Jonathan D. Mester is a principal at Nurenberg, Paris, Heller & McCarthy Co., LPA. He can be reached at 216.621.2300 or jmester@nphm.com.

King v. ProMedica Health System, Inc.[1]

by Jonathan D. Mester

I. Facts

On December 1, 2007 Virginia King was injured in an automobile accident. She was treated for her injuries at the Toledo Hospital, a member of ProMedica Health System, Inc. Upon arriving at the hospital, Mrs. King informed the hospital admitting staff that she was covered by Aetna Health, Inc. Mrs. King was also asked for, and provided, her automobile insurance carrier, which was Safeco Insurance. Rather than billing Aetna for the hospitalization, the hospital billed Safeco under the medical payments provision contained in Mrs. King's automobile insurance policy with Safeco.

Mrs. King subsequently filed a lawsuit alleging her own damages and seeking class action certification pursuant to Civil Rule 23 on behalf of all enrollees or subscribers treated within the ProMedica Health System who were covered by a health insuring corporation. Mrs. King alleged four causes of action, each of which were premised on the claim that ProMedica violated R.C. 1751.60 (A) by billing Safeco instead of Aetna. ProMedica filed a motion to dismiss the complaint pursuant to Civil Rule 12(B)(6).

The trial court granted ProMedica's motion to dismiss. However, the Sixth District Court of Appeals reversed[2] and held that health care providers that execute preferred-provider agreements with health-insuring corporations can only bill the health-insuring corporation subject to the agreement for covered services furnished to their insured, and cannot bill any other potential payors.

II. Analysis by the Ohio Supreme Court

The issue in this case is the proper reading of R.C. 1751.60(A), which states as follows:

> Except as provided for in divisions (E) and (F) of this section, every provider or health-care facility that contracts with a health insuring corporation to provide health-care services to the health insuring corporations and enrollees or subscribers **shall seek compensation for covered services solely from the health insuring corporation** and not, under any circumstances, from the enrollees or subscribers, except for approved co-payments and deductibles. (Emphasis added.)

King made two arguments as to why Safeco should not have been billed for the treatment, both of which are apparent from the face of the statute. First, she argued that billing Safeco effectively sought compensation from her contrary to the R.C. 1751.60(A) because the medical payment provision under her Safeco policy is an asset that belongs to her, and therefore represents the taking of compensation from King in violation of the statute. Second, King argued that the plain language of the statute states that ProMedica "shall seek compensation for covered services **solely** from the health insuring corporation," which, pursuant to the plain meaning of the word "solely," would forbid ProMedica from billing anyone other than Aetna. Indeed, the Court of Appeals held in King's favor simply by looking at the dictionary definition of "solely" and its meaning: "to the exclusion of others."

The Ohio Supreme Court rejected King's arguments and the reasoning of the Sixth District Court of Appeals. As to the argument that billing Safeco amounted to compensation from King, the Court referenced the definition of "compensation" found in R.C. 1751.01(G), where it is defined as "remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis." Based somehow on this definition, the Court concluded that compensation by Safeco did not equate to compensation by King.

As to the fact that R.C. 1751.60(A) states that providers are to seek compensation solely from the health insuring corporation, the Court utilized a statutory construction analysis. The Court stated that, as used here, the word "solely" means only to the exclusion of a health insuring corporation's insured. Otherwise, according to the Court, the phrase, "and not, under any circumstances, from the enrollees or subscribers" would be rendered superfluous. Therefore, the Court ruled that ProMedica was not forbidden to bill under King's coverage with Safeco, and that King's claim was therefore properly dismissed.

III. Analysis and Ramifications of the Court's Decision

The *ProMedica* decision was clearly wrong and results-driven. First, even though King was not directly paying compensation by having her automobile insurance billed, there can be no dispute that automobile insurance companies raise rates in response to the number of claims brought under a policy. Therefore, it is clear that the billing of a person's automobile insurance policy pursuant to the medical payments provision will clearly result in the payment of compensation by the insured. To hold otherwise simply ignores reality.

Second, the Court's end run around the word "solely" in R.C. 1751.60(A) was an improper use of statutory construction. The cardinal rule of statutory construction is that first and foremost words and phrases are to be given their ordinary meaning.[3] Only if there is an ambiguity should the court delve further into a statutory construction analysis.[4] The language of R.C. 1751.60(A) which states "every provider or health-care facility that contracts with a health insuring corporation... shall seek compensation for covered services **solely** from the health insuring corporation..." is clear and unambiguous on its face, and therefore it was inappropriate for the Court to undertake statutory construction analysis. As the Sixth District indicated in its opinion, the dictionary definition of the word solely is "to the exclusion of others." "Others" would, of course, include automobile insurance companies.

The true rationale behind the *ProMedica* decision was perfectly captured by Justice Pfeifer in his dissent. Justice Pfeifer stated:

> "Solely" in R.C. 1751.60(A) means solely. It does not mean "unless you can get paid closer to your top rate through an injured patient's automobile-insurance policy."[5]

For the attorney who represents injury victims, there are three take-aways that come to my mind in the aftermath of *ProMedica*. First, to the extent possible, counsel for injury victims should advise their clients that, if they go to a hospital or doctor for care, they may be asked for their automobile insurance carrier information for the purpose of billing the treatment under the medical payments provision of their policy. To the extent possible, I am informing my clients that this could happen, and that if they wish to avoid this, they should attempt to withhold that information from the provider.

The second and third take-aways are positive spins from the *ProMedica* case that come to mind. First, payment of medical bills under the medical payments portion of an automobile insurance policy will be made dollar for dollar such that the write-off problem encountered in conjunction with the *Robinson v. Bates*[6] decision is obviated. The injured party will therefore be able to present his entire bill without evidence of write offs for bills paid by the medical payments provision of the automobile insurance policy.

The other potential benefit I see from *ProMedica* is the opportunity to strengthen the causation argument in a disputed case. In many cases, the defense will claim that certain medical treatment was not related to the motor vehicle accident in question, and therefore the bills submitted for that treatment should not be part of the verdict. If this defense is raised, and the bills in question were in fact submitted by the provider and subsequently paid for by the automobile insurance carrier, then I would bring in the automobile insurance carrier as an indispensable party pursuant to Rule 19 of the Ohio Rules of Civil Procedure. I would then make certain to inform the jury that not only did my client's own automobile insurance company believe that the treatment in question was related to the accident, but the medical provider and/or hospital also clearly believed that the treatment was related to the accident in question. For the defense to suggest otherwise would be tantamount to taking the position that the doctor

or hospital was committing insurance fraud by submitting bills unrelated to the accident to the automobile insurance carrier.

IV. Conclusion

ProMedica is the latest in the long line of pro-insurance decisions which are contrary to the interests of our clients. *ProMedica* strikes me as being more disingenuous than most of the others in this regard. Nevertheless, there are some potential positive applications of *ProMedica* that can be utilized. ■

End Notes

1. 129 Ohio St.3d 596, 2011 Ohio 4200.
2. *King v. ProMedica Health System, Inc.,* 6th Dist. No. L-09-1282, 2010 Ohio 2578, *rev'd by King v. ProMedica Health System, Inc.*, 129 Ohio St.3d 596, 2011 Ohio 4200.
3. *See, e.g., Fields v. Fairfield County Board of MR/DD*, 10th Dist. No. 09AP-208, 2009 Ohio 4388, ¶15 ("The first rule of statutory construction is that a statute which is unambiguous and definite on its face is to be applied as written and not construed.... Courts must give effect to the words expressly used in a statute rather than deleting words used or inserting words not used, in order to interpret an unambiguous statute.")
4. *Proctor v. Kardassilaris*, 115 Ohio St.3d 71, 2007 Ohio 4838, ¶12 ("Statutes that are plain and unambiguous must be applied as written without further interpretation.")
5. *King*, 2011 Ohio 4200 at ¶17 (Pfeifer, J., dissenting).
6. 112 Ohio St.3d 17, 2006 Ohio 6362.