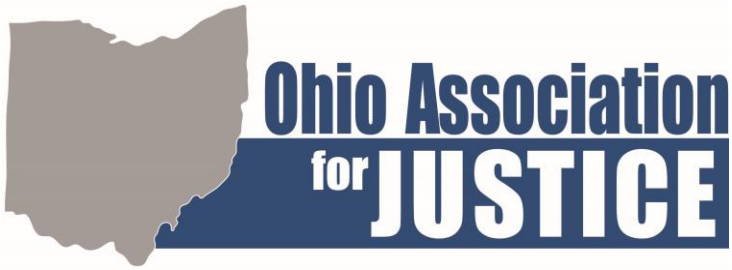

2014 Navigating Through Statutes, Insurance Policies, and Regulations

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The Dreyfuss Syndrome II

Jami Oliver, Esq., Columbus, OH

THE DREYFUSS SYNDROME (PART II)

by Jami S. Oliver, Esq.

II. FINDING A CURE FOR THE DREYFUSS SYNDROME

It is not uncommon to spend more time resolving the subrogation claims and the collection action on behalf of an injured client than in litigating the underlying case. In the last few years, medical bills, subrogation, and collection actions have taken over the typical personal injury practice requiring a level of knowledge far beyond what we could have envisioned ten years ago. In some instances, there is not much case law to look at for guidance. For this reason, it is important to follow Part I of this topic so that you have leverage when you find yourself arriving at Part II--which *will* happen.

A. What to do when they are threatening to sue your client?

Hopefully by now you have set the stage for negotiation of the unpaid hospital or medical bill. You and your client have both requested that the provider submit the bill to the health insurance company, Medicaid, Medicare or HCAP, and you have followed up in writing and have maintained a file with certified mail receipts. You now have a paper trail from Part I of The Dreyfuss Syndrome.

First, don't be tempted to "give in" to threats. Of course you and your client should take the threats seriously, as Dreyfuss will sue to collect an unpaid bill. However, you may have more negotiation power than you think, and you need to be able to talk to your client intelligently about the risks and benefits of taking a stand (i.e., being sued in municipal court) and the greater good in stopping the repeat victimization of the injured.

B. What to do when a lawsuit has been filed?

Make sure you file an Answer and a Counterclaim. Your client should already be aware that a lawsuit may be filed. This is a discussion that should happen early in the case, even before the client's personal injury case has been filed. A prepared client is a happy client (or at least not a disgruntled client). The client should be on the lookout for a civil action or for any type of certified mail from the

Clerk of Courts and should be instructed to get it to you immediately if and when it arrives. The goal is to avoid having a default entered against your client and reduced to judgment.

Make sure you file your Answer on time and include a Counterclaim. Then take the lead on the case, just as you would any other case you file on behalf of a client.

C. Counterclaim and causes of action

There are numerous affirmative defenses you can use in these cases, and a sample of them are attached to these materials. In addition to typical defenses, please consider a counterclaim if you believe it is supported. Sample causes of action are outlined below.

1. Balance billing and Coordination of Benefits statute

Before filing a counterclaim or dealing with any of these issues at all, it is important to have a basic understanding of where Ohio law lands on the issue of balance billing and coordination of benefits.

First of all, the Coordination of Benefits statute is set out in R.C. 3902.11 and primarily defines what is a primary and what is a secondary plan of insurance for purposes of coordinating benefits (who pays first and who pays second). It states, part:

> (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.
> * * *
>
> (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**. * * *
>
> **(D) A third-party 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 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.

R.C. 3902.13. Emphasis added.

Ohio's coordination-of-benefits laws apply when a provider seeks compensation from multiple insurers who are obligated to pay for health-care services rendered to an insured." *Promedica.* at Para. 13. Appendix A of the Ohio Administrative Code specifically provides which "Plans" are covered under the statute:

(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.

OAC 3901-8-01 Coordination of Benefits. Emphasis added.

Accordingly, when considering which plan is primary and which is secondary, Medicare is considered a Plan, Medicaid is not. Med Pay policies are considered a Plan, while accident (liability) policies appear not to be covered Plans for purpose of coordinating. The hospital may seek payment from the primary or the secondary plan, but neither must pay until it is determined which is primary. You may have to push them along by providing the statute and the administrative code and stating which is primary (or not primary) and thus directing the carrier NOT TO PAY a claim if they are not subject to coordination.

Another Ohio statute, however, does limit the hospital's ability to seek compensation from the actual subscriber where there is health insurance. Ohio R.C. 1751.60 reads as follows:

> every provider or health care facility that contracts with a health insuring corporation to provide health care services to the health insuring corporation's enrollees or subscribers **shall seek compensation for covered services solely from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers,** except for approved copayments and deductibles. R.C. 1751(60). Emphasis added.

RC 1751.60 and the definitions section do not specifically list or exclude Medicaid and Medicare as a "health insuring corporation." However, the fact that those entities are excluded under R.C. 1751.89 (but only for sections .77 through .83) leads one to believe that the requirement only to bill the health insurer and not the subscriber also applies to Medicaid.

It is important to note that the Supreme Court has held that this statute does not prevent billing Med Pay, as mentioned above. In *King v. ProMedica Health system (see materials)* the Ohio Supreme Court held that R.C. 1751.60 does not conflict with Ohio's coordination of benefits statute and held that R.C. 1751.60 applies *only* when a provider seeks payment from an insured, not from an insured's insurer (i.e., Med Pay). This case has encouraged hospitals to send bills directly to automobile insurance carriers for payment, instead of health insurance carriers. In summary, receiving payment from a Med Pay carrier is not the same as receiving payment from the patient and thus not a violation of the statute. **Despite the *Promedica* case, coordination of benefits laws still apply, and you should be on your toes directing the hospital and the health insurer to be sure that the correct entity pays first.** I would further argue that, because the liability carrier is not listed as a "plan" under the coordination of benefits statute, it may not be contacted under any theory.

In *Morgan v. Saint Luke's Hosp. of Kansas City (see materials),* the Missouri Court of Appeals held that a hospital could not place a "lien" and therefore collect a debt where the patient had a contract of insurance and where the hospital was required to submit the claim and accept the reduced contractually-negotiated amount as payment in full of the debt. The *Morgan* case is useful in that it

provides citations to other states with hospital and/or physician lien statutes that do not permit hospitals to engage in this type of "balance billing."

2. HCAP (Hospital Care Assurance Program) violations (RC 5168.01)

Another possible cause of action involves violations of the HCAP statute, set out in R.C. 5168.01, *et seq.* Ohio Administrative Code 5160-2-07.17 contains the details of the program and is entitled "Provision of basic, medically necessary hospital-level services" which establishes eligibility policy and requirements for HCAP.

Each hospital that receives payments under HCAP **must provide without charge basic, medically necessary hospital-level services to residents of this state who are not Medicaid recipients and who are not otherwise receiving public assistance.** Hospital level services include inpatient as well as outpatient services. The hospital must accept applications for three years from the date of the follow up notice to the party. There are certain procedures which permit the hospital to bill the patient if it has followed procedures for documenting the patient's income and if a written statement is included with the initial bill and at last the first follow-up bill explaining the poverty level guidelines. HCAP guidelines must be referenced on the front of the bill.

The statute also provides the hospital with a right of **subrogation** from any "person" or "governmental entity." Hospitals must have written procedures and must report on form JFS 02930 schedule F annually and must keep determinations of eligibility and medical records in the file for six years. This information could be accessed through a public records request or through requests for admission.

If you have prepared the case and pursued HCAP early on, and if your client qualifies for some level of assistance that was never provided by the hospital, then you may have a secondary violation ideal for a counterclaim.

Please note that under the HCAP statute, a liability insurer is not a health care third-party payor, which means that OAC 5160-2-07.17 does *not require* the hospital to pursue payment from a liability insurer before offering HCAP assistance. The bigger question, whether the hospital *may* opt to pursue liability insurance first, is unclear.

It is also interesting to note that, in order to qualify as a charitable organization under Title 26 of the Internal Revenue Code (501(c)(3)), the hospital must do certain things or risk losing that status. Specifically, the hospital must have a policy relating to non-discriminatory emergency care, must do a community needs assessment, must limit charges to not more than the amounts generally billed to individuals who have insurance coverage, and must not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy (which must also be a written policy). Collection activities polices and reporting to credit bureaus require that the hospital include measures to "widely publicize the policy with the community to be served." In most cases, these rules are clearly being violated and should jeopardize a hospital's 501(c)(3) statute. While there may not be a private right of action in pursuing a hospital's charitable status, raising it in a counterclaim is a good idea and could spark an investigation.

3. <u>Reasonableness of the Bills</u>

Another viable cause of action in defense of a collection action is the reasonableness of the bills. The amount billed, particularly in emergency situations where the client does not consent to the hospital choice or the treatment options available, or is unconscious, must be reasonable.

Perhaps our best lesson comes from the case of *Riverside Methodist Hospital v. Phillips (see materials).* In that case, the Dreyfuss firm filed for summary judgment on a $51,635.25 bill from Riverside. The Third District Court of Appeals affirmed the Order granting the Motion stating that the injured debtor admitted to receiving a bill from Riverside and the debtor had not compared Riverside's

charges to other hospital charges for similar services. Riverside attached an affidavit by Kimberly Fox, Manger of Patient Accounts, stating the amount billed and that the bill became the responsibility of the patient, not of her insurer, Aetna, when the patient failed to return requests for accident information within 45 days.

The court held that Phillips did not address the issue of reasonableness in her memorandum in opposition – stating only that Aetna should have been responsible to pay the bill. The court in dicta provided guidance for future situations, stating "because Phillips neglected to present any evidence to challenge Riverside's showing that the amount billed for the medical services was reasonable and necessary, we conclude that she failed to meet her reciprocal burden under Civ.R. 56." *Id*. at para. 22.

In contrast to the Third District case, the Sixth District in *St. Vincent Medical Center v. Sader (see materials)* granted summary judgment against a hospital holding that medical treatment is based upon an **implied contract** which revolves around the **reasonableness** of the fees. Since the hospital came back with nothing other than a statement of its customary fees, and since St. Vincent did not provide evidence to establish that those fees were "reasonable," it did not satisfy its burden.

The lesson is that you must present some evidence that the bills are beyond what is reasonable and for that you may need an expert.

D. Discovery

Submitting discovery by way of Interrogatories, Requests for Production of Documents, and Requests for Admission are important in the collection action and will pave the way for potential class actions and/or favorable case law for our clients. Once written discovery is exchanged, it is important to follow up with depositions and expert disclosures to rebut the reasonableness presumption.

1. <u>Naming experts</u>

Attached find information on possible experts who can testify in a reasonableness dispute.

2. Getting help

Do not hesitate to call upon your fellow OAJ members to assist in your lawsuit. Many of us are willing to help draft discovery and even help with a deposition or two.

3. Deposition of Hospital Administrator

Do not agree to "settle" a hospital bill collection action without doing any work on the case. It is tempting to you and to your client, since you clearly are not being paid for this extra work. However, we have to stand united in order to stop these practices. If these collection firms and hospitals stop making quick money, they won't be as eager. It is a volume practice, and if these collection agencies have to actually do trial work, they will learn quickly that they are outnumbered and out-lawyered.

E. Can I sue the collection company?

1. Business association status…are they acting as a bill collector or as a law firm?

There is case law from other jurisdictions on the issue of the status of the collection agency. Specifically, the case of *Chulsky v. Hudson Law Offices*, Case No. 3:10-cv-030578, out of New Jersey, arose when a law firm sued about 100 people (in separately filed small claims actions) and allegedly did so in violation of the Fair Debt Collection Practices Act (FDCPA). While the law firm defended stating that the lawyer did this in her capacity as an attorney, the court found that she still had legal liability under the FDCPA. Basically, the court held the firm was acting as a debt collector instead of a law firm. The class action filed against the firm was based upon the state Professional Services Corporation Act which makes it illegal for professional corporations to render services other than the ones for which they were incorporated. In this case, the law firm "bought" the debt and then filed suit. It remains to be seen if the law firm could still be acting as a "debt collector" even if it did not actually purchase the debt.

In the "early" Dreyfuss years, we were seeing a lot of letters identifying them as a "business associate" of the hospital. That may have changed in recent months, at least on some of their letters.

Being a true "business associate" of a hospital is a contractual status governed by federal law and may grant the collection company protection under the Fair Debt Collection Practices Act as they are an official contractual "arm" of the medical provider. Under the FDCPA, medical providers are generally not subject to the same types of "collection" restrictions.

Also, 45 CFR 160.103 grants the business associate HIPAA protection to assist the hospital in certain area of administration, including billing.

Business associate agreements must be specifically written with certain provisions and restrictions and it is important to ask for these agreements between the hospital and the collection agency in the course of your litigation. You may find the collection agency or law firm acting as a business associate violated some provisions of HIPAA (or FDCPA).

2. Fair Debt Collection Practices Act (15 USC 1692)

Hospitals and Medical providers (and other companies attempting to collect their own debts) are generally exempt from the FDCPA requirements and restrictions. However, once the debt is transferred to a debt collector or a law firm, the FDCPA kicks in. We must familiarize ourselves with the FDCPA so that we can file counterclaims for the illegal collection activities of the law firm or collector.

There are several issues that weave together in all of these cases and with our mutual clients that make it ripe for class action litigation. For instance, if a hospital provider is treating all patients uniformly in violation of a statute; or if a collection agency is violating a law in the procedures and policies being used to collect an unfair or incorrect amount from our clients, should we consider a class action to stop the practice?

By asking for help from others on this list serve and by pursuing discovery in the collection action, we will eventually be able to put some protections in place for our clients.

A Compendium of Regulations: Hospital Debt Collection and Consumer Credit

In general, debt collectors (whether internal or outside collections agencies) may not:

- Misrepresent the amount owed (whether principal or interest)
- Falsely claim that they are attorneys or are from the government or a credit reporting agency
- Falsely claim that the debtor has committed a crime or will be arrested if they don't pay
- Threaten legal action, such as garnishment or attachment, if not allowed by law
- Give false information about a debtor to a credit reporting agency or other person
- Threaten violence or physical harm
- Repeatedly use the phone to harass someone
- Use obscene language

The following tables summarize salient statutes and regulations that may be applicable—as of July 2012. This information is not intended as legal advice, and legal counsel familiar with debt collection laws must be consulted, of course. Readers are encouraged to augment these lists for their own use.

Statute	Citation	Main Focus	Comments
Debt Collection Provisions			
Fair Debt Collection Practices Act (FDCPA)	15 U.S.C. §§ 1692-1692o	Prohibits deceptive and abusive collection practices, harassment, threats, etc.	*See* complete text at: http://business.ftc.gov/documents/fair-debt-collection-practices-act
Fair Credit Reporting Act (FCRA)	15 U.S.C. §§ 1681-1681u	Protections regarding collection, dissemination, and use of consumer credit information	Applies mainly to "consumer reporting agencies" such as Experian, TransUnion, and Equifax
Federal Trade Commission Act	15 U.S.C. §§ 41-58	Prohibits unfair or deceptive trade practices	The FTC enforces the FDCPA and FCRA
Health Insurance Portability and Accountability Act (HIPAA)	45 C.F.R. Parts 160 and 164	Collection agencies may be "covered entities" or "business associates" and thus subject to HIPAA privacy/security rules	DHHS regulations apply
Gramm-Leach-Bliley Act	15 U.S.C. §§ 6801-6809	Requirements to protect the privacy of consumers' personal financial information	FTC and other agencies have regulations; collection agencies are considered "financial institutions"
Telephone Consumer Protection Act	47 U.S.C. § 227	Rules concerning telemarketing, "robocalls," the "Do Not Call" list, etc.	
Affordable Care Act	§ 9007 amends Internal Rev. Code § 501(c)(3)	Adds four new conditions for federal tax-exempt status, effective 2010	Hospitals must develop written financial assistance policies, limit what they charge for services, observe fair billing and debt collection practices, and conduct regular community needs assessments
Various state laws	*See* individual state statutes	Consumer protections; licensing and bonding of collection agencies; unfair trade practices, etc.	In addition to the federal laws and regulations, many states have statutes on debt collection. Their provisions tend to be similar to the FDCPA, so compliance with the latter is normally sufficient; however, check with legal counsel to be sure. *See* "Note Regarding FDCPA," below.*

Consumer Credit Provisions			
Equal Credit Opportunity Act and Regulation B	15 U.S.C. §§ 1691 et. seq. 12 C.F.R. Part 1002	Promotes access to credit for all creditworthy applicants, without regard to race, color, religion, etc. The Act prohibits creditors from discriminating against an applicant for credit on the basis of any of the protected characteristics listed.	A creditor (including a hospital) may consider any information it obtains from the applicant to evaluate the credit application as long as it does not use this information to discriminate on a prohibited basis. The act also requires creditors to provide applicants with an adverse-action notice when an application is denied, and in some other circumstances. Consumer advocates are concerned that automatic underwriting criteria and credit scores used may have an unintended discriminatory effect against minorities—denying them access to services by not being offered financing/payment options. Facilities or creditors also need to develop and implement a process to send an adverse-action notice if they deny an application for credit.
Truth in Lending Act	16 U.S.C. §§ 1601 et. seq.	Promotes the informed use of credit, provides consumer protections, and requires meaningful disclosure of credit terms. It is also intended to protect consumers against inaccurate or unfair credit billing and credit card practices.	Hospitals or their servicing partners that offer payment plan financing with either a finance charge or a written agreement to pay in more than four installments may be considered a "creditor," triggering TILA disclosures and compliance requirements. Hospitals offering cash discounts may also trigger TILA disclosures. Consumers who fail to receive the disclosures required by TILA can sue the hospital and recover actual and statutory damages, plus attorney fees. TILA also provides for the possibility of class-action liability for a creditor who has failed to comply with TILA with respect to numerous consumers. Hospitals must pay close attention to applicable TILA disclosure requirements that may apply to the offering of cash discounts or installment payment plans. A creditor (including healthcare providers) must disclose specific information to the person obligated on a consumer credit transaction, such as the proper disclosure of the finance charge, annual percentage rate (even if it is 0.0 percent), and other information specific to the type of product (including all types of open-end credit).

*Note Regarding FDCPA

The FDCPA generally applies only to third-party debt collectors and not internal collections departments of an "original creditor" such as a hospital, but numerous states have relevant statutes that must be considered.

Several have laws requiring hospitals to implement community benefit practices. *See, e.g.,* 210 Ill. Comp. Stat. Ann. 88/15, 88/20 (requiring hospitals to inform patients about charity care and limiting collection activities); 210 Ill. Comp. Stat. Ann. 89/10 (requiring hospitals to discount cost of care provided to low income people); Texas Health & Safety Code Ann. §§ 311.043-311.047 (requiring nonprofit hospitals to provide certain community benefits). *See,* Catholic Health Association, Survey of State Laws/Oversight Related to Community Health Needs Assessments and Implementation Strategies, at 2 (August 1, 2010) (collecting state laws).

These states, plus the District of Columbia, have laws requiring providers to notify patients and the public of available financial assistance programs: CA, CT, IL, IN, ME, MD, MA, MN, NH, NJ, NY, OH, PA, RI, SC, TN, TX, UT, WA, and WV.

These states have adopted billing and debt collection requirements that apply exclusively to medical debt: MD, MA, MI, MO, NH, NM, OH, OR, PA, RI, SC, TX, WA, WV, and WI.

[*Source:* The Network for Public Health Law, Issue Brief, "New Requirements for Nonprofit Hospitals Provide Opportunities for Health Department Collaboration," Oct. 2011, www.networkforphl.org.]

Additional resources:

- HFMA's Patient Friendly Billing project: http://www.hfma.org/HFMA-Initiatives/Patient-Friendly-Billing/Patient-Friendly-Billing/
- AHA Guidelines: http://www.accessproject.org/adobe/AHA_hospital_billing_and_collection_practices.pdf
- BCS Alliance, summary of state debt collection laws: http://www.bcsalliance.com/y_debt_statelaws.html
- Community Catalyst: http://www.communitycatalyst.org/projects?id=0009
- The Access Project, "Hospital Billing and Collection" publications: http://www.accessproject.org/new/pages/pubHospital.php
- HHS guidance letter on hospital discounting for uninsured patients (2004): http://archive.hhs.gov/news/press/2004pres/20040219.html
- HHS FAQ: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf
- Families USA, "Medical Debt: What States Are Doing to Protect Consumers" http://www.familiesusa.org/assets/pdfs/medical-debt-state-protections.pdf
- Pending legislation introduced by Sen. Franken on June 27, the "End Debt Collector Abuse Act of 2012," http://www.franken.senate.gov/files/documents/120627_EDCAA_Summary.pdf. Although unlikely to be enacted, it is indicative of the attitude of some legislators and may be worth watching.