IN THE COURT OF COMMON PLEAS
WILLIAMS COUNTY, OHIO

COMMUNITY HOSPITALS AND WELLNESS CENTERS **433 W. High Street** **Bryan, Ohio 43506,**	:	**Case No.**
and	:	**Judge J. T. Stelzer**
OHIO HOSPITAL ASSOCIATION **155 East Broad Street, Suite 301** **Columbus, Ohio 43215,**	:	
and	:	
OHIO STATE MEDICAL ASSOCIATION **5115 Parkcenter Avenue, Suite 200** **Dublin, Ohio 43017,**	:	
and	:	
OHIO PSYCHOLOGICAL ASSOCIATION **395 East Broad Street, Suite 310** **Columbus, Ohio 43215,**	:	
and	:	
OHIO PHYSICAL THERAPY ASSOCIATION **1085 Beecher Crossing N, Suite B** **Columbus, Ohio 43230,**	:	
and	:	
OHIO CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS **94 Northwoods Blvd.** **Columbus, Ohio 43235,**	:	
and	:	

OHIO CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS **633 N Saint Clair Street** **Chicago, IL 60611**	:
and	:
OHIO OSTEOPATHIC ASSOCIATION **53 West 3rd Avenue** **Columbus, Ohio 43215,**	:
Plaintiffs,	:
v.	:
THE STATE OF OHIO **c/o Ohio Attorney General Mike DeWine** **30 East Broad Street, 14th Floor** **Columbus, Ohio 43215,**	:
and	:
JOHN MCCARTHY **Director, Ohio Department of Medicaid** **50 West Town Street, Suite 400** **Columbus, Ohio 43215,**	:
Defendants.	:

COMPLAINT FOR TEMPORARY RESTRAINING ORDER, PRELIMINARY INJUNCTION, PERMANENT INJUNCTION, AND DECLARATORY JUDGMENT

Now come Community Hospitals and Wellness Centers, the Ohio Hospital Association, the Ohio State Medical Association, the Ohio Psychological Association, the Ohio Physical Therapy Association, the Ohio Chapter of the American Academy of Pediatrics, the Ohio Chapter of the American College of Surgeons, and the Ohio Osteopathic Association (collectively "Plaintiffs"), and hereby make the following claims and allegations against the State of Ohio and the Director of the Ohio Department of Medicaid (collectively "Defendants").

NATURE OF ACTION

1. Plaintiffs fully support efforts to make health care pricing more transparent and easier for consumers to understand.

2. Health care is unlike most other industries in that how much a consumer pays for a health care product or service is not totally determined by the provider of that product or service. Rather, how much a consumer pays is often determined by whether or not such consumer has coverage from a third party (either a government program, such as Medicare or Medicaid, or a private health insurance plan) for the health care product or service and the specific terms of that coverage.

3. In June 2015, the Ohio General Assembly enacted House Bill 52, which was "to make changes to the workers' compensation law, to make appropriations for the Bureau of Workers' Compensation …, and to provide authorization and conditions for the operation of the Bureau's programs."

4. The entire legislative history of House Bill 52 shows that it had one single subject: Workers' Compensation.

5. The bill, as introduced and initially passed in both houses of the Ohio General Assembly by June 25, 2015, contained no reference to health care price transparency.

6. Yet on June 25, 2015, with no notice to the health care community, with no prior introduction, with no prior readings of the draft legislation, with no hearings, and with no prior notice or forewarning to members of the affected industry (including Plaintiffs), and following an unusual motion to reconsider the as-passed House Bill 52, there was introduced on the Senate floor an amendment which injected a new statute that had nothing to do with Workers' Compensation and bluntly violated the Single-Subject Rule of the Ohio Constitution.

7. R.C. 5162.80 purports to be a price "transparency" act, but it is more fairly labeled the "Patient Care Disruption Act" or the "Stop-and-Paper Act."

8. The most egregious feature of R.C. 5162.80 is a prohibition that no health care provider can provide any services to a patient unless it first provides "in writing" to the patient a "good-faith estimate" of "***all of the following***" for the provider's "non-emergency products, services, or procedures":

(1) "The amount the provider will charge the patient or the consumer's health plan issuer," even though:

- It may be impossible to tell the patient what will be "charged" to the patient or the patient's health plan(s) before the provider ***even examines*** the patient;
- The provider may have no ability to make a good faith estimate of what may ultimately be charged to the patient or the patient's health plan after the claim is processed through one or more potentially covering health plans, with unknown coordination of benefits issues, unknown deductibles, and unknown coverage limitations; and
- The requirement sets up an absurd "stop-and-paper" requirement before any product, service, or procedure can be performed, as the clinician is making decisions along the way of examining the patient and learning new problems that need to be treated, creating tremendous choke-points in patient care.

(2) "The amount the health plan issuer intends to pay for the product, service, or procedure," even though:

- The provider and the health plan issuer are entirely separate organizations and businesses;
- In many cases it will be impossible to learn what the health plan "intends to pay" while a patient is sitting in front of the doctor providing service; and
- There is no statutory obligation for the health plan issuer to provide immediate information to the clinician while the clinician is with the patient;

(3) "The difference, if any, that the consumer or other party responsible for the consumer's care would be required to pay to the provider for the product, service, or procedure," even though:

- The health care provider sitting with the patient may have no ability to determine coordination of benefits issues, deductible issues or scope of coverage issues; and

- The health care provider sitting with the patient may have no ability to get the required information from the health plan issuer in a timely manner, because the health plan issuer only has to provide information "within a reasonable time of the provider's request."

9. R.C. 5162.80 is deeply disconnected from how patient care is provided in Ohio and ignores the real world in the patient-clinician environment.

10. R.C 5162.80 will disrupt patient care, will delay patient care, will damage the provider-patient relationship, will result in potentially misleading information to the patient, will drive up the cost of providing medical services by requiring the creation of an absurdly large bureaucracy in the health care environment that Ohio citizens will ultimately pay for in the form of higher charges or higher premiums, will instantly cause thousands of health care providers throughout Ohio to be in violation of Ohio law, Medicare requirements, bond covenants, and other contractual relationships, and will result in exponential irreparable harm the full extent of which cannot yet be fully contemplated.

11. R.C. 5162.80(D) mandates that the "Medicaid Director shall adopt rules… to carry out this section," but after eighteen months since the adoption of House Bill 52, no rules have been adopted to bring any clarity to this poorly written, confusing, ambiguous, vague, and impossible legislation.

12. But the Director is not to blame where he does not have the legal authority to adopt such rules, because R.C. 5164.02 limits his authority to administrating the Medicaid laws; he has no statutory authority over private health plans or participants in private health plans.

13. Because the Plaintiffs support efforts to improve price transparency for health care consumers, representatives of one or more Plaintiffs have participated in

dozens of meetings, discussions, and communications with representatives of the State of Ohio regarding the price transparency law; with such meetings, discussions and communications having been frequent and continuous since July, 2015.

14. The House sponsor of the "Stop-and-Paper Act" has since been repeatedly advised by the health care provider industry that the amendment of HB 52 was utterly unworkable, was impossible to implement, would disrupt patient care, would damage patient care, and would cause a damaging ripple effect of irreparable harm to health care providers who would instantly be in violation of the law because of its impossibility to perform.

15. But the House sponsor has ignored alternative proposals presented by Plaintiffs that would better and truly accomplish price transparency, and the sponsor has shown little regard for what is about to happen to millions of patients and thousands of providers throughout Ohio.

THE PARTIES

16. Plaintiff Community Hospitals and Wellness Centers ("CHWC") is a non-profit organization which provides health care services at three campuses in Williams County, including Archbold Medical Center, Bryan Hospital, and Montpelier Hospital, and has over 700 employees devoted to providing health care services to the community.

17. Plaintiff Ohio Hospital Association ("OHA") is a non-profit hospital association which represents 220 hospitals and 13 health systems throughout Ohio.

18. Plaintiff Ohio State Medical Association ("OSMA") is a non-profit statewide medical association representing nearly 16,000 Ohio physicians, residents, fellows, medical students, and practice managers.

19. Plaintiff Ohio Psychological Association ("OPA") is a non-profit statewide association representing Ohio member psychologists and psychology students in government, private practice, business, and health care.

20. Plaintiff Ohio Physical Therapy Association ("OPTA") is a non-profit professional organization representing approximately 3,400 therapists and therapy students around Ohio.

21. Plaintiff Ohio Chapter of the American Academy of Pediatrics ("Ohio AAP") is a non-profit organization representing over 2,900 pediatricians throughout Ohio.

22. Plaintiff Ohio Chapter of the American College of Surgeons functions through the coordinated activity of its individual members, for the support and improvement of the practice of surgery in the state of Ohio.

23. Plaintiff Ohio Osteopathic Association ("OOA") is a non-profit professional association representing more than 4,000 licensed osteopathic physicians and 21 accredited osteopathic health-care facilities throughout Ohio.

24. Defendant State of Ohio is the sovereign entity on whose behalf R.C. 5162.80 was enacted.

25. Defendant John McCarthy is named solely in his capacity as Director of the Department of Medicaid, who, pursuant to the express terms of R.C. 5162.80, is charged with the responsibility of adopting rules to carry out the statute.

VENUE

26. Venue is proper in Williams County where the irreparable harm caused as a result of the statute at issue will occur in Williams County, along with every other county in Ohio, and where Plaintiff CHWC has its principal place of business.

FACTS COMMON TO ALL CLAIMS

27. In 2015, there was introduced into the Ohio General Assembly House Bill 52 ("HB 52"), which at the time of its introduction had as its subject only changes to the Bureau of Workers' Compensation's laws and appropriations for the Ohio Bureau of Workers' Compensation.

28. At the time of its introduction and during the process of its passage in the House, and initially in the Senate, there was no provision that dealt with a different subject, let alone a broad requirement that virtually all health care providers in the state provide all "non-emergent" patients with written estimates of what patients or patients' plans would be charged, what the patient's health plan intends to pay, and what the patient's out-of-pocket financial obligation will be.

A. Violation of the Single-Subject and Three-Reading Rules of the Ohio Constitution.

29. Section 15(D) of Article II of the Ohio Constitution provides that "[n]o bill shall contain more than one subject, which shall be clearly expressed in its title," commonly referred to as the "Single-Subject" Rule, which is mandatory.

30. Where a bill includes a "disunity of subject matter" such that there is no discernable, practical, rational, or legitimate reason for combining the provisions in one act, it violates the Single-Subject Rule and is therefore void.

31. Section 15(C) of Article II of the Ohio Constitution requires that each house of the General Assembly consider each bill on at least three separate days, a rule commonly referred to as the "Three-Reading" Rule.

32. It is a violation of the Three-Reading Rule to "vitally alter" a bill just before enactment and after there have been three readings, but with no readings of the alteration.

33. A violation of the Three-Reading Rule renders the legislation void.

34. House Bill 52 received at least three readings and passed in the Ohio House on March 11, 2015, and then received at least three readings and passed in the Senate on June 25, 2015, with no inclusion of R.C. 5162.80.

35. But later in the day on June 25, 2015, HB 52 was, amended to include R.C. 5162.80 for the first time, and passed ten minutes later.

36. On June 26, 2015, the House included R.C. 5162.80 in HB 52 for the first time and adopted the amended bill five minutes later.

37. The amendment to add R.C. 5162.80 vitally altered HB 52 where the new provision had no relationship to the original bill, which was solely and completely devoted to revisions to various laws governing the operations of the Ohio Bureau of Workers' Compensation and enacting appropriations for the Ohio Bureau of Workers' Compensation.

38. R.C. 5162.80 has absolutely nothing to do with the Bureau of Workers' Compensation and Workers' Compensation laws, and is distinct and separate from the pre-amendment HB 52, such that the twilight introduction of R.C. 5162.80 into HB 52 violated both Sections 15(C) and 15(D) of Article II of the Ohio Constitution.

B. Vagueness – "Charge"

39. R.C. 5162.80 is full of vague terms where two providers can read the same language, come to different conclusions, and have no idea if they have violated the law.

40. One example of this is the simple word "charge".

41. R.C. 5162.80(A)(1) provides that the provider's written good faith estimate must include:

> "The amount the provider will charge the patient or the consumer's health plan issuer for the product, service or procedure."

42. The statute has no definition of the term "charge," which different health care providers can interpret very differently.

43. For example, some hospitals could interpret the term "charge" to mean that they must give the patient the "chargemaster" amount, which is essentially the highest possible sticker price from which insurers and health plans negotiate discounts.

44. So, one hospital might conclude that the "charge" that has to be disclosed is the high "chargemaster" amount which might significantly overstate the amount a health plan or patient would be expected to pay, but another hospital could interpret "charge" as meaning the amount the hospital expects to get paid for the service as a result of a negotiated payment from a health plan.

45. Other non-hospital providers are also likely to interpret "charge" differently, resulting in inconsistent and confusing information given to patients.

46. Two providers can read the same language in this statute and come to different conclusions and neither would know if they violated the statute.

C. Vagueness – "Emergency" and "non-emergency".

47. R.C. 5162.80 mandates written estimates as to "non-emergency products, services, or procedures," but contains no definition of what is an "emergency" or "non-emergency."

48. For example, many visits to a hospital emergency room are not considered by medical professionals to be true "emergencies," as they often deal with such things as flu symptoms, bruises, sprained joints, or colds.

49. The patient in the emergency room with the sore ankle may not be deemed an emergency compared to a shotgun or stroke victim.

50. Yet that patient who is in some pain and discomfort may view the twisted ankle as an emergency.

51. If the hospital treats the patient with the bruised ankle as an emergency and does not provide the written estimates required by the statute, the patient can later

complain after receiving the bill that it never was an emergency, that the patient never received the written estimates, that the hospital violated state law, and that the bill need not be paid due to such violation.

52. The same problem occurs with the mother in a maternity ward who suddenly decides she wants an epidural during delivery, but had directed beforehand she did not want one.

53. Women often deliver babies without epidurals, so that the application of an epidural would not be considered an "emergency."

54. In that case, the patient could not receive an epidural until the obstetrician, the hospital, and the anesthesiologist ***each and all*** "stop-and-paper" written estimates for the epidural administration, by which time the epidural will probably be too late.

55. Other examples of vagueness in the statute include such terms as "within a reasonable time of the provider's request" for health plans to respond, the amount the health plan "intends to pay," (*i.e.*, whether the service is covered by the health plan, whether within deductible or not, or if patient has maxed out on out-of-pocket), and the "difference," the patient's amount of financial responsibility (again dependent on plan coverage, deductible status, out-of-pocket maximum status).

56. These ambiguities will create endless disputes among health care providers, patients, and health plans over whether an "emergency" was presented, whether written estimates were required, whether a procedure occurred without an estimate, whether a procedure should have proceeded without an estimate, and whether the health care provider violated the law.

D. Irreparable Harm and Damage to Public Interest – Delayed Care.

57. The statute completely ignores how providers charge and are reimbursed for the delivery of medical services, particularly in the very common scenario where a third party (the health plan) is between the patient and the provider and shares responsibility, along with the patient, for such payments.

58. For example, payment by governmental and non-governmental insurers, self-funded employers, and other third party health plans for inpatient hospital services may be based upon a number of different "charge" models.

59. Three of the most popular "charge" models for hospital inpatient services are (i) percentage of "Billed Charges"; (ii) "Per Case" or "DRG" (a Medicare reimbursement methodology based on "diagnosis related groups"); and (iii) "Per Diem."

60. Under the Billed Charges model, the health plan pays the hospital an agreed upon discount based upon a percentage of the hospital's charges (usually documented in a hospital's "Chargemaster") submitted on an inpatient bill.

61. Billed Charges are comprised of every item-by-item charge during a patient's stay.

62. The discount off the Billed Charges determines what the health plan pays.

63. If a patient is admitted into a hospital for a number of conditions and the patient's health plan has negotiated a "Billed Charges" reimbursement model so that every single "product, service, or procedure" is separately billed, line-by-line to the health plan issuer, R.C. 5162.80 will create a monstrous mess in the course of that patient's care in the hospital.

64. That is because most of the products, services, or procedures provided to a typical patient in the hospital are not emergencies and often cannot be predicted at the time of the patient's admission.

65. So, before the hospital can even admit the patient for non-emergency treatment, the hospital must provide in writing to the patient:

- The amount the hospital will charge the patient ***or*** the patient's health plan;
- The amount the health plan issuer "intends to pay" for those products, services, or procedures; and
- The amount that (a) the patient, or (b) another "party responsible for the" patient's care would "be required to pay" the provider.

66. To be more specific, here is what the hospital has to do every time a new product, service, or procedure is provided in the course of a patient's hospital stay:

(a) Stop;

(b) Figure out all three items above;

(c) Contact the patient's health plan;

(d) Get a response from the patient's health plan;

(e) Reduce it all to writing; and

(f) Provide it to the patient.

67. If hospitals and other providers even tried to comply with R.C. 5162.80, emergency rooms and inpatient units across Ohio would become bloated with a new bureaucracy churning blizzards of paper required by the statute. Other types of providers face similar unfunded mandates of new bureaucracy and paperwork.

68. So, the patient who presents herself in the emergency room, urgent care center, walk-in physician clinic, or any number of other provider settings with symptoms that do not appear to be an "emergency" has to wait until the provider receives information from the patient's health plan so that the provider can provide the required written information.

69. In fact, since many patients who present to an emergency room are not true emergencies, most patients will suffer an additional delay in even seeing a physician as a result of the statute. But it only gets worse.

70. If, while the patient is visiting with the doctor after receiving the written estimates, the doctor concludes the patient may have a fractured bone, the doctor has to stop any further treatment or diagnosis and cannot send the patient down the hall to an X-ray machine, until the hospital then secures more written estimates, including information from the health plan.

71. And if the health plan takes ten hours to respond, the patient will have to sit there for ten hours, or the provider will have to violate the law and provide the service before providing an estimate.

72. In fact, the more difficult patient cases require a rolling series of diagnostic procedures, some of which cannot occur until knowing the results of the preceding procedures.

73. This means that under the law, the doctor and hospital have to "stop and paper" multiple times throughout the diagnostic process, to get information from the health plan, reduce all estimates to writing, and provide them to the patient, all before they can provide services to the patient.

74. As long as what is being diagnosed does not appear to be an "emergency," the diagnostic process could literally draw out days, where it should be hours, all because of R.C. 5162.80.

75. This causes irreparable harm to the patient, to the provider-patient relationship, to the reputation of the health care provider, and will cause irreparable harm to all health care consumers in the state of Ohio, not only in the form of a disrupted care

delivery system, but also in the form of the tremendous cost increases that necessarily will come from such delayed care.

76. And if, in the course of the patient's stay at the hospital, there are additional services, products, or procedures that need to be performed that were not initially predicted, ***every single time*** a determination is made that such is required for the patient, the provider has to "stop and paper."

77. Indeed, over the course of a seven-day in-patient stay at a hospital, there could be dozens of occasions where the hospital is prohibited from providing a product, service, or procedure to a patient, ranging from a mobile x-ray examination to a simple injection, without securing all three pieces of information and providing it in writing to the patient.

78. Worse, the statute has an inconsistent and conflicting standard of timing.

79. The patient cannot receive any treatment until it receives the written estimates from the health care provider; the health care provider cannot provide the estimate until it gets information from the health plan issuer; and the health plan issuer only has to provide such information "within a reasonable time of the provider's request," which could be days.

80. So, R.C. 5162.80 prohibits any treatment of the patient even if the health plan issuer takes days to get the information to the hospital or doctor.

81. The legislation has no safety valve for the circumstance in which the health plan is violating the law and not providing timely information to the health care provider; the only result is that the health care provider is prohibited by law from providing treatment to the patient while the health plan is in violation of the law.

82. That is, the only penalty in the statute for a circumstance where the health plan issuer does not comply with the statute is incurred *by the patient* who suffers and cannot access patient care as a result of the misconduct of another party.

83. And at the same time, the law allows no opportunity for a patient to waive his right to an estimate if he would rather receive timely health care services rather than wait for all of the steps to be completed to provide an estimate.

E. Irreparable Harm and Damage to Public Interest – Provider Certifications of Compliance with State Law

84. Providers are repeatedly required to certify, attest or otherwise represent that they are acting in compliance with state law, and face penalties and damages for failure to do so.

85. For instance, hospitals execute and are party to loan agreements, bond indentures, and other legally binding agreements that require the hospital to carry out its business and affairs in compliance with State law.

86. Violation of such loan agreements, bond indentures, and other legally binding agreements can trigger defaults under such agreements.

87. Defaults can trigger tax-exempt bonds to become taxable to the bond holders.

88. Hospitals also submit cost reports to the Medicaid and Medicare programs containing similar representations that the costs and services represented in such cost reports were presented and provided in compliance with state law.

89. Many other aspects of the everyday business of health care provider operations presume compliance with state law, including the submission of bills for services rendered.

90. A technical violation of R.C. 5162.80, even if not enforced by the Defendants, could trigger a flood of legal theories and potential litigation, including the refusal to pay for services actually rendered, premised on such technical violation..

91. Given the potential ramifications, penalties and financial exposure, providers will be irreparably harmed if R.C. 5162.80 goes into effect and they are not able to follow such law.

F. Impossibility of Performance.

92. There are a countless number of circumstances under which R.C. 5162.80 is impossible to comply with.

93. The most glaring example, as noted above, is the circumstance where the health care provider is to give immediate information to the patient as to what (a) the provider will charge the patient or will charge the patient's health plan, (b) the amount the health plan intends to pay, and (c) the amount the patient or "other party responsible" for the patient's care would be required to pay.

94. The provider's burden is to provide the estimates immediately at the point of service with the patient; there is no cushion of "a reasonable time," as granted to health plan issuers.

95. So, the health care provider is forced in an impossible situation where it cannot comply with provisions of the statute where it cannot timely get the information from the health plan.

96. Worse, as noted above, there will be occasions where it will be impossible for the provider to figure out if the service, product or procedure is within the scope of the patient's coverage under the health plan insurance agreement between the patient and the health plan.

97. Even if it is determined that the service, product or procedure is within the scope of coverage, it will be impossible for the provider to figure out the deductible of the patient where that deductible is constantly changing every time a service is provided, a product is provided, or a procedure is done, often all on the same day and in the course of multiple waves of disclosures, as described above.

G. Vagueness and Impossibility – Absence of Rules.

98. Given the vagueness described above, R.C. 5162.80 is in desperate need of rules to clarify and carry out the law.

99. Instead, R.C. 5162.80 creates more vagueness and impossibility.

100. R.C. 5162.80(D) mandates that "the Medicaid director shall adopt rules, in accordance with Chapter 119 of the Revised Code, to carry out this section."

101. R.C. 5162.80(D) directs and authorizes the Medicaid Director to "carry out" R.C. 5162.80 even though R.C. 5162.80 applies to patients and consumers who have health insurance coverage through a private "health plan" not subject to Medicaid regulations.

102. R.C. 5162.80(C) defines "health plan issuer" as "an entity subject to the insurance laws and rules of this state …"

103. As written, R.C. 5162.80 is not limited to Medicaid participants.

104. The authority conferred upon the Medicaid Director to enforce and implement rules to "carry out" R.C. 5162.80 causes a violation of other Ohio Revised Code provisions, violates principles of statutory construction, and violates the Ohio Constitution.

105. The authority of the Medicaid director is limited by R.C. 5164.02 to "adopt rules as necessary to implement this chapter".

106. R.C. 5164.02 does not convey any authority of the Medicaid Director to regulate non-Medicaid health plans or providers that do not participate in the Medicaid program so that R.C. 5162.80 is in conflict with R.C. 5164.02.

107. No other statutory authority conveys authority of the Medicaid Director to regulate all health plans and all providers as required by R.C. 5162.80.

108. State and federal law prevent the Medicaid Director from allocating funds or resources for activities outside of the Medicaid program, absent separate and special approval from federal agencies.

109. Upon information and belief, no such federal approval has been obtained for the Medicaid director to regulate all health plans and all providers as required by R.C. 5162.80.

110. To date, the Medicaid Director has not issued or proposed any rules to "carry out" R.C. 5162.80.

111. It is legally impossible for the Medicaid Director to follow R.C. 5162.80(D) and "adopt rules, in accordance with Chapter 119 of the Revised Code, to carry out this section," because of other statutory limitations on the director's authority.

COUNT I – Claim for Declaratory Judgment that Statute Violates Single-Subject and Three-Reading Rules of Ohio Constitution

112. Plaintiffs reallege and incorporate herein each and every allegation set forth above.

113. Where there is a "blatant disunity of subject matter" within a bill, the appropriate remedy is to sever the offending portion of the act to cure the defect and save the portions of the act that do relate to a single subject.

114. But for the inclusion of R.C. 5162.80, the entirety of HB 52 dealt solely with making "changes to the Workers' Compensation Law," making "appropriations for the Bureau of Workers' Compensation," and "to provide authorization and conditions for the operations of the Bureau's programs."

115. All of the statutes being amended or repealed in HB 52 dealt solely with Chapters 4121 and 4123, chapters that exclusively deal with the Ohio Industrial Commission, the Bureau of Workers' Compensation, and Workers' Compensation.

116. In contrast, Title 51 of the Ohio Revised Code is devoted to "public welfare" and Chapter 5162 is devoted to "Medicaid Programs; Medical Estate Recovery Programs; and Medicaid Funds."

117. That is, R.C. 5162.80 was inserted in a bill that did not even involve the same title, related chapters, or related subject matters; it was completely foreign and distinct from the entirety of the other sections of HB 52.

118. Accordingly, the insertion of R.C. 5162.80 into HB 52 represents a "blatant disunity of subject matter" for which Plaintiffs are entitled to judgment declaring that R.C. 5162.80 violates Section 15(D) of Article II of the Ohio Constitution and is therefore invalid and void as a matter of law.

119. Article II, Section 15(C) of the Ohio Constitution requires that each house of the General Assembly consider each bill on three separate days and is known as the Three-Reading Rule.

120. R.C. 5162.80 was never considered over three separate days.

121. The Ohio Supreme Court has long held that the purpose of the Three-Reading Rule is "to prevent hasty action and lessen the danger of ill-advised amendment at the last moment," to provide for "more publicity and greater discussion and affords each legislator an opportunity to study the proposed legislation, communication with his or her constituents, note the comments of the press and become sensitive to public opinion."

122. It is beyond dispute that the Three-Reading Rule was violated where R.C. 5162.80 vitally altered the subject matter of HB 52, such that there was no longer a common purpose or relationship between the original bill and the new amendment.

123. The last minute injection of R.C. 5162.80 into HB 52 violated the purpose of the Three-Reading Rule by failing to provide any publicity or discussion that would afford any legislator any opportunity to study the proposed legislation, communicate with his or her constituents, or to note comments of the press and become sensitive to public opinions.

124. As a result of the foregoing, Plaintiffs are entitled to judgment declaring that R.C. 5162.80 violated Article II, Section 15(C) of the Ohio Constitution and is therefore invalid and void.

COUNT II – Claim for Declaratory Judgment for Violation of Due Process Based on Impossibility

125. Plaintiffs reallege and incorporate herein each and every allegation set forth above.

126. Article I, Section 16, of the Ohio Constitution guarantees Ohioans "due course of law," which is generally the equivalent of the due process clause in the United States Constitution.

127. It is a fundamental tenant of due process that the State cannot enforce a statute that cannot be complied with.

128. Due process includes the concept of fundamental fairness in implementing a law that is incapable of being performed.

129. The Ohio Supreme Court has long held that a law which is utterly impossible to execute is void and courts should not enforce such statutes that are impossible of fulfillment.

130. For the reasons stated above, R.C. 5162.80 meets that standard of impossibility were it requires health care providers to immediately provide information to patients that is not available to health care providers and cannot be reasonably obtained in

the clinical care environment without reliance on third parties and without unreasonable delay to patient care.

131. The law is also impossible to perform because the Medicaid director is statutorily prohibited from promulgating the rules that R.C. 5162.80 requires of him; doing so would create conflict with other state and federal laws.

132. Accordingly, Plaintiffs are entitled to judgment declaring that R.C. 5162.80 violates Article I, Section 16, of the Ohio Constitution as a result of it being impossible to perform, and is therefore void.

COUNT III – Claim for Declaratory Judgment for Violation of Due Process on the Grounds of Vagueness.

133. Plaintiffs reallege and incorporate herein each and every allegation set forth above.

134. R.C. 5162.80 provides insufficient notice of its proscriptions such that persons of ordinary intelligence know that they are in compliance with the law.

135. R.C. 5162.80 is so vague that it is subject to official arbitrariness or discrimination in its enforcement.

136. Two different health care providers can look at the exact same language concerning what is a "charge" and what is an "emergency" and come to very different conclusions as to what information should be provided to the patient, when it should be provided to the patient, and whether it should be provided to the patient.

137. Hospitals and other providers across Ohio have no idea if they need to build a massive paperwork infrastructure to be able to comply with what will have to be rolling "stop-and-paper" disclosures, sometimes several in a day for a single patient.

138. For the foregoing reasons, Plaintiffs are entitled to judgment declaring that R.C. 5162.80 is irredeemably vague, in violation of Article I, Section 16 of the Ohio Constitution, and is therefore void.

COUNT IV – Claim for Declaratory Judgment for Violation of Due Process on the Grounds of Vagueness and Impossibility of Rules.

139. Plaintiffs reallege and incorporate herein each and every allegation set forth above.

140. R.C. 5162.80 requires the promulgation of rules but none have been issued.

141. R.C. 5162.80 requires the Medicaid director to issue rules applicable to non-Medicaid health plans, which requirement conflicts with state and federal law

142. The absence of rules, and the impossibility of the Medicaid director to issue rules, provide insufficient notice of the requirements of the law such that persons of ordinary intelligence know whether or not they are in compliance with the law.

143. The absence of rules, and the impossibility of the Medicaid director to issues rules, creates vagueness such that R.C. 5162.80 is subject to official arbitrariness or discrimination in its enforcement.

144. For the foregoing reasons, Plaintiffs are entitled to judgment declaring that R.C. 5162.80 is in violation of Article I, Section 16 of the Ohio Constitution, and is therefore void.

COUNT V – Claim for Injunctive Relief

145. Plaintiffs reallege and incorporate herein each and every allegation set forth above.

146. Starting on January 1, 2017, when R.C. 5162.80 goes into effect, virtually every hospital and health care provider in Ohio will be out of compliance with the statute because of its vagueness and impossibility of compliance.

147. And virtually every hospital in Ohio, including CHWC, will be out of compliance with covenants in which they are obligated to represent to Medicare, bond trustees, and in bond instruments, that they are in compliance with the laws of Ohio.

148. That is, the Ohio General Assembly has enacted a law that is impossible to comply with and will put every hospital in Ohio at risk of triggering a claim of default in obligations where they are required to covenant that they are in compliance with Ohio laws, which will cause them irreparable harm for which there is no adequate remedy at law.

149. The law will trigger endless disputes and litigation among providers, health plans, and consumers.

150. To the extent R.C. 5162.80 can even be partially complied with, the result will be significant disruption in the efficient delivery of patient care which will cause irreparable harm to the millions of health care patients throughout Ohio, to the provider-patient relationship, and to the reputations of hospitals and other health care providers throughout Ohio, all for which there can be no adequate remedy at law.

151. The Stop-and-Paper Act will trigger endless disputes among health care providers, consumers, and health plans, all as a result of the conflicting provisions within the statute, the vague provisions within the statute, the misinformation that will likely be forced upon consumers, and the immense unhappiness resulting from the disruption in patient care.

152. For all the foregoing reasons, Plaintiff CHWC and all of the members of the OHA and thousands of other providers across the state will be irreparably harmed as a result of the implementation of R.C. 5162.80 for which there is no adequate remedy at law and are entitled to preliminary and permanent injunctive relief barring any official from the State of Ohio, including the Director of Medicaid, from taking any action to implement the statute.

WHEREFORE, for the foregoing reasons, Plaintiffs hereby demand judgment as follows:

(A) As to Counts I-IV, judgment declaring that R.C. 5162.80 is unconstitutional and void;

(B) As to Count V, preliminary and injunctive relief prohibiting any enforcement of R.C. 5162.80; and

(C) Attorneys' fees, costs, and such other relief as the Court deems just and proper.

Respectfully submitted,

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