

IN THE SUPREME COURT OF OHIO

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

**BRIEF OF AMICUS CURIAE
FRATERNAL ORDER OF POLICE, AKRON LODGE #7
IN SUPPORT OF APPELLANTS OHIO STATE DEPARTMENT OF INSURANCE et al.,**

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STATEMENT OF INTEREST

The Amicus Curiae is submitted by the Fraternal Order of Police, Akron Lodge #7 (“FOP”) in support of the Appellants and for all public employees who are beneficiaries of non-ERISA, self-funded government insurance plans. The ruling by the Franklin County Court of Appeals that the Superintendent of the Ohio Department of Insurance (hereinafter “ODI”) has no jurisdiction over self-funded insurance plans, on the basis that such plans are not by definition “insurance,” would eliminate state regulation and enforcement of self-funded health insurance plans. This is alarming for the thousands of state, city, county, school district, municipal and township employees that are beneficiaries of self-funded insurance plans. If the Superintendent is unable to regulate self-funded insurance plans that violate insurance laws of this state and enforce disputed insurance coverage claims, beneficiaries will be required to file lawsuits for a breach of contract in one Ohio’s 88 common pleas courts to dispute any and all insurance claims. This would be financially devastating for the beneficiary, as well as expensive and time consuming for the self-funded insurer and a waste of judicial resources if providers and beneficiaries are forced to litigate disputed insurance coverage claims.

The Court of Appeals’ ruling must be overturned and the Superintendent of ODI must be afforded jurisdiction to execute its statutory duties and regulate, adjudicate and enforce the insurance laws of this state. Appellants’ claim that there was a violation of coordination-of-benefits laws falls under the exclusive jurisdiction of the Superintendent, who has the statutory duty to regulate insurance acts and practices that are illegal, unfair or deceptive. There is no legal or practical reason to exempt the actions of self-funded health plans from the Superintendent’s regulation. The Fraternal Order of Police, Akron Lodge #7, on behalf of the Appellants, pray this

Supreme Court to find the Superintendent of ODI has jurisdiction to regulate, adjudicate and enforce self-funded insurance plans.

STATEMENT OF THE CASE AND FACTS

Timothy Metcalfe, a retired Akron firefighter, and William Biasella, a retired Akron police officer, filed this action on November 5, 2005 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 in *Metcalfe v. Akron*, Summit C.P. No.2005-11-6527. The action was brought for City of Akron's ("Akron") non-payment of health insurance claims to the Appellants since they did not have primary health insurance through the Ohio Police & Fire Pension Fund ("OP&F") and thus, Akron would no longer provide secondary health insurance benefits. The complaint presented two counts: that the Akron, OP&F and Medical Mutual of Ohio ("MMO") violated state law with regard to the coordination-of-benefits ("COB") and had engaged in a civil conspiracy. The issue of a civil conspiracy was never before the ODI or in any way involved in the course of the appeals.

The Appellants collectively filed the instant lawsuit because as retirees, they are not part of the FOP or any other union, cannot file a grievance under any collective bargaining agreement and have no collective bargaining rights under R.C. §4117. After the initial complaint was filed in the Summit County Common Pleas Court, each Defendant ("Appellees"), citing to *Strack v. Westfield Cos.*, 33 Ohio App.3d 336, 515 N.E.2d 1005 (1986) filed motions asking the Common Pleas Court to dismiss the case on the grounds that Plaintiff ("Appellants") had no private cause of action under R.C. §3902.13. The brief by Akron filed with its motion to dismiss specifically states "Ohio's insurance laws give the Superintendent of insurance the sole authority to oversee insurance issues and enforce insurance laws." The Appellants then requested a stay of the

common pleas action, which was granted by the Common Pleas Court until the ODI ruled on the questions of the litigation or determined that it lacked jurisdiction.

On February 14, 2006 the Appellants filed a complaint with ODI, which accepted jurisdiction on the basis that Akron, OP&F and MMO were “persons” under R.C. 3901.19. In response, Akron filed a motion to dismiss on March 12, 2008, this time asserting that ODI did not have jurisdiction over Akron’s self-funded health care plan, arguing that it was not insurance, contrary to its motion to dismiss in the Common Pleas Court. The motion was overruled by ODI through its hearing officer. The parties then agreed to submit the issue to ODI on briefs.

ODI adopted the hearing officer’s report and recommendation and found that Akron had violated the COB law and committed an unfair and deceptive insurance act pursuant to R.C. §3902.13. As a result the Superintendent issued a cease and desist order to Akron, OP&F and MMO and ordered an accounting of all claims that should have been coordinated.

Each of the Appellees appealed the administrative ruling to the Franklin County Court of Common Pleas pursuant to R.C. §119. The Franklin County Court of Common Pleas ultimately found ODI lacked jurisdiction on the basis that self-funded plans were not insurance. The Appellants and ODI both appealed to the Tenth District Court of Appeals arguing that jurisdiction was granted pursuant to statute.

The Court of Appeals upheld the Franklin County Court of Common Pleas that found ODI did not have jurisdiction over self-funded plans and vastly expanded on the reasoning of the lower Court. The Court of Appeals specifically stated that the Appellants are left with a remedy through the collective bargaining process to dispute self-funded insurance claims. *Akron v. Ohio Dept. of Ins.*, 2014-Ohio-96, 9 N.E. 3d 371, ¶44 (10th Dist. 2014). The Court of Appeals stated

that unions can bargain for COB provisions in their labor contracts and use the grievance procedure if the terms of the labor contract are violated. *Id.* The Appellants, like the majority of public employees, do not have that right because they are not part of the union. The remedy the Court of Appeals suggested is simply not available to retirees or to any other public employees who are not part of a collective bargaining unit governed by Chapter 4117.

The argument of the Appellants and ODI had never been that ODI jurisdiction extended to the plan itself, but only to the COB provision inserted in the plan. As ODI 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 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.

ARGUMENT

PROPOSITION OF LAW NO. 1:

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 Superintendent of ODI has the statutory authority under R.C. §3901.04 to regulate the “laws of this state relating to insurance” which include self-insured health plans with coordination of benefits (“COB”) provisions. The Appellants were denied health insurance benefits because they were not enrolled in the OP&F insurance plan required for Akron’s supplemental insurance to take effect. See *Metcalf v. Akron*, Summit Cty. No.2005-11-6527. Appellants’ action was brought for Akron’s non-payment of health insurance claims that violated the COB provision found in Akron’s insurance plan. The Superintendent has jurisdiction to hear whether Akron, OP&F and MMO violated the coordination-of-benefits statute.

A. R.C. §3901.04 AUTHORIZES THE SUPERINTENDENT TO REGULATE THE “LAWS OF THIS STATE RELATING TO INSURANCE.”

The Superintendent of ODI has a mandatory duty to execute and enforce the laws relating to insurance. *Strack v. Westfield Cos.*, 33 Ohio App.3d 336, 338, 515 N.E.2d 1005 (9th Dist.1986). R.C. §3901.04 defines the powers of the Superintendent of Insurance. The statute authorizes the Superintendent to regulate the “laws of this state relating to insurance” including, but not limited to Title 39, which contains the laws of insurance in the Ohio Revised Code. R.C. §3901.04(A)(1). The purpose of this power, as identified in the statute, is for the Superintendent to act in the best interest of the public and protect the people of this state from insurance practices that might be illegal, deceptive or unfair. R.C. §3901.04(B). Where the legislature has enacted a complete and comprehensive statutory scheme governing review by an administrative agency, that agency is vested with *exclusive jurisdiction*. *Nielsen v. Ford Motor Co.*, 113 Ohio App.3d 495, 500, 681 N.E.2d 470 (9th Dist.1996) (citations omitted) (emphasis original).

The powers vested within the Superintendent apply, “upon complaint or otherwise,” to actions by a “person” committing an “act or practice declared to be illegal or prohibited by the laws of this state relating to insurance.” R.C. §3901.04(B). The legislature specifically entrusted the Superintendent with the directive to regulate any “unfair or deceptive acts involved the business of insurance.” R.C. §3901.20. The Superintendent has the authority to investigate allegations of unfair or deceptive practices and to order an end to those practices. *Lazarus v. Ohio Cas. Group*, 144 Ohio App.3d 716, 722, 761 N.E.2d 649, 654 (8th Dist.2001). The statute’s open-ended language empowers the Superintendent to regulate any person in the act of providing insurance or any practice related to the insurance service. This includes self-funded insurance plans, which may commit unfair or deceptive insurance practices while providing insurance.

The jurisdictional question rests upon the nature of the insurance act or practice. A self-funded insurance plan engages in the business of insurance, even if it does not meet the technical definition of “insurance,” by providing beneficiaries with health insurance and coordinating its benefits with other insurance plans and providers. Incorporating a COB provision, such as Akron did, within a self-funded insurance plan subjects the plan to the COB laws. Engaging in the act or practice of coordinating benefits may run afoul of the COB insurance laws, which would trigger the Superintendent’s authority to act. The Appellees may commit an unfair or deceptive insurance practice, as in this case, by violating the COB laws when Akron arbitrarily denied Appellants coverage.

Notwithstanding the merits of the case, the allegations presented by the Appellants fall within the jurisdiction of ODI and are the responsibility of the Superintendent to determine whether such an illegal, unfair or deceptive insurance practice occurred. There is nothing in the law that would prevent the Superintendent from regulating the insurance practices of self-funded insurance plans upon allegations that the acts were illegal, unfair or deceptive. To find otherwise goes beyond the clear language and the intent of the statute.

B. R.C. §3901.041 VESTS THE SUPERINTENDENT WITH RULE-MAKING AND ADJUDICATING POWERS TO REGULATE THE “LAWS OF THIS STATE RELATING TO INSURANCE.”

The legislature directed the Superintendent to adopt, amend and rescind rules and make adjudications necessary to discharge the duties and exercise the powers vested by the statute under Title 39 of the Revised Code. R.C. §3901.041. ODI was established for the express purpose to regulate insurance practices that were unfair or deceptive; and to enforce those laws. *Strack v. Westfield Cos.*, 33 Ohio App.3d at 338-39. Assuming arguendo, that Akron and OP&F plans are not insurance, the plans containing COB language still fall within the jurisdiction of the Superintendent according to O.A.C. §3901-08-01(B)(11)(c)(ii). Vested with the authority to

adjudicate violations of Title 39, ODI through the Superintendent is the most competent and appropriate body to administer the insurance laws irrespective of whether an insurance plan is self-funded.

This case arose from Appellants' claims that the Appellees committed deceptive and unfair practices in violation of the COB statutes found in R.C. §3902.11 to R.C. §3902.14. *Akron*, 2014-Ohio-96, 9 N.E. 3d 371, ¶3. It is undisputed that Akron's group insurance plan contained a COB provision that reflects the statutory language for determining the order of benefits. *Id.* at ¶9. A COB provision outlines the insurance practice that governs which insurance carrier will pay the claims of a certain beneficiary when there are two or more insurance plans. Ohio's COB laws apply when a provider seeks compensation from multiple insurers who are obligated to pay for health-care services rendered to an insured. *King v. ProMedica Health Sys., Inc.*, 129 Ohio St.3d 596, 599, 955 N.E.2d 348 (2011). The Superintendent is vested with the authority to make rules to regulate plans with COB language to ensure the orderly transfer of benefits of medical plans by determining which plan is primary for payment purposes when two or more plans cover a beneficiary. *Id.*

Under the COB laws, a "plan of health coverage" is simply defined as a "policy, contract or agreement" that contains a COB provision. R.C. §3902.11(B). Central to this case is Ohio Administrative Code §3901-08-01, which was promulgated pursuant to R.C. §3901.041. This regulation authorizes the Superintendent to give meaning to the COB laws found in R.C. §3902.11 to §3902.14 and create rules for health insurance plans with COB language. It defines which "plans" are subject to the COB provisions. O.A.C. §3901-08-01(B)(11). The types of plans subject to the COB statutes range from traditional insurance plans to "an uninsured

arrangement of group or group-type coverage.” O.A.C. §3901-08-01(B)(11)(c)(ii). The rule also distinguishes those “plans” that are not subject to the Superintendent’s regulatory authority:

“Plan” does not include: (i) hospital indemnity coverage or other fixed indemnity coverage; (ii) accident only coverage or specified accident coverage; (iii) supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; (iv) school accident type coverage; (v) benefits for non-medical components of long-term care policies; (vi) Medicare supplement policies; (vii) state plan under Medicaid or coverage under other governmental plans, unless permitted by law.

O.A.C. §3901-08-01(B)(11)(d)(i)-(vii).

There is nothing in this law regarding self-funded plans that removes the Superintendent’s authority to regulate plans with COB language. Even if the Akron and OP&F self-funded health plans are not technically “insurance,” they contain the COB language, which would nonetheless subject the plans to ODI jurisdiction as “uninsured plans” with COB language. O.A.C. §3901-08-01(B)(11)(c)(ii). This is consistent with the Superintendent’s authority to regulate the acts or practices in the business of insurance, such as the practice of coordinating benefits between two plans to govern which insurance carrier will pay the claims of a certain beneficiary. R.C. §3901.04, see also, R.C. §3902.11 to R.C. §3902.14.

The allegations brought by the Appellants hinge on the violation of the COB laws. Irrespective of whether the plan is self-funded, it is appropriate for ODI to retain exclusive jurisdiction over this issue because the legislature directed the Superintendent to determine whether Akron and OP&F violated the laws of insurance. Moreover, ODI and the Superintendent are administrators of the insurance laws of this state and are the most competent body to hear issues concerning a practice or act that violates a law of insurance.

C. THERE IS NO PRIVATE RIGHT OF ACTION AND NO REMEDY THROUGH THE COLLECTIVE BARGAINING PROCESS.

Astonishingly, the Court of Appeals submits that the Appellants have the collective bargaining process as their method to enforce the COB laws against Akron and OP&F. *Akron*, 2014-Ohio-96, 9 N.E. 3d 371, ¶44. Contrary to the Court of Appeals' rationale, there is no remedy for the Appellants under any collective bargaining agreement, nor is there a right of private civil action in the statute. *Id.*

First, the Court of Appeals' conclusion is entirely incorrect because Appellants are retirees and are not subject to the collective bargaining laws under R.C. §4117. *Independence Fire Fighters Ass'n v. City of Independence*, 121 Ohio App.3d 716, 721, 700 N.E.2d 909 (8th Dist.1997). In *Independence Fire Fighters Ass'n*, the retirees were permitted to sue in common pleas court for payments due under their prior collective bargaining agreement because upon retirement, the employees were no longer employees and were no longer governed by the grievance and arbitration clauses of that collective bargaining agreement. *Id.* at 720-721. To be eligible for protections under the collective bargaining agreement, the person needed to be an employee at the time the cause of action occurred. *Id.* at 721, distinguishing *Fenske v. Brook Park* Cuyahoga App. No. 64525, 1994 WL 30439, (Feb. 3, 1994). Citing to *Independence Fire Fighters Ass'n*, the Second District Court of Appeals also concluded that the grievance procedure does not apply to retirees unless they are specifically named in the CBA as persons who are entitled to bring grievances. *Carter v. Trotwood-Madison City Bd. of Edn.*, 181 Ohio App.3d 764, 774, 2009-Ohio-1769, 910 N.E.2d 1088 (2nd Dist.).

In this case, the Appellants' claims arose after retirement and during the processing of a claim for their retiree insurance. There is no language in any collective bargaining agreement that allows retirees to bring grievances. Because the incidents in question arose after the

Appellants retired and the applicable collective bargaining agreements lack language that subjects the retirees to their provisions, clearly, the Appellants are not subject to any collective bargaining agreement. The Appellants have no recourse under any collective bargaining agreements as the Court of Appeals submits.

In addition, the Ohio Supreme Court has held that a “statutory policy” may not be implemented by the Ohio courts in a private civil action absent a clear implication that such a remedy was intended by the Ohio General Assembly. *Nielsen v. Ford Motor Co.*, 113 Ohio App.3d 495, 500-501, 681 N.E.2d 470 (9th Dist.1996) citing *Fawcett v. G.C. Murphy & Co.* 46 Ohio St.2d 245, 249, 348 N.E.2d 144 (1976). The legislature’s enactment of a complete and comprehensive statutory scheme vested in the Superintendent the authority to regulate acts or practices that are unfair or deceptive. There is no private civil action within Title 39 because ODI, via the Superintendent, is entrusted with the authority to govern and enforce the statutory scheme codified by the legislature. *Nielson*, 113 Ohio App.3d at 500. A claim for a violation of an insurance plan’s COB provision, such as Appellants’ claim, is reserved to the Superintendent’s exclusive jurisdiction because there is no private civil action available to the Appellants.

The Court of Appeals’ decision has far reaching consequences for the Appellants as well as thousands of public employees under self-funded insurance plans. Like the Appellants, most public employees are not covered by collective bargaining agreements and cannot negotiate terms or enforce those terms through a grievance procedure. Moreover, because there is no express right of private civil action, beneficiaries of self-funded insurance plans are left entirely without a remedy if the only available recourse is to negotiate and grieve issues under a collective bargaining agreement.

Even if this Supreme Court were to find a right of private civil action, the consequence of eliminating ODI's jurisdiction over self-funded insurance plans means that public employee beneficiaries of self-funded insurance plans will be forced to sue in one of Ohio's 88 common pleas courts to dispute an insurance claim. This is disturbing for several reasons. First, the time and expense of litigation is simply too costly for the average public employee to dispute an insurance claim. Similarly, the common pleas courts will face the same burdens of time and expense, while lacking the expertise of ODI to hear such lawsuits.

In turn, this creates a perverse incentive for self-funded insurance providers to arbitrarily deny claims. Knowing that a public employee's cost-benefit analysis of bringing a lawsuit is unlikely to favor litigation, self-funded insurance providers will be emboldened to deny claims and skirt the laws of insurance if there is no state regulatory body holding them accountable. Yet, even if a public employee beneficiary were to litigate the insurance claim, the verdicts from court to court have the potential to vary wildly and create an inconsistent precedent across the state.

The legislature, through Title 39, authorized the Superintendent to regulate the laws of this state relating to insurance, which include the laws relating to the coordination of benefits among multiple insurers. Jurisdiction does not rest on whether a self-funded insurance plan meets the strict definition of insurance. Rather, the question is whether the acts or practices involved in the administration of that plan are illegal, deceptive or unfair under the insurance laws of this state. The Superintendent has jurisdiction to hear the Appellants' claim that the Appellees violated the COB laws by denying Appellants' payment of health insurance claims. Moreover, the remedy the Courts of Appeals suggested is inadequate and unavailable to the Appellants, as well as to the majority of public employees as beneficiaries of self-funded insurance plans.

PROPOSITION OF LAW NO. 2:

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).

The powers vested in the Superintendent apply to acts or practices by a person in the business of insurance that are illegal, prohibited, unfair or deceptive. R.C. §3901.04(B). However, in order for the Superintendent to adjudicate the claims that Akron and OP&F violated the COB statutes found in R.C. §3902.11, Akron and OP&F must qualify as “persons” under R.C. §3901.38(F)(8), for the purposes of being a “third-party payer” under R.C. §3902.11(A). Using the definition of “person” in R.C. §3901.04(A)(2) as defined by R.C. §3901.19(A), Akron and OP&F qualify as a “legal entity” and thus are a “person” within R.C. §3901.38(F)(8), for the purposes of “third-party payer” status in R.C. §3902.11(A).

The terms used in the coordination of benefits statutes are defined under R.C. §3902.11. At issue is the definition of “third-party payer” in section (A), which has the same meaning in R.C. §3901.38. In section (F) of R.C. §3901.38, a “third-party payer” can be one of eight separate definitions. Section (F)(8) states that a third-party payer can be “any other *person* that is obligated pursuant to a benefits contract to reimburse for covered health care services rendered to beneficiaries under such contract.” R.C. §3901.38(F)(8) (emphasis added). The Court of Appeals determined Akron and OP&F were not “third-party payers” under R.C. §3902.11(A), because they were not “persons” under R.C. §3901.38(F)(8). *Akron* at ¶¶34-36.

The Court of Appeals erroneously used the Revised Code’s general definition of “person” found in R.C. §1.59(C) to define the term “person” under R.C. §3901.38(F)(8). *Id.* at ¶36. The Court of Appeals concluded that Akron, as a political subdivision, and OP&F as a pension fund, did not fall within the definition of a “person” under R.C. §1.59(C). This application is incorrect

because R.C. §1.59(C) is a general definition for the term “person” that is applicable to any statute “unless another definition is provided in that statute or a related statute.” R.C. §1.59 (emphasis added).

The Court of Appeals overlooked the definition of a “person” provided in R.C. §3901.04(A)(2) that is defined by R.C. §3901.19(A). Contrary to the Court of Appeals holding, the definition of “person” in R.C. §3901.19 applies beyond R.C. §3901.19 to R.C. §3901.26, because it gives meaning to the term “person” in R.C. §3901.04(A)(2). This reference expands the application of “person” under R.C. §3901.19(A) to all of Title 39, which relates to the Superintendent’s powers to enforce the laws of this state relating to insurance.

Unmistakably, this is a related statute that applies the term “person” to the broad regulatory powers of the Superintendent and should be used for analyzing R.C. §3901.38(F)(8). The definition of “person” found under R.C. §3901.04(A)(2) would supplant the need to use the definition of “person” in R.C. §1.59(C), which is only necessary when there is no other definition in a related statute. The Court of Appeals’ use of R.C. §1.59(C) to define “person” under R.C. §3901.38(F)(8) was inaccurate because it did not apply the definition of “person” in R.C. §3901.04(A)(2).

As discussed above, the specific powers of the Superintendent are listed in R.C. §3901.04, which authorize the Superintendent to regulate any “person” that has engaged in any act or practice that is illegal, prohibited, unfair or deceptive under the laws of this state relating to insurance. R.C. §3901.04(B). These powers require the Superintendent to discharge those duties and exercise the powers vested by the statute under Title 39. R.C. §3901.041. A “person” under R.C. §3901.04(A)(2) is defined by R.C. §3901.19(A). Thus, a “person” for the purposes of R.C. §3901.04(A)(2), “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.*” R.C. §3901.19(A). (emphasis added).

OP&F is a pension fund designed to provide retirement and disability benefits to retired police officers and firefighters and their beneficiaries. 1996 Op. Att’y Gen. No. 96-032 at 3; R.C. §742.02. The systems are funded by mandatory contributions from the member employees and their respective public employers. *Id.*; R.C. §742.31; R.C. §§742.33-.34. The Akron police officers and the City of Akron contribute a percentage of each officer’s salary throughout their career to OP&F to keep in statutorily designated funds, which funds are “separate and distinct legal entities” for all purposes except deposit and investment. *Id.*; R.C. §742.38; R.C. §742.39.

The City of Akron is a political subdivision and like OP&F, is a “legal entity” as stated under R.C. §3901.19(A). Therefore, Akron and OP&F are also “persons” under R.C. §3901.04(A)(2). Had the Court of Appeals used the related statute R.C. §3901.04(A)(2), as defined by R.C. §3901.19(A), to define the term “person” in R.C. §3901.38(F)(8), the Court would have found Akron and OP&F both meet the definition. Consequently, Akron and OP&F should be subject to the Superintendent’s jurisdiction for the purposes of the COB statutes, specifically as “third-party payers” under R.C. §3901.38(F)(8).

PROPOSITION OF LAW NO. 3:

AKRON, OP&F, AND MEDICAL MUTUAL OF OHIO ARE ALL “THIRD-PARTY PAYERS” PURSUANT TO R. C. §3901.38(F).

The Court of Appeals concluded it was unreasonable to include a self-insured employer as a “third-party payer” on the basis of “expressio unius est exclusio alterius” meaning the expression of one thing is the exclusion of the other. *Akron*, 2014-Ohio-96, 9 N.E. 3d 371, ¶38, citing *Thomas v. Freeman*, 79 Ohio St.3d 221, 224, 680 N.E.2d 997 (1997). In reaching this result, the Court of Appeals relied on the fact that under R.C. §3901.38(F)(5), an intermediary

organization cannot be a third-party payer if it is a health delivery network contracting solely with a self-insured employer under R.C. §1751.01(P). *Akron* at ¶37. The Court of Appeals assumes incorrectly that the express reference to self-insured employers in R.C. §3901.38(F)(5) excludes self-insured employers from third-party payer status throughout R.C. §3901.38(F). *Id.* at ¶38.

A. AKRON QUALIFIES AS A “THIRD-PARTY PAYER” PURSUANT TO R.C. §3901.38(F)(4) AND R.C. §3901.38(F)(8).

The statute expressly excludes intermediary organizations that are health delivery networks contracting solely with “self-insured employers” from third-party payer status. R.C. §3901.38(F)(5). Thus, as the Court of Appeals’ logic goes, because the legislature used the term “self-insured employers” in section (F)(5) and did not expressly include “self-insured employers” as third party payers under R.C. §3901.38(F), it appeared the legislature meant to intentionally exclude self-insured employers. *Id.* at ¶38. However, the application is not appropriate for this statute.

In assembling language of entities to be listed as a “third-party payer,” the legislature actively modified certain terms to limit their application and chose to leave other terms broad in scope. The statute is constructed with all inclusive terms such as “employer” or “labor organization.” R.C. §3901.38(F)(3)-(4). These terms cast a wide net and do not distinguish among the types of employers or labor organizations. *Id.* On the other hand, the statute expressly narrows the scope of other terms, such as “intermediary organization” or “health delivery network,” with language to limit the breadth of those terms. R.C. §3901.38(F)(5), (7). In fact, of the eight subsections under R.C. §3901.38(F), three have qualifying language limiting the scope of the term. *See* §3901.38(F)(5)-(7).

“Self-insured employers” acts as limiting language for intermediary organizations. It prevents health delivery networks contracting *solely* with self-insured employers from qualifying as third-party payers under R.C. §3901.38(F)(5). The corollary of negative implication would include intermediary organizations that are health delivery networks that contract *solely* with licensed health insuring corporations and/or *both* licensed health insuring corporations and self-insured employers as third-party payers. R.C. §3901.38(F)(5); R.C. §1751.01(P). Were it the desire of the legislature to exclude “self-insured employers” it just as easily could have limited “an employer” under section (F)(4) to exclude a “self-insured employer” as a third-party payer, just as it limited “intermediary organization” under section (F)(5). R.C. §3901.38(F).

Instead, the legislature left R.C. §3901.38(F)(4) broad and open-ended by listing “an employer” without distinguishing the type of employer. When read *in pari materia*, there is no condition in (F)(4) that would distinguish a type of “employer” – such as a self-insured employer – from being a “third-party payer” under R.C. §3901.38(F)(4). *Thomas v. Freeman*, 79 Ohio St.3d at 225, 680 N.E.2d 997 (discussing *in pari materia* meaning “upon the same matter or subject” Black's Law Dictionary at 791). The Court of Appeals’ discussion failed to recognize the language in R.C. §3901.38(F)(4) is all inclusive as “an employer” just like the catchall, “any other person” in R.C. §3901.38(F)(8). Both provisions lack qualifiers to distinguish among employers or persons, unlike R.C. §3901.38(F)(5) that distinguishes among types of intermediary organizations. *See e.g.* R.C. §§3901.38(F)(4)-(5); *see also* R.C. §3901.38(F)(8).

It’s an uncontroverted fact that Akron is an employer of public employees and at one time the employer of the Appellants. Akron qualifies as an employer under R.C. §3901.38(F)(4), regardless of whether they are a self-insured employer because the statute does not condition the type of employer that qualifies as a “third-party payer.”

As discussed above, Akron also qualifies as a third-party payer because, as a legal entity, they meet the definition of “person” used in R.C. §3901.38(F)(8). Akron is a “legal entity” as specified under R.C. §3901.19(A) and therefore a “person” under R.C. §3901.04(A)(2). Accordingly, Akron is a person under R.C. §3901.38(F)(8), subject to the Superintendent’s jurisdiction for the purposes of the COB statutes as a “third-party payer” under R.C. §3902.11(A).

B. OP&F QUALIFIES AS A “THIRD-PARTY PAYER” PURSUANT TO R.C. §3901.38(F)(8).

OP&F is a pension fund designed to provide retirement and disability benefits to retired police officers and firefighters and their beneficiaries. 1996 Op. Att’y Gen. No. 96-032 at 3; R.C. §742.02. OP&F is not statutorily obligated, but chooses to provide health insurance for retirees. *See, OP&F, Health Care and Other Insurance Plans*, <http://www.op-f.org/Members/OPFHealthCare.aspx>, (accessed Nov. 6, 2014).

The terms used in the coordination of benefits statutes are defined under R.C. §3902.11. At issue is the definition of “third-party payer” under R.C. §3902.11(A), which has the same meaning in R.C. §3901.38. In section (F)(8) of R.C. §3901.38, a “third-party payer” can be “any other person that is obligated pursuant to a benefits contract to reimburse for covered health care services rendered to beneficiaries under such contract.” R.C. §3901.38(F)(8). In finding that OP&F was not a third-party payer, the Court of Appeals overlooked the definition of a “person” provided in R.C. §3901.04(A)(2) that is defined by R.C. §3901.19(A).

As discussed in Proposition of Law No. 2, OP&F is a “legal entity” under R.C. §3901.19(A). R.C. §3901.19(A) also defines a “person” under R.C. §3901.04(A)(2). A “person” for the purposes of R.C. §3901.04(A)(2), “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.*” R.C. §3901.19(A). (emphasis added). OP&F meets the definition of a “person” under the R.C. §3901.04(A)(2). This definition of “person” applies to the Superintendent’s authority to regulate the insurance laws under Title 39. Accordingly, R.C. §3901.04(A)(2) is the appropriate statute to define “person” in the ambiguous phrase “any other person” under R.C. §3901.38(F)(8).

In applying R.C. §3901.04(A)(2) to define a “person” in R.C. §3901.38(F)(8), OP&F is a “person” obligated “pursuant to a benefits contract to reimburse for covered health care services.” As such, OP&F qualifies as a “third-party payer” pursuant to R.C. §3902.11(A) because it is obligated to provide retiree insurance to the Appellants as members of the OP&F Fund. The correct interpretation will find that OP&F is a person under R.C. §3901.38(F)(8), subject to the Superintendent’s jurisdiction for the purposes of the COB statutes as a “third-party payer” under R.C. §3902.11(A).

C. MMO QUALIFIES AS A “THIRD-PARTY PAYER” PURSUANT TO R.C. §3901.38(F)(1) AND R.C. §3901.38(F)(8).

It is undisputed that Medical Mutual of Ohio (“MMO”) is an insurance company that provides insurance in the State of Ohio. Yet, MMO disputes that it is an insurance company in the instant case, as it applies to “third-party payer” status under R.C. §3901.38(F). MMO contends its role as administrator of healthcare benefits exempts it as an “insurance company” under R.C. §3901.38(F)(1) because it was not providing actual insurance to the Appellants.

MMO’s convenient interpretation of R.C. §3901.38(F)(1) attempts to defy its obvious status as an insurance company by rationalizing that it was not acting as an insurance company. The statute does not distinguish, for the purposes of finding “third-party payer” status, the nature of the role a particular entity is assuming. R.C. §3901.38(F)(1). The statute merely states a third-party payer is an insurance company. R.C. §3901.38(F)(1). MMO may take on different roles, as

in this case, but it does not alter the fact that it is an insurance company involved in the administration of benefits to the Appellants. There is no ambiguity in the language that requires anything more than a straight forward reading of R.C. §3901.38(F)(1) to find that MMO is a “third-party payer” as an insurance company.

Were the Supreme Court to find that MMO is not an insurance company under R.C. §3901.38(F)(1), MMO would nonetheless qualify as a third-party payer under the catchall in R.C. §3901.38(F)(8). MMO is obligated under a benefits contract with Akron to reimburse Appellants for covered health services provided pursuant to the contract. *Akron*, 2014-Ohio-96, 9 N.E. 3d 371 ¶9. MMO, like Akron and OP&F, is a legal entity under R.C. §3901.19(A) and a “person” under R.C. §3901.04(A)(2). Applying this definition to the phrase “any other person,” MMO would qualify as a “person” under R.C. §3901.38(F)(8). R.C. §3901.38(F)(8) makes no exception even if “any other person” is merely an administrator of health benefits for the beneficiaries. *Id.* MMO’s involvement, even as administrator, still obligates MMO to make payments for the claims under the contract for health services.

MMO is a “person” for purposes of R.C. §3901.38(F)(8) as defined by R.C. §3901.04(A) and R.C. §3901.19(A) and is therefore subject to ODI jurisdiction as a third-party payer under R.C. §3902.11(A).

CONCLUSION

The Court of Appeals’ decision and rationale that the Superintendent of ODI does not have subject matter jurisdiction over self-insured plans is in error. The Superintendent is vested with broad authority over the statutory scheme to regulate the laws of this state relating to insurance and makes no exception for self-insured or self-funded plans. The health insurance plans provided by Akron and OP&F, and administered by MMO, contain COB language that is

within the exclusive jurisdiction of the Superintendent to oversee. Likewise, Akron, OP&F and MMO are subject to the Superintendent's regulation as third-party payers under the COB statutes.

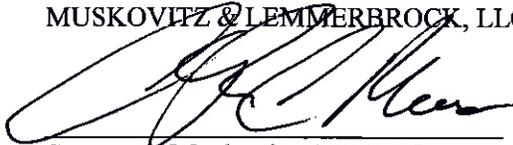
To exclude the self-funded health insurance plans, as well as the entities that are responsible for them, from the regulation of the Superintendent would create a mass of unregulated insurance plans. Beneficiaries will be left with no other option but to sue in one of Ohio's 88 common pleas courts to dispute insurance claims. This result is not only expensive and time consuming for the parties involved, but it is also highly unjust. Beneficiaries will be caught between two undesirable choices; paying out of pocket for a disputed and potentially expensive medical bill, or fighting the provider for coverage of the claim in common pleas court. Both options have overwhelming financial consequences for public employees. In essence, this will create a chilling effect on beneficiaries who cannot afford the financial risk of litigating uncovered medical claims against their insurance provider. More disturbing is the perverse incentive self-funded insurance providers will have to deny claims in the absence of regulatory oversight.

As it stands now, the beneficiary of an insurance plan is a distinct disadvantage when seeking payment for a disputed medical claim against their provider. However, that was the reason the legislature created ODI and empowered the Superintendent with regulatory powers to ensure that the public is not taken advantage of and harmed by unfair or deceptive practices. With the Court of Appeals' decision eliminating ODI jurisdiction, that protection would vanish for thousands of workers and retirees receiving benefits under self-funded insurance plans. The Fraternal Order of Police, Akron Lodge #7 prays this Supreme Court to find the Superintendent

of ODI has jurisdiction to regulate, adjudicate and enforce self-funded insurance plans with COB language that commit unfair or deceptive insurance acts and practices.

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true copy of the foregoing Brief of Amicus Curiae in Support of Appellants Ohio State Department of Insurance, et. al. was served by electronic mail on November 17, 2014, upon:

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