.

II. THE TRIAL COURT ERRED IN RULING THAT THE OHIO DEPARTMENT OF INSURANCE DID NOT HAVE SUBJECT MATTER JURISDICTION.

III. STANDARD OF REVIEW

{¶ 19} Under R.C. 119.12, a common pleas court, in reviewing an order of an administrative agency, must consider the entire record to determine whether reliable, probative, and substantial evidence supports the agency's order and the order is in accordance with law. *Univ. of Cincinnati v. Conrad*, 63 Ohio St.2d 108, 110-11 (1980). The common pleas court's "review of the administrative record is neither a trial *de novo* nor an appeal on questions of law only, but a hybrid review in which the court 'must appraise all the evidence as to the credibility of the witnesses, the probative character of the evidence, and the weight thereof.' " (Emphasis sic.) *Lies v. Veterinary Med. Bd.*, 2 Ohio App.3d 204, 207 (1st Dist.1981), quoting *Andrews v. Bd. of Liquor Control*, 164 Ohio St. 275, 280 (1955). The common pleas court must give due deference to the administrative agency's resolution of evidentiary conflicts, but "the findings of the agency are by no means conclusive." *Univ. of Cincinnati* at 111. The common pleas court conducts a *de novo* review of questions of law, exercising its independent judgment in determining whether the administrative order is "in accordance with law." *Ohio Historical Soc. v. State Emp. Relations Bd.*, 66 Ohio St.3d 466, 471 (1993).

{¶ 20} An appellate court's review of an administrative decision is more limited than that of a common pleas court. *Pons v. Ohio State Med. Bd.*, 66 Ohio St.3d 619, 621 (1993). The appellate court is to determine only whether the common pleas court abused its discretion. *Id.* Absent an abuse of discretion, a court of appeals may not substitute its judgment for that of an administrative agency or the common pleas court. *Id.* An appellate court, however, has plenary review of purely legal questions. *Big Bob's, Inc. v. Ohio Liquor Control Comm.*, 151 Ohio App.3d 498, 2003-Ohio-418, ¶ 15 (10th Dist.)

{¶ 21} The trial court dismissed the administrative appeal upon finding that ODI did not possess subject-matter jurisdiction to issue the cease and desist order at issue. Jurisdiction is a legal question, which courts review *de novo*. *In re: P.N.M.*, 4th Dist. No. 07CA841, 2007-Ohio-4976, ¶ 38.

IV. COMPLAINANTS' FIRST ASSIGNMENT OF ERROR—A SELF-FUNDED HEALTH CARE PLAN IS NOT INSURANCE

{¶ 22} The complainants' first assignment of error asserts the trial court erred in holding that the self-funded health care plans offered by Akron and OP&F were not insurance. The complainants note that *Black's Law Dictionary* (8th Ed.2004) defines insurance as "a contract by which one party (the insurer) undertakes to indemnify another party (the insured) against the risk of loss, damage or liability arising from some specified contingency." The complainants assert that Akron and OP&F offer plans of insurance because they have agreed to pay or indemnify the retirees when they incur costs resulting from medical services.

{¶ 23} Complainants focus solely on the fact that, ultimately, Akron's retired police officers and firefighters will have their medical bills paid through the health care plans offered by Akron and OP&F. However, the fact that the retirees' medical bills will ultimately be paid is not the correct basis on which to determine whether the health care plans at issue amount to insurance.

{¶ 24} All of the parties agree that Akron's retiree health care plan and OP&F's health care plan are self-funded. A self-funded plan or " 'self-insurance,' is not 'insurance.' " *Physicians Ins. Co. of Ohio v. Grandview Hosp. and Med. Ctr.*, 44 Ohio App.3d 157 (1988), syllabus ("*PICO*"). As the *PICO* court explained, " 'an insurance contract denotes a policy issued by an authorized and licensed insurance company whose primary business it is to assume specific risks of loss of members of the public at large in consideration of the payment of a premium.' " *Id.*, quoting *American Nurses Assn. v. Passaic Gen. Hosp.*, 192 N.J.Super. 486 (1984).

{¶ 25} While "[i]nsurance shifts the risk of loss from an insured to an insurer," self-insurance " 'is the retention of the risk of loss by the one upon whom it is directly imposed by law or contract.' " *Id.* at 158. *See also Platte v. Ford Motor Co.*, N.D. Ohio No. 3:00CV7171 (June 18, 2002), quoting *Black's Law Dictionary* 1360 (6th Ed.1990) (noting that "[s]elf-insurance is 'the practice of setting aside a fund to meet losses instead of insuring against such through insurance'"); *Young v. Progressive Southeastern Ins. Co.*, 753 So.2d 80, 85 (Fl.2000), quoting 1 Eric Mills Holmes and Mark S. Rhodes, *Appleman on Insurance*, Section 1.3, at 10 (2d Ed.1996) (explaining

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496 12

that, self-insurance does not constitute insurance in any traditional form, because " '[i]n self-insurance the company, governmental entity or individual chooses not to purchase insurance but rather retains the risk of loss' " and sets " 'aside funds on a regular basis to provide its own pool from which losses will be paid' "). *Compare FMC Corp. v. Holliday*, 498 U.S. 52, 63 (1990) (in concluding that the deemer clause in ERISA exempted self-funded ERISA plans from state laws regulating insurance, the Supreme Court noted that "[b]y recognizing a distinction between insurers of plans and the contracts of those insurers, which are subject to direct state regulation, and self-insured employee benefit plans governed by ERISA, which are not," the Supreme Court observed "Congress' presumed desire to reserve to the States the regulation of the 'business of insurance' ").

{¶ 26} Thus, fundamentally, the self-funded health care plans offered by Akron and OP&F are not insurance. Akron and OP&F have not shifted their risk of loss onto an insurer by purchasing an insurance policy. Rather, OP&F and Akron each individually set money aside in order to pay the health care costs incurred by the police and fire retirees covered under their plans. OP&F and Akron have thus both retained the risk of loss resulting from such medical services and, as such, their self-funded health care plans do not constitute insurance.

{¶ 27} Based on the foregoing, the complainants' first assignment of error is overruled.

**V. ODI'S FIRST AND SECOND ASSIGNMENTS OF ERROR;
COMPLAINANTS' SECOND ASSIGNMENTS OF ERROR: ODI'S
JURISDICTION**

{¶ 28} ODI's first assignment of error and the complainants' second assignment of error collectively assert that the trial court abused its discretion by finding that ODI did not possess jurisdiction to regulate the coordination of benefits between Akron's and OP&F's self-funded healthcare plans. In its second assignment of error, ODI contends that the trial court's rationale for determining that ODI lacked jurisdiction was flawed and internally inconsistent. As these assignments of error all relate to the determination that ODI lacked jurisdiction to issue the cease and desist order, we will address them jointly.

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496 13

{¶ 29} ODI and the complainants collectively assert that ODI possesses jurisdiction to regulate the coordination of benefits between Akron's and OP&F's health care plans, pursuant to the relevant statutes. ODI asserts that it is not attempting to regulate Akron or OP&F as individual entities, "but rather seeks to have the parties follow Ohio's coordination of benefits laws when offering health insurance plans containing such provisions." (ODI's Appellate Brief, 14-15.) ODI thus frames the issue before this court as whether ODI possesses "limited jurisdiction over the subject of coordination of benefits" between the retiree health care plans offered by Akron and OP&F. (ODI's Appellate Brief, 15.) Although ODI now frames the issue as whether it has limited jurisdiction over the issue of coordination of benefits, we note that in ruling on Akron's motion to dismiss, the ODI hearing officer expressly found that the self-funded health care plans offered by Akron and OP&F were insurance and thus subject to the insurance laws of this state.

{¶ 30} An administrative agency can exercise only those powers that are expressly conferred upon it by the Ohio General Assembly. *Shell v. Ohio Veterinary Med. Licensing Bd.*, 105 Ohio St.3d 420, 2005-Ohio-2423, ¶ 32. "[A]uthority that is conferred upon an administrative agency by the General Assembly cannot be extended by the agency." *Burger Brewing Co. v. Thomas*, 42 Ohio St.2d 377, 379 (1975). In construing a grant of administrative power from a legislative body, the intention of that grant of power, and the extent of the grant, must be clear, and, if there is doubt, that doubt must be resolved against the grant of power. *D.A.B.E., Inc. v. Toledo-Lucas Cty. Bd. of Health*, 96 Ohio St.3d 250, 2002-Ohio-4172, ¶ 40. Furthermore, where jurisdiction is dependent upon a statutory grant, courts are without authority to create jurisdiction when the statutory language does not, as that power resides only in the General Assembly. *Waltco Truck Equip. Co. v. Tallmadge Bd. of Zoning Appeals*, 40 Ohio St.3d 41, 43 (1988).

{¶ 31} " 'A basic rule of statutory construction requires that 'words in statutes should not be construed to be redundant, nor should any words be ignored.' " *D.A.B.E.* at ¶ 26, quoting *E. Ohio Gas Co. v. Pub. Util. Comm.*, 39 Ohio St.3d 295, 299 (1988). Furthermore, statutory language " 'must be construed as a whole and given such interpretation as will give effect to every word and clause in it.' " *Id.* at ¶ 26, quoting

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496 14
State ex rel. Myers v. Spencer Twp. Rural School Dist. Bd. of Edn., 95 Ohio St. 367,
 372-73 (1917).

{¶ 32} Coordination of benefits means "a procedure establishing the order in which plans shall pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses." Ohio Adm.Code 3901-8-01(C)(6). R.C. 3902.13 codifies Ohio's coordination of benefits laws. The statute provides that "[a] plan of health coverage determines its order of benefits using the first that applies: * * * (6) If none of the rules in divisions (A)(1), (2), (3), (4) and (5) of this section determines the order of benefits, the primary plan is the plan that covered the employee * * * longer." Here, none of the provisions in R.C. 3902.13(A)(1) through (5) could apply. Notably, ODI determined that the plans at issue have covered the complainants for the same amount of time, as each plan became effective upon the complainants' retirement. Ohio Adm.Code 3901-8-01(G)(6) provides that if none of the "preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans."

{¶ 33} R.C. 3902.13(K)(1) provides that "[n]o third-party payer shall knowingly fail to comply with the order of benefits as set forth in division (A) of this section." R.C. 3902.13(K)(2) provides that "[n]o primary plan shall direct or encourage an insured to use the benefits of a secondary plan that results in a reduction of payment by such primary plan." Whoever violates R.C. 3902.13(K) "is deemed to have engaged in an unfair and deceptive insurance act or practice under sections 3901.19 to 3901.26 of the Revised Code, and is subject to proceedings pursuant to those sections." R.C. 3902.13(L).

{¶ 34} R.C. 3902.11 provides definitions for the terms used in sections 3902.11 to 3902.14 of the Revised Code. R.C. 3902.11(B) defines a plan of health coverage to include any of the following:

- (1) An individual or group sickness and accident insurance policy, which policy provides for hospital, dental, surgical, or medical services;
- (2) Any individual or group contract of a health insuring corporation, which contract provides for hospital, dental, surgical, or medical services;

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496

15

(3) Any other individual or group policy or agreement under which a third-party payer provides for hospital, dental, surgical, or medical services.

(C) "Provider" means a hospital, nursing home, physician, podiatrist, dentist, pharmacist, chiropractor, or other licensed health care provider entitled to reimbursement by a third-party payer for services rendered to a beneficiary under a benefits contract.

{¶ 35} The self-funded health care plans offered by Akron and OP&F contain coordination of benefits provisions. Accordingly, ODI and complainants contend that Akron and OP&F offer plans of health coverage under R.C. 3902.11(B)(3). R.C. 3902.11(B)(3), however, is only applicable to a third-party payer. R.C. 3902.11(A) states that the term "third-party payer" has the same meaning as that term has in R.C. 3901.38. R.C. 3901.38(F) defines a third-party payer to include any of the following:

- (1) An insurance company;
- (2) A health insuring corporation;
- (3) A labor organization;
- (4) An employer;
- (5) An intermediary organization, as defined in section 1751.01 of the Revised Code, that is not a health delivery network contracting solely with self-insured employers;
- (6) An administrator subject to sections 3959.01 to 3959.16 of the Revised Code;
- (7) A health delivery network, as defined in section 1751.01 of the Revised Code;
- (8) Any other person that is obligated pursuant to a benefits contract to reimburse for covered health care services rendered to beneficiaries under such contract.

{¶ 36} ODI asserts that Akron and OP&F qualify as third-party payers under R.C. 3901.38(F)(8), as they have obligated themselves to pay the health benefits of their retirees pursuant to contract. R.C. 3901.38(F)(8) applies only to a person who is obligated to reimburse for covered health care services. Neither R.C. 3901.38 nor

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496 16

3902.11 define the word person. Although R.C. 3901.19 defines the term "person," the definitions therein are applicable only to section 3901.19 to 3901.26 of the Revised Code. Accordingly, the definition of person in R.C. 3901.19(D) is inapplicable to either R.C. 3902.11 or 3901.38. As such, we must rely on the general definition of the word "person" contained in R.C. 1.59(C), which defines a person to include "an individual, corporation, business trust, estate, trust, partnership, and association." Akron is a political subdivision and OP&F is a pension fund. Thus, as neither entity qualifies as a person under R.C. 1.59(C), neither Akron nor OP&F can qualify as a third-party payer under R.C. 3901.38(F)(8).

{¶ 37} Although Akron is technically an employer, R.C. 3901.38(F) distinguishes between employers and self-insured employers. While an employer may be a third-party payer under R.C. 3901.38(F)(4), and 3901.38(F)(5) states that an intermediary organization may qualify as a third-party payer, the intermediary organization will not qualify as a third-party payer if it is a health delivery network contracting solely with a self-insured employer. *See* R.C. 1751.01(P) (defining an intermediary organization). A health delivery network alone may also be a third-party payer under R.C. 3901.38(F)(7).

{¶ 38} It appears unreasonable to construe one of the provisions in R.C. 3901.38(F) to include a self-insured employer, when the statute expressly excludes a health delivery network contracting solely with a self-insured employer from the definition of a third-party payer. *Compare Thomas v. Freeman*, 79 Ohio St.3d 221, 224 (1997), quoting *Black's Law Dictionary* 581 (6th Ed.1990) (noting the principle of *expressio unis est exclusio alterius*, which means " 'the expression of one thing is the exclusion of the other' "); *New Albany Park Condominium Assn. v. Lifestyle Communities, Ltd.*, 195 Ohio App.3d 459, 2011-Ohio-2806 (10th Dist.), ¶ 23, quoting *Barnhart v. Peabody Coal Co.*, 537 U.S. 149, 168 (2003) (noting that the " 'canon *expressio unius est exclusio alterius* does not apply to every statutory listing or grouping; it has force only when the items expressed are members of an "associated group or series," justifying the inference that items not mentioned were excluded by deliberate choice, not inadvertence' "). As the statute expressly mentions self-insured employers, but does not include them among the list of entities that may be considered a

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496 17

third-party payer, it appears the General Assembly intentionally did not include self-insured entities in the definition of third-party payer in R.C. 3901.38(F).

{¶ 39} Our conclusion herein is further bolstered by the fact that other sections in the Revised Code which regulate insurance do expressly apply to self-insured entities. All statutes relating to the same subject matter must be read in *pari materia*, and construed together, so as to give the proper force and effect to each and all such statutes. *State v. Cook*, 128 Ohio St.3d 120, 2010-Ohio-6305, ¶ 45. *See also State v. Moaning*, 76 Ohio St.3d 126, 128 (1996) (noting that courts should construe statutory provisions together and read the Revised Code "as an interrelated body of law"); *Santarelli v. Western Reserve Transit Auth.*, 7th Dist. No. 88 C.A. 57 (Feb. 10, 1989), quoting 85 Ohio Jurisprudence 3d, Statutes, Section 225, 228 (noting that "[t]he rule of *in pari materi* is a reflection of the fact that the General Assembly, in enacting a statute, is assumed, or presumed, to have legislated with full knowledge and in the light of all statutory provisions concerning the subject matter of the act' "). "The *in pari materia* rule of construction may be used in interpreting statutes where some doubt or ambiguity exists." *State ex rel. Herman v. Klopfleisch*, 72 Ohio St.3d 581, 585 (1995).

{¶ 40} Chapter 39 of the Revised Code relates specifically to insurance. Several provisions in Chapter 39 expressly regulate self-insured plans and self-insured entities. *See* R.C. 3901.40 (providing that "[n]o insurance company, health insuring corporation, or self-insured plan authorized to do business in this state shall include or provide in its policies * * * reimbursement for services in any hospital which is not certified or accredited"); R.C. 3901.45(A)(2) (prohibiting insurers from considering an applicant's sexual orientation when determining insurability, and defining insurer for purposes of the statute to mean "any person authorized to engage in the business of life or sickness and accident insurance * * * or any person or governmental entity providing health services coverage for individuals on a self-insurance basis"); R.C. 3901.50(B)(1) (providing that "[n]o self-insurer, in processing an application for coverage under a plan of self-insurance or in determining insurability under such a plan, shall * * * [r]equire an individual seeking coverage to submit to genetic screening or testing"); R.C. 3923.38(A)(1) (providing for the continuation of health care coverage to certain terminated employees, and defining group policy for purposes of the statute to mean

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496 18

"any group sickness and accident policy or contract * * *, and any private or public employer self-insurance plan"); R.C. 3923.382(A)(2) (providing for the continuation of group plan coverage during an eligible person's military service, and stating that a group plan includes "any private or public employer self-insurance plan" which provides for health benefits "other than through an insurer or health insuring corporation"). Compare R.C. 9.833(B)(1) and (C)(10) (providing that political subdivisions "that provide health care benefits for their" employees may "[e]stablish and maintain an individual self-insurance program with public moneys to provide authorized health care benefits," that these individual self-insurance programs can join together and agree to be jointly administered; and providing that a joint self-insurance program is "not an insurance company" and its operation "does not constitute doing an insurance business and is not subject to the insurance laws of this state").

{¶ 41} Construing R.C. 3902.13 and 3901.38(F) in pari materia with the other statutes in Chapter 39 which expressly regulate self-insurance, it is apparent that the General Assembly intentionally chose not to make self-insured health care plans subject to the coordination of benefits laws. The General Assembly could have included a self-insured entity in the definition of third-party payer in R.C. 3901.38(F), or expressly made R.C. 3902.13 applicable to self-insured plans of health coverage. As the General Assembly did not make the coordination of benefits applicable to self-insured entities, when it has made other insurance laws applicable to self-insured entities, we conclude that the coordination of benefits in R.C. 3902.13 is inapplicable to self-insured health care plans. Accordingly, ODI lacked jurisdiction to regulate Akron's and OP&F's self-insured retiree health care plans.

{¶ 42} We further note that ODI issued the cease and desist order on the basis that, due to the violation of R.C. 3902.13(K), Akron's actions constituted an unfair or deceptive act under R.C. 3901.20. R.C. 3901.221 states that if a violation of R.C. 3901.20 has caused or is about to cause substantial and material harm, the superintendent of insurance may issue an order that the person cease and desist from any activity violating that section. R.C. 3901.20 provides that "[n]o person shall engage in this state in any trade practice which is defined in sections 3901.19 to 3901.23 of the Revised Code as, or determined pursuant to those sections to be, an unfair or deceptive

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496 19

act or practice in the business of insurance." Because the self-funded plans at issue are fundamentally not insurance, ODI could not find that Akron or OP&F had committed an unfair or deceptive act in the business of insurance. *See also* R.C. 3901.19(I) and 3901.32(D) (defining an insurer as "any person engaged in the business of insurance, * * * excepting any agency, authority, or instrumentality of the United States, its possessions and territories, * * * or a state or political subdivision of a state").

{¶ 43} Accordingly, we find that the trial court correctly concluded that ODI lacked jurisdiction to issue the cease and desist against Akron, OP&F and MMO. Because Akron, OP&F and MMO are not subject to the requirements of R.C. 3902.13, they could not have been deemed to engage in an unfair or deceptive insurance acts under R.C. 3902.13(L). By issuing the cease and desist order against Akron, OP&F and MMO, ODI sought to impermissibly expand its authority, beyond what authority the General Assembly saw fit to provide it with.

{¶ 44} Complainants and ODI argue that the result herein is unjust, as the complainants are now left without a remedy. We disagree. Although it is true that the complainants do not have a cause of action to enforce Ohio's coordination of benefits laws against Akron and OP&F, this is because the coordination of benefits laws are not applicable to self-funded health care plans. Akron police officers and firefighters are both members of unions. These unions enter into collective bargaining agreements with Akron. The unions may negotiate and attempt to include provisions in their collective bargaining agreements which would obligate Akron to coordinate the benefits in their retiree health care plans in a way the complainants' desire. Complainants may then enforce these provisions by filing grievances under their respective collective bargaining agreements. *See Fraternal Order of Police, Akron Lodge No. 7* at ¶ 4, 30 (finding that the grievance, asserting that Akron violated the collective bargaining agreement by increasing premiums, requiring retirees to maintain OP&F as their primary coverage, and ceasing to provide secondary coverage to certain retirees, was subject to arbitration). As the issue before us does not come within ODI's statutory jurisdiction, the complainants' remedy lies in their ability to negotiate for new terms under their collective bargaining agreements.

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496 20

{¶ 45} Based on the foregoing, ODI's first and second assignments of error, and the complainants' second assignment of error are overruled.

VI. ODI'S THIRD ASSIGNMENT OF ERROR—PRIMARY ADMINISTRATIVE JURISDICTION

{¶ 46} ODI's third assignment of error asserts the trial court erred by failing to acknowledge or address ODI's jurisdiction under the doctrine of primary administrative jurisdiction.

{¶ 47} The doctrine of primary administrative jurisdiction permits a court to avail itself of the expertise of an administrative agency having special competence in the matter at hand. *Cleveland Elec. Illuminating Co. v. Cleveland*, 50 Ohio App.2d 275, 287 (8th Dist.1976). Primary administrative jurisdiction "applies where a claim is originally cognizable in the courts, and comes into play whenever enforcement of the claim requires the resolution of issues which, under a regulatory scheme, have been placed within the special competence of an administrative body." *United States v. Western Pacific Ry. Co.*, 352 U.S. 59, 64 (1956). In such a case, "the judicial process is suspended pending referral of such issues to the administrative body for its views." *Id.* There is no fixed formula for applying the doctrine of primary administrative jurisdiction, rather in each case "the question is whether the reasons for the existence of the doctrine are present and whether the purposes it serves will be aided by its application in the particular litigation." *Id.*

{¶ 48} ODI asserts that even if R.C. 3902.13 "did not specifically vest the Department with jurisdiction over the issue of coordination, the doctrine of primary administrative jurisdiction would provide a separate alternative basis for the Department to assert jurisdiction." (ODI's Appellate Brief, 34.) We disagree. As ODI did not possess subject-matter jurisdiction to regulate the self-funded health care plans offered by Akron and OP&F, the doctrine of primary administrative jurisdiction could not vest jurisdiction in ODI.

{¶ 49} Based on the foregoing, ODI's third assignment of error is overruled.

Nos. 13AP-473, 13AP-483, 13AP-484, 13AP-486, 13AP-495 and 13AP-496

21

VII. DISPOSITION

{¶ 50} Having overruled ODI's first, second and third assignments of error, and having overruled the complainants' first and second assignments of error, we affirm the judgment of the Franklin County Court of Common Pleas.

Judgment affirmed.

BROWN and KLATT, JJ., concur.

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

City of Akron,	:	
Appellant-Appellee,	:	
v.	:	Nos. 13AP-473
	:	and 13AP-486
	:	(C.P.C. No. 10CVF-08-11258)
Ohio State Department of Insurance et al.,	:	(REGULAR CALENDAR)
Appellees-Appellants,	:	
[Timothy Metcalfe & William Biasella,	:	
Appellees-Appellants].	:	
Ohio Police & Fire Pension Fund,	:	
Appellee-Appellee,	:	
v.	:	Nos. 13AP-483
	:	and 13AP-496
	:	(C.P.C. No. 10CVF-08-11426)
Ohio Department of Insurance et al.,	:	(REGULAR CALENDAR)
Appellees-Appellants.	:	
Medical Mutual of Ohio,	:	
Appellant-Appellee,	:	
v.	:	Nos. 13AP-484
	:	and 13AP-495
	:	(C.P.C. No. 10CVF-08-11513)
Ohio Department of Insurance et al.,	:	(REGULAR CALENDAR)
Appellants-Appellants,	:	
[Timothy Metcalfe & William Biasella,	:	
Appellants-Appellants.]	:	

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 Mar 25 2:53 PM-13AP000473

Nos. 13AP-473, 13AP-486, 13AP-483, 13AP-496, 13AP-484 & 13AP-495

2

JOURNAL ENTRY

For the reasons stated in the memorandum decision of this court rendered herein on March 25, 2014, it is the judgment and order of this court that appellants' application for reconsideration is denied. Costs assessed against appellants.

CONNOR, BROWN and KLATT, JJ.

/S/JUDGE

Judge John A. Connor

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 Mar 25 2:53 PM-13AP000473

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

City of Akron,	:	
Appellant-Appellee,	:	
v.	:	Nos. 13AP-473
	:	and 13AP-486
	:	(C.P.C. No. 10CVF-08-11258)
Ohio State Department of Insurance et al.,	:	(REGULAR CALENDAR)
Appellees-Appellants,	:	
[Timothy Metcalfe & William Biasella,	:	
Appellees-Appellants].	:	
Ohio Police & Fire Pension Fund,	:	
Appellee-Appellee,	:	
v.	:	Nos. 13AP-483
	:	and 13AP-496
Ohio Department of Insurance et al.,	:	(C.P.C. No. 10CVF-08-11426)
Appellees-Appellants.	:	(REGULAR CALENDAR)
Medical Mutual of Ohio,	:	
Appellant-Appellee,	:	
v.	:	Nos. 13AP-484
	:	and 13AP-495
Ohio Department of Insurance et al.,	:	(C.P.C. No. 10CVF-08-11513)
Appellants-Appellants,	:	(REGULAR CALENDAR)
[Timothy Metcalfe & William Biasella,	:	
Appellants-Appellants.]	:	

Franklin County Ohio Court of Appeals Clerk of Courts- 2014 Mar 25 12:45 PM-13AP000473

MEMORANDUM DECISION

Rendered on March 25, 2014

Roetzel & Andress, LPA, Paul L. Jackson and Karen D. Adinolfi; Cheri B. Cunningham, Director of Law, and Tammy L. Kalail, for appellee City of Akron.

Michael DeWine, Attorney General, Jennifer S. M. Croskey and Matthew T. Green, for appellee Ohio Police & Fire Pension Fund.

Larry D. Shenise, for appellants Timothy Metcalfe and William Biasella.

ON MOTION FOR RECONSIDERATION

CONNOR, J.

{¶ 1} Appellants, Timothy Metcalfe and William Biasella ("complainants"), have timely applied for reconsideration, pursuant to App.R. 26(A), of our decision in *Akron v. Ohio Dept. of Ins.*, 10th Dist. No. 13AP-473, 2014-Ohio-96. Appellees, the City of Akron ("Akron") and the Ohio Police & Fire Pension Fund ("OP&F"), have filed memoranda in opposition to reconsideration.

{¶ 2} When presented with an application for reconsideration filed pursuant to App.R. 26, an appellate court must determine whether the application "calls to the attention of the court an obvious error in its decision, or raises an issue for consideration that was either not considered at all or was not fully considered by the court when it should have been." *Columbus v. Hodge*, 37 Ohio App.3d 68 (10th Dist.1987), syllabus. Importantly, an appellate court will not grant "[a]n application for reconsideration * * * just because a party disagrees with the logic or conclusions of the appellate court." *Bae v. Drago & Assoc., Inc.*, 10th Dist. No. 03AP-254, 2004-Ohio-1297, ¶ 2.

{¶ 3} In *Akron*, we affirmed the judgment of the Franklin County Court of Common Pleas which dismissed the administrative appeal filed by the complainants and the Ohio Department of Insurance ("ODI"). The trial court dismissed the appeal upon finding that ODI did not have jurisdiction to regulate the self-funded retiree health care plans sponsored by Akron and OP&F, and administered by Medical Mutual of Ohio ("MMO"). In *Akron*, we determined that: (1) the self-funded health care plans were not insurance, (2) ODI did not have jurisdiction to regulate the coordination of benefits between Akron's and OP&F's health care plans because the coordination of benefits statutes did not apply to self-funded plans, (3) ODI accordingly lacked jurisdiction to issue the cease and desist order at issue, and (4) the doctrine of primary administrative jurisdiction could not vest ODI with jurisdiction over the action.

{¶ 4} In their application for reconsideration, the complainants note that they take no issue with this court's determination that the self-funded health care plans offered by Akron and OP&F were not insurance. Rather, the complainants take issue with this court's determination that ODI lacked jurisdiction over the coordination of benefits provisions contained within those self-funded health care plans.

{¶ 5} Complainants first assert that, "a point missed when the Court was discussing the procedural history and facts is that the case first arrived at ODI after each of the Defendants filed" motions to dismiss in *Metcalf v. Akron*, Summit C.P. No. 2 ██████████, "arguing that the common pleas court had no jurisdiction because there was no private right" of action to enforce a violation of R.C. 3902.13. (Application for Reconsideration, 3.) This court was aware that Akron and OP&F had filed motions to dismiss in the Summit County action. That fact was intentionally omitted from our decision, as it is not particularly relevant to the instant action, which originated when the complainants filed a complaint with ODI asserting that Akron, OP&F, and MMO had violated Ohio's coordination of benefits law.

{¶ 6} The complainants next note that the Superintendent of Insurance promulgated Ohio Adm.Code 3901-8-01 pursuant to the Superintendent's rulemaking authority in R.C. 3901.041 and 3902.14. See Ohio Adm.Code 3901-8-01(A); R.C. 3901.041 (stating that the "superintendent of insurance shall adopt * * * rules * * *

necessary to discharge the superintendent's duties * * * and powers under * * * Title XXXIX [39] of the Revised Code"); R.C. 3902.14 (stating that the "superintendent of insurance may, pursuant to Chapter 119. of the Revised Code, adopt rules to carry out the purposes of sections 3902.11 to 3902.14 of the Revised Code"). The purposes of Ohio Adm.Code 3901-8-01 is to "[p]ermit plans to include a coordination of benefits '(COB)' provision" to "[e]liminate duplication of benefits" to "[r]educe claim payment delays" and to "[f]urther define the 'COB' statute." Ohio Adm.Code 3901-8-01(B).

{¶ 7} Ohio Adm.Code 3901-8-01(C)(11)(a) defines the term "plan" as "a form of coverage with which coordination is allowed." The code section states that a "plan" includes "[g]roup and non-group insurance and subscriber contracts." Ohio Adm.Code 3901-8-01(C)(11)(c)(i). Complainants note that "[b]ased on this Court's ruling that the self-funded plans of the City of Akron and OP&F are not insurance * * *, both plans would be excluded from" the Ohio Adm.Code 3901-8-01(C)(11)(c)(i) definition of a plan. (Application for Reconsideration, 6.)

{¶ 8} Complainants further note that Ohio Adm.Code 3901-8-01(C)(11)(c)(ii) states that a "plan" includes "[a]n uninsured arrangement of group or group-type coverage." Complainants do not advance any argument as to what an uninsured arrangement of group-type coverage is precisely, and this court's independent research has not revealed any case law interpreting the phrase "uninsured arrangement." As pertinent to the instant motion, the complainants do not assert that Ohio Adm.Code 3901-8-01(C)(11)(c)(ii) encompasses self-funded health care plans, nor do the complainants assert that ODI had jurisdiction over the self-funded health care plans at issue due to Ohio Adm.Code 3901-8-01(C)(11)(c)(ii). Rather, complainants state that "[m]ore notably [sic] is the language not found in O.A.C. § 3901-8-01(C)(11)(d) which specifically defines what are not plans." (Application for Reconsideration, 6.) Ohio Adm.Code 3901-8-01(C)(11)(d) states that the term "plan" does not include the following:

- (i) Hospital indemnity benefits or other fixed indemnity coverage;
- (ii) Accident only coverage or specified accident coverage;

(iii) A supplemental sickness and accident policy excluded from coordination of benefits pursuant to sections 3923.37 and/or 1751.56 of the Revised Code;

(iv) School accident-type coverage;

(v) Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(vi) Medicare supplement policies; or

(vii) A state plan under medicaid, or other governmental plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

Complainants note that "[n]owhere is the term self-funded plan found" in Ohio Adm.Code 3901-8-01(C)(11)(d). (Application for Reconsideration, 7.)

{¶ 9} It is difficult for this court to ascertain what complainants' argument is regarding Ohio Adm.Code 3901-8-01. The complainants note that self-funded health care plans are not expressly excluded from the definition of "plan" in Ohio Adm.Code 3901-8-01(C)(11)(d). However, simply because self-funded plans are not expressly excluded from the definition of "plan" in Ohio Adm.Code 3901-8-01(C)(11)(d) does not lead to the conclusion that ODI possessed jurisdiction to regulate such plans, especially as the coordination of benefits law is not applicable to self-insured entities or self-funded plans. *See Akron* at ¶ 41. Complainants cite Ohio Adm.Code 3901-8-01(C)(11)(c)(ii), but do not argue that self-insured plans are included within that definition. To the extent the complainants' citation to Ohio Adm.Code 3901-8-01(C)(11)(c)(ii) may be construed as an argument that Ohio Adm.Code 3901-8-01(C)(11)(c)(ii) encompasses self-funded health care plans, and thus subjects self-funded plans to the coordination of benefits rules and regulations, this argument fails.

{¶ 10} Initially, we note that the complainants did not present any argument regarding Ohio Adm.Code 3901-8-01 in their appeal to this court.¹ Complainants asserted in their appellate brief that R.C. 3902.13, 3902.11, and 3901.38, and Ohio Adm.Code 3901-8-05, granted ODI jurisdiction over the coordination of benefits provisions contained within Akron's and OP&F's self-funded health care plans. "Errors or issues which were not placed before the court on appeal, cross-appeal, or by cross assignment of error need not be considered for the first time on a motion for reconsideration." *Matter of Certain Certificates of Deposit Issued by Hocking Valley Bank of Athens Co.*, 4th Dist. No. 1419 (Sept. 5, 1990). Compare *Jeffries v. Jeffries*, 12th Dist. No. CA86-09-064 (April 27, 1987) (noting that "even though appellant has clearly failed to raise this issue before this application for reconsideration, we will consider the issue at this time, in part because * * * of the serious due process violation alleged").

{¶ 11} However, even if the complainants had advanced an argument regarding Ohio Adm.Code 3901-8-01(C)(11) in their appellate brief, we would not find that Ohio Adm.Code 3901-8-01(C)(11)(c)(ii) demonstrates an obvious error in our prior decision, as that code provision cannot permissibly be construed to encompass self-insured plans. ODI is a creature of statute. "[A]s a creature of statute, [ODI] may exercise only that jurisdiction conferred upon it by statute." *Time Warner AxS v. Pub. Util. Comm.*, 75 Ohio St.3d 229, 234 (1996). See also *Waltco Truck Equip. Co. v. City of Tallmadge Bd. of Zoning Appeals*, 40 Ohio St.3d 41, 43 (1988). "[A]uthority that is conferred upon an administrative agency by the General Assembly cannot be extended by the agency." *Burger Brewing Co. v. Thomas*, 42 Ohio St.2d 377, 379 (1975). In construing a grant of administrative power from a legislative body, the intention of that grant of power, and the extent of the grant, must be clear, and, if there is doubt, that doubt must be resolved against the grant of power. *D.A.B.E., Inc. v. Toledo-Lucas Cty. Bd. of Health*, 96 Ohio St.3d 250, 2002-Ohio-4172, ¶ 40. "[A]n administrative rule may not add to or subtract from a legislative enactment. * * * If it does, the rule clearly conflicts with the statute,

¹ The other appellant in the action, ODI, also did not argue on appeal that Ohio Adm.Code 3901-8-01(C) vested ODI with jurisdiction over the action. ODI has not filed an application for reconsideration of our decision in *Akron*.

and the rule is invalid." *State ex rel. Am. Legion Post 25 v. Ohio Civ. Rights Comm.*, 117 Ohio St.3d 441, 2008-Ohio-1261, ¶ 14.

{¶ 12} As noted in our decision in *Akron*, the General Assembly did not make R.C. 3902.13, the coordination of benefits law, applicable to self-insured entities or self-insured plans. See *Akron* at ¶ 32-41. Accordingly, if we were to construe Ohio Adm.Code 3901-8-01(C)(11)(c)(ii) to encompass self-insured plans, such a construction of the code section would amount to an impermissible administrative addition to the coordination of benefits statute. Such a construction would thus render that portion of the administrative rule invalid. See *Pacella v. Ohio Dept. of Commerce, Div. of Real Estate*, 10th Dist. No. 02AP-1223, 2003-Ohio-3432, ¶ 28 (holding that, as R.C. 4735.58(A) did not require a licensee to obtain a signature from the seller when providing the seller with the agency disclosure form, but Ohio Adm.Code 1301:5-6-06 did require the licensee to obtain the seller's signature, "[a]n interpretation of Ohio Adm.Code 1301:5-6-06 to require an agent to secure or request the signature of the seller upon presentment of the disclosure would exceed the scope of power delegated to the division [in] R.C. 4735.58"); *Holtz v. Ohio Dept. of Commerce*, 8th Dist. No. 92403, 2009-Ohio-6304, ¶ 19 (where R.C. 1322.041 barred only applicants convicted of " 'theft' from obtaining [residential mortgage loan officer's] licenses," and Ohio Adm.Code 1301:8-7-01(K) defined theft to include a broad variety of offenses, thereby barring "applicants convicted of a variety of offenses from obtaining licenses," the code section was invalid); *State ex rel. Am. Legion Post 25* at ¶ 15 (noting that where the "administrative rule add[ed] to the legislative enactment" and thereby required an "extra step" which "conflict[ed] with the statute," the court concluded that the rule "must fail").

{¶ 13} We further note that, even if ODI had attempted to impermissibly extend its jurisdiction by including self-insured plans in the Ohio Adm.Code 3901-8-01(C)(11) definition, we believe ODI would have expressly used the term "self-funded plan" or "self-insured plan." Our belief here results from the fact that ODI has expressly made other sections in Ohio Adm.Code 3901-8 applicable to self-insured plans and entities. See Ohio Adm.Code 3901-8-03(D) (stating that the rule providing for standardized forms to be used in the billing of health care costs applies to "all issuers of policies or

contracts of insurance, [and] administrators of self-funded employee benefit plans"); Ohio Adm.Code 3901-8-05(B)(1) (providing rules for sections 3959.01 to 3959.16 and 3959.99 of the Revised Code, and defining a third part administrator as "any person that adjusts or settles claims in connection with life, dental, vision, health or disability insurance plans, [and] self-insurance programs"); Ohio Adm.Code 3901-8-05(B)(8) (specifically defining the term "self-insurance program" and "self-insured plan" for purposes of Ohio Adm.Code 3901-8-05); Ohio Adm.Code 3901-8-06(D)(4) (delineating the form and content for a HIV model consent form, and defining "insurer" to mean "any person authorized to engage in the business of life or sickness and accident insurance * * * or any person or governmental entity providing health services coverage for individuals on a self-insurance basis").

{¶ 14} Lastly, complainants assert that Akron and OP&F are third-party payers under R.C. 3901.38(F), as they are "persons" under R.C. 3901.38(F)(8). Complainants argued on appeal that Akron and OP&F were persons under R.C. 3901.38(F)(8) because they were legal entities and thus persons under the R.C. 3901.19(A) definition of the term person. We rejected that argument, as R.C. 3901.19 expressly provides definitions for only sections 3901.19 to 3901.26 of the Revised Code. *Akron* at ¶ 36.

{¶ 15} Complainants assert in their application for reconsideration that Akron and OP&F are persons for purposes of R.C. 3901.38(F)(8), because "[t]he term person is clearly defined for the purpose of all of Title 39 within" R.C. 3901.04(A)(2). (Application for Reconsideration, 7.) R.C. 3901.04 states that "[a]s used in this section: * * * 'Person' has the meaning defined in division (A) of section 3901.19 of the Revised Code." R.C. 3901.04(A)(2). R.C. 3901.04(A)(2) provides that the term "person" as used in that section, i.e. section 3901.04 of the Revised Code, has the same definition as the term "person" has in R.C. 3901.19(A). There is no indication in R.C. 3901.04 that the R.C. 3901.19(A) definition of the term "person" is applicable to every section in Title 39 of the Revised Code. *Compare* R.C. 3901.32(E) (providing a definition of "person" for sections 3901.32 to 3901.37 of the Revised Code).

{¶ 16} Complainants finally assert that our holding that Akron and OP&F do not qualify as third-party payers under R.C. 3901.38(F) was in error. Complainants,

however, do not direct this court to an error in our analysis regarding R.C. 3901.38(F). Rather, complainants simply disagree with this court's logic regarding why Akron and OP&F are not third-party payers under R.C. 3901.38(F). Although complainants note that MMO is an insurance company, for purposes of this action, MMO was merely the administrator of the self-insured health care plans offered by Akron and OP&F.

{¶ 17} Having thoroughly reviewed the complainants' arguments in support of their application for reconsideration, we conclude the application neither calls our attention to an obvious error in our judgment, nor does it raise an issue for consideration that was not fully considered when it should have been. Accordingly, we deny the complainants' application for reconsideration.

Application for reconsideration denied.

BROWN and KLATT, JJ., concur.

Ohio Statutes
Title 39. INSURANCE
Chapter 3901. SUPERINTENDENT OF INSURANCE

Current through the 130th General Assembly

§ 3901.04. Superintendent – specific powers

- (A) As used in this section:
- (1) "Laws of this state relating to insurance" include but are not limited to Chapter 1751, notwithstanding section 1751.08, Chapter 1753., Title XXXIX, sections 5725.18 to 5725.25, and Chapter 5729. of the Revised Code. Sections 4717.31, 4717.33, 4717.34, 4717.35, and 4717.37 of the Revised Code are "laws of this state relating to insurance" to the extent those sections apply to insurance companies or insurance agents.
 - (2) "Person" has the meaning defined in division (A) of section 3901.19 of the Revised Code.
- (B) Whenever it appears to the superintendent of insurance, from the superintendent's files, upon complaint or otherwise, that any person has engaged in, is engaged in, or is about to engage in any act or practice declared to be illegal or prohibited by the laws of this state relating to insurance, or defined as unfair or deceptive by such laws, or when the superintendent believes it to be in the best interest of the public and necessary for the protection of the people in this state, the superintendent or anyone designated by the superintendent under the superintendent's official seal may do any one or more of the following:
- (1) Require any person to file with the superintendent, on a form that is appropriate for review by the superintendent, an original or additional statement or report in writing, under oath or otherwise, as to any facts or circumstances concerning the person's conduct of the business of insurance within this state and as to any other information that the superintendent considers to be material or relevant to such business;
 - (2) Administer oaths, summon and compel by order or subpoena the attendance of witnesses to testify in relation to any matter which, by the laws of this state relating to insurance, is the subject of inquiry and investigation, and require the production of any book, paper, or document pertaining to such matter. A subpoena, notice, or order under this section may be served by certified mail, return receipt requested. If the subpoena, notice, or order is returned because of inability to deliver, or if no return is received within thirty days of the date of mailing, the subpoena, notice, or order may be served by ordinary mail. If no return of ordinary mail is received within thirty days after the date of mailing, service shall be deemed to have been made. If the subpoena, notice, or order is returned because of inability to deliver, the superintendent may designate a person or persons to effect either personal or residence service upon the witness. Service of any subpoena, notice, or order and return may also be made in any manner authorized under the Rules of Civil Procedure. Such service shall be made by an employee of the department designated by the superintendent, a sheriff, a deputy sheriff, an attorney, or any person authorized by the Rules of Civil Procedure to serve process.
In the case of disobedience of any notice, order, or subpoena served on a person or the refusal of a witness to testify to a matter regarding which the person may lawfully be interrogated, the court of common pleas of the county where venue is appropriate, on application by the superintendent, may compel obedience by attachment proceedings for contempt, as in the case of disobedience of the requirements of a subpoena issued from such court, or a refusal to testify therein. Witnesses shall receive the fees and mileage allowed by section 119.094 of the Revised Code. All such fees, upon the presentation of proper vouchers approved by the superintendent, shall be paid out of the appropriation for the contingent fund of the department of insurance. The fees and mileage of witnesses not summoned by the superintendent or the superintendent's designee shall not be paid by the state.
 - (3) In a case in which there is no administrative procedure available to the superintendent to resolve a matter at issue, request the attorney general to commence an action for a declaratory judgment under Chapter 2721. of the Revised Code with respect to the matter.
 - (4) Initiate criminal proceedings by presenting evidence of the commission of any criminal offense established under the laws of this state relating to insurance to the prosecuting attorney of any county in which the

offense may be prosecuted. At the request of the prosecuting attorney, the attorney general may assist in the prosecution of the violation with all the rights, privileges, and powers conferred by law on prosecuting attorneys including, but not limited to, the power to appear before grand juries and to interrogate witnesses before grand juries.

Cite as R.C. § 3901.04

History. Effective Date: 10-01-1998; 2008 HB525 07-01-2009; 2008 SB196 07-06-2009

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Ohio Statutes**Title 39. INSURANCE****Chapter 3901. SUPERINTENDENT OF INSURANCE**

Current through the 130th General Assembly

§ 3901.041. Rule-making and adjudicating powers of superintendent

The superintendent of insurance shall adopt, amend, and rescind rules and make adjudications, necessary to discharge the superintendent's duties and exercise the superintendent's powers, including, but not limited to, the superintendent's duties and powers under Chapters 1751. and 1753. Title XXXIX [39] of the Revised Code, subject to Chapter 119. of the Revised Code.

Cite as R.C. § 3901.041

History. Effective Date: 10-01-1998

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Ohio Statutes
Title 39. INSURANCE
Chapter 3902. INSURANCE POLICIES AND CONTRACTS

Current through the 130th General Assembly

§ 3902.11. Coordination of benefits definitions

As used in sections 3902.11 to 3902.14 of the Revised Code:

- (A) "Beneficiary" and "third-party payer" have the same meanings as in section 3901.38 of the Revised Code.
- (B) "Plan of health coverage" means any of the following if the policy, contract, or agreement contains a coordination of benefits provision:
 - (1) An individual or group sickness and accident insurance policy, which policy provides for hospital, dental, surgical, or medical services;
 - (2) Any individual or group contract of a health insuring corporation, which contract provides for hospital, dental, surgical, or medical services;
 - (3) Any other individual or group policy or agreement under which a third-party payer provides for hospital, dental, surgical, or medical services.
- (C) "Provider" means a hospital, nursing home, physician, podiatrist, dentist, pharmacist, chiropractor, or other licensed health care provider entitled to reimbursement by a third-party payer for services rendered to a beneficiary under a benefits contract.

Cite as R.C. § 3902.11

History. Effective Date: 07-24-2002

Ohio Statutes
Title 39. INSURANCE
Chapter 3902. INSURANCE POLICIES AND CONTRACTS

Current through the 130th General Assembly

§ 3902.13. Order of benefits for health coverage plan

- (A) A plan of health coverage determines its order of benefits using the first of the following that applies:
- (1) A plan that does not coordinate with other plans is always the primary plan.
 - (2) The benefits of the plan that covers a person as an employee, member, insured, or subscriber, other than a dependent, is the primary plan. The plan that covers the person as a dependent is the secondary plan.
 - (3) When more than one plan covers the same child as a dependent of different parents who are not divorced or separated, the primary plan is the plan of the parent whose birthday falls earlier in the year. The secondary plan is the plan of the parent whose birthday falls later in the year. If both parents have the same birthday, the benefits of the plan that covered the parent the longer is the primary plan. The plan that covered the parent the shorter time is the secondary plan. If the other plan's provision for coordination of benefits does not include the rule contained in this division because it is not subject to regulation under this division, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.
 - (4)
 - (a) Except as provided in division (A)(4)(b) of this section, if more than one plan covers a person as a dependent child of divorced or separated parents, benefits for the child are determined in the following order:
 - (i) The plan of the parent who is the residential parent and legal custodian of the child;
 - (ii) The plan of the spouse of the parent who is the residential parent and legal custodian of the child;
 - (iii) The plan of the parent who is not the residential parent and legal custodian of the child.
 - (b) If the specific terms of a court decree state that one parent is responsible for the health care expenses of the child, the plan of that parent is the primary plan. A parent responsible for the health care pursuant to a court decree must notify the insurer or health insuring corporation of the terms of the decree.
 - (5) The primary plan is the plan that covers a person as an employee who is neither laid off or retired, or that employee's dependent. The secondary plan is the plan that covers that person as a laid-off or retired employee, or that employee's dependent.
 - (6) If none of the rules in divisions (A)(1), (2), (3), (4), and (5) of this section determines the order of benefits, the primary plan is the plan that covered an employee, member, insured, or subscriber longer. The secondary plan is the plan that covered that person the shorter time.
- (B) When a plan of health coverage is determined to be a secondary plan it acts to provide benefits in excess of those provided by the primary plan.
- (C) The secondary plan shall not be required to make payment in an amount which exceeds the amount it would have paid if it were the primary plan, but in no event, when combined with the amount paid by the primary plan, shall payments by the secondary plan exceed one hundred per cent of expenses allowable under the provisions of the applicable policies and contracts.
- (D) A third-party payer may require a beneficiary to file a claim with the primary plan before it determines the amount of its payment obligation, if any, with regard to that claim.
- (E) Nothing in this section shall be construed to require a plan to make a payment until it determines whether it is the primary plan or the secondary plan and what benefits are payable under the primary plan.

- (F) A plan may obtain any facts and information necessary to apply the provisions of this section, or supply this information to any other third-party payer or provider, or any agent of such third-party payer or provider, without the consent of the beneficiary. Each person claiming benefits under the plan shall provide any information necessary to apply the provisions of this section.
- (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.
- (H) No third-party payer shall administer a plan of health coverage delivered, issued for delivery, or renewed on or after June 29, 1988, unless such plan complies with this section.
- (I)
 - (1) A third-party payer that is subject to this section and has reason to believe payment has been made by another third-party payer for the same service may request from that third-party payer, and shall be provided by the third-party payer, such data as necessary to determine whether duplicate payment has been made.
 - (2) A third-party payer that meets the criteria of a secondary payer in accordance with this section may seek repayment of any duplicate payment that may have been made from the person to whom it made payment. If the person who received the duplicate payment is a provider, absent a finding of a court of competent jurisdiction that the provider has engaged in civil or criminal fraudulent activities, the request for the return of any duplicate payment shall be made within three years after the close of the provider's fiscal year in which the duplicate payment has been made.
- (J) Nothing in this section shall be construed to affect the prohibition of section 3923.37 of the Revised Code.
- (K)
 - (1) No third-party payer shall knowingly fail to comply with the order of benefits as set forth in division (A) of this section.
 - (2) No primary plan shall direct or encourage an insured to use the benefits of a secondary plan that results in a reduction of payment by such primary plan.
- (L) Whoever violates division (K) of this section is deemed to have engaged in an unfair and deceptive insurance act or practice under sections 3901.19 to 3901.26 of the Revised Code, and is subject to proceedings pursuant to those sections.

Cite as R.C. § 3902.13

History. Effective Date: 06-04-1997

Ohio Statutes
Title 39. INSURANCE
Chapter 3902. INSURANCE POLICIES AND CONTRACTS

Current through the 130th General Assembly

§ 3902.14. Rules

The superintendent of insurance may, pursuant to Chapter 119. of the Revised Code, adopt rules to carry out the purposes of sections 3902.11 to 3902.14 of the Revised Code.

Cite as R.C. § 3902.14

History. Effective Date: 06-29-1988

Ohio Statutes
Title 39. INSURANCE
Chapter 3901. SUPERINTENDENT OF INSURANCE

Current through the 130th General Assembly

§ 3901.19. Unfair and deceptive practices definitions

As used in sections 3901.19 to 3901.26 of the Revised Code:

- (A) "Person" means any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, fraternal benefit society, title guarantee and trust company, health insuring corporation, and any other legal entity.
- (B) "Residents" includes any individual, partnership, or corporation.
- (C) "Maternity benefits" means those benefits calculated to indemnify the insured for hospital and medical expenses fairly and reasonably associated with a pregnancy and childbirth.
- (D) "Insurance" includes, but is not limited to, any policy or contract offered, issued, sold, or marketed by an insurer, corporation, association, organization, or entity regulated by the superintendent of insurance or doing business in this state. Nothing in any other section of the Revised Code shall be construed to exclude single premium deferred annuities from the regulation of the superintendent under sections 3901.19 to 3901.26 of the Revised Code.
- (E) "Affiliate" means any company that controls, is controlled by, or is under common control with, another company.
- (F) "Customer" means an individual who purchases, applies to purchase, or is solicited to purchase insurance products primarily for personal, family, or household purposes.
- (G) "Depository institution" means a bank, savings bank, savings and loan association, or credit union that is subject to regulation or supervision by the United States or any state. "Depository institution" does not include an insurance company.
- (H) "Insurance agent" or "agent" has the same meaning as in section 3905.01 of the Revised Code.
- (I) "Insurer" has the same meaning as in section 3901.32 of the Revised Code.
- (J) "Policy" or "certificate" means a contract of insurance, indemnity, medical, health or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any insurer.

Cite as R.C. § 3901.19

History. Effective Date: 09-01-2002

Ohio Statutes
Title 39. INSURANCE
Chapter 3901. SUPERINTENDENT OF INSURANCE

Current through the 130th General Assembly

§ 3901.38. Prompt payments to health care providers definitions

As used in this section and sections 3901.381 to 3901.3814 of the Revised Code:

- (A) "Beneficiary" means any policyholder, subscriber, member, employee, or other person who is eligible for benefits under a benefits contract.
- (B) "Benefits contract" means a sickness and accident insurance policy providing hospital, surgical, or medical expense coverage, or a health insuring corporation contract or other policy or agreement under which a third-party payer agrees to reimburse for covered health care or dental services rendered to beneficiaries, up to the limits and exclusions contained in the benefits contract.
- (C) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.
- (D) "Provider" means a hospital, nursing home, physician, podiatrist, dentist, pharmacist, chiropractor, or other health care provider entitled to reimbursement by a third-party payer for services rendered to a beneficiary under a benefits contract.
- (E) "Reimburse" means indemnify, make payment, or otherwise accept responsibility for payment for health care services rendered to a beneficiary, or arrange for the provision of health care services to a beneficiary.
- (F) "Third-party payer" means any of the following:
 - (1) An insurance company;
 - (2) A health insuring corporation;
 - (3) A labor organization;
 - (4) An employer;
 - (5) An intermediary organization, as defined in section 1751.01 of the Revised Code, that is not a health delivery network contracting solely with self-insured employers;
 - (6) An administrator subject to sections 3959.01 to 3959.16 of the Revised Code;
 - (7) A health delivery network, as defined in section 1751.01 of the Revised Code;
 - (8) Any other person that is obligated pursuant to a benefits contract to reimburse for covered health care services rendered to beneficiaries under such contract.

Cite as R.C. § 3901.38

History. Effective Date: 07-24-2002

Ohio Administrative Code
3901 . Department of Insurance
Chapter 3901-8. Health Insurance

All rules passed and filed through October 31, 2014

3901-8-01. Coordination of benefits

(A) Authority

This rule is promulgated pursuant to section 3901.041 of the Revised Code, providing that the superintendent of insurance shall adopt, amend and rescind rules and make adjudications necessary to discharge his duties and exercise his powers under Title 39 of the Revised Code; and section 3902.14 of the Revised Code, providing that the superintendent may adopt rules to carry out the purposes of sections 3902.11 to 3902.14 of the Revised Code.

(B) Purpose

The purpose of this rule is to:

- (1) Permit plans to include a coordination of benefits "(COB)" provision;
- (2) Provide the authority for the orderly transfer of information needed to pay claims promptly;
- (3) Eliminate duplication of benefits by permitting a plan to reduce benefits paid when, pursuant to this rule, it is not required to pay its benefits first;
- (4) Reduce claim payment delays; and
- (5) Further define the "COB" statute.

(C) Definitions

As used in this rule:

- (1) (a) "Allowable expense" means, except as set forth below or otherwise defined by statute, any health care expense, including coinsurance or co-payments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.
- (b) If a plan is advised by the covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.
- (c) An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.
- (d) Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.
- (e) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of "COB" to certain coverages or benefits may limit the definition of allowable expenses in its contract to expenses that are similar to the expenses that it provides. When "COB" is restricted to specific coverages or benefits in a contract, the definition of allowable expense shall include similar expenses to which "COB" applies.
- (f)

When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

- (g) The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:
 - (i) Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions for services; or
 - (ii) Because the covered person has a lower benefit because the covered person did not use a preferred provider.

- (2) "Birthday" means the month and day in a calendar year and does not include the year in which an individual is born.
- (3) "Claim" means a request that plan benefits be provided or paid. This term includes a request for:
 - (a) Services, including supplies;
 - (b) Payment for all or a portion of expenses incurred;
 - (c) A combination of paragraphs (C)(3)(a) and (C)(3)(b) of this rule; or
 - (d) Indemnification.
- (4) "Closed panel plan" means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- (5) "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means coverage provided under a right of continuation pursuant to federal law.
- (6) "Coordination of benefits" or "COB" means a procedure establishing the order in which plans shall pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.
- (7) "Custodial parent" means:
 - (a) The parent awarded custody of a child by a court decree; or
 - (b) In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
- (8) "Group-type contract" means a contract not available to the general public which is obtained and maintained only because of membership in, or in connection with, a particular organization or group, including blanket coverage. This term shall not include an individually underwritten and issued, guaranteed renewable policy even if purchased through payroll deduction at a premium savings to the insured since the insured would have a right to maintain or renew the policy independently of continued employment with the employer.
- (9) "High-deductible health plan" has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.
- (10) "Hospital indemnity benefits" means benefits which are not related to actual expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.
- (11)
 - (a) "Plan" means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no "COB" among the separate parts of the plan.
 - (b) The definition of plan in a contract shall state the types of coverage which will be considered in applying the "COB" provision of that contract. Whether the contract uses the term "plan" or some other term such as "program", the contractual definition may be no broader than the definition of "plan" in paragraph (C)(11) of this rule.
 - (c) Plan includes:
 - (i) Group and non-group insurance and subscriber contracts;

- (ii) An uninsured arrangement of group or group-type coverage;
 - (iii) Group or group-type and non-group coverage through a health insuring corporation, closed panel plan or other prepayment, group practice or individual practice plan;
 - (iv) Group-type contracts;
 - (v) The medical care components of long term care contracts, such as skilled nursing care;
 - (vi) Medical benefits coverage under automobile "no fault" and traditional "fault" type contract; and
 - (vii) Medicare or other governmental benefits, as permitted by law, except as provided in paragraph (C)(11)(d)(x) of this rule. That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.
- (d) The term "plan" shall not include:
- (i) Hospital indemnity benefits or other fixed indemnity coverage;
 - (ii) Accident only coverage or specified accident coverage;
 - (iii) A supplemental sickness and accident policy excluded from coordination of benefits pursuant to sections 3923.37 and/or 1751.56 of the Revised Code;
 - (iv) School accident-type coverage;
 - (v) Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
 - (vi) Medicare supplement policies; or
 - (vii) A state plan under medicaid, or other governmental plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.
- (12) "Primary plan" means a plan whose benefits for a person's health care coverage shall be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either of the following conditions is true:
- (a) A plan either does not contain order of benefit rules, or it has rules which differ from those permitted by this rule; or
 - (b) All plans which cover the person use the order of benefits determination required by this rule, and under this rule that plan determines its benefits first.
- (13) "School accident-type coverage" means a contract covering elementary, junior high, high school and or college students for accidents only, including athletic injuries, on a twenty-four hour basis or on a "to and from school" basis.
- (14) "Secondary plan" means any plan which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of this rule shall determine the order in which their benefits are determined in relationship to each other.
- (15) "This plan" means, in a "COB" provision, the part of a contract providing health care benefits to which the "COB" provision applies and which may be reduced because of the benefits of other plans.

(D) Solicitation, certificate and contract provisions

- (1) The following language shall be included as a separate and distinct paragraph on the first page in at least one solicitation, marketing, advertising or enrollment document which shall be provided to potential subscribers of a plan subject to this rule and shall be printed in twelve point type:
- "WARNING: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY."**

- (2) The following language shall be included as a separate and distinct paragraph on the first page in every contract, policy, certificate/evidence of coverage and summary plan description issued to a beneficiary under a plan subject to this rule, and shall be printed in twelve-point type:
 "NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY."
- (3) A contract which utilizes "COB" shall contain the "COB" provisions set forth in appendix A to this rule. Changes in words and format may be made to fit the language and style of the rest of the contract or to reflect the difference among plans which provide services, which pay benefits for expenses incurred, and which indemnify. No substantive changes are permitted.
- (4) Each certificate issued under a group contract which utilizes "COB" shall contain the "COB" provisions set forth in appendix A to this rule. Changes in words and format may be made to fit the language and style of the rest of the group certificate or to reflect the difference among plans which provide services, which pay benefits for expenses incurred and which indemnify. No substantive changes are permitted.
 If a group policyholder or contractholder distributes its own solicitation, marketing, advertising or enrollment documents to its members who are potential subscribers of a plan subject to this rule, then the plan shall make the foregoing language available for use by the group.

(E) Prohibited coordination and benefit design

- (1) A contract shall not reduce benefits on the basis that:
- (a) Another plan exists and the covered person did not enroll in that plan;
 - (b) A person is or could have been covered under another plan, except with respect to part B of medicare;
or
 - (c) A person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.
- (2) No contract, certificate or policy shall contain a provision that its benefits are "always excess" or "always secondary" to any other plan, except as otherwise provided in this rule.
- (3) Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel plan provider. In most instances, "COB" does not occur if a covered person is enrolled in two or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, "COB" may occur during the plan year when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan shall use the provisions of paragraph (H) of this rule to determine the amount it should pay for the benefit.
- (4) No plan may use a "COB" provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan under paragraph (C) (11) of this rule.

(F) Requirements

- (1) Allowable expense
- (a) When plans have differing allowable expenses, the larger allowable expense shall be used for the purpose of division (C) of section 3902.13 of the Revised Code. When benefits paid by a primary plan are less than the allowable expenses, the secondary plan shall pay or provide its benefits toward any remaining balance otherwise payable by the insured or the certificate holder. A secondary plan shall not be required to make a payment of an amount which exceeds the amount it would have paid if it were the primary plan, but in no event, when combined with the amount paid by the primary plan, shall payments by the secondary plan exceed one hundred per cent of the larger of the expenses allowable under the provisions of the applicable policies and contracts.
 - (b) When a plan provides benefits in the form of services, the reasonable cash value of each service shall be both an allowable expense and a benefit paid.
 - (c) When a contract restricts "COB" to specific coverage, allowable expense shall include the expenses or services to which "COB" applies under the contract.

- (2) A secondary plan shall not be required to pay for services unless such services are received in accordance with the rules and provisions outlined in its policy, contract or certificate.
- (3) A primary plan shall pay or provide its benefits as if the secondary plan does not exist. A plan that does not contain a coordination of benefits provision shall not take into account benefits of other plans. However, a contract holder's coverage which is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by that contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits. A plan that does not contain order of benefit determination provisions that are consistent with this rule is always the primary plan unless the provisions of both plans, regardless of the provisions of paragraph (F)(3) of this rule, state that the complying plan is primary.
- (4) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.
- (5) When multiple contracts providing coordinated coverage are treated as a single plan under this rule, this paragraph applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this rule.
- (6) A secondary plan may take the benefits of another plan into account when, under this rule, it is secondary to the other plan.
- (7) Nothing in this rule shall be construed to prevent a third party payer and a provider from entering into an agreement under which the provider agrees to accept, as payment in full from any or all plans providing benefits to a beneficiary, an amount which is less than the provider's regular charges.

(G) Order of benefit determination

Order of benefits shall be determined by the first applicable provision set forth in this paragraph:

- (1) Non-dependent or dependent. The benefits of a plan covering the person as an employee, member, insured, subscriber or retiree, other than as a dependent, shall be determined before those of a plan which covers the person as a dependent. However, the benefits of a plan covering the person as a dependent shall be determined before the benefits of a plan covering the person as other than a dependent if the person is a medicare beneficiary, and as a result of Title XVIII of the Social Security Act and its implementing regulations:
 - (a) Medicare is secondary to the plan covering the person as a dependent; and
 - (b) Medicare is primary to the plan covering the person as other than a dependent (e.g. a retired employee).
- (2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - (a) For a dependent child whose parents are married (not separated or divorced) or are living together, whether or not they have ever been married:
 - (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan;
 - (ii) If both parents have the same birthday, the plan which has covered the parent for a longer period of time is the primary plan;
 - (iii) If one plan does not have the rule described in paragraphs (G)(2)(a)(i) and (G)(2)(a)(ii) of this rule because that plan is not subject to the "COB" statutes, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the plan containing the rule based upon the gender of the parent shall determine the order of benefits.
 - (b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (i) If the specific terms of the court decree state that one of the parents is responsible for the health care expenses or health care coverage of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health

care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

- (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of paragraph (G)(2)(a) of this rule shall determine the order of benefits.
 - (iii) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses or health care coverage of the child, the plans covering the child shall be subject to the order of benefit determination contained in paragraph (G)(2)(a) of this rule.
 - (iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The plan covering the custodial parent;
 - (b) The plan covering the custodial parent's spouse;
 - (c) The plan covering the non-custodial parent; and then
 - (d) The plan covering the non-custodial parent's spouse.
- (c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under paragraph (G)(2)(a) or (G)(2)(b) of this rule as if those individuals were the parents of the child.
- (3) Active employee or retired or laid-off employee. The benefits of a plan which covers a person as an active employee who is neither laid off nor retired, or as that active employee's dependent, is the primary plan. If the other plan does not have this provision, and if, as a result, the plans do not agree on the order of benefits, this provision shall be ignored.
This paragraph does not supersede paragraph (G) (1) of this rule. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under paragraph (G)(1) of this rule. Paragraph (G)(3) of this rule covers the situation where one individual is covered under one policy as an active worker and under another policy as a retired worker. It would also apply to an individual covered as a dependent under both of those policies.
- (4) "COBRA" or state continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:
- (a) The plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is the primary plan;
 - (b) The continuation coverage provided pursuant to federal or state law is the secondary plan. If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This provision does not apply if the order of benefits can be determined under paragraph (G)(1) of this rule.
- (5) Longer or shorter length of coverage. If none of the preceding provisions determines the order of benefits, the plan which has covered the person for the longer period of time is the primary plan and the plan which covered that person for the shorter period of time is the secondary plan. For the purposes of this provision:
- (a) The time covered under a plan is measured from the claimant's first date of coverage under that plan, or, if that date is not readily available for a group plan, the date the claimant first became a member of the group covered by that plan shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force;
 - (b) Two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended;
 - (c) The start of a new plan does not include:
 - (i) A change in the amount or scope of a plan's benefits;
 - (ii) A change in the entity that pays, provides or administers the plan's benefits; or
 - (iii)

A change from one type of plan to another, such as, from a single plan to a multiple employer plan.

- (6) If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.
- (H) Procedure to be followed by secondary plan to calculate benefits and pay a claim.
In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed one hundred per cent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- (I) Miscellaneous provisions
- (1) A secondary plan which provides benefits in the form of services may recover the reasonable cash value of the services from a primary plan, to the extent that benefits for the services are covered by, and have not already been paid or provided by the primary plan. Nothing in this paragraph shall be interpreted to require a plan to reimburse a covered person in cash for value of services provided by a plan that provides benefits in the form of services.
- (2) A plan with order of benefit determination rules which comply with this rule (complying plan) may coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with this rule (non-complying plan) as follows:
- (a) If the complying plan is the primary plan, it shall pay or provide its benefits first;
- (b) If the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. Such payment shall be the limit of the complying plan's liability;
- (c) If a non-complying plan does not provide the information needed by a complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own, and shall pay its benefits accordingly. However, if the complying plan receives information within two years of payment as to the actual benefits of the non-complying plan, it shall adjust payments accordingly.
- (d) If a non-complying plan which paid or provided benefits as a primary plan reduces its benefits so that a claimant receives less in benefits than he would have received had the complying plan paid or provided its benefits as the secondary plan, the complying plan shall advance to, or on behalf of, the claimant an amount equal to such difference. The amount advanced, combined with other amounts previously paid by the complying plan, shall not exceed the liability of the complying plan as calculated as if the complying plan were the primary plan.
In consideration of the advance, the complying plan shall be subrogated to all rights of the claimant against the non-complying plan. The advance by the complying plan shall be without prejudice to any claim it may have against the non-complying plan in the absence of subrogation.
- (3) A term such as "medical care" or "dental care" may be substituted for the term "health care" in describing the coverages to which the "COB" provisions of a contract apply.
- (4) Provisions regarding either "COB" or subrogation may be included in a health care benefits contract without compelling the inclusion or exclusion of the other in that contract.
- (5) If the plans cannot agree on the order of benefits within thirty calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.
- (J) This rule is applicable to every contract which provides health care benefits and which was issued on or after the effective date of this rule. A contract which provides health care benefits and was issued before the effective date of this rule shall comply with this rule by:

- (1) The later of:
 - (a) The next anniversary date or renewal date of the contract, whichever is sooner; or
 - (b) Three hundred sixty-five days following the effective date of the rule; or
- (2) The expiration of any applicable collectively bargained contract pursuant to which the contract was written. For the transition period between the adoption of this rule and the timeframe for which plans are to be in compliance pursuant to paragraph (K)(1) of this rule, a plan that is subject to the prior "COB" requirements shall not be considered a non-complying plan by a plan subject to the new "COB" requirements and if there is a conflict between the prior "COB" requirements under the prior rule and the new "COB" requirements under the new rule, the prior "COB" requirements shall apply.

(K) Penalties

Whoever violates this rule or any paragraph thereof shall be deemed to have engaged in an unfair and deceptive insurance act or practice under sections 3901.19 to 3901.26 of the Revised Code, and is subject to proceedings pursuant to those sections.

(L) Severability

If any section, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other section, term or provision of this rule, but the remaining sections, terms and provisions shall be and continue in full force and effect.

APPENDIX A

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS

- A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - (1) Plan includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - (2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law. Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
- B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C.

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The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

- D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

- (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
- (2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
- (3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
- (4) 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.
- (5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

- E. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

- F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B.
 - (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
 - (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and

insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
- (1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
 - (2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
 - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
 - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
 - (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
 - (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
 - (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The Plan covering the Custodial parent;
 - The Plan covering the spouse of the Custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the spouse of the non-custodial parent.
 - (c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
 - (3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a

person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

- (4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.
- (6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

- A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. [Organization responsible for COB administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. [Organization responsible for COB administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give [Organization responsible for COB administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, [Organization responsible for COB administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. [Organization responsible for COB administration] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by [Organization responsible for COB administration] is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION DISPUTES

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. [Insert plan's phone number and website] (For health insuring corporations, reference evidence of coverage's description of appeal procedures). If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at <http://insurance.ohio.gov>.

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