

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

**REPLY BRIEF OF APPELLANTS
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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES.....	iii
REPLY TO THE STATEMENT OF THE CASE AND FACTS.....	1
Argument in Support of Propositions of Law.....	3
<u>Proposition of Law No. I:</u> 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.....	3
<u>Proposition of Law No. II:</u> 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	8
<u>Proposition of Law No. III:</u> 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 <i>any other legal entity</i> as stated in R. C. 3901.04(A)(2) and/or R.C. 3901.19.....	9
<u>Proposition of Law No. IV:</u> 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 relating to unfair and deceptive acts as specifically defined in R.C. 3902.13(K).....	10
<u>Proposition of Law No. IV:</u> The appellate court decision has created an issue of denial of due process and either intentionally or inadvertently created a private cause of action contrary to Ohio law.....	12
REPLY TO OHIO POLICE & FIRE PENSION FUND BRIEF.....	13
REPLY TO MEDICAL MUTUAL OF OHIO BRIEF.....	15
Conclusion	16
Certificate of Service	18

TABLE OF AUTHORITIES

	Page
Cases	
<i>McFee v. Nursing Care Mgt. of Am., Inc.</i> , <u>126 Ohio St.3d 183</u> , 2010-Ohio-2744	5
Statutes	
R.C. 1.59.....	10
R.C. 119.....	15, 16
R.C. 742.01.....	14
R.C. 742.43.....	14
R.C. 742.444.....	14
R.C. 742.46.....	14
R.C. 742.464.....	14
R.C. 742.61.....	14
R.C. Title 39.....	1, 9, 10
R.C. 3901.04.....	6, 7, 9, 10
R.C. 3901.17.....	10
R.C. 3901.19.....	2, 9, 10
R.C. 3901.31.....	10
R.C. 3901.32.....	10
R.C. 3901.37.....	10
R.C. 3901.38.....	10, 11
R.C. 3902.13.....	1, 10
R.C. 3922.01.....	4
R.C. 3922.11.....	4, 10
R.C. 3923.37.....	7
R.C. 3959.01.....	18
O.A.C. 3901-1-56.....	8
O.A.C. 3901-8-01.....	8, 9
O.A.C. 3901-8-02.....	8, 11
O.A.C. 3901-8-06.....	8

REPLY TO STATEMENT OF CASE AND FACTS

The City of Akron (“City” or “Akron”) in the very last paragraph of its response prior to its conclusion states that the Tenth District Court of Appeals only decided the issue of whether the Ohio Department of Insurance has jurisdiction over a self-funded supplemental health care retiree program sponsored and maintained by a political subdivision. That is clearly not the case and is not the reason this case is before this Court. The Tenth District in its decision stated “As the General Assembly did not make the coordination of benefits law 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” (Judgment Entry P. 18, ¶ 41) Thus the Court included every self-funded plan in the State of Ohio. As stated in Appellants jurisdictional brief the decision also now affects any traditional insurance plan that must coordinate with a self-funded plan. The traditional plan has to follow the rules why the self-funded plan has no rules.

Akron begins its statement by discussing the history of prior litigation which it argues involves the same issues that are now before this Court. The prior legal actions mentioned by the City have no bearing on the matter before this Court and should be taken for what they are “red herrings” meant to distract this Court from the real issue. Each of the legal actions the City outlines involved direct interpretations of the collective bargaining agreement between the Fraternal Order of Police and the City. In fact in the original action in the Department of Insurance (ODI), the Superintendent in her Order that is the basis of this case stated at paragraph 38, “The City of Akron’s Collective Bargaining Agreement with police and firefighters is inapplicable to an analysis of the coordination of benefits provisions of the City of Akron’s self-funded medical plan” The issue before this Court involves a straight interpretation of statutory law under Title 39 of the Ohio Revised Code and nothing more.

The City also argues that it is significant that the Ohio Department of Insurance ODI is no longer involved in the case. ODI's non-participation can be summoned up in three words "change of administration." This case was originally filed in 2005 and at that time Mary Jo Hudson was the Director of Insurance. The decision to end ODI's current involvement was made by the now current Director of Insurance and Lieutenant Governor, Mary Taylor. It is simply a matter of different administrations possessing a different mindset on how to handle the issue. ODI appealed the original common pleas decision on jurisdiction, so obviously the Department feels that legal ruling was incorrect and nothing that ODI has done since indicates that position has changed.

To support its position the City once again raises the multiple letters received from customer service level employees of ODI with regards to self-funded plans. Those letters were raised in the City's Motion to Dismiss filed in the Department of Insurance and rejected. Not one of the letters involves an actual opinion from the legal department of ODI. When the legal department became involved they obviously took a completely different position.

REPLY TO INTRODUCTORY STATEMENT OF THE CITY OF AKRON

Akron's initial argument is nothing new and simply is a restatement of the fact that their self-funded plan is not insurance, which the City states forms the basis for the Court's finding that ODI lacked jurisdiction. As Appellant's stated in their merit brief they are willing to concede the plan itself is not insurance.

Appellants also are willing to concede that the Hearing Officer at the Department Level may have erred in finding that Akron's self-funded medical plan is an organization under the definition of insurance pursuant to R.C. 3901.19(D). However that finding was nothing more than a harmless error because this Court does not need to consider whether the plan itself is

insurance as the Superintendent's jurisdiction does not rest on such a finding. Her jurisdiction is statutory in nature.

Akron states that "Despite all of Appellants' attempts to obscure the issue, insurance is not involved and the City of Akron is not involved in the business of Insurance ... and firefighters. (Akron Merit Brief P. 7). This Court only needs to look as far as the first line of the Introduction of Appellants' merit brief to see who is trying to obscure the true issue. There Appellants state"

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.

Appellants are not trying to confuse anybody this case is about the interpretation of statutory law and that issue only.

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.

The sole issue before this Court is whether or not the Department of Insurance, through the powers granted to the Superintendent of Insurance has any jurisdiction over self-funded plans, as to the issue of coordination of benefits and unfair and deceptive acts. The specific issue in this case involves the coordination of benefit clauses contained in the non-ERISA governmental plans of the City of Akron (Akron) and the Ohio Police & Fire Pension Fund (OP&F) as administered by Medical Mutual of Ohio (Medical Mutual). However the larger issue is the Appellate Court's application to all self-funded plans. There are issues that arise even

within ERISA plans that the federal government specifically defers jurisdiction to the State. Under the Court's ruling even if that jurisdiction is deferred there is no vehicle in Ohio for enforcement of any dispute. While the underlying issue in this case is the superintendent's authority with regards to the coordination of benefits, the Appellate Court ruling covers all aspects of self-funded plans.

Significantly missing from Akron's response is any argument with regards to its inclusion in its health plans of the specific right of claim review by the Ohio Department of Insurance of any dispute that arises under the plan. The plan contains the following language granting specific authority:

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 (Appellants' Merit Brief, Supp. 57)

As the Appellants demonstrated the language goes on to allow the Department to make the final determination. Akron doesn't respond because it doesn't have an answer. It simply has no way of arguing its way out from under its own language.

Of note as of April 2014, Medical Mutual amended the certificate it issues to Akron participants with regards to the specific issue of claim review in compliance with R.C.

3922.11(A) which states:

The superintendent of insurance shall establish and maintain a system for receiving and reviewing requests for external review for adverse benefit determinations where the determination by the health plan issuer was based on a contractual issue and did not involve a medical judgment or a determination based on any medical information, except for emergency services, as specified in division (C) of section 3922.05 of the Revised Code.

R.C. 3922.01(P) states:

Health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, ***or a nonfederal, government health plan. "Health plan issuer" includes a third party administrator licensed under Chapter 3959. of the Revised Code to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.***

The above language is unambiguously conclusive that Akron's governmental self-funded health plan, OP&F's self-funded governmental self-funded plan, and Medical Mutual as a third-party administrator are "subject to the insurance laws and rules of this state"

Appellants do not disagree with the legal argument that an administrative agency of the state can only exercise those powers conferred upon it by the General Assembly. Appellants further do not disagree that an administrative agency cannot use its rule making power to create authority not conferred upon it by the enabling statute.

However this Court has held an administrative agency only "exceeds its grant of authority when it creates rules that reflect a public policy not expressed in the governing statute." *McFee v. Nursing Care Mgt. of Am., Inc.*, 126 Ohio St.3d 183, 2010-Ohio-2744, ¶25. R.C. 3901.04(B) unequivocally expresses the intent of the superintendent of insurance to take action against unfair and deceptive acts relating to the insurance laws of the State of Ohio, which includes the coordination of benefits. That is all the Superintendent has done in this case, exercising the authority she was granted by statute.

The issue before this Court is the law that the Superintendent is attempting to enforce, not the nature of the plan. The law and subsequent rules make clear that the plans in question are included.

All three Appellees take great effort to stay away from responding to the fact that each of them initially in pleading to the original complaint in common pleas court argued for Ohio Department of Insurance (ODI) jurisdiction, with each filing similar motions asking the 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. (Appellants Merit Brief Supp. 17). Akron in its response goes as far as trying to deceive this Court into believing that the filing of a complaint by Appellants Metcalfe and Biasella with ODI is the reason for the stay in the common pleas case, when in actuality the motion for stay was filed by OP&F and agreed to by all parties and then the complaint with ODI was filed as a result of that agreement so that ODI could consider the issue of jurisdiction.

While the City and Medical Mutual adopting the City's response attempt to interject back into the picture arguments to do with the fact that Akron's self-funded plan is not insurance and that the City is not in the business of insurance, Appellant's argument is much simpler. ODI and the superintendent are granted unconditional statutory authority over Title 39 of the Ohio Revised Code pursuant to R.C. 3901.04(A)(1), which grants the superintendent authority over "Laws of this state relating to insurance" In fact none of the Appellees dispute that particular fact. It is simply a matter of connecting the dots from that point forward starting with R.C. 3901.04(A)(2) which involves the definition of a person.

R.C. 3901.04 is headlined with “As used in this section,” and thus refers to section 3901.04 and the superintendent’s specific powers. R.C. 3901.04(A)(2) states "Person" has the meaning defined in division (A) of section 3901.19 of the Revised Code which is:

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*.

Akron and the Ohio Police and Fire Pension Fund meet the definition of a person as legal entities. Medical Mutual of Ohio (Medical Mutual) meets the definition of a person as a corporation or in the alternative as a legal entity.

R.C. 3901.04 (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, ... may do any one or more of the following:

R.C. 3901.04(B) is thus a description of what jurisdiction the superintendent has with regards to laws relating to insurance or any act or practice defined as unfair or deceptive.

Akron argues that jurisdiction does not apply to them because the definition of a person is not applicable. Each of the Appellees in their briefs make the argument that the superintendent cannot exceed the jurisdictional authority granted to her by the legislature. As stated earlier, Appellants do not disagree with that argument. What Appellants disagree with is the argument that the superintendent has not been granted jurisdiction over the Appellants.

Appellees entire argument that the Superintendent exceeded her authority here seems to be centered around the definition of the word “person” Appellants now ask this question. Why would the legislature place a definition of person in a section that describes the superintendent’s

authority when dealing with unfair or deceptive acts if it wasn't meant to apply to that authority?

The simple and obvious answer is the General Assembly wouldn't.

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

The argument with regards to the definition of a person is discussed in more detail in Appellants' Proposition of Law No. III. but the question of jurisdiction does not stop with determining, whether the Appellees meet the statutory definition of a person. O.A.C. 3901-8-01 and its predecessor O.A.C. 3901-1-56 incorporate Ohio's coordination of benefits laws and what plans are subject to those laws.

O.A.C. 3901-8-01(C)(11)(c)(ii) states a plan includes "an uninsured arrangement of group or group-type coverage." The City in its response makes no argument that its plan does not meet the definition. Instead, Akron argues that because no specific language stating self-insurance plans is used it does not include them. In support the City cites to O.A.C. 3901-08-02 and O.A.C. 3901-08-06(D) as proof that if their plan was meant to be included the term self-insurance would be included. First, the City's argument with regards to O.A.C 3901-08-02 is a misstatement of law. O.A.C 3901-08-02 refers to "Provider Discounts" and nowhere within the rule is term self-insurance used. With regards to O.A.C. 3901-08-06(D) the term self-insurance is used in terms of identifying what is an insurer for the purpose of using a standardized model consent form for HIV testing. The reason the term self-insurance is used is because if the statute simply stated insurer by definition self-insurance providers would not be included. The term is needed for inclusion purposes. In contrast there is no need to use the term self-funded plan for

inclusion purposes when referring to O.A.C. 3901-08-01. The definition within the rule clearly includes self-funded plans. While it may be an overused cliché, it's still true that "a rose by any other name is still smells the same" In other words what is an uninsured arrangement of group or group type coverage if it is not a self-funded plan. Uninsured denotes that an insurance policy is not purchased to pay claims and that claims are self-paid and thus self-funded. The paragraph below demonstrates that the City itself defines its plan as group coverage.

O.A.C. 3901-8-01(C)(11)(c)(iv) states that a plan includes "Group type contracts." The certificate issued to participants of the plan, and which is contained within the "Group Insurance Plan" as it is identified by the City states: "This certificate describes the health care benefits available to you as part of a Group Contract" See Ohio Department of Insurance, State Exhibit #2, P. 4.

By definition the health plans of the city of Akron and OP&F are both uninsured arrangements of group or group type coverage pursuant to O.A.C. 3901-8-01(C)(11)(c)(ii) and group type contracts pursuant to O.A.C. 3901-8-01(C)(11)(c)(iv).

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

The City argues that the definition of a person as found in R.C. 3901.04(A)(2) is not applicable to all of Title 39, but has no response contrary to Appellants' argument that the definition is contained within the statute defining the superintendents general authority as granted by the General Assembly, and more specifically within the context of the

superintendent's specific powers in dealing with acts that are unfair or deceptive according to the laws of the State of Ohio.

Akron cites to R.C. 3901.32 as an example of where the definition of a person is not similar as to that found in R.C. 3901.04, through reference to R.C. 3901.19. R.C. 3901.32 refers to definitions related to R.C. section 3901.31 through R.C. 3901.37. Those sections refer to insurance holding companies and are no way related to the issue before this Court. Appellants have never contended that Akron was an insurance company or an insurance holding company.

The argument of the City for using the general definition of a person as found in R.C. 1.59 is simply a restatement of the ruling of the Court of Appeals and with the intent not being to insult the Court is ludicrous at best. There is no fundamental purpose in reaching outside of Title 39 for a definition, when a clear definition is provided within Title 39. Ironically, Appellants argument is supported by the introduction to R.C. 1.59 which in referring to the listed definitions states they apply in any statute "unless another definition is provided in that statute or a related statute." The City argues that no definition of person is provided in R.C. 3901.38(F), and while that statement is true, there is a definition which is applicable in related statutes and those are 3901.04(A)(2), R.C. 3901.19 as well as R.C. 3901.17 and R.C. 3922.01, which demonstrates the general applicability of the definition proposed by Appellants.

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 they relate to unfair and deceptive acts as specifically defined in R.C. 3902.13(K)

Akron in its response states that "Appellants assert that the City is a third-party payer under R.C. 3901.38(F), as it meets one the categories set forth under R.C. 3901.38(F)(8)," which refers to a person.

The City of Akron also meets the criteria of an employer pursuant to R.C. 3901.38(F)(4). As Appellants put forth in their merit brief, the Appellate Court states in its decision Akron is technically an employer, but it doesn't qualify as one under the statute because 3901.38(F) distinguishes between employers and self-insured employers. (Appellants' Merit Brief, Appx.21). Appellants presented an argument showing that nowhere in the statute is there a distinction made between employers and self-insured employers. The City attempts to raise the issue of a "health insuring corporation" as being some form of prerequisite for its inclusion as a third-party payer. Appellants have previously demonstrated that the argument has absolutely no legal merit and should not even be included in the discussion at hand. R.C. 3901.38 deals with third-party payers and that means either third-party payers involved in payments related to traditional insurance plans or third-party payers related to payments from self-funded plans. In other words the statute is all inclusive and there is no need to make a distinction, the same as there was no need to use inclusive language in O.A.C. 3901-08-02.

The same logic applies to the term employers. There is no need to distinguish between what type of employer is involved. An employer is an employer whether or not his company uses a traditional insurance plan or a self-insurance plan and thus Akron is not technically an employer, Akron *is an employer* pursuant to R.C. 3901.38(F).

Akron also raises for the first time the argument that it is not an employer because the City is not covering the Appellants under any current employer-employee relationship. The language contained with the City's Group Insurance Plan demonstrates the argument has no merit. In the eligibility section of the plan those who are eligible for coverage are listed under the heading "Classes of Eligible *Employees*" The Plan goes on to state "This plan is offered to you as retired *employee*." (Ohio Department Of Insurance, State Exhibit #2, P.7). Clearly the City

contemplated that the group insurance plan was being offered as a result of the employee – employer relationship.

However, limiting the arguments to the City of Akron retirees loses focus of the larger argument and that is that the Court of Appeals has held that the Department of Insurance has no jurisdiction over any self-funded plan. While Akron’s immediate dispute is with its retirees, the overall jurisdictional issue is far more important. The Akron retiree plan is only one example of a self-funded plan. Just using the City of Akron for example, its plan that covers full time-active employees has also been directly affected by the Court’s decision. It is also self-funded and under the Court’s ruling the City has no duty to comply with the State’s coordination of benefits laws with regards to that plan either.

As thirds party-payers each of the Appellees are subject to the laws as found in R.C.

Proposition of Law No. V

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

The City in its response builds its discussion again around the issue of the retirees and ignores the bigger picture. The Court of appeals ruling held that the retirees would have a way address any issue that arises through the bargaining and grievance process. However, the Ninth District Court of Appeals in a decision holding in favor of the FOP requiring arbitration stated that the FOP and the retirees are not in privity, that their interests are different and that the FOP is not the bargaining agent for retirees. What the FOP does is bargain for rights for future retirees. Thus retirees do not have access to the grievance procedure and any action they take must be through a private breach of contract action as was taken in *Metcalfe I*, as it has been referred to. The problem that exists is that in line with all of this Court’s prior decisions, there is

no private right of action with regards to insurance law. So either the retirees have no recourse or a private right of action has been created under an insurance law.

The City further states “It is also not true that employees of self-insured non-Erisa employers who are not members of union . . . , will not have recourse to redress issues. The position of the City is “the recourse would be for an action under state law if a program is not administered according to its written terms.” This case has already proved that a self-funded plan can place anything within the plan with regards to the coordination of benefits and rest assured that the plan is safe from any legal attack. More importantly non-union employees have no grievance procedure they can pursue and additionally there is no common law contract claim that can be pursued. There is no avenue to address any dispute for those individuals.

Taking this Court all the way back to all three Appellees’ motions to dismiss in common pleas court when the Appellants filed their original complaint the argument was that state law provided for no private right of action. Apparently those opinions have now changed since Appellees must show some way for this potential class of employees to redress issues.

REPLY TO THE OHIO POLICE & FIRE RESPONSE BRIEF

Any response to OP&F’s brief is difficult in the sense that the argument (1) does not counter or directly respond to the argument presented by the Appellants and (2) OP&F for the first time in the entire appellate process including all briefing in this Court raises the issue that the specific statutes and regulations governing the fund take precedence over general insurance laws.

In other words OP&F does not challenge Appellants argument that that the superintendent has authority with regard to self-funded plans only that it doesn’t apply to their plan because of more specific authority that controls.

The statute that OP&F argues takes precedence over the general insurance laws with regards to coordination of benefits is R.C. 742.46 which is titled “Vested Right to Pension or Benefit” and reads as follows:

Except as provided in section 742.464 of the Revised Code, the granting of a benefit or pension to any person under sections 742.01 to 742.61 of the Revised Code, other than a person participating in the deferred retirement option plan established under section 742.43 of the Revised Code, vests a right in such person to obtain and receive the amount of such benefit or pension granted to the person subject to sections 742.01 to 742.61 of the Revised Code. Subject to sections 742.444 and 742.464 of the Revised Code, a person participating in the deferred retirement option plan vests in the right to obtain and receive the amount accrued to the benefit of the person when the person ceases participating in the plan.

Such right *may be enforced* by an action in mandamus instituted in the court of common pleas in the county in which the person granted such benefit or pension resides.

The important point to make is the language of the statute says the right may enforced by an action in mandamus. There is no requirement of an action in mandamus or a bar to enforcement of the right by another avenue if it is available. In this case a specific health care issue related to the coordination of benefits has another avenue for enforcement and that is through the Department of Insurance who possesses the expertise that a court would not.

OP&F also offers the argument that an action in mandamus is far more expedient than an action before the superintendent of insurance. While this case is unique, the current complaint process as established in R.C. 3922 is established with expediency as a priority. Any court action will far exceed the time it takes the superintendent to review the complaint.

OP&F also mischaracterizes the nature of the underlying action stating that it is really an issue of receiving primary health care benefits, which is a collective bargaining issue and has already been resolved. While the end result would be that the retirees would receive primary health care from the City it's because the coordination of benefits rules would so require. That has nothing to do with the collective bargaining agreement.

OP&F also argues that there has never been a specific finding of any violation on their part, but because of the nature of this appeal, the sole issue before this Court is whether or not ODI had jurisdiction to make any decision on the self-funded plans in the first place. If this Court would so find then the matter would remand to the Franklin County Court of Common Pleas for a R.C. 119 review on the merits. That is when any argument as to specific findings would be decided.

Overall, OP&F has submitted a brief that exceeds the page limitation allowed by rule and there are over 150 referrals in the brief to a supplement that was not filed with this Court. Both are grounds for the brief being stricken, so in considering Appellees brief, the proper weight should be given to the Appellants and Amicus ability to reply.

REPLY TO MEDICAL MUTUAL RESPONSE BRIEF

Medical Mutual's main response is that we agree with the City of Akron in its response to the propositions of law as put forth by the Appellants.

Appellee argues that Appellants arguments are *non sequitur*. Once again the Appellees are trying to interject an argument that there is a requirement that the self-funded plan be insurance or that the City be in the business of insurance. The argument has no merit. Matters relating to insurance, such as the issue here, the coordination of benefits, does not require either for the superintendent's statutory authority to be invoked.

What Appellants find important is that Medical Mutual claims that any coordination of benefit claim can be resolved in a common law contract claim. This is in direct contrast to the representation made in its original motion to dismiss in the Summit County Common Pleas Court when it maintained no private cause of action existed. It also does not in any way explain how non-union, non-contract employees can get redress when they can't even bring a contract claim.

Ironically, Medical Mutual's argument is based on the argument that Ohio courts have interpreted coordination of benefit clauses in *insurance policies* on a straight contract basis. One of the tenets of all three Appellees arguments is that insurance policies are not involved. If in fact Medical Mutual is saying that Akron's self-funded plan is insurance, then the issue for this Court is resolved. If not then the above argument is meritless.

The last argument Medical Mutual makes is that we are an insurance company, but in this case since we are acting as a third-party administrator over a self-funded plan, we are not really a insurance company subject to the jurisdiction of the department of insurance. There is no exclusion in the revised code for third party administrators who administer self-funded plans. Medical Mutual presents no authority to support its argument.

CONCLUSION

For all reasons set forth in Appellants' Merit Brief and Reply Brief Appellants respectfully request that the decision of the Tenth District Court of Appeals be reversed and that the matter be remanded to the Franklin County Court of Common for further proceedings pursuant to R.C. 119.

Respectfully submitted,

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CERTIFICATE OF SERVICE

This is to certify that a true copy of Appellants' Reply was sent by regular U.S. Mail, postage prepaid, this 26th day of January 2015 to the following:

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