ORIGINAL

IN THE SUPREME COURT OF OHIO

PHILIP LABOY, et al.,	:	Case No. 14-0708
Plaintiffs-Appellees,	:	
v.	:	On Appeal From the Cuyahoga County Court of Appeals, Eighth Appellate District
GRANGE MUTUAL CASUALTY COMPANY,	:	
Defendant-Appellant.	:	Court of Appeals Case No. 13-100116

MEMORANDUM IN SUPPORT OF JURISDICTION OF APPELLANT GRANGE MUTUAL CASUALTY COMPANY

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THIS CASE IS OF PUBLIC AND GREAT GENERAL INTEREST

The Eighth District Court of Appeals failed to reject Appellees' novel claim that their automobile insurer, Appellant Grange Mutual Casualty Company ("Grange"), paid too much for their medical care, and assumed actual injury where none exists. The Eighth District's decision, which reversed a well-considered decision granting summary judgment for Grange, is at odds with traditional notions of contractual privity and with the purpose of medical payments coverage. Left to stand, this ruling would force Ohio insurers to fulfill an impossible mandate in administering medical payments coverage, slowing payment of such claims and impacting the cost of coverage. This Court should accept Grange's appeal to restore fundamental concepts of contract law and injury required for standing, and to reaffirm the principle that interpretation of an unambiguous contract is a question of law not subject to fact-finding.

After Appellees were injured in an accident, Grange quickly paid all of their medical expenses submitted under the medical payments coverage of their automobile insurance policy. Grange did not deny any part of Appellees' claims, Appellees did not forgo any medical care, did not incur any out of pocket expense for their medical care, and their medical payments coverage was not exhausted.

Nevertheless, Appellees filed a putative class action against Grange claiming that they were injured because Grange had paid Appellees' medical providers too much for their medical care because it did not pay lower rates for medical services that Appellees' *health care insurer* had apparently negotiated for *itself* with those providers. Appellees allege they were injured when Grange exercised its contractual right of subrogation on Appellees' recovery from a third-party tortfeasor, claiming damage from an alleged reduction in their net settlement proceeds because Grange's subrogated amount was larger than it should have been due to higher payments for medical expenses. Even though the net effect of the subrogation was zero – Grange

recovered only what it paid – Appellees speculate that their settlement proceeds were less than they would have been had Grange paid less for their medical expenses.

The policy permits Grange to pay medical bills at the lesser of "reasonable expenses" or "any negotiated reduced rate accepted by a medical provider." Appellees, Grange, the trial court, and the appellate court all agreed that this language is unambiguous. Giving this language its only reasonable meaning, the trial court held that "any negotiated reduced rate" refers to a rate that a provider has agreed to accept *from Grange* and entered summary judgment for Grange. (Trial Op. p. 5). But the Eighth District reversed, ruling that the unambiguous policy required "fact-finding" to determine whether Grange had "access" to pay Appellees' medical providers at the rates those providers had negotiated *not* with Grange, but with Appellees' health care insurer. (Op. ¶ 9). That is not Ohio law.

The Eighth District left unchallenged Appellees' theory that, as a matter of law, if one has automobile insurance from Grange and health care insurance from another, then Grange somehow automatically has "access" to – meaning the right to pay – rates for medical treatment that the insured's health care insurer negotiated for itself with medical providers. The fallacy in this theory is obvious: Grange has no right to compel, and medical providers have no obligation to accept, payments from Grange at rates they negotiated with other insurers.

The Eighth District also failed to address whether Appellees incurred an injury sufficient to confer standing as an alternative basis to affirm the lower court's judgment. A speculative reduction in an insured's settlement proceeds with a third-party tortfeasor, based on an insurer allegedly overpaying for the insured's medical care, is insufficient to confer standing. As a matter of law, an insured has no legally protected interest in the subrogated amount of proceeds, which are held in trust for the insurer who made the payments represented by the subrogated amount. But the court of appeals' decision lets stand Appellees' claims even though Grange did

not deny their claim or refuse to pay any expenses, the hallmarks of cognizable injury. *Kincaid v. Erie Ins. Co.*, 128 Ohio St.3d 322, 2010-Ohio-6036, 944 N.E.2d 207, ¶ 13.

Moreover, Appellees' "injury" is too remote from the purpose of medical payments coverage to constitute an injury. The goal of medical payments coverage is to "pay *immediate* medical bills, regardless of fault, to an injured insured . . . [and to] *expedite payment* or reimbursement of medical expenses to the injured parties . . . ." (Emphasis added.) *See* 6-64 Carley, *New Appleman on Insurance*, Section 64.01 (Law Library Ed.2012). But the court of appeals did not address Appellees' theory that an insurer also has the hitherto unrecognized duty "not to impair its insureds' rights to . . . third party settlement funds." (Appellees' Br. in Opp. to Summ. J. p. 6).

Not only is the court of appeals' decision antithetical to the purpose of insurance, it is also unworkable and puts Ohio auto insurers and medical providers in an impossible position. Insurers have a contractual duty to pay covered claims, and a legal duty to pay claims in a timely manner. *E.g., Zaychek v. Nationwide Mut. Ins. Co.*, 9th Dist. Summit No. 23441, 2007-Ohio-3297, ¶ 16. Left to stand, the Eighth District's decision would require Ohio insurers to scour the market for the lowest rate before paying insureds' medical expenses, a duty that would be impossible to satisfy. Insurers would be repeatedly placed in the quandary of paying quickly and risking overlooking a lower rate, or searching for the lowest rate and risking not paying claims in a timely manner.

Insurers already have an incentive to manage costs while fulfilling policy obligations, but the primary goal of medical payments coverage is to pay covered claims in a timely manner. Appellees' legal theory is antithetical to this principle. Ohio insurers should not have to second guess how good a bargain they obtained for their insureds' medical care – the paramount object is to promptly pay covered claims. And, allowing insurers to recoup payments through the right

of subrogation responsibly manages the cost of insurance. No public purpose is served by exposing insurers to litigation over whether payments they made to medical providers on behalf of insureds were "too high."

For all of these reasons, intervention by this Court is necessary to ensure that Ohio courts consistently apply fundamental rules of contract interpretation to insurance policies, to prevent the imposition of new and inconsistent duties on insurers and to prevent the concept of injury from intruding into the policy right of subrogation.

STATEMENT OF THE CASE AND FACTS

After Appellees were injured in an automobile accident in May 2006, Grange quickly paid 100% of their submitted expenses for medical care under the medical payments coverage of the policy.[1] Grange made payment directly to Appellees' medical providers, as permitted under the policy. For providers within the PPO Midwest Ohio network, a preferred provider network to which Grange is a party through its contractual relationship with a third-party bill review service, Grange paid based on rates negotiated through the network, if those rates were less than the reasonable and necessary amount billed by the medical provider. For providers not within that network, the amounts paid were based upon whether the expenses were reasonable and necessary in accordance with the policy.

After Grange paid all of Appellees' medical expenses, Appellees reached a settlement with the tortfeasor. Under the policy, "[i]f [Grange] make[s] a payment under this policy and the person to or for whom payment is made recovers damages from another, that person shall . . . [h]old in trust for us the proceeds of the recovery; . . . ." Pursuant to this provision, Grange was

[1] Contrast *Wolfe v. Grange Indemn. Ins. Co.*, 137 Ohio St.3d 561, 2013-Ohio-5201, 2 N.E.3d 238, recently before this Court, where claims alleged that Grange paid *too little* for its insureds' medical expenses under the same policy provision at issue here.

reimbursed from Appellees' settlement with the tortfeasor for the exact amount of medical expenses that it had already paid for Appellees' medical bills under the policy.

Appellees filed a putative class action against Grange in January 2012.[2] Appellees' claims for breach of contract and breach of the implied duty of good faith target subsection (B)(2) of the medical payments coverage of the policy. Section (B) states:

> B. We will pay under Part B – Medical Payments Coverage, the lesser of:
> 1. reasonable expenses incurred by the insured for necessary medical and funeral services because of bodily injury; or
> 2. any negotiated reduced rate accepted by a medical provider.

Grange moved for summary judgment, contending that the only reasonable interpretation of this language is that "any negotiated reduced rate accepted by a medical provider" refers to rates that Grange has the ability (i.e., the contractual right) to pay, and that a medical provider is contractually obligated to accept.

Appellees argued that Grange breached the insurance contract by not making payment based on lower negotiated rates that Appellees' health care insurer, Medical Mutual, had negotiated for itself with Appellees' medical providers. Although they had ample opportunity, Appellees submitted no evidence that Medical Mutual's agreements with those providers required the providers to accept the same rates from Grange or other insurers, or that Grange and other insurers are third party beneficiaries of such agreements.[3] Rather, Appellees contended only that, as a matter of law, Grange had "access" to Medical Mutual's negotiated rates simply because Appellees are insured by both entities. Based on this purported "access," Appellees argue that Grange "overpaid" for some of their medical care and that they were injured when

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[2] The propriety of class certification has not yet been addressed.

[3] During her deposition, Grange's representative repeatedly stated that Grange does not have access to pay the negotiated rates of Appellees' health care insurer because it does not have a contract entitling it to do so.

Grange exercised its subrogation rights to recover from Appellees' settlement proceeds the exact amount of medical expenses that Grange had paid on behalf of Appellees.

On June 24, 2013, the trial court granted Grange's motion for summary judgment, holding that Appellees' claims were based on an "illogical and an impossible construction of the [insurance] contract" and that the "only reasonable interpretation" of the policy provision is that it "clearly and unambiguously implies a contracted rate negotiated between Defendant Grange and a medical provider." (Trial Op., p. 5). As the trial court noted, Appellees never "cited any evidence showing that Grange had a contractual right to pay a reduced rate" negotiated between medical providers and Appellees' health insurer, and never "explained how Grange could force medical providers to accept rates that the medical providers negotiated with other entities than Grange." (*Id.* pp. 5-6).

Appellees appealed, and the Eighth District at first agreed with the trial court and the parties that the policy language is unambiguous: "The words are plain. There is no ambiguity." (Op. ¶ 6). But then, even while noting that the trial "court found no evidence to show that Grange had access to the negotiated rate charged by Medical Mutual because Grange was not a party to the contracts between Medical Mutual and its providers," the court of appeals criticized the trial court for "not engag[ing] in fact-finding to ensure the most sensible and reasonable interpretation of the policy." (*Id.* ¶¶ 2, 8). Contradicting its conclusion that the policy was not ambiguous, the court of appeals also found that Appellees were entitled to have any ambiguity construed in their favor. (*Id.* ¶ 8). Citing not to any evidence in the record but only to an argument in Appellees' brief, the Eighth District reversed the grant of summary judgment. (*Id.* ¶ 9). Although Grange raised Appellees' lack of injury as an alternative reason to uphold the trial court's judgment, the court of appeals did not address Grange's argument.

ARGUMENT IN SUPPORT OF PROPOSITIONS OF LAW

Proposition of Law No. I: An Insurer Does Not Breach An Obligation To Pay Negotiated Rates For Medical Care When It Has No Contractual Right To Pay Those Rates.

The Eighth District's opinion runs roughshod over fundamental principles of contract law by assuming that Grange had "access" to rates under agreements between Appellees' health care insurer and medical providers simply because both Grange and the health insurer insured Appellees. It is self-evident that because party "A" has a contract with parties "B" and "C," it does not follow that parties "B" and "C" thereby are in privity of contract as a matter of law – there is no transitive property of equality in contract law. But that is exactly what Appellees claim: "When the insured has access to a lesser negotiated rate through their own health insurer, then Grange is obligated to pay that lesser rate under the . . . policy, because it is available to Grange. . . . [M]edical providers are obligated to accept those rates [from Grange] by entering into a contract with the health insurer – in this case Medical Mutual on behalf of the Laboys." (Appellees' Br. in Opp. to Summ. J., p. 14–15); (Appellees' Br., p. 16) ("The Laboys' health [insurer] negotiated a discounted rate for medical services from medical providers . . . And since those providers are forced to accept the negotiated rate determined by [the] Laboys['] health carrier, that rate is accessible to Grange.").

Appellees' interpretation of the policy, which the court of appeals failed to reject, is unreasonable and impractical and obligates Grange to do the impossible – to pay negotiated rates that it does not have a contractual right to pay. "An unreasonable interpretation [of a contract] produces an absurd result or one that no reasonable person would have accepted when entering the contract." (Citation omitted.) *Walnut Private Equity Fund, L.P. v. Argo Tea, Inc.*, S.D. Ohio No. 1:11-cv-770, 2011 U.S. Dist. LEXIS 138884, *22 (Dec. 2, 2011). For a "negotiated rate" to exist, one party must *agree* to pay certain rates, and another must *agree* to accept those rates.

But the court of appeals ignored this common-sense truth and required unspecified "fact-finding" on whether Grange committed itself to the impossible – to pay rates negotiated between Appellees' health care insurer and medical providers, without any agreement from those providers to accept those rates from *Grange*.

Indeed, if the phrase "any negotiated rate" in the policy is not limited to rates that Grange has the contractual right to pay, then it refers to "any negotiated rate" accepted by "a medical provider" anytime, anywhere. Grange's obligation to pay this "lowest rate" is, according to Appellees, unlimited because the policy "places no [express] limits on who the medical provider is, who has the relationship with the medical provider, or how Grange may access the reduced rate." (Appellees' Br. in Opp. to Summ. J., p. 13). If *any* medical provider *anywhere* has agreed to accept a lower rate, then under the plain import of Appellees' interpretation Grange is obligated to pay that rate to a medical provider. This is the logical conclusion of Appellees' argument; the trial court did not "misconstrue" it. And while Appellees argue that their interpretation is limited to the rates negotiated by their health insurer, their construction is no less unreasonable than one meaning the rates of any provider anywhere.

The Eighth District's decision, if allowed to stand, would have profound consequences for Ohio insurers and medical providers handling medical payments coverage claims. Automobile insurers would be required to pay the rates negotiated by their insureds' health care insurers for medical care, even if the providers have not agreed (or refused) to accept those rates from the automobile insurer. And, left unanswered by the court of appeals is how automobile insurers would learn of these negotiated rates in the first place. By extension, medical providers would be compelled to accept payment by automobile insurers for medical expenses at rates those providers agreed to with a health insurer, regardless of whether the providers agreed to accept those rates from the automobile insurer.

The folly of Appellees' argument is manifest. No one has the ability, or right, to force another to enter into a contract or abide by the terms of a contract to which it is not a party. That is why the trial court found Appellees' theory to be "illogical and impossible" in that it would require Grange to "force medical providers to give them the lowest negotiated rate that the medical provider has offered to any other person when [the insurer] has no access or right to that lower rate." (Tr. Op. p. 5–6). This Court should accept Grange's appeal in order to forestall the adverse consequences to Ohio's auto insurers under medical payments coverage and medical providers resulting from the Eighth District's decision.

Proposition of Law No. II: When A Contract Is Found To Be Unambiguous, It Is Error To Order Further Fact Finding About Its Meaning.

A contract is ambiguous only when it is susceptible of more than one *reasonable* interpretation. *Lager v. Miller-Gonzalez*, 120 Ohio St.3d 47, 2008-Ohio-4838, 896 N.E.2d 666, ¶ 16. "If a contract is . . . unambiguous, then its interpretation is a matter of law and there is no issue of fact to be determined." *Nationwide Mut. Fire Ins. Co. v. Guman Bros. Farm*, 73 Ohio St.3d 107, 1995-Ohio-214, 652 N.E.2d 684, 686. In this case, the Eighth District found that, even though the policy is unambiguous, further fact-finding was needed to decide its meaning because the policy could be given Appellees' absurd construction. (Op. ¶¶ 6-8). This is not Ohio law.

"There is a long tradition in contract law of reading contracts sensibly; contracts . . . are not parlor games but the means of getting the world's work done. . . ." (Citation omitted.) *Beanstalk Group v. AM Gen. Corp.*, 283 F.3d 856, 860 (7th Cir.2002). "If literalness is sheer absurdity, [a court is] to seek some other meaning whereby reason will be instilled and absurdity avoided." *Outlet Embroidery Co. v. Derwent Mills, Ltd.*, 172 N.E. 462, 463 (N.Y.1930) (Cardozo, C.J.). Ambiguity does not exist simply because it can be created. "[M]ost words in the English language have multiple meanings, [but] ambiguity should not be created where it

does not exist." *Dominish v. Nationwide Ins. Co.*, 129 Ohio St.3d 466, 2011-Ohio-4102, 953 N.E.2d 820, ¶ 7; *accord Lager* at ¶ 16 (same).

When interpreting a contract, "[a] court has an obligation to give plain language its ordinary meaning . . . ." *Miller v. Marrocco*, 28 Ohio St.3d 438, 439, 504 N.E.2d 67 (1986). "[A] court must determine whether the contract can be interpreted giving reasonable, lawful, effective meaning to all terms." *State Auto. Ins. Co. v. Childress*, 1st Dist. Hamilton No. C-960376, 1997 Ohio App. LEXIS 88, *8 (Jan. 15, 1997). In this vein, "[c]ommon words appearing in a written instrument are to be given their plain and ordinary meaning unless manifest absurdity results or unless some other meaning is clearly intended from the face or overall contents of the instrument." *Alexander v. Buckeye Pipe Line Co.*, 53 Ohio St.2d 241, 245-46, 374 N.E.2d 146 (1978). *See also Beanstalk Group*, 283 F.3d at 860 ("A blinkered literalism, a closing of one's eyes to the obvious, can produce nonsensical results . . . .").

The Eighth District disregarded these long established principles and committed several errors. First, it created ambiguity where there was none. *Lager* at ¶ 16. Grange, Appellees, and the trial court all agreed that Section (B)(2) of the policy was unambiguous. The appellate court also found Section (B)(2) to be unambiguous, but then, focusing on the word "any", seemingly also found the policy to be ambiguous because it was susceptible to an "impossible" interpretation. (Op. ¶¶ 6-8). Notably, the appellate court admitted that this was an "absurd[]" interpretation of the Policy. (*Id.* ¶ 9). But a contract's susceptibility to an unreasonable interpretation does not make it ambiguous. "[I]n isolation, any word or phrase in . . . contested policy language may be ambiguous." *Dominish* at ¶ 8.

It was not for the appellate court to "create ambiguity in a contract where there is none." *Lager* at ¶ 16. Contracts "are not to be construed so as to arrive at absurd or impossible results." *City of Cincinnati v. Cameron*, 33 Ohio St. 336, 364 (1878). The appellate court isolated the

word "any," divorced from its context in the policy, gave it an "impossible" meaning, and then declared the policy (which it labeled unambiguous) to then be ambiguous. In so doing, the appellate court erred by failing to "determine whether the contract can be interpreted giving reasonable, lawful, effective meaning to all terms." *Childress*, 1997 Ohio App. LEXIS 88, at *8.

Moreover, the appellate court created new law by holding that when a contract is susceptible to an "absurd" interpretation, then a trial court must "engage in fact-finding to give the contract the most sensible and reasonable interpretation." (Op. ¶¶ 8-9).[4] But the law in Ohio is that "before language may be found ambiguous, a court must find that more than one *reasonable* interpretation of the language exists." (Emphasis added.) *Bethel Village Condominium Assn. v. Republic-Franklin Ins. Co.*, 10th Dist. Franklin No. 06AP-691, 2007-Ohio-546, ¶ 16; *accord State Auto. Mut. Ins. Co. v. Dolosich,* 135 Ohio App.3d 601, 610, 735 N.E.2d 38 (8th Dist.1999) ("Courts must interpret insurance contracts to the end that a reasonable interpretation of the insurance contract consistent with the apparent object and plain intent of the parties may be determined.").

The Eighth District's "impossible" construction of the policy is by definition unreasonable and cannot create an ambiguity. The appellate court was obligated to evaluate Grange's and Appellees' contentions as to the meaning of the unambiguous policy as a question of law so that "some other meaning whereby reason will be instilled and absurdity avoided." *Outlet Embroidery,* 172 N.E. at 463. It did not. Rather, it reversed and ordered "fact-finding" due to the mere existence of two interpretations without assessing whether both are reasonable.

In sum, the appellate court held that fact-finding was required before the trial court could rule on the meaning of an unambiguous contract, and that an unambiguous contract became

[4] The appellate court relied on case law from other jurisdictions and an inapposite Ohio decision for this proposition.

ambiguous because it is capable of being given an impossible, unreasonable construction. These holdings are contrary to Ohio law.

<u>Proposition of Law No. III</u>: An Appellate Court Errs When It Fails To Consider Alternative Grounds Upon Which Summary Judgment Could Have Been Sustained.

This Court should also accept review of the Eighth District's judgment because the court of appeals failed to address Grange's alternative argument that a reduction in an insured's settlement payments cannot constitute an "injury" sufficient to confer standing.

An appellate court must consider all possible reasons for sustaining a trial court's judgment, not only those ruled on below. *See Joyce v. Gen. Motors Corp.*, 49 Ohio St.3d 93, 96, 551 N.E.2d 172 (1990). This Court has "consistently held that a reviewing court is not authorized to reverse a correct judgment merely because erroneous reasons were assigned as the basis thereof." *Id.*, citing *Agric. Ins. Co. v. Constantine*, 144 Ohio St. 275, 284, 58 N.E.2d 658 (1944); *see also Loudenback v. Collins*, 4 Ohio St. 251, paragraph two of the syllabus (1854) ("A correct judgment will not be reversed, because a bad reason for it was given by the court that rendered it."). Appellate courts review judgments – not reasons. *State ex rel. Covington & Cincinnati Bridge Co. v. Judges of Court of Common Pleas of Hamilton Cty.*, 69 Ohio St. 372, 380, 69 N.E. 659 (1904).

An appellate court is therefore "required to affirm" a trial court's summary judgment order "if any valid grounds are found on appeal to support it." *McKay v. Cutlip*, 80 Ohio App.3d 487, 491, 609 N.E.2d 1272 (9th Dist.1992). So "even if a trial court has stated an erroneous basis for its judgment, a reviewing court will affirm the judgment if it is legally correct for another reason." (Quotation omitted.) *Perry v. Gen. Motors Corp.*, 113 Ohio App. 3d 318, 325-26, 680 N.E.2d 1069 (10th Dist.1996). These rules are firmly rooted in the de novo standard of review that applies to summary judgment appeals. *See Columbus Steel Castings Co. v. Transp. & Transit Assocs., LLC*, 10th Dist. Franklin No. 12AP-970, 2014-Ohio-272, ¶ 28. Accordingly,

the appellate court "must affirm the trial court's judgment if any grounds that the movant raised in the trial court support it." *Id.*; *see also Carpenter v. Long*, 196 Ohio App.3d 376, 393-94, 2011-Ohio-5414, 963 N.E.2d 857 (2d Dist.).

Yet the Eighth District did not perform an independent, de novo review. Rather than reviewing the trial court's judgment, the court of appeals reversed on one issue, while ignoring Grange's argument that Appellees had suffered no cognizable injury. This Court should accept review and direct that alternative grounds for affirming a judgment must be considered.

Proposition of Law No. IV: Speculation That A Settlement With A Third-Party Tortfeasor Was Reduced Because An Insurer Allegedly "Overpaid" Its Insured's Medical Expenses And Then Exercised Its Subrogation Right Is Not An Injury Sufficient For Standing.

Appellees claim that they were injured based on their speculation that the proceeds of their settlement with a third-party tortfeasor were lower because Grange recouped a larger subrogation amount due to its allegedly paying too much for Appellees' medical care. As Grange argued before the court of appeals, as an alternative basis upon which to affirm the trial court's judgment, this alleged "injury" is not sufficient to confer standing under Ohio law. However, that argument was not addressed by the Eighth District.

"Standing is defined at its most basic as '[a] party's right to make a legal claim or seek judicial enforcement of a duty or right.'" (Citation and quotations omitted.) *Ohio Pyro, Inc. v. Ohio Dep't of Commerce*, 115 Ohio St.3d 375, 2007-Ohio-5024, 824 N.E.2d 550, ¶ 27. A plaintiff "must have suffered an injury in fact -- an invasion of a legally protected interest." (Citations and quotations omitted.) *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560, 112 S.Ct. 2130, 119 L.Ed.2d 351 (1992). Standing is a preliminary inquiry that must be made before a court may consider the merits of a legal claim. *Kincaid v. Erie Ins. Co.*, 128 Ohio St.3d 322, 2010-Ohio-6036, 944 N.E.2d 207, ¶ 9.

Appellees have no legally protected interest in subrogated settlement proceeds because Appellees always held those funds *in trust for Grange*. The policy provides that: "If [Grange] make[s] a payment under this policy and the person to or for whom payment is made recovers damages from another, that person shall: 1. Hold in trust for [Grange] the proceeds of the recovery; and 2. Reimburse [Grange] to the extent of our payment. . . ." Therefore, by contract, it was Grange and not Appellees who had a legally protected interest in the proceeds of any recovery from Appellees' tortfeasor to the extent of claims paid by Grange. Grange received no more in subrogation than what it paid in Appellees' medical expenses and it never denied Appellees' claim or refused to pay any medical expenses, thus Appellees lack any injury or harm. *Kincaid* at ¶13 (no injury if no claim denied or expense not paid).

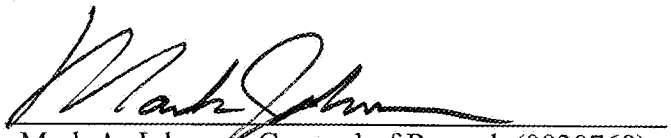
Appellees' alleged injury is also too remote and speculative to confer standing. "Remoteness is . . . related to the issues of proximate causation or standing . . . . [A] complaint will fail on remoteness grounds if the harm alleged is the remote consequence of the defendant's misconduct (causation) . . . ." *City of Cleveland v. JP Morgan Chase Bank, N.A.*, 8th Dist. Cuyahoga No. 98656, 2013-Ohio-1035, ¶ 11. Medical payments coverage is a "truly passive and derivative right in which the insurer has no recovery unless and until the insured chooses to seek recovery from another party and is successful in the attempt." *See* 16 Russ, *Couch on Insurance*, Section 226.1 (2011). These two steps, neither of which is controlled by the insurer, separate the alleged wrong from the purported harm. Further, Appellees' settlement proceeds-reduction theory is too far removed from the purpose of medical payments coverage to constitute an injury. Medical payments coverage does not serve to maximize Appellees' settlement with a third party tortfeasor, but to insure those *not* made whole by the tortfeasor who caused their injury. *See* 6-64 Carley, *New Appleman on Insurance*, Section 64.01 (Law Library Ed. 2012).

It is undisputed that Grange paid all of Appellees' submitted medical expenses, Appellees paid nothing out of pocket, and Grange only recovered in subrogation exactly what it paid for Appellees' medical care. Appellees' alleged injury is insufficient to grant them standing.

CONCLUSION

This Court should grant jurisdiction and reverse the decision below.

Respectfully submitted,



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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the foregoing Memorandum in Support of Jurisdiction of Appellant Grange Mutual Casualty Company was served upon the following by first class U. S. mail, postage prepaid, this 5th day of May, 2014:

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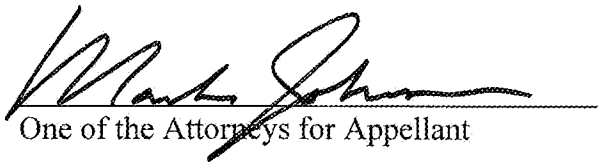

One of the Attorneys for Appellant

Appendix A

APR 10 2014

Court of Appeals of Ohio

EIGHTH APPELLATE DISTRICT
COUNTY OF CUYAHOGA

JOURNAL ENTRY AND OPINION
No. 100116

PHILIP LABOY, ET AL.

PLAINTIFFS-APPELLANTS

vs.

GRANGE INDEMNITY INSURANCE CO., ET AL.

DEFENDANTS-APPELLEES

CA13100116
83801640

JUDGMENT:
REVERSED AND REMANDED

Civil Appeal from the
Cuyahoga County Court of Common Pleas
Case No. CV-12-773808

BEFORE: Stewart, J., S. Gallagher, P.J., and E.A. Gallagher, J.

RELEASED AND JOURNALIZED: April 10, 2014

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FILED AND JOURNALIZED
PER APP.R. 22(C)

APR 10 2014

CUYAHOGA COUNTY CLERK
OF THE COURT OF APPEALS
By _____ Deputy

MELODY J. STEWART, J.:

{¶1} Plaintiffs-appellants Philip and Heidi Laboy carried automobile insurance issued by defendant-appellee Grange Mutual Casualty Company ("Grange"). The policy contained a medical payments clause that said Grange would pay the lesser of reasonable medical expenses or "any negotiated reduced rate accepted by a medical provider." When the Laboys were injured in an automobile accident, they submitted their medical bills not only to Grange, but to their health insurance company, Medical Mutual of Ohio. Medical Mutual reimbursed the Laboys' health care providers at negotiated rates; Grange reimbursed those same health care providers at higher rates. After all the bills were paid, Grange exercised its contractual right of subrogation against the Laboys for the medical payments it made on their behalf. The Laboys complained that Grange violated the terms of the policy by paying a higher rate than that negotiated by Medical Mutual for the same bills. They claimed that Grange's higher rate of reimbursement ($891.99) meant that Grange could seek a higher amount in subrogation, which would lead to a corresponding reduction in the net proceeds they received from their settlement with the tortfeasor.

{¶2} The court rejected the Laboys' arguments. It found that the Laboys' interpretation of the medical payments clause would lead to the absurd result that the obligation to reimburse medical expenses at a negotiated reduced rate accepted by "a medical provider" would result in Grange having to reimburse

medical expenses at a rate negotiated by any medical provider, anywhere, regardless of whether the Laboys had a right, or access, to that rate. It found that a more reasonable interpretation of the policy language was that the language "any negotiated reduced rate accepted by a medical provider" implies that "Defendant Grange has to have access to that negotiated rate by contracting with the medical provider." Grange negotiated its own rate with PPOM Ohio network and made that rate available to its insureds if they chose to receive medical treatment in that network. The court found no evidence to show that Grange had access to the same negotiated rate charged by Medical Mutual because Grange was not a party to the contracts between Medical Mutual and its providers. On that basis, the court granted summary judgment to Grange and this appeal followed. The sole assignment of error contests the court's ruling.

{¶3} The language at issue appears in a "limit of liability" section of the policy. It states:

> B. We will pay under Part B - Medical Payments Coverage, the lesser of:
>
> 1. reasonable expenses incurred by the insured for necessary medical and funeral services because of bodily injury; or
>
> 2. any negotiated reduced rate accepted by a medical provider.

{¶4} When reviewing language used in an insurance policy, we give words their plain and ordinary meaning unless another meaning is clearly apparent

from the contents of the policy. *Alexander v. Buckeye Pipe Line Co.*, 53 Ohio St.2d 241, 374 N.E.2d 146 (1978), paragraph two of the syllabus.

{¶5} The parties give different interpretations of the policy. Grange maintains that Section (B)(2) should mean any reduced rate negotiated *by Grange* that is accepted by a medical provider (i.e., its PPOM network); the Laboys maintain that the clause should mean a lesser negotiated rate that Grange has access to through its insured's health insurer (i.e., Medical Mutual). Their differences center on whether Grange has "access" to reduced negotiated rates accepted by medical providers (Grange says it does not because it lacks privity; the Laboys say it does through reduced negotiated rates by its insurer, Medical Mutual). These differing interpretations of the policy suggest that Section (B)(2) is ambiguous. On its face, it is not.

{¶6} Section (B)(2) requires Grange to pay *any* negotiated reduced rate accepted by a health care provider. Taken literally, this section clearly indicates that Grange's duty to pay a negotiated reduced rate is without qualification and applies regardless of geographic proximity or even privity of contract. It would apply to rates negotiated on the other side of the globe or to the rate negotiated by someone who perhaps persuades a medical provider to accept less than that provider's normal rate for services. The words are plain. There is no ambiguity.

{¶7} The difficulty with Section (B)(2) is that it is so all-encompassing, it would be impossible for Grange to comply. This brings into application the rule

that "[e]ven an apparently unambiguous contract may be rendered ambiguous and open to construction if its words, taken literally, lead to absurdity or illegality when applied to the facts." *Clappenback v. New York Life Ins., Co.*, 136 Wis. 626, 630, 118 N.W. 245 (1908); *United Refining Co. v. Jenkins*, 410 Pa. 126, 138, 189 A.2d 574 (1963); *Sanders v. Gen. Motors Acceptance Corp.*, 180 S.C. 138, 185 S.E. 180 (1936). When this kind of absurdity exists, the court should engage in fact-finding to give the contract the most sensible and reasonable interpretation. *Kelly v. Med. Life Ins. Co.*, 31 Ohio St.3d 130, 132, 509 N.E.2d 411 (1987).

{¶8} The trial court ruled that Grange's interpretation of the policy, that Section (B)(2) applies only to reduced rates negotiated by Grange and accepted by medical providers in their network, was "the only reasonable interpretation" of the policy, but it did so on the mistaken basis that the Laboys were arguing that Section (B)(2) should be applied as written and be found to mean any negotiated rate regardless of geography. The Laboys' brief in opposition to Grange's motion for summary judgment made it clear that "Grange does, in fact, have access to a lesser negotiated rate via medical providers who have agreed with [sic] Laboys' medical insurer to provide a discounted rate." Brief In Opposition to Motion for Summary Judgment at 12. Furthermore, the court did not consider the merits of the Laboys' argument when deciding how to interpret the policy and did not engage in fact-finding to ensure the most sensible and

reasonable interpretation of the policy. This error was doubly prejudicial because the Laboys, as the insureds, were entitled to have any ambiguity in the policy construed most favorably to them. *Fed. Ins. Co. v. Executive Coach Luxury Travel, Inc.*, 128 Ohio St.3d 331, 2010-Ohio-6300, 944 N.E.2d 215, ¶ 8.

{¶9} We agree that interpreting Section (B)(2) to mean any negotiated reduced rate anywhere in the world would be an absurd interpretation. However, without the benefit of fact-finding, we are not convinced that interpreting the policy as Grange asserts is the only reasonable interpretation. There are genuine issues of material fact and Grange has not demonstrated that it is entitled to judgment as a matter of law. We, therefore, sustain the assigned error.

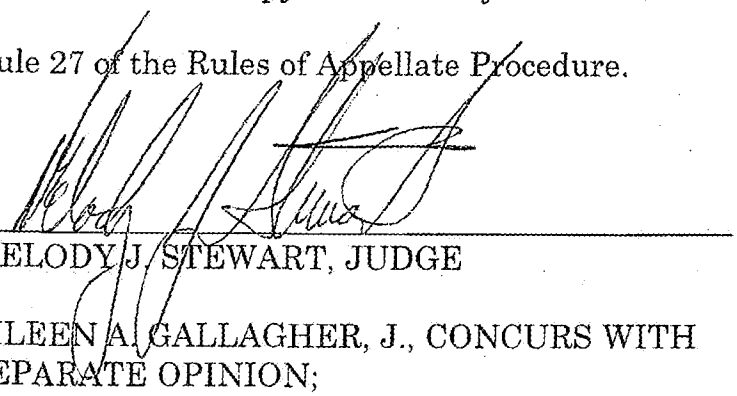
{¶10} This cause is reversed and remanded to the trial court for further proceedings consistent with this opinion.

It is ordered that appellants recover of appellee their costs herein taxed.

The court finds there were reasonable grounds for this appeal.

It is ordered that a special mandate issue out of this court directing the Cuyahoga County Court of Common Pleas to carry this judgment into execution.

A certified copy of this entry shall constitute the mandate pursuant to Rule 27 of the Rules of Appellate Procedure.



MELODY J. STEWART, JUDGE

EILEEN A. GALLAGHER, J., CONCURS WITH SEPARATE OPINION;
SEAN C. GALLAGHER, P.J., CONCURS IN JUDGMENT ONLY

EILEEN A. GALLAGHER, J., CONCURRING:

{¶11} I concur with the majority but write separately to express my concerns regarding the initiation of this case.

{¶12} The Cuyahoga County Court of Common Pleas case designation sheet in this case, completed by plaintiff's counsel, identifies this case as a "Commercial Docket" case.

{¶13} This matter, however, is not a case appropriate for a commercial docket pursuant to the parameters set out by the Ohio Supreme Court.

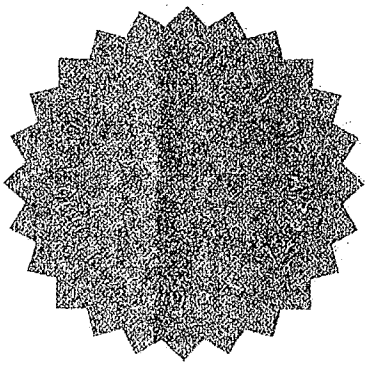
{¶14} The commercial dockets were established to focus on litigation between business entities or a business entity and an owner, sole proprietor, shareholder, partner or member of a business entity.

{¶15} A class action lawsuit is eligible for the commercial docket if it qualifies under one of the several provisions under Sup.R. 49.05 for the Courts of Ohio. This case does not so qualify.

{¶16} In order to maintain the integrity of commercial dockets as envisioned, I suggest that plaintiffs, as well as commercial docket judges, be cautious in their identification of commercial docket cases and the maintenance of a case that is inappropriate on a commercial docket.

The State of Ohio,
Cuyahoga County. } ss.

I, ANDREA F. ROCCO, Clerk of the Court of Appeals within and for said County, and in whose custody the files, Journals and records of said Court are required by the laws of the State of Ohio, to be, kept, hereby certify that the foregoing is taken and copied from the Journal entry dated on 4/10/14 CA 100116 of the proceedings of the Court of Appeals within and for said Cuyahoga County, and that the said foregoing copy has been compared by me with the original entry on said Journal entry dated on 4/10/14 CA 100116 and that the same is correct transcript thereof.



In Testimony Whereof, I do hereunto subscribe my name officially, and affix the seal of said court, at the Court House in the City of Cleveland, in said County, this 10 day of April A.D. 20 14

ANDREA F. ROCCO, Clerk of Courts

By _____ Deputy Clerk

Appendix B

79926200

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

PHILLIP A. LABOY - ET AL.
Plaintiff

GRANGE INDEMNITY INSURANCE COMPANY - ET AL.
Defendant

Case No: CV-12-773808

Judge: RICHARD J MCMONAGLE

JOURNAL ENTRY

89 DIS. W/ PREJ - FINAL

DEFENDANTS' MOTION FOR SUMMARY JUDGMENT IS GRANTED. OSJ.
COURT COST ASSESSED TO THE PLAINTIFF(S).

OSJ

Judge Signature Date

- 89
06/21/2013

STATE OF OHIO	)	IN THE COURT OF COMMON PLEAS
	) SS:	
CUYAHOGA COUNTY	)	CASE NO. CV- 12 - 773808

PHILIP LABOY, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	**OPINION AND ORDER**
v.	)	
	)	
GRANGE INDEMNITY INSURANCE COMPANY, *et al.*,	)	
	)	
	)	
Defendants.	)	

Richard J. McMonagle, J.:

This matter is before the Court on the Grange Defendants' Motion for Summary Judgment against the Plaintiffs. Consistent with the following opinion, the Court hereby **GRANTS** the Defendants' motion.

I. FACTUAL BACKGROUND

Defendant Grange Mutual Casualty Company ("Defendant Grange") issued an automobile insurance policy to Plaintiff Phillip Laboy as the named insured, and Plaintiffs Heidi Laboy, Alexandrea Laboy, and Gabriella Laboy were all insureds under that policy. On May 23, 2006, Plaintiffs Heidi Laboy, Alexandrea Laboy, and Gabriella Laboy were involved in an automobile accident that required them to receive medical treatment for personal injuries sustained in that accident. The Plaintiffs received treatment from various medical providers, and their medical bills were submitted to both their health insurance carrier, Medical Mutual Insurance Company ("Medical Mutual"), as well as, Defendant Grange under their automobile insurance. The Plaintiffs' automobile policy with Defendant Grange provided up to $5000 in medical care for each person injured in any one accident. Defendant Grange did not deny any

part of the Plaintiffs' insurance claims for Heidi Laboy's, Alexandrea Laboy's, and Gabriella Laboy's medical treatment, and made payments directly to the medical provider covering the total cost of all the medical treatments. The Plaintiffs received all of the medical treatment they sought, and suffered no out-of-pocket expenses for the treatment.

At issue is the amount Defendant Grange paid for the Plaintiffs' medical treatment. Defendant Grange paid discounted rates for any medical provider within its preferred provider network, but paid the full amount billed for all the reasonable and necessary treatments performed by any medical provider not within its preferred provider network. The Plaintiffs' health insurance carrier, Medical Mutual Insurance Company, was able to obtain negotiated or discounted rates with the medical providers that treated the Plaintiffs. The Plaintiffs argue that Defendant Grange had access to Medical Mutual's discounted rate via the Plaintiffs, and therefore was contractual obligated to use that discounted rate under Part B(2) of the Medical Payments Coverage form. The Plaintiffs further argue that as a result of the Defendant not paying the negotiated or discounted rate, the Plaintiffs received less money in the settlement of their civil claim because the Defendant was entitled to a larger portion of the settlement proceeds through their subrogation claim.

II. LEGAL STANDARD

Summary judgment is appropriate when, "(1) no genuine issue as to any material fact remains to be litigated; (2) the moving party is entitled to judgment as a matter of law; and (3) it appears from the evidence that reasonable minds can come to but one conclusion, and viewing such evidence most strongly in favor of the party against whom the motion for summary judgment is made, that conclusion is adverse to the party whom the motion for summary judgment is made." *State ex rel. Parsons v. Fleming*, 68 Ohio St.3d 509, 511 (1994).

The moving party "bears the initial burden of informing the trial court of the basis for the motion, and identifying those portions of the record that demonstrate the absence of a genuine issue of material fact on the essential elements of the non-moving party's claims." *Drescher v. Burt*, 75 Ohio St.3d 280, 293 (1996). Once the moving party meets its initial burden, the nonmoving party must produce evidence on any issue that the party bears the burden of production at trial. *Wing v. Anchor Media, Ltd. Of Texas*, 59 Ohio St.3d 108,111 (1991).

III. THE PLAINTIFFS' STIPULATION AND ABANDONMENT OF CLAIMS.

In the Plaintiffs' Brief in Opposition, the Plaintiffs responded to several of the Defendants' arguments by stipulation or voluntary dismissal. The Plaintiffs have stipulated that Grange Mutual Casualty Company is the only proper party. Additionally, the Plaintiffs have abandoned their claims for the value of the insurance policy and loss of premiums, as well as, their breach of fiduciary duty claim.

Therefore, the Court will not address the Defendants' arguments on those matters. All the Defendants except for Grange Mutual Casualty Company are hereby dismissed, and the Plaintiffs' claims for the value of the insurance policy, loss of premiums and breach of fiduciary duty are also dismissed.

IV. ANALYSIS

A. The Plaintiffs' Contract Theory is Unreasonable and Illogical.

It is this Court's "primary objective is to give effect to the intent of the parties, which is presumed to rest in the language that they have chosen to employ." *Saunders v. Mortensen*, 101 Ohio St. 3d 86, 2004 Ohio 24, at P9, 801 N.E.2d 452, citing *Kelly v. Med. Life Ins. Co.*, 31 Ohio St.3d 130, 31 OBR 289, 509 N.E.2d 411 (1987), paragraph one of the syllabus. "Common

words appearing in a written instrument will be given their ordinary meaning unless manifest absurdity results, or unless some other meaning is clearly evidenced from the face or overall contents of the instrument." *Alexander v. Buckeye Pipe Line Co.*, 53 Ohio St.2d 241, 245-246 (1978).

The contract language at issue is the "Medical Payments Coverage," which states in the "Limit of Liability" section that:

> **B.** We will pay under Part B- Medical Payments Coverage, the lesser of:
> **1.** Reasonable expenses incurred by the insured for necessary medical and funeral services because of bodily injury; or
> **2.** Any negotiated reduced rate accepted by a medical provider.

The Plaintiffs' assert claims that Part B(2) obligates Defendant Grange to pay lower negotiated rates when their insureds' health insurance carrier has a lower negotiated rate. The Defendant argues that the Plaintiffs' breach of contract claim requires an unreasonable and illogical interpretation of the contract language. The Defendant argues that the Plaintiffs' entire theory hinges on the word "any" in Part (B)(2), which the Plaintiffs have interpreted literally to mean every single negotiated rate between any medical provider and any other person or entity; rather than a negotiated rate to which the medical provider has contractually agreed to accept from Defendant Grange. The Defendant asserts the only reasonable interpretation of the language is "any negotiated reduced rate accepted by a medical provider" so long as that medical provider is in the preferred provider network and has an agreement with Defendant Grange.

Whereas insurance contracts are liberally construed in favor the insured, the Court must not apply that liberal construction "so as to provide an unreasonable interpretation of the words of the policy." *Cincinnati Ins. v. CPS Holdings*, 115 Ohio St. 3d 306, 308 (2007). "An unreasonable interpretation produces an absurd result or one that no reasonable person would

have accepted when entering into the contract." *Walnut Private Equity Fund, L.P. v. Argo Tea, Inc.* No:1:11-cv-770, 2011 U.S. Dist. LEXIS 138884, at *22 (S.D. Ohio 2011). Therefore, the Court **does not** interpret the contract's language in Part B(2) so broadly as to require the Defendant to pay any negotiated rate that a medical provider has with any person or entity. Such an interpretation would be illogical and an impossible construction of the contract. It would require the Defendant to force medical providers to give them the lowest negotiated rate that the medical provider has offered to any other person when the Defendant has no access to or right to that lower rate. No reasonable person would agree to such a contract provision.

Rather, the Court finds that the only reasonable interpretation of the language "any negotiated reduced rate accepted by a medical provider" implies that Defendant Grange has to have access to that negotiated rate by contracting with the medical provider. Simply put, the provision clearly and unambiguously implies a contracted rate negotiated between Defendant Grange and a medical provider.

Pursuant to Civil Rule 30(B)(5), the Plaintiffs deposed two Grange representatives in April 2013, Roxanne Miller and Michael Brode. The Plaintiff also subpoenaed and deposed two former Grange employees, Linda Reynolds and Devon Maestri. However, these depositions failed to provide the Plaintiffs with any useful evidence. Rather, the fruits of those depositions all supported the Defendant's position that Defendant Grange did not have access to the Medical Mutual's negotiated rate because Grange was not a party to that contract and had no access to Medical Mutual's negotiated rates.

To date, the Plaintiffs have neither cited any evidence showing that Grange had a contractual right to pay a reduced rate, nor have the Plaintiffs explained how Grange could force medical providers to accept rates that the medical providers negotiated with other entities

than Grange. Therefore, the Court finds the Defendants' are entitled to judgment as a matter of law as to the Plaintiffs' breach of contract claim.

B. The Implied Covenant of Good Faith and Fair Dealing Cannot Survive without a Breach of Contract Claim.

It is well settled law that in Ohio "covenant of good faith is part of a contract claim, and does not stand alone as a separate cause of action from a breach of contract claim." *Westwinds Dev. Corp. v. Outcalt,* 2009 Ohio 2948, P89-P90 (Ohio Ct. App., Geauga County June 19, 2009), citing *Lakota Loc. School Dist. Bd. of Edn. v. Brickner*, 108 Ohio App.3d 637, 646, 671 N.E.2d 578 (1996).

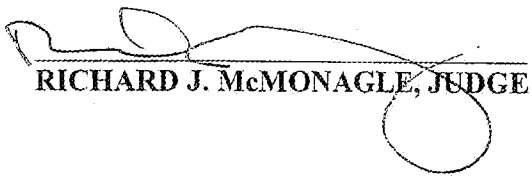
As the Plaintiffs' breach of contract claim failed as a matter of law, consequently so does their claim based on the implied covenant of good faith and fair dealing.

V. CONCLUSION

Therefore, this Court hereby **GRANTS** the Defendants' Motion for Summary Judgment and finds the Defendants' are entitled to judgment as a matter of law as to the Plaintiffs' breach of contract claim and claim based on implied covenant of good faith and fair dealing.

IT IS SO ORDERED. NO JUST REASON FOR DELAY.

June 21st, 2013



RICHARD J. McMONAGLE, JUDGE

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CUYAHOGA COUNTY
CLERK OF COURTS
By _____ Deputy

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