The Elusive "*Robinson* Number" in an Age of Balance Billing

Almost a decade has passed since the Ohio Supreme Court's decision in *Robinson v. Bates*[1]. Since then, the term "*Robinson* number," referring to the amount a medical provider has agreed to accept as full payment for the services provided after being paid by one or more third parties, has become commonplace in every negligence case involving injuries.

With the ever growing practice of balance billing by medical providers, determining the "*Robinson* number" based on a provider's billing statement has become increasingly difficult and may even subject the injured party to reimbursement claims made by third parties that exceed an apparent "*Robinson* number." To avoid this situation, Evid.R. 403 should apply to exclude "*Robinson* evidence" where balance billing is possible.

I. A look back at *Robinson* and its Progeny

Up until recently, "the reasonable value of medical care required to treat the injury"[2] was solely determined by the amount a medical provider charged for the services performed because evidence of what a third party paid towards the satisfaction of a medical bill was generally considered inadmissible under Ohio's collateral-source rule.[3]

This all changed in 2006 with the Ohio Supreme Court's decision in *Robinson v. Bates*, wherein the Court held that Ohio's common law collateral source rule does not preclude a defendant from presenting evidence of the amount that a medical provider agrees to accept as full payment after a provider is paid by a third party, such as a patient's health or automobile insurer. In *Robinson*, the Court concluded:

> "[T]he original medical bill rendered and the amount accepted as full payment are admissible to prove the reasonableness and necessity of charges rendered for medical and hospital care. The jury may decide that the reasonable value of medical care is the amount originally billed, the amount the medical provider accepted as payment, or some amount in between."[4]

Four years later the Supreme Court decided *Jaques v. Manton*[5] and upheld its decision in *Robinson* as it applied to newly enacted R.C. 2315.20, which codified Ohio's common law collateral source rule.

Most recently in 2012, the Supreme Court decided *Moretz v. Muakkassa*[6], and held that evidence of what a medical provider agrees to accept as full payment does not require expert testimony pursuant to Evid.R. 702(A) prior to being admitted into evidence to support that amount as being the reasonable value of a medical expense because the written-off figure (the difference between the

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[1] 112 Ohio St.3d 17, 2006-Ohio-6362, 857 N.E. 2d 1195.
[2] *Robinson* at ¶ 7.
[3] *Pryor v. Webber*, 23 Ohio St.2d 104, 107, 263 N.E.2d 235 (1970) (Defining the collateral-source rule as "the judicial refusal to credit to the benefit of the wrongdoer money or services received in reparation of the injury caused which emanates from sources other than the wrongdoer."), quoting Maxwell, *The Collateral Source Rule in the American Law of Damages*, 46 Minn.L.Rev. 669, 670 (1962).
[4] *Robinson* at ¶¶ 18-19.
[5] 112 Ohio St.3d 17, 2006-Ohio-6362, 857 N.E. 2d 1195.
[6] 137 Ohio St.3d 171, 2013-Ohio-4656, 998 N.E.2d 479.

amount a provider bills and the amount accepted by the provider as full payment[7]) obtains the same foundational presumption as the billed amount does under R.C. 2317.421.[8]

Neither in *Robinson*, *Jaques*, or *Moretz*, did the Supreme Court anticipate or address how the practice of balance billing by medical providers would affect the determination of the "*Robinson* number" from a medical provider's billing statement.

II. Balance Billing by Medical Providers

When a medical provider is paid by a third party health insurer, the medical provider will typically agree to accept a less amount than what the provider billed for its services. The reduced amount that a provider agrees to accept comes as a result of the agreement entered into between the provider and insurer. In exchange for agreeing to accept a reduced amount from the insurer, the medical provider receives benefits in the form of guaranteed prompt payment and patient referrals by becoming an in network provider for that insurer.

Balance billing occurs when a medical provider, after receiving contracted for payment from a health insurer, seeks additional payment from another source for the written-off portion to obtain the full billed amount. Another form of balance billing, sometimes referred to as "substitute billing,"[9] occurs when medical providers return the money they initially received from a health insurer and submit their bill to another third party that pays at a better rate, such as an injured plaintiff's automobile insurer to obtain medpay benefits which pays at a 100% rate.

The practice of balance billing multiple insurers came before the Ohio Supreme Court in 2011 in *King v. Promedica,*[10] in which the Court held that R.C. 1751.60(A) only precludes a medical provider from billing an insured for services covered by a health insurer with which the provider had contracted with, except for approved co-pays and deductibles. In other words, the Court ruled that a medical provider is permitted to seek payment from as many third party sources as it would like in an effort to collect the full billed amount.

The practice of balance billing was exemplified recently in the case of *Hayberg v. Robinson Mem. Hosp. Found.*[11], in which the Eleventh District Court of Appeals held that it was permissible for a medical provider to obtain payment from a tort victim's health insurer, send back the payment it received from the health insurer, and then bill the plaintiff's medpay carrier to obtain the full amount billed.

III. *Robinson* Meets Balance Billing-The Perfect Storm

Since the Court gave medical providers the green light to balance bill in *King*, medical providers have become increasingly aggressive in balance billing tort victims, especially those injured in motor vehicle accidents in an effort to collect the full billed amount. [12]The problem this creates for tort victims is that now the "*Robinson* number" for a medical expense is fluid and subject to change over time in any case where there is more than one potential source for the medical provider to balance bill.

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[7] *Robinson* at ¶ 10.

[8] *Moretz v. Muakkassa*, 9th Dist. Summit No. 25602, 2012-Ohio-1177, ¶¶ 36-41, *rev'd*, 137 Ohio St.3d 171, 2013-Ohio-4656, 998 N.E.2d 479.

[9] *See Miller v. Gorski Wladyslaw Estate*, 547 F.3d 273, 283 (5th Cir.2008).

[10] 129 Ohio St.3d 596, 2011-Ohio-4200, 955 N.E.2s 348.

[11] 11th Dist. Portage No. 2012-P-0015, 2013-Ohio-2828.

[12] http://www.dispatch.com/content/stories/local/2015/03/11/aggressive-billing-called-into-question.html; http://www.fiercehealthcare.com/finance/st-luke-s-health-settles-patient-litigation-over-insurance-billing-practices.

To illustrate the problem, consider the case in *Hayberg*. In *Hayberg*, after being injured by a negligent driver the plaintiff received medical care from the defendant hospital which billed $13,861.45 for its services.[13] Initially, the hospital submitted their bill to the plaintiff's health insurer, Anthem[14], which paid the hospital $11,295.39 for the satisfaction of the bill.[15] Pursuant to the contractual agreement between Anthem and the hospital, the remaining $2,566.06 was to be written-off.[16] Instead of accepting the $11,295.39, the hospital, having learned that the plaintiff also had medpay coverage, submitted their bill to the plaintiff's automobile insurer, Nationwide, who paid the full billed amount of $13,861.45, and then sent back the $11,295.39 they had previously received from Anthem so that in the end the hospital was able to obtain the full billed amount.[17] Relying on the Supreme Court's decision in *King*, the Eleventh District held that this form of balance billing was permissible.

In *Hayberg*, the defendant hospital balance billed Nationwide shortly after receiving payment from Anthem and the plaintiff's attorney was able to discover this. This does not always occur when providers balance bill, as sometimes a provider will not balance bill until months or even longer after receiving initial payment. Further, providers will not automatically notify a patient or provide an updated billing statement when they balance bill, thus making it difficult for plaintiffs and their attorneys to discover when a provider balance bills.

Let's assume that the hospital in *Hayberg* had balance billed Nationwide after it had provided the plaintiff's attorney with its initial billing statement, a common occurrence. Assume also that the plaintiff proceeded to trial against the tortfeasor and submitted into evidence the hospital's pre balance billing statement, reflecting a billed amount of $13,861.45, a paid amount of $11,295.39, and a write-off of $2,566.06. Pursuant to *Moretz* and R.C. 2317.421, the tortfeasor would then be able to submit evidence indicating that the hospital had accepted $11,295.39 as full payment as reflected on the hospital's pre balance billing statement. The jury then, assuming the hospital had agreed to accept $11,295.39 as payment in full, may award the plaintiff $11,295.39 as part of the verdict with the intent of fully compensating the plaintiff for the hospital's expense. However, unbeknownst to the plaintiff, the hospital had balance billed Nationwide sometime after sending its pre balance billing statement. Following the trial, Nationwide could then assert its contractual reimbursement claim pursuant to its policy to recoup from the plaintiff the full $13,861.45 it had paid the hospital. This results in the plaintiff losing $2,566.06 even though the jury had intended on fully compensating the plaintiff for the hospital's expense.

In this scenario, the medical provider wins because it receives both the full billed amount for their service in addition to the contractual benefits it receives from the health insurer. The health insurer and medpay insurer win because they recoup the health benefits paid to the medical provider pursuant to the first priority subrogation/reimbursement provisions in their policies in addition to the premiums paid by the plaintiff to obtain the coverage. The negligent party's liability insurer wins because they only have to pay for the reduced "*Robinson* number" reflected on the pre balance billing statement as opposed to the larger billed amount. The loser in this scenario is the injured plaintiff, who ends up with a loss of $2,566.06. Now consider that this loss only occurred because the injured plaintiff had health and medpay insurance at the time as a result of the plaintiff paying premiums. The plaintiff would have in effect paid for the loss she incurred, thus resulting in a double loss. This is the quandary injured plaintiffs may now find themselves in as a result of "*Robinson* evidence" being admissible,

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[13] *Id*. at ¶ 4.
[14] Anthem was the plan administrator for the employer sponsored health benefit plan that she was a beneficiary of. *Id*. at ¶ 3.
[15] *Id*. at ¶ 4.
[16] *Id*.
[17] *Id*. at ¶ 5.

medical providers being permitted to balance bill, and insurers having first priority subrogation/reimbursement rights in their policies. The same result may occur if a settlement is reached prior to trial as well because liability insurers now value a medical expense based solely on the perceived "*Robinson* number."

The foundational presumption that R.C. 2317.421 gives the billed amount stated on a provider's billing statement works because the billed amount never changes. As *Hayberg* illustrates however, providing the same foundational presumption to the written-off figure on a billing statement to determine the "*Robinson* number" does not work because that figure is now subject to change as long as balance billing is permitted.

IV. Dealing with *Robinson* and Balance Billing

To prevent the quandary that *Robinson* and balance billing places plaintiffs in, Evid.R. 403 may provide a safe guard to exclude "*Robinson* evidence" where balance billing is possible.

In appealing to Evid.R. 403 to exclude "*Robinson* evidence," it is important to recognize the scope of the decisions in *Robinson*, *Jaques*, and *Moretz*. In *Robinson* and *Jaques*, the Court's decision was limited to whether the collateral source rule excluded evidence of write-offs. The Court did not consider whether any other rules of evidence would apply to exclude such evidence. In *Jaques*, the Court specifically stated, "[b]ecause R.C. 2315.20 does not prohibit evidence of write-offs, the admissibility of such evidence is determined under the Rules of Evidence."[18] In *Moretz*, the Court's decision was limited to whether expert testimony was required to present evidence of write-offs pursuant to Evid.R. 702, or whether such evidence receives the same presumption as the billed amount under R.C. 2317.421. Again, there were no other evidentiary rules considered by the Court in *Moretz*. R.C. 2317.421 also states that any relevant portion of a bill, which the Court in *Moretz* interpreted to include write-offs, is prima-facie evidence of the reasonable value of the bill only if "otherwise admissible." Thus, the door has been left open for trial courts to determine whether *Robinson* evidence is admissible when applied to other rules of evidence, such as Evid.R. 403.

Under Evid.R. 403(A), exclusion of evidence is mandatory when its "probative value is substantially outweighed by the danger of unfair prejudice" or it "mislead[s] the jury." In any case where there is more than one potential source of payment and an opportunity for a medical provider to balance bill, allowing "*Robinson* evidence" by way of billing statements would be prejudicial since the plaintiff could incur a loss if the jury were to compensate based on the "*Robinson* number," the provider balance bill, and then the balance billed insurer(s) assert their reimbursement claims against the plaintiff, like in the above example. It would also be misleading and speculative to tell a jury that the final amount a provider has agreed to accept as full payment is what is stated on a provider's billing statement when that figure is actually subject to change.

To date, it does not appear that any reviewing Court in Ohio has addressed whether *Robinson* evidence is admissible under an Evid.R. 403 challenge, let alone in a situation where balance billing is possible. Thus, until the Supreme Court can resolve the dilemma created by *Robinson* and the ever increasing practice of balance billing by medical providers following *King*, Evid.R. 403 should apply to exclude any *Robinson* evidence where balance billing is possible.

[18] *Jaques*, 137 Ohio St.3d 171, 2013-Ohio-4656, 998 N.E.2d 479, ¶ 15.