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No. 2019-0939

In the Supreme Court of Ohio

APPEAL FROM THE COURT OF APPEALS
EIGHTH APPELLATE DISTRICT
CUYAHOGA COUNTY, OHIO
CASE NO. CA-18-107615

MENORAH PARK CENTER FOR SENIOR LIVING,
Appellant,

v.

IRENE ROLSTON,
Appellee.

BRIEF OF AMICUS CURIAE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO IN SUPPORT OF APPELLANT MENORAH PARK CENTER FOR SENIOR LIVING

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I. Statement of Interest of Amicus Curiae

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is a nonprofit § 501(c)(6) professional medical association serving the northern Ohio medical community. It has been in existence since 1824 and became known as The Academy of Medicine in 1902. Now known as AMCNO, it has a membership of over 5,000 physicians, making it one of the largest regional medical associations in the United States.

AMCNO provides legislative advocacy for its physician members before the Ohio General Assembly, and also advocates on behalf of its members before the state medical board, other state and federal regulatory boards, and Ohio courts. AMCNO sponsors numerous community initiatives and works collaboratively with hospitals, chiefs of staff, and other related organizations on a myriad of different projects of interest and concern to its members. Put simply, AMCNO is the voice of physicians in northern Ohio—and has been so for over 190 years.

As this Court is aware, physicians, including those in the northern Ohio community, are often involved in a wide variety of civil disputes both as individual practitioners and as members of a professional organization or other health care entity. Some of those disputes may involve seeking payment for professional health care services rendered. Because doing so may intersect with privacy concerns under state and federal law, it is appropriate that AMCNO weigh in on the important matters presented in this case, which also affect the interests of its physician members.

Towards that end, AMCNO urges the Court to adopt two rules of law in this appeal. First, that the Health Insurance Portability and Accountability Act (HIPAA) provides guidance to courts as to what constitutes an "unauthorized disclosure" under *Biddle v.*

Warren General Hospital, 86 Ohio St.3d 395, 715 N.E.2d 518 (1999), and that guidance does not constitute a private right of action. Second, the disclosure of protected health information authorized under HIPAA for payment-related services satisfies 45 C.F.R. 164.502(b)'s "minimum necessary" standard if the information disclosed consists of the provider's name and address, the patient's name and address, the dates services were provided, billing or procedure codes, a description of the general category of services provided, and the amounts charged, paid, and due, and thus are "authorized disclosures" that do not run afoul of *Biddle*.

II. Statement of the Case and Facts

Amicus defers to the Statement of Facts set forth in Appellant Menorah Park Center for Senior Living's Merit Brief. For purposes of the amicus brief, however, AMCNO highlights the following facts that are important to resolving the issue before the Court:

- Appellee Irene Rolston agreed to pay for outpatient therapy services provided to her while she was a resident of Menorah Park;
- She failed to pay for those services as agreed;
- Menorah Park sued Rolston in small-claims court, attaching to its complaint two statements for these services. Each statement included:
    - Menorah Park's name and address;
    - Rolston's name and address;
    - dates services were provided to Rolston;
    - procedure codes for the services provided;
    - a short (two- to four-word) description of the general category of services provided for each service date; and
    - charges for services, payments made, and the balance due.

- The statements did not provide Rolston's diagnoses, any medical test results or medications administered, or any other medical treatment-related information. *See generally* Small Claim Compl., 10/9/17 Statement Dates.

These facts fit squarely within what should be considered the minimum necessary for the payment-related exception to apply under 45 C.F.R. 164.502(b). The information contained in Rolston's statement is standard information that would appear in a medical statement, reveals minimal details of the health care services provided, and yet it puts her on notice of the nature of those services and the corresponding amount due. The Eighth Appellate District's conclusion that the statement should have been redacted except for the amount due borrows from inapposite case law construing a different federal act furthering different interests. That analysis should be rejected and its decision reversed.

III. Argument

Proposition of Law No. 1:

> Courts are guided by the Health Insurance Portability and Accountability Act (HIPAA) when determining what constitutes an "unauthorized disclosure" of protected health information under *Biddle v. Warren General Hospital*, 86 Ohio St.3d 395, 715 N.E.2d 518 (1999), and that guidance does not constitute a private right of action.

Courts in Ohio appear divided on whether they can look to HIPAA for guidance on what constitutes an unauthorized disclosure that may give rise to a *Biddle* claim. On one hand, courts have necessarily looked to HIPAA when determining whether the disclosure was authorized or unauthorized. In *OhioHealth Corporation v. Ryan*, for example, the Tenth Appellate District looked to HIPAA in concluding that an unredacted reference to a patient's insured status on a medical statement was an authorized, as opposed to unauthorized, disclosure that did not give rise to a claim under *Biddle*. *Ryan*, 10th Dist. Franklin No. 10AP-

937, 2012-Ohio-60, ¶ 14-15. In reaching this conclusion, the court relied on the analytical framework of HIPAA and its Privacy Rule to find that HIPAA's general rule of nondisclosure does not apply when the information disclosed "is for purposes of obtaining payment" as it was in that case. *Id*. at ¶ 15. Because the court recognized the disclosure as an "authorized" disclosure under HIPAA, it could not be deemed an "unauthorized" disclosure that would be actionable under *Biddle*. *Id*.

The Ninth Appellate District in *Barberton Hospital v. Hughes* also looked to HIPAA when it concluded that a child's mother was not prohibited from testifying or inquiring about the medical care her child received when she was sued to recover payment. Relying, in part, on *Ryan* and HIPAA's payment-related exception, the court concluded that disclosing information about the nature of the injury and its treatment is not prohibited by HIPAA and the failure to allow her to discuss it materially prejudiced her defense, causing reversible error. *Hughes*, 9th Dist. Summit No. 26783, 2013-Ohio-5800, ¶ 15.

The Second Appellate District in *Sheldon v. Kettering Health Network*, however, saw reliance on HIPAA as involving "a seemingly unsolvable conundrum" when the "validity of authorization is disputed." 2015-Ohio-3268, 40 N.E.3d 661, ¶ 28 (2d Dist.). On one hand, the parties and the courts were justified in looking to HIPAA for guidance. If a disclosure was authorized under HIPAA, it could not be unauthorized under state law without being contrary to federal preemption principles. *Id*. But, on the other hand, the court questioned whether reliance on HIPAA for guidance as to what constituted an unauthorized disclosure contravened HIPAA's prohibition against allowing private rights of action. *Id*. Finding it unnecessary to resolve that issue, the *Sheldon* court left it unanswered. *Id*.

But looking to HIPAA for guidance for what constitutes an unauthorized disclosure necessary to satisfy the unauthorized-disclosure element of a *Biddle* claim does not, in turn, equate that guidance with a private right of action. Unlike the plaintiff in *Sheldon* who sought a remedy against Kettering for violating specific provisions of HIPAA, simply relying on HIPAA for guidance on what constitutes an unauthorized disclosure to satisfy an element of a *Biddle* claim that is not preempted by HIPAA does not transform that guidance into a private right of action. To conclude otherwise would then run afoul of federal preemption principles because state law cannot make unauthorized what is authorized under federal law.

The Eighth District recognized this when it, too, looked to HIPAA for guidance in determining whether Menorah Park's disclosure was unauthorized. Relying on *Ryan*, it recognized that "whether health information is protected under HIPAA, such that it is authorized, may be relevant to the determination of a *Biddle* claim," just as it was in *Ryan*. *Menorah Park Ctr. for Senior Living v. Rolston*, 8th Dist. Cuyahoga No. 107615, 2019-Ohio-2114, ¶ 20, fn. 1. Although the Eighth District went on to find *Ryan* distinguishable because the account statement in *Ryan* was redacted, it does not change the fact that HIPAA regulations provide guidance to courts for what constitutes an unauthorized disclosure. But looking to HIPAA regulations for guidance on what kind of disclosure is authorized under HIPAA does not violate HIPAA's no-private-right-of-action mandate.

Proposition of Law No. 2:

> The disclosure of protected health information authorized under HIPAA's payment-related exception satisfies 45 C.F.R. 164.502(b)'s "minimum necessary" standard if the information disclosed consists of the provider's name and address, the patient's name and address, the dates services were provided, billing or procedure codes, a description of the general category of services provided, and the amounts charged, paid, and due, and thus are "authorized disclosures" that do not run afoul of *Biddle v. Warren General Hospital*, 86 Ohio St.3d 395, 715 N.E.2d 518 (1999).

A. HIPAA statutory framework

Looking to HIPAA for guidance for what constitutes an unauthorized disclosure to satisfy the unauthorized-disclosure element of a *Biddle* claim requires understanding HIPAA's analytical framework and its privacy regulations.

1. The general rule of nondisclosure

Enacted in 1996, HIPAA started as a legislative mechanism to protect the health coverage of individuals who changed employment by making their health coverage more "portable" as a means to limit eligibility restrictions based on health status. *See* HIPAA, Pub.L. No. 104-191, 110 Stat. 1936. It was expanded to include a Privacy Rule intended to protect confidentiality of patient information.[1] Governed by regulations promulgated under HIPAA, the general rule is that a covered entity—and Menorah Park is a covered entity[2]—"may not

[1] As enacted, HIPAA instructed the Secretary of Health and Human Services (HHS) to provide Congress with detailed recommendations on privacy standards, and to promulgate rules incorporating those recommendations if Congress did not pass its own privacy legislation within three years of passage. Pub.L. No. 104-191, 110 Stat. 2033, 42 U.S.C. 1320d-2, note. Three years came and went, and HHS issued the HIPAA Privacy Rule on August 21, 1999.

[2] *See* 45 C.F.R. 160.103 ("Covered entity means * * * a health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter.").

use or disclose protected health information," unless an exception applies. 45 C.F.R. 164.502(a).

"Protected health information" means "individually identifiable health information," which includes information that "[r]elates to * * * past, present, or future payment for the provision of health care to an individual" and that either "identifies the individual" or "there is a reasonable basis to believe the information can be used to identify the individual." 45 C.F.R. 160.103 (Protected health information; Individually identifiable health information (2)(i), (ii)). Thus, payment information related to the provision of health care services is protected health information.

2. HIPAA permits disclosure of protected health information for payment-related activities, but it must be the minimum necessary for that purpose.

There are exceptions to the general rule of nondisclosure. A covered entity is permitted to use and disclose protected health information when seeking "payment," as permitted by 45 C.F.R. 164.506. *See* 45 C.F.R. 164.502(a)(1)(ii). Under that regulation, a covered entity "may use or disclose protected health information for * * * payment," including its "own * * * payment[.]" 45 C.F.R. 164.506(a), (c)(1). "Payment" includes a health care provider's activities "to obtain or provide reimbursement for the provision of health care[.]" 45 C.F.R. 164.501 (Payment (1)(ii)). These activities include "billing" and "collection activities." *Id*. at (2)(iii).

When using or disclosing protected health information for a permitted use, the covered entity "must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose" of the use or disclosure. 45 C.F.R. 164.502(b)(1).

HIPAA does not define either "reasonable efforts" or "minimum necessary." Instead, its Privacy Rule recognizes the need to be flexible regarding the many different applications of that standard, be it bill collecting, conducting audits, or teaching doctors in training. The Rule places a great deal of discretion in the hands of covered entities, and depending on the type of disclosure in question, the covered entity is expected to "implement policies and procedures" or "[d]evelop criteria designed to limit the protected health information disclosed to the information reasonably necessary to accomplish the purpose for which disclosure is sought." 45 C.F.R. 164.514(d)(3). In certain circumstances, a covered entity may, if reasonable under the circumstances, rely on "a professional who is a member of its workforce or is a business associate," if it is that professional's opinion that the public health information to be disclosed "is the minimum necessary for the stated purpose." *Id.* In other words, the law gives health care providers considerable discretion in determining the minimum disclosure necessary for a particular purpose. It is not a hard-and-fast rule.

Primary oversight of HIPAA's Privacy and Security Rules belongs to the HHS Office of Civil Rights (OCR). This oversight takes the form of issuing regulatory guidance, conducting inspections and audits of the regulated community, and bringing enforcement actions, which can yield penalties of up to $50,000 or more per violation, and up to ten years in jail, for knowing and willful unauthorized disclosures. 42 U.S.C. 1320d-5, 1320d-6. Although, as stated, private parties cannot bring a cause of action against a covered entity or business associate under HIPAA, they can file complaints with HHS under 45 C.F.R. 160.306.

Because the HIPAA Privacy Rule has such broad application, covered entities rely heavily on OCR's regulatory guidance. A wealth of regulatory guidance can be found on OCR's

web page,[3] which covered entities are expected to consult regularly. One "FAQ" document, for example, advises that the "minimum necessary" standard "is not an absolute standard" but rather a "reasonableness standard * * * intended to reflect and be consistent with, and not override, professional judgment and standards."[4] A similar FAQ document answers "yes" to the question of whether protected health information can be disclosed in litigation, specifically noting that a "plaintiff in a suit to obtain payment [] may use or disclose protected health information for such litigation as part of its health care operations," although it should "make reasonable efforts to limit such uses * * * to the minimum necessary to accomplish the intended purpose."[5]

In deciding this case, AMCNO urges the Court to keep in mind the extent to which HIPAA's regulatory framework relies heavily on the independent judgment of its covered entities. It is not a system that second-guesses the industry it regulates and subjects them to harsh penalties and civil lawsuits for mere differences of opinion in interpretation. Rather, it expects them to develop their own policies and criteria to measure what levels of protected health information need to be disclosed in various situations to complete the given task. As noted, HIPAA employs a "reasonableness" standard, not an absolutist one. Health care

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[3] *See* www.hhs.gov/hipaa (last accessed November 18, 2019).

[4] FAQ No. 207, Mar. 14, 2006 at https://www.hhs.gov/hipaa/for-professionals/faq/207/how-are-covered-entities-to-determine-what-is-minimum-necessary/index.html (last accessed November 18, 2019).

[5] FAQ No. 705, Jan. 7, 2005 at https://www.hhs.gov/hipaa/for-professionals/faq/705/may-a-covered-entity-in-a-legal-proceeding-use-protected-health-information/index.html (last accessed November 18, 2019).

providers are accorded considerable deference by their federal regulators if their methods of compliance are reasonable and made in good faith.

These regulatory principles provide the framework for adopting a rule of law that is not as restrictive as the Eighth District applied under inapplicable law nor as loose as giving covered entities carte blanche to any document labeled “payment.” In short, a disclosure of protected health information for the purposes of seeking payment for services rendered is reasonable and satisfies the minimum-necessary standard when the medical bill includes the provider’s name and address, the patient’s name and address, the dates services were provided, billing or procedure codes, a description of the general category of services provided, and the amounts charged, paid, and due. This minimally necessary information is reasonable and provides the patient with information about the nature of the debt owed without disclosing medical information unnecessary to collect payment. And it is consistent with what would be considered the minimum necessary under HIPAA’s regulatory guidance.

3. Inapposite federal law does not define “minimum necessary” under HIPAA.

To the extent that the Eighth District may have looked *outside* of HIPAA for guidance and instead looked to federal case law construing what was necessary for debt verification under the Fair Debt Collection Practices Act (FDCPA), that guidance is misplaced. *Menorah Park*, 8th Dist. Cuyahoga No. 107615, 2019-Ohio-2114, ¶ 13, citing *Chaudhry v. Gallerizzo*, 174 F.3d 394, 406 (4th Cir.1999). To the *Chaudhry* court, the “verification of a debt [under the FDCPA] involves nothing more than the debt collector confirming in writing that the

amount being demanded is what the creditor is claiming is owed; the debt collector is not required to keep detailed files of the alleged debt." *Id.*[6]

That this may be so under the FDCPA is of no consequence here in a case looking to HIPAA for guidance as to what constitutes the minimum necessary disclosure of protected health information to satisfy the exception to nondisclosure for payment-related activities. Indeed, the *Chaudhry* court recognized the information needed for debt verification is consistent with the FDCPA's legislative history and its intent to "'eliminate the . . . problem of debt collectors dunning the wrong person or attempting to collect debts which the consumer has already paid.'" *Id.*, quoting S. Rep. No. 95-382 at 4 (1977), reprinted in 1977 U.S.C.C.A.N. 1695, 1699.

Looking to the FDCPA for guidance on what constitutes the minimum necessary disclosure for unauthorized-disclosure purposes, however, is misplaced because the FDCPA and HIPAA have different purposes and provide different remedies. The FDCPA's purpose "is to protect consumers by eliminating abusive debt collection practices by debt collectors." *Azar v. Hayter*, 874 F.Supp. 1314, 1317 (N.D. Fla. 1995), citing 15 U.S.C. 1592(e). It provides a right of action against the debt collector for actual damages. *Id.*, citing 15 U.S.C. 1692k ("[A]ny debt collector who fails to comply with any provision of this subchapter with respect to any person is liable to such person in an amount equal to the sum of * * * any actual damage sustained by such person as a result of such failure[.]"). It certainly would be

[6] The Eighth District also noted *Zaborac v. Mut. Hosp. Serv. Inc.*, S.D.Ind. No. 1:03-cv-1199, 2004 WL 2538643 (Oct. 7, 2004), which discussed both the FDCPA and HIPAA. *Menorah Park* at ¶ 13. But *Zaborac* simply relied on *Chaudhry* for its construction of minimum information necessary. Thus, to the extent it looked to that case for guidance, it is similarly misplaced.

consistent with the FDCPA's intent to curb abusive debt-collection practices that any disclosure be the most restrictive information necessary to verify a debt.

HIPAA, in contrast, provides no private right of action and its Privacy Rule was promulgated to protect confidentiality of patient information.

> A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.[7]

HIPAA simply provides a mechanism for compliance through agency enforcement. What constitutes the minimum necessary for a permitted disclosure should look to HIPAA, not the FDCPA.

AMCNO anticipates that Rolston may argue that what is minimally necessary for a permitted disclosure is an issue of fact to be determined by a jury. But adopting that rule of law would essentially create a private right of action for violating a HIPAA regulation rather than using HIPAA as permissible guidance for what constitutes an authorized disclosure under *Biddle*. The rule of law proposed here is consistent with that guidance.

[7] *See* https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html (last accessed November 18, 2019).

B. Public-policy interests support the rules of law proposed.

There are additional overarching concerns the Court should consider. In an age where the amount of electronically stored data, and the places where that data is stored, are multiplying exponentially, patient privacy is a critical concern. Yet even though a document filed with a court today may be obtainable online, litigants must still satisfy Ohio's notice pleading requirements, not the least of which is Civ.R. 10(D)(1)'s requirement that a copy of an account be attached to a pleading. Creating a framework, however, where every complaint seeking recovery of unpaid medical bills has to be filed under seal or reviewed in camera would not be the ideal solution, as doing so would carry with it its own logistical and judicial efficiency challenges.

A separate, but no less important, consideration is the effect on health care providers who are trying to comply in good faith with HIPAA, and likewise trying to get paid for their services. If HIPAA's regulatory framework tells us anything, it is that the answer to what constitutes the "minimum necessary" operates in a regulatory world insulated from class-action lawsuits, where reasonable actions are accorded a measure of deference by OCR. To allow a jury to supplant that deference in determining whether a disclosure is "authorized" under *Biddle* would render every health care provider attaching a medical bill to a complaint vulnerable to a hindsight accusation that the information disclosed was not minimal enough. Yet providers who err too far the other way risk having their suit dismissed. This would be an unfair standard, especially when considering how many lawsuits for unpaid bills are filed in small claims courts. A slight misstep while attempting to collect a $400 debt should not result in exposure to a million dollar counterclaim.

AMCNO urges the Court to adopt a clear standard that provides regulatory certainty to Ohio's regulated health care community as to what level of protected health information is reasonable for purposes of filing a lawsuit seeking payment of an overdue medical bill. Balancing the various factors of privacy, clarity, and notice pleading discussed above, the limited disclosure of the provider's name and address, the patient's name and address, the dates services were provided, the billing or procedure codes, a description of the general category of services provided, and the amounts charged, paid, and due, in a complaint seeking payment for health care services rendered is reasonable and thus should qualify as "authorized disclosures" sufficient to defeat a *Biddle* claim. Informing health care providers that this clear data set satisfies the minimum-necessary standard ensures consistency within the heath care community for collecting payment and ensures consistency among the courts in resolving disputes under *Biddle*.

IV. Conclusion

AMCNO urges this Court to find that courts can look to HIPAA when determining whether a disclosure is unauthorized for purposes of pursuing a *Biddle* claim. And looking to HIPAA for that purpose, it urges the Court to adopt a clear "minimum necessary" standard consistent with widely established billing practices so that the disclosure of the provider's name and address, the patient's name and address, the dates services were provided, the billing or procedure codes, a description of the general category of services provided, and the amounts charged, paid, and due, in a complaint seeking payment for health care services rendered is reasonable and are "authorized disclosures" that do not run afoul of *Biddle*.

Adopting these rules of law would then result in reversing the Eighth District's decision and upholding the dismissal of Rolston's counterclaim.

Respectfully submitted,

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