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Med Pay or Not Med Pay: That is the Question

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In the not-so-long-ago "good old days," medical payments coverage was a useful and recommended component of any Ohioan's automobile insurance coverage. A responsible citizen, with adequate financial means, would purchase such coverage to work in conjunction with his or her health insurance. If and when injuries were sustained in an automobile collision, that person and/or that person's attorney, would typically utilize health insurance benefits to pay for the bulk of medical bills incurred and *then* utilize med pay monies to satisfy deductibles and co-payments not covered by health insurance.

This approach was seemingly supported by R.C. §1751.60 which required health care providers which contracted with health insurance companies to seek compensation for services "solely" from those health insurance companies. The same statute also made it clear that medical providers were not to seek compensation from insured patients themselves, except for co-payments and deductibles.

Given this construct, paying a second premium for a second set of insurance benefits to cover medical expenses was advisable, for in this way a person would, in most instances, be able to cover all expenses – co-payments and deductibles included - without having to utilize personal, out-of-pocket funds.

Everything changed, however, in 2011, when the Ohio Supreme Court decided in *King v. ProMedica*[i] that the statutory word "solely" was to be applied only within the context of two entities – the health insurance company and that company's insured – and that it did not apply to a third entity, the insured's med pay carrier. This interesting interpretation of the word "solely" paved the way for medical providers to look outside of their own contractual relationships – and contractually reduced rates of reimbursement – toward their patients' own auto coverage as an initial and primary source of compensation. The decision was embraced by medical providers, which could now get paid at a higher reimbursement rate directly from med pay sources. It also benefitted health insurers, which often are not billed until after medical payments coverage is exhausted, if at all.

Despite this change, it is worth noting that the Supreme Court stated that Ohio's coordination-of-benefits statute, R.C. 3902.11, *et seq.* still applied, and that nothing in *King* created a conflict between R.C. §1751.60 and R.C. §3902.11.[ii] Hence, it still holds true that if a health insurance policy's language indicates it is primary, then it is supposed to be the first to pay.

As a practical matter, however, medical providers, rarely, if ever, possess or read the insurance policies in question, and one might question whether they base their billing on coordination-of-benefits language. Seemingly, medical providers now simply look to "auto coverage" for their billing since they are financially incentivized to do so in order to seek the highest rate of reimbursement. Such providers often confuse and/or fail to bill health insurance even after being provided with such information. If and when delays result in ascertaining priority of payment and/or processing the same, providers have been known to send standard notices of delinquent payment and have even attempted to assess late fees and charges.

Thus, it is the competent practitioner who recognizes these issues early and acts to address them proactively on behalf of his or her client. A well-drafted letter to the medical provider demanding the basis for billing med pay first can be helpful. Letters to the insurance companies asking the same question and demanding policy language can also constitute effective advocacy. It can be useful to point out that a provider that seeks compensation for medical bills directly from a patient when that patient maintains health insurance with a company which has entered into a contract with said provider is in direct violation of Ohio statutory law (1751.60). Furthermore, a health insurance company which refuses to pay an insured's bills, when obligated to pay the same, may be liable for damages resulting from such conduct, and one who improperly attempts to collect a debt in this context could arguably be liable for violations of the Ohio Consumer Sales Practices Act and the Federal Fair Debt Collection Practices Act.

It is important to involve the health insurance company in managing and paying bills to the extent they are obligated to do so. It is also good practice to assure the health insurance company that the insured (and/or the insured's lawyer) will work with that insurance company to satisfy subrogation interests if and when recovery is made from an at-fault party.

Where then, though, does this leave med pay? And, should our clients continue to pay for this "benefit"?

When medical payments coverage is utilized, medical bills are typically paid dollar for dollar. The value of one's case arguably increases based upon a higher "*Robinson*[iii] number." However, if medical payments coverage is primary and utilized to pay medical bills first, when it is exhausted there are no monies left with which to pay co-payments or deductibles which accompany one's health insurance coverage. Thus, a client is left to pay such co-payments and deductibles out-of-pocket. Furthermore, upon resolution of a client's personal injury claim against the at-fault party, many insurance companies are now demanding 100% payment of medical payments coverage subrogation interest. Moreover, the typical policy is limited to $5,000 worth of medical payments coverage. Under such circumstances, the *Robinson*-related increase in value of one's overall personal injury claim is often quite low - perhaps low enough that this one benefit is negatively outweighed by the overall cost of the premium paid for such coverage, particularly over an appreciable span of time.

Thus, it is reasonable to ask whether paying for medical payments coverage is a financially sound decision. One could argue that the responsible citizen no longer enjoys the benefit which traditionally accompanied such responsibility, but rather, essentially incurs an increased financial responsibility without any commensurate benefit.

If one were to carry $100,000 worth of medical payments coverage and need every bit of it to pay medical bills dollar-for-dollar, the *Robinson* effect might tip the scales back in the favor of having and utilizing such coverage.

Go big or don't go at all? Perhaps.

A change could be on the horizon, however, which would remove even this benefit. Pending before the Ohio Supreme Court is *Philip Laboy, et al. v. Grange Indemnity Insurance Co.*, et al., 2014-0708. The

issue in *Laboy* concerns Grange's medical payments coverage language, which states that Grange will pay the lesser of "reasonable expenses" or "any negotiated reduced rate accepted by a medical provider." The Laboys contend that this means Grange must pay the provider the same rates as the negotiated reduced rates their health insurer paid. While this argument was initially intended to benefit the plaintiff at issue, such an effect would place med pay coverage on the same reimbursement level as health insurance, thus truly creating the question of whether med pay coverage inures to anyone's benefit, except for the health insurance company, if a person maintains both of these coverages.

Keep an eye on this decision and its interrelationship with the other matters referenced herein in order to address the question - and to advise clients - whether one should med pay or not med pay.

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[i] *King v. ProMedica Health Sys., Inc.*, 129 OhioSt.3d 596, ¶¶12-14

[ii] Id.

[iii] *Robinson v. Bates*, 112 Ohio St.3d 17 (2006)