

ORIGINAL

IN THE SUPREME COURT OF OHIO

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

MERIT BRIEF OF APPELLEES PHILLIP & HEIDI LABOY

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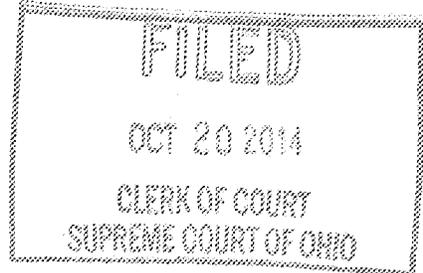
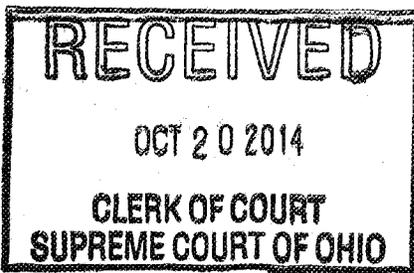


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APPELLEES' MERIT BRIEF

INTRODUCTION

This case is about the meaning of “mutuality” in interpreting the language of insurance policies in Ohio. Section (B)(2) of this policy requires Grange Insurance to pay the lowest of “any negotiated reduced rate accepted by a provider.” Both parties (Grange and the insured) agree that common sense limits “any...” to any discount that can actually be “accessed” somehow by Grange. Grange asserts that this policy language is limited to only the “access” that Grange chooses itself to obtain by contracting directly with medical providers. The insured asserts, to the contrary, that “access” should mean what common sense implies: access to an available discount, regardless of whether it is arranged by Grange or the insured.

In this case, Grange has arranged a discount through its preferred medical provider and the insured has purchased a discount through its health insurance with Medical Mutual. The billing evidence in this case showed that Grange’s discounted price is roughly double the insured’s discounted price. Section (B)(2) of the policy mandates that only the lowest discounted price will be paid. Grange refused to pay the lower Medical Mutual price because Grange itself does not have a direct contract with Medical Mutual (or the medical provider).

In so doing, Grange chooses to ignore the fact that the other party to this contract (the insured) does have direct access to that price and can provide to Grange access to that same price. In other words (according to Grange), when it comes to the meaning of “any” and “access”, there is not mutuality of rights between the parties to this insurance contract. That is not, and should not be, the law of Ohio.

In effect, the Court of Appeals confirmed the principle of mutuality and held that only the lower Medical Mutual price obtained by the insured should be paid, as long as the insured can somehow provide Grange access to that lower price. As that is a “factual” issue which precludes summary judgment, the Court of Appeals remanded this case for further fact-finding on that factual issue before summary judgment could be granted. That is a decision which should be affirmed by this Court.

I. STATEMENT OF PROPOSITIONS OF LAW PRESENTED

This Honorable Court accepted Appellant’s appeal as to Propositions of Law Nos. 1 and 2 set forth in Appellant’s Jurisdictional Memorandum filed in this case. Under Proposition of Law No. 1, Appellant asserts that “an insurer does not breach an obligation to pay negotiated rates for medical care when it has no contractual right to pay those rates.” However, in this case Appellant can have access to their insureds’ lowered negotiated reduced rate. Appellant assumes that the terms and conditions set forth in the medical payment coverage form of the policy relative to securing the lowest negotiated reduced rate refers only to Grange. To the contrary, it naturally must refer equally to the other contracting party: the insured. If the insured, also a party to the insurance contract, can secure a lower negotiated reduced rate through its private health care provider, and thereby provide Grange access to that lower negotiated rate, then Grange is obligated under the terms and conditions of the policy of insurance to pay that lower rate.

Under Proposition of Law No. 2 Appellant asserts that “when a contract is found to be unambiguous, it is error to order further fact finding about its meaning.” Appellant contends that “the Appellate Court held the opposite - - that an unambiguous contract needed a further fact finding because the policy could be given an absurd construction.” (Merit Brief of Appellant p.

13). But Appellants argument is misleading. The Appellant Court did not find ambiguity in Section (B)(2) of the medial payment coverage form - - “The words are plain. There is no ambiguity.” (App. Op. ¶6). But the Appellate Court did find an unresolved factual issue: whether Grange can gain access to the Medical Mutual rate thru its insured’s health insurance. However, recognizing the Laboy’s argument that Appellant does, in fact, “have access to a lesser negotiated rate with medical providers who have agreed with [sic] Laboy’s medical insurer to provide a discounted rate.” (App. Op. ¶8), the Appellate Court ordered fact-finding to confirm whether or not Grange has access to that rate. Expressly per the Court of Appeals opinion, the further fact-finding has nothing to do with “ambiguity” in the contract (indeed the Court found that there is no ambiguity); rather fact-finding is necessary to determine a factual issue: can this insured provide access to Grange to the discount provided by his health care provider, Medical Mutual.

II. STATEMENT OF THE RELEVANT FACTS

On May 23, 2006 Grange insureds, Heidi C. Laboy, Alexandria Laboy, and Gabrielle Laboy (“Appellee” or “Laboys”) sustained personal injuries in an automobile accident. (First Amended Complaint at ¶26.) At the time of the accident, the Laboys were insured under the Grange policy. (Policy, Supp. pp. 1-37). Grange does not dispute that the insurer/insured contractual relationship, nor does Grange dispute that the Laboys were covered under the subject policy related to their injuries sustained in the May 23, 2006 accident.

The Laboys sought and received medical treatment from ER Professional Services, Horizon Orthopedics, Dr. Joseph Jamhour, M.D., and Fairview Hospital. The Laboys submitted a portion of their medical bills to their health insurance carrier, Medical Mutual Insurance Company. The Laboys also submitted the same medical bills to Grange under the “Medical

Payments Coverage.” The “Medical Payments Coverage” policy form, under Limit of Liability, provides in relevant part:

- A. 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; or

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

The Laboys paid a premium for health insurance coverage from Medical Mutual Insurance Company which includes, but is not limited to, benefitting from the discount rate that Medical Mutual obtains from a medical provider. Medical Mutual Insurance Company obtained, i.e. negotiated a reduced (discounted) rate from the medical providers the Laboys treated with, and these rates can be made available and accessible to Grange via its own insureds’ health carrier.¹ (Appellant’s Discovery Responses Supp. pp. 37-49)

Part B(2) of the Medical Payments Coverage form does not limit Appellant to using a lesser negotiated reduced rate accessible only through the preferred provider network it has access to through its third-party provider, Review Works. The express language states “**Any** negotiated reduced rate accepted by **a** medical provider.” (Policy, Supp. p. 16) (emphasis added). Appellant is the author of its policy language. Appellant intended to use reduced rates accepted by “a medical provider.” Appellant advises its insureds that “As a Grange insured you are eligible (at your option) to receive care through the PPOM² Ohio network providers.” (July 14 2006 letter from Grange Indemnity Insurance Company Claim Representative, Linda Reynolds,

¹ See Plaintiffs’/Appellants’ discovery responses, attached to Defendant’s/Appellee’s Motion for Summary Judgment.

² This is the preferred Provider Network Grange has access to through its agreement with Review Works.

to Heidi Laboy, Supp. pp. 36-37). Appellant does *not* advise its insureds that it will accept reduced (discounted) rates only from its PPOM Ohio network.³ Thus, if either the Appellant or the Appellees can gain access to a lower negotiated reduced rate, that reduced rate must be paid by Appellant in accordance with Part (B)(2) of the medical payments coverage form.

Roxanne Miller is a Medical Payments Supervisor for Grange. Ms. Miller is purportedly the Grange representative who has knowledge regarding internal policies and guidelines that Grange uses to investigate, analyze, interpret, and adjust medical payment claims under the relevant policy of insurance; as well as claims handling guidelines as they pertain to medical payments and, specifically, to Appellees' claim file. (Miller Depo at pp.55-56, Supp. pp. 51-52).

Ms. Miller concedes that a Grange insured is entitled to the lowest medical payment amount under either B(1) or B(2) of the medical payment coverage. (Miller Depo at p. 88, Supp. p. 53). Ms. Miller admits that Appellant has a duty and obligation to identify for its insureds all coverages the insured has available under the policy; and to explain the medical payment coverage under parts B(1) and B(2) to Grange insureds. (Miller Depo p. 86, 98-108 Supp. pp. 54, 56-65). Ms. Miller acknowledges that a reduction in the amount paid for medical services under the med pay coverage causes an increase in the value of the applicable "limit of liability" (here, \$5,000.00) because more services can be covered by the \$5,000.00 limit. (Miller Depo. P. 125, Supp. p. 66). She further concedes that Appellant reviews the medical bills to "get the best cost available. (Miller Depo. p. 126, Supp. p. 67).

³ Note: Ohio Revised Code §3901-1-54(E)(1) states that "an insurer shall fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance contract under which a claim is presented." Thus, if Grange intended to limit payment for the lower negotiated reduced rate under Part B(2) only to participants in its third-party PPOM network, it was obligated under Ohio Statutory law to disclose that limitation.

Importantly, and contrary to Appellant's arguments, Ms. Miller admits that Appellant's negotiations with providers on medical billings are not limited only to those providers that Appellant has a contract with:

Q: Okay. I'm going to show you what's been marked as Plaintiffs' Exhibit 8.

A: Okay.

Q: This is Bates Stamped GRANGE _ 000359. The second sentence down says, "Negotiations with providers are expected on medical billings which are in question." Do you see that?

A: Okay.

Q: That's part of Grange's best medical coverage practices, correct?

A: Yes.

Q: Something that your people have been trained on, correct?

A: Yes.

Q: Something that you train your people on, correct?

A: Yes.

Q: Does that limit anyone to negotiate with medical providers that Grange *only* has a contract with?

A: [over objection] No.

(Miller Depo. pp. 156-157, Supp. pp 68-69. See also Grange document bates stamped 000359, Supp. p. 100)

Ms. Miller further admitted that nothing in Grange's "Best Practices" prevents or limits Grange from using and/or paying the discounted amount negotiated by the insured's health care provider:

Q: There's nothing in the best practices limiting Grange from negotiating with the insured's health carrier, correct?

A: Well, they don't have a contract with them.

Q: There's nothing in that best practices that limits Grange from negotiating with the insured's health carrier, correct?

A: Correct.

(Miller Depo p. 157, Supp. p. 69)

Ms. Miller admits that there is no reason Grange could not take advantage of paying a lower rate from a provider, even if Grange did not have a contract with that provider. Indeed, Ms. Miller could think of no reason why Grange would not pay a lower rate if it had access to a lower rate through the insured's health care provider – as it did in this case:

Q: Can you think of any reason why Grange would not pay a lower rate if they had access to it?

A: It's only on ones we have a contract rate with.

Q: No. If there is somebody you didn't have a contract with but they offered you a lower rate, is there any reason why Grange would not take advantage of paying the lower rate?

A: No.

Q: Thank you. So whether or not there was a contract between Grange and a provider, if a provider was able to provide a lower rate for your insured, Grange would take advantage of that, correct?

A: Possibly, uh-huh.

Q: You would certainly look into it, right?

A: Yes.

Q: And if there was no reason not to accept the lower rate because it would benefit both Grange and the Grange insured, Grange would likely pay for it, correct?

A: Yeah, I would have to know all the circumstances, but possibly.

Q: Can you think of any reason as we sit here if Grange had access to a lower rate through the insured's health provider, that they would not pay that lower rate?

A: No.

(Miller Depo pp. 161-162, Supp pp. 70-71)

Confirming the above, Ms. Miller admitted that Grange has, in fact, utilized discounts from providers that Grange did not have a contract with.(Miller Depo pp.198-200), Supp. pp. 72-74)

There is no policy at Grange that prohibits Grange from paying a lower reduced rate that its insured, such as Laboys, have access to through their own health insurance carrier:

Q: There is no policy that Grange has related to the medical payment coverage that says you would be prohibited from paying that lower reduced rate that the insured might have access to through their health carrier, correct?

A: Correct.

(Miller Depo p. 224, Supp. p. 75)

Ms. Miller acknowledges that during investigations related to medical payment coverage, Grange will inquire of its insureds whether or not other insurance, i.e. medical health insurance, may be applicable to their injury; and it is not unusual for Grange to ask if an insured has health insurance. (Miller Depo. pp. 37-38, Supp. pp. 76-77). In fact, it is a very reasonable inquiry of the insured. (Miller Depo. p. 204, Supp. p. 78)

Ms. Miller concedes that the Laboys' third-party injury settlement was reduced by the amount of the subrogation claim paid to Grange by the Laboys. (Miller Depo. pp. 172-173, Supp. pp. 79-80) She further admits that the higher the medical lien the less the insured is going to get from any third-party settlement. (Miller Depo. pp. 177-179, Supp. pp. 81-83) Ms. Miller admits that it is Appellant's obligation to keep the medical pay payments as low as possible, so that the insured can maximize their recovery from the third-party tortfeasor. (Miller Depo. p. 181, Supp. p. 84)

Linda Reynolds, now retired from Grange, was the medical payment adjuster on the Laboy file. Ms. Reynolds worked for Grange for twenty-five (25) years. Ms. Reynolds expressly testified that "*Grange did not have a contract with any medical providers.*" (Reynolds Depo. p. 45, Supp. p. 86) Ms. Reynolds confirms that Appellant reimburses health carriers – which have a lower rate – if the service covered by med pay were initially paid by the health insurer instead of Grange, and Grange did/does not require a contract with a health insurance carrier in order for Grange to reimburse the health insurance carrier. (Reynolds Depo. p. 49, Supp. p. 87)

Mr. Mike Brode was presented as Grange's representative related to Grange's alleged policy interpretation of Part B(2) of the medical payment coverage. Mr. Brode confirms that Grange is obligated to pay the lesser medical payment between Part B(1) and Part B(2) of the medical payment coverage. (Brode Depo. p. 63, Supp. p. 89) Mr. Brode confirmed that the language in Part B(2) "says what it says," and even Grange's counsel stipulated on the record that the language in Part B(2) does not state that a contract with Grange is required. (Brode Depo. pp. 88-90, Supp. pp. 90-92) Mr. Brode admits that the purpose, scope and intent of Part B(2) does not prevent Grange from contacting an insured's health insurance carrier in order for Grange to gain access to the health carrier's reduced rate.

III. LAW AND ARGUMENT

A. Standard of Review

An Appellate Review on the interpretations of insurance agreements is *de novo*. *Nationwide Mut. Fire Ins. Co. v. Guman Bros. Farm* (1995), 73 Ohio St.3d 107, 108, 1995 Ohio 214, 652 N.E. 2d 684. The principles of interpretation are the same as with contracts in general. *Hybud Equip Corp. v. Sphere Drake Ins. Co., Ltd.*, (1992), 64 Ohio St.3d 657, 665, 597 N.E. 2d 1096.

Further, it is well-established that this court reviews the granting of summary judgment under a *de novo* standard. *Coleman v. Beachwood*, Cuyahoga App. No. 92399, 2009-Ohio-5560, ¶¶15, 33. In a *de novo* review, this court must independently review all legal issues without deference to the determination of the trial court. *Id.* See also, *Novak v. Camino*, 2013-Ohio-2907; 2013 Ohio (Cuyahoga) App. LEXIS 2959, 2013 WL 3422894.

Civil Rule 56 provides in pertinent part that:

A summary judgment shall not be rendered unless it appears from the evidence or stipulation, and only from the evidence or stipulation, that reasonable minds can come to but one conclusion and that conclusion is adverse to the party against whom the motion for summary judgment is made, that party being entitled to have the evidence or stipulation construed most strongly in the party's favor. It is axiomatic that a motion for summary judgment shall only be granted when there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. Summary judgment shall not be granted unless it appears from the evidence that reasonable minds could come to but one conclusion and that conclusion is adverse to the party against whom the motion is made. See *Temple United, Inc. Wean* (1977), 50 Ohio St. 2d 317.

To grant a motion for summary judgment, a court must find that: (1) no genuine issue as to any material fact remains to be litigated; (2) the movant is entitled to judgment as a matter of law; and (3) construing the evidence most strongly in favor of the non-movant, reasonable minds

could conclude only for the movant. Civ R. 56(C); See also *Morely v. Lordi* (1995), 72 Ohio St. 3d 510, 512.

When evaluating a motion for summary judgment, the court must construe the evidence, as well as all reasonable inferences drawn therefrom, in a light most favorable to the non-movant. See *Morris v. Ohio Cas. Ins. Co.* (1988), 35 Ohio St. 3d 45. Because the granting of summary judgment results in the bypass of the normal litigation process by avoiding trial, it is essential that the granting of summary judgment be made with caution. Consequently, any doubts must be resolved in favor of the non-movant. See *Murphy v. Reynoldsburg* (1992), 65 Ohio St.3d 356, 358-59; see also *Viock v. Stowe-Woodward Co.* (1983), 13 Ohio App. 3d 7.

B. Proposition of Law No. 1: The Trial Court Erred by Concluding that Plaintiffs' Theory of Liability is Premised on the Word "Any" in Part B(2) of the Medical Payment Coverages Meaning "Every Single Negotiated Rate Between Any Medical Provider and Any Other Person or Entity"

Appellees do not argue to have the term "any" in Part B(2) of the "Medical Payments Coverage" to mean "every single negotiated rate between any medical provider and any other person or entity." (Trial Court Op. and Order p. 4, Supp. p. 96) Appellees assert, that Grange has an express duty under the policy of insurance to negotiate and pay any reduced rate *accepted by its insured third-party health insurance provider*, because that rate can be made available to Grange. Appellant's arguments completely ignore the mutuality of the contract.

Appellant discounts the fact that the subject insurance agreement has two parties to it – Grange and the insured. This is elementary contract law, and a significant fact in this case, that the trial court apparently overlooked – but the Eighth District Court of Appeals did not. It is axiomatic that an insurance agreement is a contract between the insured(s) and the insurance

company.⁴ And, “an insurance policy is a contract whose interpretation is a matter of law.” *Sharonville v. Am. Emps. Ins. Co.*, 109 Ohio St.3d 186, 2006 Ohio 2180, 846 N.E.2d 833. Insurance contracts must be construed in accordance with the same rules as other written contracts. *Insurance Co. of N. Am. v. Travelers Ins. Co.*, 118 Ohio App. 302, 692 N.E.2d 1028, 1997 Ohio App. (Cuyahoga) LEXIS 394. Citing, *Hybud Equip. Corp. v. Sphere Drake Ins. Co., Ltd.* (1992), 64 Ohio St.3d 657, 665, 597 N.E.2d 1096. As recognized by Appellant in their supplemental motion for summary judgment, “in construing any contract, the court should adopt a meaning that gives it vitality rather than a meaning that is unreasonable or renders its performance impossible.” *Kebe n. Nutro Mach. Corp.*, 30 Ohio App.3d 175, 177 (8th Dist. 1985). And, “Where the plain and ordinary meaning of an insurance policy’s language is clear and unambiguous, a court cannot resort to construction of that language, or alter its provisions, and the contract must be enforced as written and the words given their plain and ordinary meaning. In other words, when the terms within an insurance contract have a plain and ordinary meaning, it is not necessary or permissible for a court to resort to construction to construe a different meaning unless the plain meaning would lead to an absurd result.” *Andrews v. Nationwide Mut. Ins. Co.* (Cuyahoga county Court of Common Pleas, Case No. CV-11-756463 (McMonagle, J.)). Citing, *Toledo-Lucas County Port Authority v. Axa Marine & Aviation Ins. (UK), Ltd.*, 368 F.3d 524, 2004 FED App. 0128P (6th Cir. 2004) (*applying Ohio law*); *Holliman v. Allstate ins. Co.*, 86 Ohio St.3d 414, 1999-Ohio-116, 715 N.E.2d 532 (1999); *Friemoth v. Fruehauf Trailer Corp.*, 146 Ohio App.3d 519, 2001-Ohio-2172, 767 N.E.2d 281 (3d Dist. Allen County 2001), appeal dismissed as improvidently allowed, 94 Ohio St.3d 1252, 2002-Ohio-1493, 764 N.E.2d 1032

⁴ Indeed, on the first page of the insurance policy, under “**Agreement**” the policy reads “In return for payment of the premium and subject to all the terms of this policy, we agree with you as follows:”

(2002); *Hitt v. Anthem Cas. Ins. Group*, 142 Ohio App.3d 262, 755 N.E.2d 418 (11th Dist. Trumbull County 2001); *Fairview Hosp. v. Fortune*, 141 Ohio App.3d 314, 750 N.E.2d 1203 (8th Dist. Cuyahoga County 2001); *Ledyard v. Auto-Owners Mut. Ins. Co.*, 137 Ohio App.3d 501, 739 N.E.2d 1 (8th Dist. Cuyahoga County 2000). Further, a court is precluded from rewriting a contract when the intent of the parties is evident, *i.e.*, if the language of the policy's provisions is clear and unambiguous, the court may not resort to construction of the language. *Id.* See also, *Karabin v. State Auto Mut. Ins. Co.* (1984), 10 Ohio St.3d 163, 167, 462 N.E.2d 403.

General contract law requires a court to interpret a contract so as to carry out the intent of both parties, not just one of the parties. *Hoppel v. Feldman*, 7th Dist. No. 09CO34, 2011-Ohio-1183, ¶31, citing *Foster Wheeler Envirespone, Inc. v. Franklin Cty. Convention Facilities Auth.*, 78 Ohio St.3d 353, 1997-Ohio 2002, 678 N.E.2d 519. Indeed, this Honorable Court has stated, "When confronted with an issue of contractual interpretation, the role of the court is to give effect to the intent of the parties'[plural] to the agreement. *Westfield Ins. Co. v. Galatis*, 100 Ohio St.3d 216, 2003 Ohio 5849, 797 N.E.2d 1256. (Emphasis added) "[T]he intent of the parties to a contract resides in the language they chose to employ in the agreement." (Emphasis added) *N. Frozen Foods, Inc. v. Picciotti*, 2011-Ohio-2399;; 2011 Ohio App. (Cuyahoga), LEXIS 2054; 2011 WL 1935816. Quoting, *Shifrin v. Forest City Ent., Inc.* (1992), 64 Ohio St.3d 635, 638, 1992 Ohio 28, 597 N.E.2d 499; *Skivolocki v. East Ohio Gas. Co.* (1974), 38 Ohio St.2d 244 (Paragraph one of the syllabus)("...it is well known that contracts are to be interpreted so as to carry out the intent of the parties, [not just one party] as that intent is evidenced by the contractual language.); (Emphasis added) *Harvard Mfg. Co. v. Security Pacific Business Credit (Ohio), Inc.* (Oct. 23, 1986), Cuyahoga App. No. 51167.

This Honorable Court is required to examine the insurance contract as a whole and presume that the intent of both parties is reflected in the language used in the policy. *Kelly v. Med. Life Ins. Co.* (1987), 31 Ohio St.3d 130, 31 O.B.R. 289, 509 N.E.2d 411. Here, it is axiomatic that Appellant must have intended that the terms and conditions of Section (B)(2) apply equally to Appellant and Appellee. In other words, the unambiguous language of Section (B)(2) places no limits on Appellant's obligation to pay the lower reduced rate, where such rate can be accessed. Access to the lower reduced rate is not limited in the subject policy by any modifier requiring Grange to have a preexisting contractual relationship with a PPOM. Access can come from either party to the contract.

But Appellant argues that the reading, interpretation and application of Part B(2) of the Medical Payments Limit of Liability language is narrowly confined to apply only to a discount obtained directly by Grange, and not to any discount obtained by its insured. That position and interpretation, improperly reads into the contract language which simply does not exist, i.e., it places an invented limit on who can provide Appellant access to the lesser reduced rate. This argument ignores the fact that Appellant does, in fact, have access to a lesser negotiated reduced rate provided to the insured thru Medical Mutual. Appellant's limiting interpretation fails to give the intended benefit to its insured, and the vitality to the terms and conditions required under Ohio contract law.

The term "medical provider" is left undefined in the policy, and is not conditioned by any language limiting medical providers only to those that Grange has access to or has a contractual relationship with. Nothing in the terms or conditions of the policy excludes the undefined "medical provider" from being one that the insured has access to via its own health carrier. Certainly, the intent of both Appellant and the Laboys is to be subject to the lowest reduced rate

possible. For Appellant, this language under Part B (2) is language which was incorporated into the policy prior to the relationship established between Review Works and Grange and therefore prior to Appellant having access to only their lower negotiated reduced rates. How could Grange's interpretation of B(2) make sense at a time when Grange had no contracts for any reduced rates?

In addition, Appellant could have easily drafted the language to express their intent had they chose to do so. It would have been as easy as simply stating under Part B (2): Any negotiated reduced rate which **we** have in place with a medical provider. **We** is defined under the policy is Grange. However, Appellant chose not do so – a simple drafting construction – which would have clearly outlined their intent. But by not doing so, their intent clearly assumes the alternative, that is, any negotiated reduced rate, that either party to the insurance agreement has access to.

The subject insurance agreement is between Appellant and the Laboys, *i.e.* “*In return for payment of the premium and subject to all terms of this policy, we agree with you as follows.*”⁵ Thus, Laboys did not intend to limit accessibility to a lower negotiated reduced rate to only those (undefined) medical providers in the Review Works PPO Network, because not only were those medical providers never disclosed to them, but the Laboys have already paid for a discounted rate secured by their own health carrier. Indeed, the Laboys and insureds like them pay a separate premium for health insurance. The Laboys' health carrier negotiated a discounted rate for medical services from medical providers that Laboys are entitled to benefit from, in exchange for premium paid for health insurance. And since those medical providers are forced to accept the

⁵ The term “**we**” refers solely to Grange, not Grange *and/or* Review Works.

negotiated reduced rate determined by Laboys health carrier, and that rate is accessible to Grange, by way of its insureds, Grange must pay that reduced rate under Part (B)(2) .

The Laboys, like most other Grange insureds, have health insurance. The insureds' health providers are able to pass a negotiated discount rate to insured's like the Laboys. So, if Appellant will not pay the discount rate it has access to through its own insured's health carrier – then why is Grange selling Medical Payment Coverage to its insureds. In other words, the Laboys are paying more by submitting their medical bills to Grange, than by submitting their medical bills to their health carrier. The Laboys pay premiums for both sets of insurance, so why should they not benefit from the lowest reduced rate they can get, which is through their own health insurance carrier – a rate that the Laboys can make available to Grange.

C. PROPOSITION OF LAW NO. 2 *Grange has an Express Duty Under the Contract (Which it Breached) to Negotiate and Pay any Reduced Rate Accepted by its Insured's Third-Party Health Insurance Provider*

It was not error for the Eighth District Court of Appeals to order fact-finding on the application of unambiguous language of Section (B)(2).

Appellant misleadingly asserts that the Court below found the language of Section (B)(2) unambiguous, but then, in error, ordered the fact-finding to resolve an ambiguity. That is not what the Court below held. The Eighth District Court of Appeals held that the language found in Section (B)(2) was plain and unambiguous. Laboy agrees. But the Eighth District Court of Appeals held that fact-finding was necessary to determine an important fact: whether or not the Laboys can make their discounted rate available to Grange. Representatives from Appellant have already admitted that it would not require a contractual relationship to pay a reduced rate available through its insureds' healthcare provider. Now this Court should permit the fact-finding as to that discount available to Grange.

V. CONCLUSION

For the foregoing reasons, this Honorable Court should issue an Order affirming the appellate court's Opinion and remand this matter back to the Trial Court, consistent with the opinion and order of the Eighth District Court of Appeals.

Respectfully submitted



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CERTIFICATE OF SERVICE

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