

IN THE SUPREME COURT OF OHIO

PHILLIP LABOY, et al.,	:	Case No. 2014-0708
	:	
Plaintiffs-Appellees	:	
	:	On Appeal From the
v.	:	Cuyahoga County Court
	:	of Appeals, Eighth
	:	Appellate District,
GRANGE MUTUAL CASUALTY	:	Case No. 13-100116
COMPANY,	:	
	:	
Defendant-Appellant	:	

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**MERIT BRIEF OF APPELLANT GRANGE MUTUAL  
CASUALTY COMPANY**

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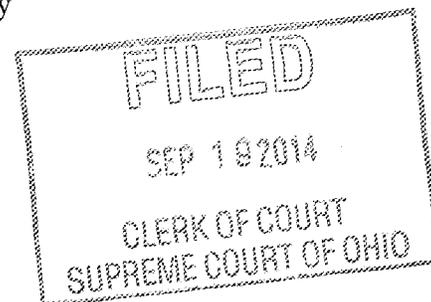
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**Table of Contents**

	<u>Page</u>
TABLE OF AUTHORITIES .....	iii
INTRODUCTION .....	1
STATEMENT OF FACTS .....	2
I.    The Policy Language And Payment Of Appellees’ Claim. ....	2
II.   Grange Has No Right Or “Access” To Pay Medical Expenses At Any Other Insurer’s Negotiated Rates.....	3
III.  The Eighth District Erroneously Reversed The Trial Court’s Correct Summary Judgment Decision .....	6
ARGUMENT IN SUPPORT OF PROPOSITIONS OF LAW.....	7
<u>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.....</u>	<u>7</u>
<u>Proposition of Law No. II: When A Contract Is Found To Be Unambiguous, It Is     Error To Order Further Fact Finding About Its Meaning .....</u>	<u>13</u>
CONCLUSION.....	20
CERTIFICATE OF SERVICE .....	21
APPENDIX.....	<u>Appx. Page</u>
A.    Notice of Appeal to the Ohio Supreme Court (May 5, 2014).....	A-1
B.    Journal Entry and Opinion of the Eighth District Court of Appeals (April 10, 2014) .....	A-4
C.    Opinion and Order of the Cuyahoga County Court of Common Pleas (June 24, 2013) .....	A-13

## TABLE OF AUTHORITIES

Cases	Page(s)
<i>Aerel, S.R.L. v. PCC Airfoils, L.L.C.</i> , 448 F.3d 899 (6th Cir.2006) .....	15
<i>Alexander v. Buckeye Pipe Line Co.</i> , 53 Ohio St.2d 241, 374 N.E.2d 146 (1978) .....	17
<i>Beanstalk Group v. AM Gen. Corp.</i> , 283 F.3d 856 (7th Cir.2002) .....	17
<i>Capital City Community Urban Redevelopment Corp. v. City of Columbus</i> , 10th Dist. Franklin No. 08AP-769, 2009-Ohio-6835 .....	17
<i>Cincinnati Ins. Co. v. CPS Holdings, Inc.</i> , 115 Ohio St.3d 306 (2007).....	8, 15
<i>Clappenback v. New York Life Ins. Co.</i> , 136 Wis. 626, 118 N.W. 245 (1908).....	15
<i>Davala v. Ferraro</i> , 5th Dist. Stark No. 2011CA00135, 2012-Ohio-446 .....	19
<i>Dominish v. Nationwide Ins. Co.</i> , 129 Ohio St.3d 466, 2011-Ohio-4102, 953 N.E.2d 820 .....	15
<i>Foster Wheeler Enviresponse v. Franklin Cty. Convention Facilities Auth.</i> , 78 Ohio St.3d 353 (1997).....	19
<i>Kebe v. Nutro Mach. Corp.</i> , 30 Ohio App.3d 175 (8th Dist.1985) .....	17
<i>Kelly v. Med. Life Ins. Co.</i> , 31 Ohio St.3d 130 (1987).....	16
<i>Kuhn v. AIG Natl. Ins. Co.</i> , N.D. Ohio No. 5:09CV1202, 2009 U.S. Dist. LEXIS 121567 (Dec. 31, 2009).....	9
<i>Lager v. Miller-Gonzalez</i> , 120 Ohio St.3d 47, 2008-Ohio-4838, 896 N.E.2d 666 .....	14, 15
<i>Lingerfelt v. Nuclear Fuel Servs.</i> , 6th Cir. No. 90-5320, 1991 U.S. App. LEXIS 1822 (Feb. 5, 1991) .....	17
<i>Nationwide Mut. Fire Ins. Co. v. Guman Bros. Farm</i> , 73 Ohio St.3d 107, 652 N.E.2d 684 (1995) .....	13

<i>Ohio Water Dev. Auth. v. W. Res. Water Dist.</i> , 149 Ohio App.3d 155, 2002-Ohio-4393, 776 N.E.2d 530 (10th Dist.) .....	14, 15
<i>Outlet Embroidery Co. v. Derwent Mills, Ltd.</i> , 254 N.Y. 179, 172 N.E. 462 (1930).....	17
<i>Sanders v. Gen. Motors Acceptance Corp.</i> , 180 S.C. 138, 185 S.E. 180 (1936) .....	15, 16
<i>Secy. of USAF v. Commemorative Air Force</i> , 585 F.3d 895 (6th Cir.2009) .....	14
<i>Skurka Aerospace, Inc. v. Eaton Aerospace, L.L.C.</i> , 781 F.Supp.2d 561 (N.D. Ohio 2011).....	16
<i>State Auto. Ins. Co. v. Childress</i> , 1st Dist. Hamilton No. C-960376, 1997 Ohio App. LEXIS 88 (Jan. 15, 1997).....	19
<i>State v. Porterfield</i> , 106 Ohio St.3d 5, 2005-Ohio-3095, 829 N.E.2d 690 .....	14, 15
<i>United Refining Co. v. Jenkins</i> , 410 Pa. 126, A.2d 574 (1963).....	15
<i>United States v. Med. Mut. of Ohio</i> , N.D. Ohio No. 1:98 CV 2171, 1999 WL 670717 (Jan. 29, 1999).....	11
<i>Walnut Private Equity Fund, L.P. v. Argo Tea, Inc.</i> , S.D. Ohio No. 1:11-cv-770, 2011 U.S. Dist. LEXIS 138884 (Dec. 2, 2011).....	19
<i>Weaver v. Caldwell Tanks, Inc.</i> , 190 Fed. Appx. 404 (6th Cir.2006).....	13
<i>Westfield Ins. Co. v. Galatis</i> , 100 Ohio St.3d 216, 2003-Ohio-5849, 797 N.E.2d 1256 (2003).....	18
<i>Wolfe v. Grange Indemn. Ins. Co.</i> , 137 Ohio St.3d 561, 2013-Ohio-5201, 2 N.E.3d 238 .....	10, 12
<b>Other Authorities</b>	
6-64 Carley, <i>New Appleman on Insurance</i> , Section 64.01 (Law Library Ed.2012).....	11
<a href="http://www.medmutual.com/global/corporate/default.aspx">http://www.medmutual.com/global/corporate/default.aspx</a> (last visited July 2, 2012) .....	12

**Rules**

Civ. R. 30(B)(5) .....4  
Civ. R. 56(E) .....16  
Civ. R. 56(F) .....4

## INTRODUCTION

Appellees Phillip and Heidi Laboy filed this putative class action claiming that Appellant Grange Mutual Casualty Company (“Grange”) breached their insurance policy by paying *too much* for covered medical expenses under Appellees’ automobile insurance medical payments coverage. Appellees contend that the phrase “any negotiated reduced rate accepted by a medical provider” in the policy means that Grange must pay for medical expenses at rates that providers agreed to accept from Appellees’ health insurer, Medical Mutual, if those rates are *lower* than the rates Grange had the right to pay through its own preferred provider network. Appellees base this claim on the wholly unsupported notion that rates negotiated between Medical Mutual and medical providers are automatically available to Grange simply because Appellees are insureds of both. Appellees’ claims were properly dismissed by the trial court. But the court of appeals revived those claims in a decision that is unsupported by any evidence and directly at odds with well-settled Ohio law regarding contract interpretation and privity principles.

No one disputes that Grange promptly paid all medical expenses that Appellees submitted under the medical payments coverage in their automobile insurance policy and that Grange did not deny any part of their claims. Appellees admit that they did not forgo any treatment, incur any out of pocket expense, or exhaust their coverage. And, most important, the parties, the trial court, and the court of appeals (at least initially) all agreed that the language of the policy is unambiguous. All that is disputed is Appellees’ novel legal theory that, because Appellees’ health insurer had negotiated rates with certain medical providers, Grange was somehow contractually obligated to pay those rates too. The fallacy in this theory is obvious: Grange had no contractual right to pay, and medical providers had no obligation to accept, payments from Grange at rates the providers had negotiated with other insurers.

Adopting the only reasonable meaning that can be given to the policy language, the trial court entered summary judgment for Grange and correctly held that “any negotiated reduced rate accepted by a medical provider” means a rate that a provider has agreed to accept from Grange. (Trial Op. p. 5). But the Eighth District reversed despite finding the policy unambiguous, ruling that unspecified “fact-finding” was needed to answer the legal question – already decided by the trial court – of whether Grange had “access” to pay Appellees’ medical providers at rates those providers had agreed to accept *not* from Grange, but from Appellees’ health insurer. (App. Op. ¶ 9). That is not Ohio law.

## STATEMENT OF FACTS

### I. The Policy Language And Payment Of Appellees’ Claim.

Grange issued Appellees an automobile insurance policy (the “Policy”) that defines the “Limit of Liability” for medical payments coverage:

- 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.

(Policy, Supp. pp. S-15, S-16) (emphasis added).

Appellees were injured in an automobile accident and made claims under the medical payments coverage in the Policy. (2/2/12 Am. Compl. ¶¶ 26–27; 3/13/12 Answer ¶¶ 26–27). Grange paid all medical bills submitted by Appellees, and did not deny *any* part of Appellees’ claims. (RFA no. 4, Supp. p. S-38). None of the Appellees refused or forwent any medical treatment for injuries sustained in the accident. (*Id.* no. 9, Supp. p. S-40). Appellees did not incur any “out-of-pocket expenses” – medical expenses that they incurred, but that were not paid by Grange. (*Id.* no. 7, Supp. p. S-39). None of Appellees reached their coverage limit with respect to the accident. (*Id.* at nos. 5 and 6, Supp. pp. S-38, S-39; Policy, Supp. p. S-3).

Grange paid Appellees' medical providers directly, as permitted under the Policy. (Policy, Supp. p. S-16). In some instances, the amounts paid were based upon invoices adjusted by a third-party medical review service, Review Works, which determined that not all reported expenses were "reasonable" and "necessary" as required under the Policy. (Affidavit of John R. Delucia ("Delucia Aff.") ¶¶ 3, 5, Supp. pp. S-48, S-49; Grange Ltr. to Heidi Laboy of 5/7/07, Supp. p. S-51; Miller Depo., pp. 114–15, 275, 276 Supp. pp. S-53, S-54, S-63, S-64). In other instances, Appellees' medical treatments were from providers within the PPO Midwest Ohio ("PPOM") network, a preferred-provider network to which Grange belongs through its contractual relationship with Review Works. (Delucia Aff. ¶ 5, Supp. p. S-49). When Grange had the contractual right to pay a rate lower than the "reasonable and necessary" rate through its membership in the PPOM network, Grange paid that rate in accord with Section B(2) of the Policy. (*Id.*) Grange was able to pay those preferred rates only because those providers had agreed to become part of the PPOM network and Grange was a party to a contract entitling it to pay those network rates. (*Id.*) For providers outside the network, Grange paid all "reasonable and necessary" expenses as invoiced, in accordance with the Policy. (*Id.*)

After Grange had paid all of Appellees' medical expenses, Appellees reached a settlement with the third-party tortfeasor in the accident. (Appellees' Resp. to Grange's Interrogatories ("ROG") nos. 17-18, Supp. p. S-43). Grange was subsequently reimbursed from the settlement proceeds for the amount it had paid for Appellees' medical care, as the Policy's subrogation clause provides. (ROG nos. 17-18, Supp. p. S-43; Policy, Supp. p. S-31).

## **II. Grange Has No Right Or "Access" To Pay Medical Expenses At Any Other Insurer's Negotiated Rates.**

Appellees filed this putative class action alleging that Grange breached the Policy and the duty of good faith and fair dealing by *overpaying* for their medical care. Appellees' claims rest

entirely on the repeated assertion that Grange has “access,” which term Appellees never explain, to the lower rates that Medical Mutual negotiated with medical providers. (*E.g.*, Appellees’ 10/4/12 Br. in Opp. to Summ. J., pp. 12, 14). Appellees assert that this “access” arises as a matter of law – an automobile insurer has the right to pay, and a medical provider the corresponding obligation to accept, rates that the insured’s health insurer negotiated for itself with medical providers. (*Id.*) Appellees, however, have never explained how Grange could be contractually entitled to pay providers at rates negotiated by another insurer, let alone pointed to any evidence showing that this is true. And, all of the undisputed evidence is to the contrary. Appellees then speculate that this alleged overpayment harmed them by causing Grange’s subrogation reimbursement from the settlement they negotiated with a third-party tortfeasor to be larger than it otherwise might have been.<sup>1</sup>

Following exchange of written discovery, Grange moved for summary judgment. After that motion was fully briefed, the trial court granted Appellees’ motion to allow depositions and ordered submission of supplemental briefs following the depositions.<sup>2</sup> Appellees deposed two Civ. R. 30(B)(5) representatives of Grange and two other Grange employees involved with Appellees’ insurance claim. As the trial court correctly found, these “depositions failed to provide [Appellees] with any useful evidence.” (Tr. Op. p. 5). None of these individuals testified that Grange had the contractual right to pay Medical Mutual’s negotiated rates. To the contrary, the testimony “supported [Grange’s] position” that Grange does *not* have such

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<sup>1</sup> In the alternative to its contract arguments, Grange also argued that Appellees had failed to identify a cognizable injury. Neither court below addressed that argument.

<sup>2</sup> Grange opposed Appellees’ motion to compel depositions because it was tardy and not supported as required by Civ. R. 56(F), and because the interpretation of the unambiguous Policy is a question of law to which extrinsic evidence is inadmissible. (Grange’s 12/13/12 Opp. to Appellees’ Mtn. to Compel, pp. 1–5).

“access.” (*Id.*)

Appellees’ counsel repeatedly asked Grange’s representative whether Grange had access to the rates negotiated between an insured’s health insurer and a medical provider. The answer was always “no”:

Q: Okay. Would you ever contact the insured’s health carrier?

A: To determine [their negotiated] rate?

Q: Yeah.

A: No.

Q: Why not?

A: Because we don’t have a contract with them.

Q: But would you ever contact the health carrier to see if the insured had a lower rate that is available to them that you could use?

A: No.

Q: Why don’t you do that?

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A: Because we don’t have that, we don’t have the same contract. We wouldn’t be able to do that.

(Miller Depo. at 115, Supp. p. S-54; *accord id.* at 128, Supp. p. S-55 (“[W]e don’t have the contract amount [Medical Mutual] ha[s], we don’t have that agreement.”), 133, Supp. p. S-57 (“We don’t have access [to Medical Mutual’s rates].”)). Appellees’ counsel repeatedly asked this same question, but the answer was always the same – Grange does not have a contractual right to pay Medical Mutual’s negotiated rates:

Q. And your insured has access to this lower rate. Okay? And if you could pay, “you” being Grange[,] can pay that lower rate through your insured’s relationship with their health provider, would Grange do that to benefit the insured?

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A: We don’t have access to that.

Q: If you had access through your insured, then you would have access, correct?

A: But we don’t, we don’t have the contract that the insured has with the health carrier.

(Miller Depo. at 130, 133, Supp. pp. S-56, S-57).

Despite being given repeated opportunities, Appellees could not muster any evidence to support their novel legal theory that Grange has a contractual right to pay rates that Medical

Mutual negotiated for itself.<sup>3</sup>

### **III. The Eighth District Erroneously Reversed The Trial Court's Correct Summary Judgment Decision.**

After depositions and supplemental briefing, the trial court entered summary judgment in favor of Grange. In a well-reasoned decision, the trial court found that Appellees' claims rested entirely upon an "illogical and impossible construction" of the insurance contract, *i.e.*, that Grange was obligated to pay for medical care at rates contractually available only to others. (Tr. Op., p. 5). Appellees' interpretation was unreasonable because it would require Grange "to force medical providers to give [Grange] the lowest negotiated rate that the medical provider has offered \* \* \* when [Grange] has no access or right to that lower rate." (*Id.*, p. 5). The trial court also reviewed the record and correctly found that Appellees "neither cited any evidence showing that Grange had a contractual right to pay [Medical Mutual's] rates, nor \* \* \* explained how Grange could force medical providers to accept rates that the medical providers negotiated with other entities than Grange." (*Id.*, pp. 5–6).

The Eighth District Court of Appeals reversed. The appellate court initially determined that the Policy language was not ambiguous, but then found that an ambiguity did exist because that language was susceptible to an "impossible" and "absurd[]" construction. (App. Op. ¶ 7). Based on that conclusion, the court of appeals then found that the trial court should have engaged in fact finding about the "most sensible and reasonable" interpretation of the contract. (App. Op. ¶¶ 6, 7, 9). The court of appeals did not determine whether there were two *reasonable* interpretations of the Policy or address the only, undisputed, evidence in the record, which shows

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<sup>3</sup> Appellees promised to subpoena a representative of Medical Mutual, but never did so, nor did they submit in evidence any agreements between Medical Mutual and providers. (Appellees' 12/3/12 Mtn. to Compel, Ex. A, p. 2).

that Grange does not have access to Medical Mutual's rates.

The appellate court acknowledged the trial court's finding that there is "no evidence to show that Grange had access to the same negotiated rate charged by Medical Mutual." (*Id.* ¶ 2). But then, relying solely on the unsupported assertion in Appellees' summary judgment brief that Grange has "access to a lesser negotiated rate via medical providers who have agreed with [the] Laboys' medical insurer to provide a discounted rate," the court of appeals found that the trial court erred by not engaging in undefined "fact finding." (*Id.* ¶ 8). Again, the appellate court did not point to any evidence, and there is none, that would support Appellees' legal theory.

The court of appeals overlooked the fact that the trial court had given Appellees more than ample opportunity to present evidence in support of their theory and that the trial court did engage in fact finding based on the undisputed evidence before it. Although the appellate court criticized the trial court for "mistak[ing]" Appellees' argument "to mean any negotiated rate regardless of geography," rather than just the rates of Appellees' health care insurer, the trial court specifically referenced the latter argument and rejected it as unreasonable: "Grange did not have access to the Medical Mutual's negotiated rates because Grange was not a party to that contract and had no access to Medical Mutual's negotiated rates." (*Id.* ¶ 8; Tr. Op. p. 5).

#### **ARGUMENT IN SUPPORT OF PROPOSITIONS OF LAW**

**Proposition of Law No. 1: An Insurer Does Not Breach An Obligation To Pay Negotiated Rates For Medical Care When It Has No Contractual Right To Pay Those Rates.**

This case focuses on the interpretation of Section (B)(2) of the Policy in the context of medical payments coverage:

- 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.*

(Policy, Supp. pp. S-15, S-16) (emphasis added). As the trial court correctly found, the only reasonable construction of this language is that it means a rate that Grange was contractually entitled to pay, and the only evidence is that Grange did not have a contractual right to pay providers at rates negotiated by Appellees' health care insurer. (Tr. Op. pp. 4–5). Citing this Court's decision in *Cincinnati Ins. Co. v. CPS Holdings, Inc.*, 115 Ohio St.3d 306 (2007), the trial court concluded that Appellees' interpretation is unreasonable and illogical, as Appellees did not “explain[] how Grange could force medical providers to accept rates that the medical providers negotiated with other entities than Grange.” (Tr. Op. pp. 5–6). In reversing, however, the court of appeals failed to determine whether Appellees' construction was reasonable and overlooked that Appellees did not submit any evidence in support of their interpretation.

No contract between Grange and medical providers (or anyone else) gives Grange the right to pay Medical Mutual's negotiated rates for medical care. (*E.g.*, Miller Depo. at 130, 133, Supp. pp. S-56, S-57). And no such right arises by operation of law simply because an automobile insurer and a health insurer share an insured. It is self-evident that just because a medical provider agreed to accept certain rates from one insurer does not mean that any other insurer is contractually entitled to pay, or the medical provider obligated to accept, those same rates. It is equally apparent that an insurer does not breach its insurance policy by not paying a provider at rates that it has no ability to compel the provider to accept. *See Johnston v. Cochran*, 10th Dist. Franklin No. 06AP-1065, 2007-Ohio-4408, ¶ 22 (privity is foundation of breach of contract). Yet that is exactly Appellees' claim here – that health insurers and automobile insurers are somehow in privity of contract if they share an insured. (See Appellees' 10/4/12 Br. in Opp. to Summ. J., p. 14–15 (“When the insured has access to a lesser negotiated rate through their own health insurer, then \* \* \* that lesser rate \* \* \* is available to Grange \* \* \*. [M]edical

providers are obligated to accept those rates [from Grange] by entering into a contract with the health insurer \* \* \*.”); Appellees’ 8/28/13 Ct. App. 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.”) (emphasis added).

Appellees’ theory requires automobile insurers to pay medical providers for care at rates negotiated by their insureds’ health insurers. And a corollary is that providers must accept payment from 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 right to force another to abide by the terms of a contract to which it is not a party. Although Appellees never argued that Grange was a third-party beneficiary of Medical Mutual’s agreements with providers, those provider agreements were for the benefit of Medical Mutual’s insureds; they were not for the benefit of the insureds’ automobile insurer.

The Eighth District based its decision not on any evidence, but solely on Appellees’ unsupported legal argument in their trial court brief that Grange ““does, in fact have access to a lesser negotiated rate *via medical providers who have agreed with Laboys’ [sic] medical insurer* to provide a discounted rate.”” (App. Op. ¶ 8) (emphasis added). But a stranger to a contract between two other parties has no rights under the contract, and cannot force one of those parties to accept the same terms in its dealings with the stranger. *Kuhn v. AIG Natl. Ins. Co.*, N.D. Ohio No. 5:09CV1202, 2009 U.S. Dist. LEXIS 121567, at \*9 (Dec. 31, 2009) (“It is axiomatic that to sue on the [contract], there must be privity of contract.”) Neither Appellees nor the court of appeals pointed to any case law, statute, or legal principle by which Grange could enforce

Medical Mutual's contractual rights against providers merely by virtue of Appellees' relationship with Medical Mutual. (App. Op. ¶ 8).

Contractual privity is the "heart of [an] actionable breach and \* \* \* essential to a claim for breach of contract." *Johnston*, 2007-Ohio-4408, ¶ 22. Grange is not a party to Appellees' health insurance contract, nor does it have a contract with medical providers obligating them to accept Medical Mutual's rates. (E.g., Miller Depo. at 115, Supp. p. S-54). Medical Mutual negotiated rates for *its* payments to some providers who treat *its* insureds, and Medical Mutual and those providers can enforce those agreements. Grange, however, cannot force providers to accept payment at Medical Mutual's negotiated rates when those providers never agreed to accept those rates *from Grange*. Appellees cannot reasonably claim that Grange breached the insurance contract by not exercising someone else's contractual rights, yet that is the essence of their claim.

No evidence supports Appellees' interpretation, either. The court of appeals required unspecified "fact-finding" as to whether the Policy compels Grange to do the impossible – to pay rates negotiated between Appellees' health insurer and medical providers – without any agreement from those providers to accept those rates from *Grange*. But any necessary fact finding already occurred through the discovery process and post-briefing depositions, and the trial court found that there was no evidence to support Appellees' claims. (Tr. Op., p. 5). No "fact-finding" is necessary, not only because the question presented here is a question of law, but also because Appellees submitted no evidence that Grange had "access" to pay providers at rates the providers had agreed to with Medical Mutual.

In addition to being legally and factually unsound, Appellees' theory makes no practical sense for at least two reasons. First, Appellees have never explained what incentive Grange

could possibly have to “overpay” its insureds’ medical expenses. Second, Appellees’ interpretation would require Grange to determine, each time a medical claim was made, if the injured insured has other applicable insurance; if that other insurer(s) has negotiated rates with providers; if so, what those rates are; whether those providers submitted claims to Grange for the same medical services; and whether those other insurer’s rates are lower than any rates Grange might have contractual access to through its preferred provider network. Almost none of this information is directly available to Grange, and is certainly confidential and proprietary. And even were this information available, it would significantly lengthen the claims process for both insureds and insurers, contrary to the purpose of medical payments coverage. 6-64 Carley, *New Appleman on Insurance*, Section 64.01 (Law Library Ed.2012) (“[P]ay *immediate* medical bills \* \* \* to an injured insured . . . [and to] *expedite payment* or reimbursement of medical expenses to the injured parties \* \* \*.”) (Emphasis added.)

Moreover, economic reality explains why Medical Mutual is able to negotiate lower rates with some of the same providers than the PPOM network to which Grange belongs. Different insurers are able to negotiate, and providers agree to accept, different rates for a variety of reasons inherent in the negotiation of all contracts.<sup>4</sup> For example, Appellees’ health insurer, Medical Mutual, is the oldest and largest health insurance company headquartered in the state of

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<sup>4</sup> Rates available to an insurer depend on many variables, such as: the insurer’s size, stability, and bargaining power; the method and terms of payment to healthcare providers; the time, economic conditions, and legislative conditions in which the rates are negotiated; the demographics of the insurer’s customers; the type of insurance the insurer sells; the risks inherent in the coverage; and even the length of the relationship between the entities. *See, e.g., United States v. Med. Mut. of Ohio*, N.D. Ohio No. 1:98 CV 2171, 1999 WL 670717, at \*12 (Jan. 29, 1999) (discussing insurers’ negotiation of rates with medical providers and enumerating factors that impact available rates).

Ohio, deals exclusively in health insurance, and consequently has significant bargaining power.<sup>5</sup>

The implausibility of Appellees' theory is also shown by the duties and rights it would impose or bestow upon complete strangers to the Policy. If Appellees were to prevail, Grange would be required to pay providers at a lower rate than a provider had agreed to accept from Grange. But, those medical providers would not be obligated to accept Grange's payments as satisfaction in full, and likely would balance bill Grange's insureds for the difference, subjecting Grange to claims that it did not pay enough for its insureds' medical expenses. This is not a hypothetical concern – Grange was recently before this Court to overturn certification of a class alleging claims, based on the same policy provision at issue here, that it paid *too little* for its insureds' medical expenses because its insureds were being balance billed by medical providers when Grange did not pay the full amount demanded by the provider.<sup>6</sup> The claims both here and in *Wolfe* are dependent on unreasonable interpretations of the Policy or ignoring it altogether, but the fact remains that the same conduct claimed to be a breach of the Policy in one case is claimed to be required under the Policy in the other.

Appellees have separate contracts with Medical Mutual and Grange. Appellees' privity with Medical Mutual gives them rights under the health insurance contract. Appellees' privity with Grange allows them a different set of rights under the automobile insurance contract. And neither Appellees nor Grange can import rights from the health insurance contract into the automobile insurance contract (or vice versa). The essential element of privity, as between Grange and Medical Mutual and the medical providers that agreed to Medical Mutual's rates, is missing from Appellees' breach of contract theory. The only reasonable interpretation of the

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<sup>5</sup> <http://www.medmutual.com/global/corporate/default.aspx> (last visited July 2, 2012).

<sup>6</sup> *Wolfe v. Grange Indemn. Ins. Co.*, 137 Ohio St.3d 561, 2013-Ohio-5201, 2 N.E.3d 238.

Policy is that Grange cannot breach an obligation to pay a health insurer's negotiated rates when Grange has no contractual right to pay those rates, and the court of appeals erred in endorsing otherwise.

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

Under Ohio law, interpretation of an unambiguous contract is a matter of law for the court. *Nationwide Mut. Fire Ins. Co. v. Guman Bros. Farm*, 73 Ohio St.3d 107, 108, 652 N.E.2d 684 (1995). Here, however, the appellate court held the opposite – that an unambiguous contract needed further fact finding because the Policy could be given an absurd construction. (App. Op. ¶¶ 6–8). This was error.

Grange and Appellees agreed that the Policy phrase, “any negotiated reduced rate accepted by a medical provider,” is unambiguous. (Appellees’ 10/4/12 Br. in Opp. to Summ. J., p. 16) (“The express language of the [Medical Payments Coverage] in dispute under the Policy is clear and, Plaintiffs believe, unambiguous.”); Grange’s 8/13/12 Mem. in Sup. of Summ. J., p. 16). Such an agreement, though not binding, typically is accepted by courts. *See, e.g., Allied Environmental Servs. v. Miami Univ.*, Ct. of Cl. No. 2004-06887, 2006-Ohio-5668, ¶ 27 (Sept. 15, 2006) (stating that the parties stipulated that a disputed contract was “clear and unambiguous” and thus would be applied as written); *Weaver v. Caldwell Tanks, Inc.*, 190 Fed. Appx. 404, 409 (6th Cir.2006) (noting that the parties agreed that the contract at issue was unambiguous, thus parol evidence was inadmissible).

The trial court also agreed that the Policy language was unambiguous (Tr. Op., p. 5), and the appellate court initially concurred. (App. Op. ¶ 6). The appellate court also stated, accurately, that interpreting Section (B)(2) to require Grange to pay literally “any negotiated reduced rate” would be “impossible” because it would require Grange to “pay a negotiated

reduced rate \* \* \* regardless of geographic proximity or even privity of contract.” (*Id.* ¶ 6). But then the appellate court went astray. Instead of determining whether Appellees’ interpretation was also impossible, it held that this “absurd” interpretation invoked the “rule” that an “apparently unambiguous contract may be rendered ambiguous \* \* \* if its words, taken literally, \* \* \* lead to absurdity when applied to the facts.” (*Id.* ¶ 7). Based on this “absurd[]” interpretation, the appellate court found the Policy was ambiguous and ordered fact finding about the meaning of a contract that it, and the parties, all agreed was unambiguous. However, under Ohio law a contract’s susceptibility to an “impossible” and “absurd” construction does not make it ambiguous.

Time and again this Court and others have held that a contract is ambiguous only when it is susceptible to more than one *reasonable* interpretation. *Lager v. Miller-Gonzalez*, 120 Ohio St.3d 47, 2008-Ohio-4838, 896 N.E.2d 666, ¶ 16; *Ohio Water Dev. Auth. v. W. Res. Water Dist.*, 149 Ohio App.3d 155, 2002-Ohio-4393, 776 N.E.2d 530, ¶ 25 (10th Dist.) (“It is of course well settled that the fact that parties may adopt conflicting interpretations of a contract between them while involved in litigation will not create ambiguity or a basis for unreasonable interpretation \* \* \*.”); *Secy. of USAF v. Commemorative Air Force*, 585 F.3d 895, 900 (6th Cir.2009) (“A contract is ambiguous when it is susceptible to two or more reasonable interpretations, each of which is consistent with the contract language.”).

This Court, in reviewing “the level of lucidity necessary for a writing to be unambiguous,” rejected the position that language of a contract becomes ambiguous merely “when multiple readings are possible,” the stance taken by the court of appeals here. *State v. Porterfield*, 106 Ohio St.3d 5, 2005-Ohio-3095, 829 N.E.2d 690, ¶ 11. Rather, “[o]nly when a definitive meaning proves elusive should rules for construing ambiguous language be employed.

Otherwise, allegations of ambiguity become self-fulfilling.” *Id.* Ohio law “has \* \* \* consistently rejected” the argument that “the existence of competing readings of contractual language is sufficient in and of itself to render the provision ambiguous.” *Aerel, S.R.L. v. PCC Airfoils, L.L.C.*, 448 F.3d 899, 904 (6th Cir.2006) (observing that contract language is ambiguous only if two conflicting interpretations are both reasonable).

An “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). “[I]n isolation, any word or phrase in \* \* \* contested policy language may be ambiguous.” *Dominish* at ¶ 8. And, a contract’s susceptibility to two or more reasonable interpretations is a question of law for the court, not a subject of fact finding. *Ohio Water Dev. Auth.*, 149 Ohio App.3d at 161. While the appellate court correctly noted that ambiguities must be construed in favor of the insured, this rule “will not be applied so as to provide an unreasonable interpretation of the words of the policy.” *Cincinnati Ins. Co.*, 115 Ohio St.3d at 308; (App. Op. ¶ 8). But the court of appeals not only ignored these principles, it announced a new rule at odds with them.

To support its application of the “rule” that an unambiguous contract may be rendered ambiguous if reading it literally leads to absurdity, the appellate court relied on dicta from a 106-year-old Wisconsin decision, which did not even hold the contract at issue to be ambiguous. *Clappenback v. New York Life Ins. Co.*, 136 Wis. 626, 118 N.W. 245 (1908); (App. Op. ¶ 7). The court of appeals also cited for this rule *Sanders v. Gen. Motors Acceptance Corp.*, 180 S.C. 138, 185 S.E. 180, 184 (1936) (quoting *Clappenback*, but rejecting literal, unreasonable interpretation of contract and adopting one “consonant with common sense”), and *United Refining Co. v. Jenkins*, 410 Pa. 126, 189, A.2d 574 (1963) (determining the “only sensible and

reasonable interpretation of [the] agreement”). But all three of these dated, non-Ohio cases support the trial court’s conclusion that a reasonable interpretation of a contract should be followed rather than an impossible or nonsensical one. Indeed, *Sanders* stated that “[i]nstruments should receive a sensible and reasonable construction and not such a construction as will lead to absurd consequences \* \* \*.” 180 S.C. at 146.

The court of appeals also cited *Kelly v. Med. Life Ins. Co.*, 31 Ohio St.3d 130, 132 (1987) for the proposition that when a literal construction of a contract is absurd, fact finding to determine “the most sensible and reasonable interpretation” should be undertaken, but *Kelly* does not support that ruling. (App. Op. ¶ 7). Before concluding that the divorce decree at issue in that case expressed the parties’ intent “in clear and intelligible language,” the *Kelly* court merely stated that “[a] court will resort to extrinsic evidence \* \* \* to give effect to the parties’ intentions only where the language is unclear or ambiguous \* \* \*.” 31 Ohio St.3d at 132. Nowhere does *Kelly* authorize a fact investigation of a contract’s meaning when faced with only one reasonable interpretation and another that is admittedly impossible to perform. Regardless, the trial court already had conducted “fact finding” when it permitted Appellees to take depositions post-summary judgment briefing, testimony that only confirmed that Grange does not have a contractual right to pay providers at another insurer’s rates. (Tr. Op., p. 5).<sup>7</sup>

“[C]ourts should interpret contracts in a way that avoids absurd results \* \* \*.” *Skurka Aerospace, Inc. v. Eaton Aerospace, L.L.C.*, 781 F.Supp.2d 561, 571 (N.D. Ohio 2011). When

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<sup>7</sup> Grange submitted evidence that it did not have the contractual right to pay Medical Mutual’s rates. It was therefore incumbent upon Appellees to submit evidence to the contrary. Civ. R. 56(E). Appellees did not submit any evidence to the contrary, either in the initial round of summary judgment briefing, or in the supplemental briefing after Appellees were subsequently given leave to conduct depositions.

interpreting a contract term, a court must adopt the meaning that gives the “contract vitality, rather than the meaning that renders performance impossible.” *Capital City Community Urban Redevelopment Corp. v. City of Columbus*, 10th Dist. Franklin No. 08AP-769, 2009-Ohio-6835, ¶ 31. Rather than following these rules, the appellate court isolated the word “any” from its context in the Policy, gave it an “impossible” meaning, and then declared the Policy to be ambiguous. This is precisely the opposite of how contracts are supposed to be interpreted. *See Beanstalk Group v. AM Gen. Corp.*, 283 F.3d 856, 860 (7th Cir.2002) (“A blinkered literalism, a closing of one’s eyes to the obvious, can produce nonsensical results \* \* \*.”).

In interpreting contracts reasonably, courts should be guided by the principle that contract interpretation is a pragmatic, not abstract, exercise. *See id.* at 860 (“There is a long tradition in contract law of reading contracts sensibly \* \* \*.”) (citation omitted); *Kebe v. Nutro Mach. Corp.*, 30 Ohio App.3d 175, 177 (8th Dist.1985) (contracts must also be interpreted sensibly). “[C]ontracts \* \* \* are not parlor games but the means of getting the world’s work done \* \* \*.” *Beanstalk Group*, 283 F.3d at 860. The “common-sense canons of contract interpretation” dictate that “courts have no right to torture language in an attempt to force particular results or to convey \* \* \* nuances the contracting parties neither intended nor imagined.” *Lingerfelt v. Nuclear Fuel Servs.*, 6th Cir. No. 90-5320, 1991 U.S. App. LEXIS 1822, at \*12 (Feb. 5, 1991).

Common words, like “any,” in a contract “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.” (Emphasis added.) *Alexander v. Buckeye Pipe Line Co.*, 53 Ohio St.2d 241, 245-46, 374 N.E.2d 146 (1978). Courts have long recognized that “[i]f literalness is sheer absurdity, we are to seek some other meaning whereby reason will be instilled and absurdity avoided.” *Outlet Embroidery Co. v. Derwent Mills, Ltd.*, 254 N.Y. 179,

183, 172 N.E. 462 (1930) (Cardozo, C.J.). But the court of appeals violated these principles of contract interpretation.

It is reasonable to conclude, as the trial court did, that “any negotiated reduced rate accepted by a medical provider” under the Policy “clearly and unambiguously implies a contracted rate negotiated between \* \* \* Grange” and entities that have agreed to accept those rates from Grange, such as the medical providers in the PPOM network. (Tr. Op., p. 5). This interpretation is consistent with the Policy and common sense, and should have been adopted by the appellate court because, “[a]s a matter of law, a contract is unambiguous if it can be given a definite legal meaning.” *Westfield Ins. Co. v. Galatis*, 100 Ohio St.3d 216, 2003-Ohio-5849, 797 N.E.2d 1256, ¶ 11 (2003).

It is *not* reasonable to read “any negotiated reduced rate” to refer to literally any rate ever accepted by a medical provider anytime, anywhere. Nor is it reasonable to read the phrase as referring to rates agreed to between the provider and Appellees’ health insurer, as the appellate court did. This is particularly true because Grange’s obligation to pay this “lowest rate” is, according to Appellees, unlimited. (Appellees’ 10/4/12 Br. in Opp. to Summ. J., p. 13) (arguing that 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.”). The import of Appellees’ argument is that if *any* medical provider *anywhere* has agreed to accept a lower rate from *anyone*, then 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 as the appeals court concluded. (Op. ¶ 8).

Appellees argued for a grossly expansive reading of “any,” but then tried to make its consequences seem less impossible by limiting that interpretation in their briefs to the rates

negotiated by their health insurer. But Appellees cannot mask the illogic of their argument with such artificial limitations. Once the word “any” is disconnected from its context in the Policy between Grange and its insureds (*i.e.*, what Grange has the contractual right to do and compel others to do), then it has no limitation – it means any rate in existence. Either “any” refers to the rates that Grange has the contractual right to pay, or it is unlimited. Either Grange committed to the possible, or it agreed to the impossible. The inconsistency in Appellees removing “any” from its context in the Policy and stating that it has “no limits” – but then arguing that it really is limited to rates negotiated by Appellees’ health insurer – is glaring.

Like all contracts, “[i]nsurance contracts are to be read and interpreted in the context of the entire policy.” *Davala v. Ferraro*, 5th Dist. Stark No. 2011CA00135, 2012-Ohio-446, ¶ 18; *State Auto. Ins. Co. v. Childress*, 1st Dist. Hamilton No. C-960376, 1997 Ohio App. LEXIS 88, at \*8 (Jan. 15, 1997) (“[A] court must determine whether the contract can be interpreted giving reasonable \* \* \* meaning to all terms.”). Inherent in the Policy is the concept that Grange did not commit itself to the impossible – to pay rates that it lacks the contractual right to pay. *See Walnut Private Equity Fund, L.P. v. Argo Tea, Inc.*, S.D. Ohio No. 1:11-cv-770, 2011 U.S. Dist. LEXIS 138884, at \*22 (Dec. 2, 2011) (“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); *Foster Wheeler Enviresponse v. Franklin Cty. Convention Facilities Auth.*, 78 Ohio St.3d 353, 363 (1997) (“[T]he point to reading the contract as a whole is to avoid this very kind of abstract interpretation.”).

The Policy is an agreement between Grange and Appellees. Appellees’ medical providers did not agree to accept payments from Grange at Medical Mutual’s negotiated rates, and those rates are not available to Grange simply because it shares an insured with Medical

Mutual. Also, Grange is not a party to the agreements between Medical Mutual and medical providers. When Grange agreed to pay “any negotiated reduced rate accepted by a medical provider,” the only reasonable interpretation is that Grange committed itself to the possible – to paying medical providers at rates that it has a contractual right to pay.

### **CONCLUSION**

For all of the foregoing reasons, Grange respectfully requests that this Court reverse the appellate court’s decision, and reinstate and affirm the trial court’s grant of summary judgment in favor of Grange.

Respectfully submitted,



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**CERTIFICATE OF SERVICE**

The undersigned hereby certifies that a true and accurate copy of the foregoing Merit Brief of Appellant was served upon the following by first class U. S. mail, postage prepaid, this 19th day of September, 2014:

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IN THE SUPREME COURT OF OHIO

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

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NOTICE OF APPEAL OF APPELLANT GRANGE MUTUAL CASUALTY COMPANY

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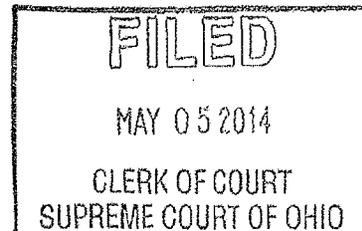
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**NOTICE OF APPEAL OF APPELLANT GRANGE MUTUAL CASUALTY COMPANY**

Grange Mutual Casualty Company hereby gives notice of appeal to the Supreme Court of Ohio from the judgment of the Cuyahoga County Court of Appeals, Eighth Appellate District, entered in Court of Appeals Case No. 13-100116 on April 10, 2014. This case is of public or great general interest.

Respectfully submitted,



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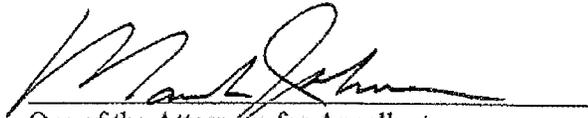
The undersigned hereby certifies that a true and accurate copy of the foregoing Notice of Appeal of Appellant Grange Mutual Casualty Company was served upon the following by first class U. S. mail, postage prepaid, this 5th day of May, 2014:

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APR 10 2014

# Court of Appeals of Ohio

EIGHTH APPELLATE DISTRICT  
COUNTY OF CUYAHOGA

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JOURNAL ENTRY AND OPINION  
No. 100116

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**PHILIP LABOY, ET AL.**

PLAINTIFFS-APPELLANTS

vs.

**GRANGE INDEMNITY INSURANCE CO., ET AL.**

DEFENDANTS-APPELLEES

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**JUDGMENT:  
REVERSED AND REMANDED**

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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.

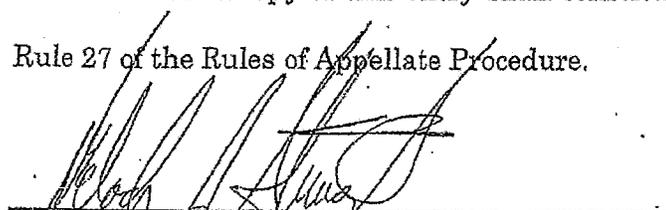
{¶10} This cause is reversed and remanded to the trial court for further proceedings consistent with this opinion.

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.



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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.

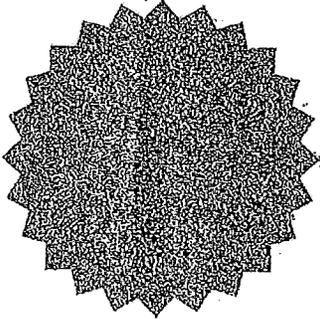
{¶15} A class action lawsuit is eligible for the commercial docket if it qualifies under one of the several provisions under Sup.R. 49.05 for the Courts of Ohio. This case does not so qualify.

{¶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 [Signature] Deputy Clerk



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**IN THE COURT OF COMMON PLEAS  
CUYAHOGA COUNTY, OHIO**

PHILLIP A. LABOY - ET AL.  
Plaintiff

Case No: CV-12-773808

Judge: RICHARD J MCMONAGLE

GRANGE INDEMNITY INSURANCE COMPANY - ET  
AL.  
Defendant

**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

STATE OF OHIO )  
 ) SS:  
CUYAHOGA COUNTY )

IN THE COURT OF COMMON PLEAS  
CASE NO. CV- 12 - 773808

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



**OPINION AND ORDER**

**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, Alexandra Laboy, and Gabriella Laboy were all insureds under that policy. On May 23, 2006, Plaintiffs Heidi Laboy, Alexandra 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, Alexandra 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).

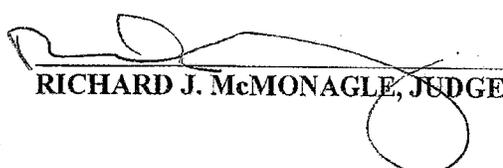
As the Plaintiffs' breach of contract claim failed as a matter of law, consequently so does their claim based on the implied covenant of good faith and fair dealing.

**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.

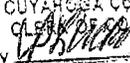
**IT IS SO ORDERED. NO JUST REASON FOR DELAY.**

June 21<sup>st</sup>, 2013

  
**RICHARD J. McMONAGLE, JUDGE**

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JUN 24 2013

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