IN THE SUPREME COURT OF MISSOURI

No. SC92788

RICHARD HOOVER,

Plaintiff/Appellant,

v.

MERCY HEALTH, MERCY HOSPITALS EAST COMMUNITIES,
and ST. JOHN'S MERCY MEDICAL CENTER,

Defendants/Respondents.

RESPONDENTS' SUBSTITUTE BRIEF

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STATEMENT OF FACTS

The brief of Plaintiff/Appellant Richard Hoover, M.D. ("Hoover"), does not contain a fair and concise statement of the facts as required under Rule 84.04(c).[1] Moreover, in violation of Rule 84.14(i), Hoover's brief contains numerous bald and unsupported claims and statements that are unsupported by any references to the legal file and have no evidentiary support in the record.

Hoover's statement of facts is found in the section entitled "Factual Background." (Hoover's Br. 2-3). Hoover's brief contains no references to the legal file for these unsupported statements. One example, and there are many, of supposed factual statements is his claims that he received pre-approval for his surgery from his health insurer (Coventry Health) and that his health insurer initially paid $5,201.19 to Defendants, but retracted the payment. These supposed factual statements are nowhere to be found in Hoover's amended petition or the record, are devoid of any evidentiary support, and were never presented to the trial court.

Similarly, Hoover's brief contains an argument section entitled "Hospital Billing Practices and the 'Chargemaster,'" which is nothing more than a diatribe and makes more bald and unsupported assertions about hospital billing practices and hospital chargemasters that are not found in Hoover's statement of facts. (Hoover's Br. 9-12). Hoover's brief contains no references to the legal file for these assertions. These

[1] Hoover's brief in this Court is the same as his brief in the court of appeals because Hoover did not to file a substitute brief. This brief is referred to as "Hoover's Br."

assertions are found nowhere in Hoover's amended petition or the record, are devoid of any evidentiary support, and were never presented to the trial court. Hoover bases some of them on two law review articles, an alleged report of a private consulting group, and a physician's alleged testimony before a congressional subcommittee. Hoover cites no purported "authority" for other factual statements.

Accordingly, Respondents provide the following statement of facts.[2] These facts are drawn from the allegations in Hoover's amended petition (LF 62-80); the admissions that Hoover made in his brief in this Court ("Hoover's Br."), his amended reply brief in the court of appeals ("Hoover's Am. Reply Br."), or his trial court memoranda[3]; and the undisputed evidence presented by the parties to the trial court.[4]

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[2] Citations to "LF" are to the Legal File. Citations to "Appendix" are to the Appendix to Respondents' Substitute Brief. Hoover's brief in this Court is the same as his brief in the court of appeals because Hoover chose not to file a substitute brief in the Supreme Court.

[3] This Court may consider the factual admissions made by Hoover in his appellate briefs in this Court or the court of appeals or in his trial court memoranda. *See Magee v. Blue Ridge Professional Building Co.*, 821 S.W.2d 839, 843 (Mo. banc 1991); *Klemme v. Best*, 941 S.W.2d 493, 497 n.2 (Mo. banc 1997).

[4] As discussed below in Section I.B.2. of the Argument, if necessary to affirm the trial court's judgment of dismissal, this Court (as the court of appeals did) may treat Defendants' motion to dismiss as a motion for summary judgment and consider certain additional undisputed facts that are outside of Hoover's amended petition because

A. The parties.

Hoover was or is a practicing physician who resides in St. Louis County and is the former Professor and Chairman of the Pathology Department of St. Louis University School of Medicine. (Hoover's Br. 2; LF 65). His amended petition names three entities as defendants:

1. "Mercy Health, d/b/a Mercy Health System";
2. "Mercy Hospitals East Communities, d/b/a St. John's Mercy Medical Center and/or St. John's Mercy Health System"; and
3. "St. John's Mercy Medical Center, d/b/a Mercy Hospitals East Communities and/or St. John's Mercy Health System."

(LF 62).

Hoover underwent surgery at Mercy Hospital St. Louis in Creve Coeur, Missouri. Mercy Hospitals East Communities (Defendant No. 2), a Missouri non-profit corporation, owns and operates Mercy Hospital St. Louis, which is not a separate legal entity. Mercy Health (Defendant No. 1) is a Missouri non-profit corporation that is the indirect parent company of Mercy Hospitals East Communities.[5] Only Mercy Hospitals East Communities (Defendant No. 2) ("Mercy") is a proper defendant in this case.

Hoover introduced evidence beyond the scope of his pleadings and did not object to the evidence that Defendants introduced.

[5] Mercy Hospital St. Louis was formerly known as "St. John's Mercy Medical Center." The corporate name of Mercy Hospitals East Communities was "St. John's Mercy

B. Hoover undergoes surgery at Mercy.

On March 10, 2009, Hoover underwent oral surgery at Mercy. (LF 73; Hoover's Br. 2). At the time, he had health insurance with Coventry Health. (LF 85; Hoover's Br. 2-3).

C. Hoover's contract with Mercy.

Before the surgery, Hoover entered into an express contract with Mercy when he selected Mercy to treat his oral surgery requirements and signed a document entitled "Release of Information, Assignment of Benefits, and Financial Responsibility." (Appendix 1; LF 71, 82-83, 123; Hoover's Br. 19-20, 28). In pertinent part, Hoover's contract with Mercy provides as follows:

> **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to the Facility and my physicians…. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance or amounts in excess of insurance benefits.
>
> **FINANCIAL RESPONSIBILITY:** In consideration of services rendered or to be rendered to the patient designated herein at my request for this occasion of service, *I guarantee and agree to pay Facility charges for those*

Medical Center" until May 1997 and was "St. John's Mercy Health System" from May 1997 until April 2011. (Appendix 14-15). The corporate name of Mercy Health was formerly "Sisters of Mercy Health System." (Appendix 16).

> *services rendered including any amount not paid by my insurance plan*, Medicare, health service plan or health maintenance organization…. By signing the financial responsibility statement, *the patient and guarantor(s) acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health maintenance organization (or preferred provider organization) because of a failure to comply with such coverage requirements or for any other reason*….

(Appendix 1; LF 123) (emphasis added).

D. Coventry Health denies coverage for Hoover's surgery and makes no payment to Mercy.

After Hoover underwent the surgery, his health insurer, Coventry Health, denied coverage for the surgery on the basis that his health insurance plan did not cover dental services and treatment. (LF 85; Hoover's Br. 2-3). Hoover erroneously asserts in his brief (pp. 2-3), but does not allege in his amended petition, that Coventry Health initially paid $5,201.19 to Mercy, but later retracted the payment. Mercy never received any payment from Coventry Health. The $5,201.19 amount mentioned by Hoover likely comes from Mercy's billing statement to Hoover. (LF 104-05). On March 28, 2009, Mercy posted a credit to Hoover's account in the amount of $5,201.19, or 30 percent of the billed charges ($17,337.29), to reflect the expected contractual discount that would have applied under Mercy's provider agreement with Coventry Health if Coventry Health covered Hoover's surgery. (LF 105). On April 21, 2009, after Coventry Health denied coverage, Mercy

posted a debit to Hoover's account in the amount of $5,201.19 to reverse this expected contractual discount because it did not apply. (LF 105).

E. Mercy bills Hoover based on its standard charges set forth in its chargemaster.

Mercy billed Hoover $17,337.29 for the medical goods and services that it provided to him pursuant to its agreement with him. (Hoover's Br. 3; LF 90, 104-06). Mercy maintains a "chargemaster" that contains its standard charges to all patients for medical goods and services. (LF 71-73, 75, 77, 85; Hoover's Br. 9-10). Mercy's charges to Hoover were the standard charges established in Mercy's chargemaster at the time of Hoover's treatment that Mercy applied to all patients, whether insured or uninsured, for the same goods and services. (LF 71-73, 75, 77, 85).

F. Hoover makes no payments to Mercy for over two years and then pays $5,300 to Mercy after retaining his current attorney and threatening to sue Mercy.

Despite his agreement with Mercy, Hoover paid Mercy nothing toward his bill for over two years. (Hoover's Br. 3). On June 13, 2011, Hoover told Mercy's collection agency that he had hired his current attorney (Paul Passanante) to represent him and that he intended to file a class action lawsuit against Mercy. (Appendix 10; LF 132). After hiring his attorney and threatening to sue Mercy, Hoover paid $1,000 to Mercy's collection agency on June 17, 2011 and paid an additional $4,300 to Mercy's collection agency on June 27, 2011, the same date that he filed this lawsuit. (Appendix 10-11; LF 132-33; Hoover's Br. 3). His current attorney (Mr. Passanante) told the media that

Hoover paid $5,300, or 30.5 percent of the billed charges, because Hoover considered this to be a "reasonable amount." (Appendix 2-3; LF 124-25; Hoover's Am. Reply Br. 4).

G. Hoover sues Mercy the same day that he pays $4,300 toward his bill.

On June 27, 2011, the same day that he made his $4,300 payment, Hoover filed this lawsuit. (LF 2). His original petition named only Mercy Health as a defendant and asserted claims for violation of the Missouri Merchandising Practices Act, RSMo § 407.010 *et seq.* (the "MMPA") (Count I), and punitive damages (Count II). (LF 3-19).

H. Mercy Health's motion to dismiss Hoover's original petition.

Mercy Health filed a motion to dismiss for failure to state a claim upon which relief can be granted. (LF 20-24). Mercy Health submitted a copy of Hoover's contract with Mercy as Exhibit 1 to its motion to dismiss because Hoover's original petition alleged the existence of this contract and alleged the contract as a basis for his lawsuit. (LF 9).

I. Hoover's response to Mercy Health's motion to dismiss.

Hoover submitted a lengthy memorandum in opposition to Mercy Health's motion to dismiss. (LF 81-116). Notably, he did not object to Mercy Health's submission of the contract (Exhibit 1). Instead, he readily admitted that the contract "is a document that plaintiff signed before the medical care and treatment was rendered to him" and "speaks for itself." (LF 82-83).

Moreover, in his opposition papers, Hoover went well beyond the allegations of his petition and relied on several new factual assertions not found in his original petition. For example, he injected new allegations about his health insurance coverage:

> At the time of the medical care and treatment at issue, plaintiff had a policy of medical insurance with Coventry Health. The policy of medical insurance issued by Coventry Health to plaintiff excluded dental care and treatment from coverage. Coventry Health concluded that the medical goods and services furnished to plaintiff by defendant Mercy Health was dental care, and therefore not covered by the policy. Plaintiff was therefore uninsured for the medical goods and services at issue in this case, and defendant billed plaintiff its full "standard charge" or "sticker price" for the goods sold and services rendered to plaintiff.

(LF 85). Hoover also asserted new allegations that "the original balance on [his] account [was] $17,337.29," that "the current balance is $12,037.39," and that he "had paid over $5,000 on this account." (LF 90). Hoover further submitted a letter dated June 28, 2011, accompanied by a copy of Mercy's itemized statement of account, that his attorney (Mr. Passanante) received from Mercy's collection agency. (LF 90, 103-106).

J. Hoover's amended petition.

One of Mercy Health's grounds for dismissal was that Hoover had sued the wrong legal entity because he received medical treatment from Mercy, not Mercy Health. (LF 26). In response, Hoover filed an amended petition, which repeated the allegations of the original petition and added two defendants, both of which are the same corporate entity (Mercy Hospitals Communities East) that owns and operates the hospital where he underwent surgery (Mercy Hospital St. Louis). (LF 62-80). (Hoover inexplicably did not drop Mercy Health as a defendant.)

K. Defendants' motion to dismiss Hoover's amended petition.

Defendants moved to dismiss Hoover's amended petition for failure to state a claim upon which relief can be granted. (LF 117-134). Defendants repeated the same grounds for dismissal as Mercy Health had asserted.

Defendants once again submitted a copy of Hoover's undisputed contract with Mercy as Exhibit 1. (LF 123). Moreover, in response to Hoover's assertion that he had paid $5,300 toward his bill, Defendants submitted as Exhibit 2 an article dated June 29, 2011 from *The St. Louis Countian* that reported on Hoover's lawsuit and quoted Hoover's attorney (Mr. Passanante): "The hospital billed [Hoover] more than $17,000 for the surgery, and Hoover paid what he considered to be a reasonable amount, $5,300." (Appendix 2-3; LF 124-25; Hoover's Am. Reply Br. 4).

These exhibits were submitted by Defendants to counter materials and assertions Hoover made outside the four corners of his petition and amended petition. Hoover did not object to Defendants' submission of these exhibits. He has never disputed the authenticity of these exhibits or anything contained therein.

L. The trial court dismisses Hoover's amended petition.

On November 2, 2011, the trial court granted Defendants' motion to dismiss and entered judgment dismissing Hoover's amended petition. (LF 161). Hoover did not ask the trial court for leave to further amend his petition, even though his brief asserts numerous new purported "facts" that were never presented to the trial court. Instead, Hoover chose to stand on the merits (or lack thereof) of his amended petition and

appealed. (LF 154). Nor did Hoover ask the trial court for a legal opinion laying out the basis for its judgment of dismissal.

M. The Court of Appeals' affirmance and this Court's transfer.

On July 2, 2012, the Court of Appeals for the Eastern District affirmed the trial court's judgment of dismissal. 2012 WL 2549485. On November 20, 2012, this Court granted Hoover's application for transfer.

ARGUMENT

I. The Court should dismiss Hoover's appeal because his brief fails to comply with Rules 84.04(c) and 84.04(i).

"Rule 84.04(c) requires that the 'statement of facts shall be a fair and concise statement of the facts relevant to the questions presented for determination without argument.'" *FIA Card Services, NA v. Hayes*, 339 S.W.3d 515, 517 (Mo. App. E.D. 2011) (quoting Rule 84.04(c)).

> Further, Rule 84.04(i) requires that both the statement of facts and the argument section have specific page references to the legal file or the transcript. This requirement is mandatory and essential for the effective functioning of appellate courts because courts cannot spend time searching the record to determine if the factual assertions in the brief are supported by the record. To do so would effectively require the court to act as an advocate for the non-complying party.

Id. (quotations omitted).

"Compliance with Rule 84.04 briefing requirements is mandatory in order to ensure that appellate courts do not become advocates by speculating on facts and on arguments that have not been made. Failure to comply with the rules of appellate procedure is a proper basis for dismissing an appeal." *Id.* Indeed, "failure to comply with Rule 84.04's mandatory requirements regarding the statement of facts is grounds, in itself, to dismiss [an] appeal." *Moseley v. Grundy County Dist. R-V Sch.*, 319 S.W.3d 510, 512 (Mo. App. E.D. 2010); *see also Johnson v. Buffalo Lodging Associates*, 300

S.W.3d 580, 581 (Mo. App. E.D. 2009) ("These violations of Rule 84.04(c) and (i) alone warrant dismissal of this appeal.").

Hoover repeatedly violated Rules 84.04(c) and 84.04(i) in his brief. His brief does not contain a fair and concise statement of the facts, and his brief does not provide any references to the legal file for any of the supposed factual statements made in: (a) the "Factual Background" section of his statement of facts (pp. 2-3); and (b) the "Hospital Billing Practices and the 'Chargemaster'" section of his argument (pp. 9-12). Many of the supposed factual statements in (a), and all of the supposed factual statements in (b), are found nowhere in Hoover's amended petition or the record, lack evidentiary support, and should be disregarded by the Court. Because Hoover has failed to comply with Rule 84.04, this Court should dismiss his appeal. *FIA Card Services*, 339 S.W.3d 517-18 (dismissing appeal for failure to comply with Rule 84.04); *First Bank v. The Annie-Joyce Group, LLC*, 334 S.W.3d 589, 591-92 (Mo. App. E.D. 2011) (dismissing appeal for failure to comply with Rule 84.04, including stating facts that were not supported by the record); *Allen v. ABM Janitorial Services*, 326 S.W.3d 509, 510 (Mo. App. E.D. 2010) (dismissing appeal for failure to comply with Rule 84.04); *Moseley*, 319 S.W.3d at 512 (dismissing appeal for failure to comply with Rule 84.04, including appellant's failure to "include a single citation to the record in his statement of facts"); *Johnson*, 300 S.W.3d at 581-82 (dismissing appeal for failure to comply with Rule 84.04).

II. The trial court correctly dismissed Count I of Hoover's amended petition for violation of the Missouri Merchandising Practices Act ("MMPA") because Hoover's amended petition contains no legally-sufficient factual basis to support his contention that Mercy overcharged him in violation of the MMPA, Hoover has no ascertainable loss of money or property as a result of Defendants' alleged violation of the MMPA, and Hoover does not otherwise state a cognizable MMPA claim. (Responds to Hoover's Point One).

A. Introduction.

Hoover's amended petition contains two counts, violation of the Missouri Merchandising Practices Act, RSMo § 407.010 *et seq.* (the "MMPA") (Count I), and punitive damages (Count II). (LF 62-80). Hoover claims that Defendants violated the MMPA by allegedly charging him more than the reasonable value of his health care and by allegedly misrepresenting that its billed charges were reasonable. The gist of Hoover's claim is that Mercy did not give him the same "discounts" from its standard charges that it affords: (a) to certain private insurers pursuant to negotiated contracts with the private insurers; and (b) to patients covered by the federal Medicare program as a federal statutory condition of Mercy's participation in the Medicare program. (LF 84-86). Hoover is not a party to or beneficiary of any applicable contracts between Mercy and

private insurers; nor is he a Medicare beneficiary.[6] As a matter of law, Hoover is not entitled to such "discounts" from Mercy's standard charges.

By voluntarily seeking medical care from Mercy and signing his contract with Mercy, Hoover entered into an express agreement to pay Mercy's standard charges for his medical care. Mercy's charges to Hoover were the standard charges set forth in advance in its chargemaster that Mercy applies to all patients for the same goods and services.

Hoover erroneously asserts that he is entitled to be charged some unspecified "fair and reasonable charge." Under his express contract with Mercy, Hoover is liable to Mercy for its standard charges. But assuming, *arguendo*, that Hoover is obligated to pay an unspecified "reasonable value" for his medical care instead of Mercy's standard charges, Hoover fails to allege a legally-sufficient factual basis for establishing that Mercy charged him more than the reasonable value of his medical care. Hoover's claim is based solely on the legally-deficient premise that the reasonable value of his medical care should be determined by the discounted amounts from Mercy's standard charges that certain insurers and Medicare pay. Hoover is not legally entitled to these discounts under any contract or statute, and such discounted amounts paid for medical care provided to other patients do not determine the reasonable value of Hoover's medical care.

[6] Hoover's health insurer, Coventry Health, has a contract with Mercy, but it denied coverage for his oral surgery.

Additionally, Hoover has not incurred any "ascertainable loss of money or property" as a result of Defendants' alleged violation of the MMPA. Hoover has only paid Mercy what he considers to be the reasonable value of his medical care after consulting with his attorney and determining that Mercy had allegedly overcharged him and misrepresented that its billed charges were the reasonable value of his medical care. He has not alleged—and in light of his admissions, cannot allege—any facts demonstrating how or why the amount that he paid, $5,300, was more than the reasonable value of his medical care. As a result, Hoover fails to satisfy the damages and causation elements of an MMPA claim.

Hoover's lawsuit is a repeat of similar meritless attempts by uninsured patients to pursue putative class action lawsuits against hospitals for alleged overcharging. Such lawsuits have been repeatedly rejected and dismissed by:

1. The Missouri Court of Appeals for the Southern District in *Freeman Health System v. Wass*, 124 S.W.3d 504 (Mo. App. S.D. 2004), a case that is directly on point.

2. Judges Robert Cohen, Mark Siegel, and James Hartenbach in the Circuit Court of St. Louis County and Judges Mark Powell and Dan Conklin in the Circuit Court of Greene County. *See Polsgrove v. St. John's Regional Health Center*, Civ. No. 31107CC2451 (Mo. Cir., Greene County, Dec. 30, 2009) (Appendix 17-22); *Richardson v. SSM Health Care Corp.*, Civ. No. 07SL-CC0574 (Mo. Cir., St. Louis County, Dec. 20, 2007) (Appendix 27); *Jarvis v. SSM Health Care Corp., et al.*, Civ. No. 05CC-5726 (Mo. Cir., St. Louis County, Sept. 11, 2006) (Appendix 26); *Stinson v. St. Anthony's Medical Center*, Civ. No. 06CC-581 (Mo. Cir., St. Louis County, Sept. 5, 2006) (Appendix 25);

Meierer v. St. John's Regional Health Center, Civ. No. 104CC4384 (Mo. Cir., Greene County, July 11, 2006) (Appendix 23-24).

3. The United States District Court for the Western District of Missouri in *Lester E. Cox Med. Centers v. Huntsman*, 2003 WL 22004998 (W.D. Mo. Aug. 5, 2003).

4. Numerous state and federal courts throughout the country. *See Allen v. Clarian Health Partners, Inc.*, --- N.E.2d ---, 2012 WL 6608042 (Ind. Dec. 19, 2012); *Collection Professionals, Inc. v. Schlosser*, 977 N.E.2d 315, 320-21 (Ill. App. Ct. 2012); *Holland v. Trinity Health Care Corp.*, 791 N.W.2d 724 (Mich. Ct. App. 2010); *Galvan v. Northwestern Memorial Hosp.*, 888 N.E.2d 529 (Ill. App. Ct. 2008); *DiCarlo v. St. Mary's Hospital*, 530 F.3d 255 (3d Cir. 2008); *Firelands Regional Med. Ctr. v. Jeavons*, 2008 WL 4408600 (Ohio Ct. App. Sept. 30, 2008); *Nygaard v. Sioux Valley Hosps. & Health Sys.*, 731 N.W.2d 184 (S.D. 2007); *Kolari v. New York-Presbyterian Hospital*, No. 604340/06 (N.Y. Sup. Nov. 1, 2007); *GEICO Indemnity Ins. Co. v. Kannaday*, Case No. 06-1067-JTM (D. Kan. Oct. 11, 2007) (Appendix 28-33); *Shelton v. Duke University Health System, Inc.*, 633 S.E.2d 113 (N.C. Ct. App. 2006); *Cox v. Athens Regional Medical Center, Inc.*, 631 S.E.2d 792 (Ga. Ct. App. 2006); *Davis v. Phoebe Putney Health System, Inc.*, 634 S.E.2d 452 (Ga. Ct. App. 2006); *Morrell v. Wellstar Health System, Inc.*, 633 S.E.2d 68 (Ga. Ct. App. 2006); *Pitts v. Phoebe Putney Memorial Hospital, Inc.*, 631 S.E.2d 830 (Ga. Ct. App. 2006); *Satterfield v. Southern Regional Health System, Inc.*, 634 S.E.2d 530 (Ga. Ct. App. 2006); *Amato v. UPMC*, No. GD-015753 (Pa. Ct. Common Pleas May 3, 2006); *Buckner v. Banner Health System*, CV 2005-003052 (Ariz. Superior Ct. Nov. 22, 2005); *Service Finance Corp. v. Pope*, Civ.

No. CV-04-526 (Ark. Cir. Ct. Nov. 8, 2005); *Elliott Hospital v. Boerner*, No. 04-C-739 (N.H. Superior Ct. July 15, 2005) (Appendix 34-70).

In the face of these voluminous precedents, Hoover relies on a decision by Judge David Mason in the Circuit Court of the City of St. Louis, *Quinn v. BJC Health System*, 2007 WL 7308622 (Mar. 2, 2007). Judge Mason's decision in *Quinn* did not address *Freeman* or any of the above authorities, cites no pertinent legal authority, and flies in the face of *Freeman*, the decisions of five other Missouri trial judges, and the overwhelming national judicial consensus. *Quinn* is not persuasive and should not be followed.

Beyond *Quinn*, Hoover relies on law review articles, a report prepared by a private consulting group, and some congressional testimony to make a legislative argument as to what he believes the law ought to be with respect to hospital pricing, not what the law actually is. However, "the contentions of the plaintiff should be directed to the deliberative process of the legislature," not the courts. *Galvan*, 888 N.E.2d at 539 (dismissing uninsured patient's lawsuit against hospital).

In the end, Hoover is effectively asking the Court to restrict Mercy's prices and make him a beneficiary/party to contracts and government programs under which he has no rights. The MMPA, however, does not regulate prices. Absent pertinent legislation or regulation, sellers of goods and services are entitled to set their prices as they choose. Prices are a matter for the marketplace or the legislature, not the courts. This Court should affirm the trial court's judgment of dismissal.

B. The standard of review and the scope of the record before the Court.

1. The Court reviews the trial court's judgment of dismissal *de novo* and may consider facts Hoover admitted in his trial court memoranda and his appellate briefs that are outside Hoover's amended petition.

"This Court reviews the trial court's grant of a motion to dismiss *de novo.*" *Foster v. Smith*, 352 S.W.3d 357, 359 (Mo. banc 2011). "In reviewing the propriety of the trial court's dismissal of the petition, this Court considers the grounds raised in the defendant's motion to dismiss and does not consider matters outside the pleadings." *Id.* "If the motion to dismiss can be sustained on any ground alleged in the motion, the trial court's ruling will be affirmed." *Id.*

While the Court ordinarily does not consider matters outside the pleadings, the Court does consider facts outside the petition that the plaintiff admits in his appellate briefs (whether in this Court or in the court of appeals) or in his trial court memoranda:

> Where the plaintiff's brief on appeal admits facts omitted from the petition that if true will defeat plaintiff's cause of action, the appellate court will treat the petition as amended to include the omitted facts in determining if plaintiff stated a cause of action. The purpose of this rule is to avoid the useless and time consuming remand of the case when the plaintiff agrees the omitted facts are true and those facts are dispositive of the case.

Magee v. Blue Ridge Professional Building Co., 821 S.W.2d 839, 843 (Mo. banc 1991); *see also Klemme v. Best*, 941 S.W.2d 493, 497 n.2 (Mo. banc 1997) (in review of trial

court order dismissing action, Court could properly consider facts admitted in plaintiff's reply brief in the court of appeals).

Hoover has admitted the following facts in his appellate briefs or his trial court memoranda:

- Hoover is a physician and former Professor and Chairman of the Pathology Department of St. Louis University School of Medicine. (Hoover's Br. 2).
- On March 10, 2009, Hoover underwent oral surgery at Mercy. (Hoover's Br. 2).
- At the time of his surgery, Hoover had health insurance with Coventry Health. (Hoover's Br. 2-3).
- Before the surgery, Hoover signed his contract with Mercy (the document entitled "Release of Information, Assignment of Benefits, and Financial Responsibility," a copy of which is Exhibit 1 to Defendants' motion to dismiss). (Hoover's Br. 19-20, 28).
- After Hoover underwent the surgery, his health insurer, Coventry Health, denied coverage for the surgery on the basis that his health insurance plan did not cover dental services and treatment. (Hoover's Br. 2-3).
- Mercy billed Hoover $17,337.29 for the medical goods and services that Mercy provided to him. (Hoover's Br. 3).
- Mercy's charges to Hoover were based on the standard charges established in Mercy's chargemaster at the time of Hoover's treatment. (LF 85).

- In June 2011, Hoover made payments totaling $5,300.00 towards his bill from Mercy. (Hoover's Br. 3).
- Hoover's current counsel (Paul Passanante) told the media (*The St. Louis Countian*) that "[t]he hospital billed [Hoover] more than $17,000 for the surgery, and Hoover paid what he considered to be a reasonable amount, $5,300." (Hoover's Am. Reply Br. 4).[7]

In deciding the propriety of the trial court's dismissal, this Court may consider these facts that Hoover has admitted. *Magee*, 821 S.W.2d at 843; *Klemme*, 941 S.W.2d at 497 n.2.

[7] Hoover concedes that his counsel made these remarks to the media, but attempts to dismiss the remarks as "not relevant." (Hoover's Am. Reply Br. 4) ("Appellant's counsel's remarks to the media and speculation concerning the amount Appellant paid are not relevant to whether Appellant stated a claim under the MMPA….").

2. The Court may treat Defendants' motion to dismiss as a motion for summary judgment and consider additional undisputed facts that are outside of Hoover's amended petition because Hoover knowingly and purposefully chose to introduce evidence before the trial court beyond the scope of his pleadings and did not object to the evidence that Defendants introduced.

This Court may affirm the trial court's dismissal by considering only the allegations in Hoover's amended petition and the admissions in Hoover's appellate briefs and trial memoranda. However, if necessary to affirm the trial court's judgment of dismissal, this Court, as the court of appeals did, may treat Defendants' motion to dismiss as a motion for summary judgment and consider additional undisputed facts that are outside of Hoover's amended petition because Hoover introduced evidence beyond the scope of his pleadings and did not object to the evidence that Defendants introduced. When, as here, both parties introduce evidence beyond the scope of the pleadings and the plaintiff does not object to the introduction of evidence, then a motion to dismiss is automatically converted to a motion for summary judgment and the parties are charged with knowledge that the motion to dismiss was so converted. *Mitchell v. McEvoy*, 237 S.W.3d 257, 259 (Mo. App. E.D. 2007); *Reed v. Director of Revenue*, 184 S.W.3d 564, 566 (Mo. banc 2006) (where trial court allowed both parties to present matters outside pleadings, motion for judgment on pleadings had to be treated as motion for summary judgment).

> Review of the trial court's ruling on a motion to dismiss is generally limited to the sufficiency of the pleadings on their face. Where, however, the parties introduce evidence beyond the pleadings, a motion to dismiss is converted to a motion for summary judgment. In order to consider matters outside of the pleadings and treat a motion to dismiss as one for summary judgment, the trial court must first give the parties notice that it is going to do so, and it must provide all parties a reasonable opportunity to present all materials made pertinent to a motion for summary judgment. However, notice by the trial court is not required when a party or parties acquiesce in the trial court treating a motion to dismiss as a motion for summary judgment. Thus, where the parties introduce evidence beyond that contained in the petition, a motion to dismiss is converted to a motion for summary judgment and the parties are charged with knowledge that the motion was so converted.

ADP Dealer Services Group v. Carroll Motor Co., 195 S.W.3d 1, 6 (Mo. App. E.D. 2005) (citations omitted). In particular, when, as here, the *plaintiff* introduces evidence beyond his own pleadings, the plaintiff is charged with knowledge that the defendant's motion to dismiss is converted to a motion for summary judgment and the plaintiff "cannot complain on appeal about an alleged error created by his or her own conduct or in which such party joined or acquiesced at trial." *Fulkerson v. W.A.M. Investments*, 85 S.W.3d 745, 749-50 (Mo. App. S.D. 2002). Missouri courts have long applied these principles in numerous cases. *See Vinstickers, LLC v. Stinson Morrison Hecker LLP*, 369

S.W.3d 764, 766 (Mo. App. W.D. 2012); *Wilson v. Cramer*, 317 S.W.3d 206, 208-09 (Mo. App. W.D. 2010); *Brown v. Simmons*, 270 S.W.3d 508, 510-11 (Mo. App. S.D. 2008); *Osage Water Co. v. City of Osage Beach*, 58 S.W.3d 35, 41 (Mo. App. S.D. 2001); *Xavier v. Bumbarner & Hubbell Anesthesiologists*, 923 S.W.2d 428, 430 (Mo. App. W.D. 1996); *Geary v. Missouri State Employees' Retirement System*, 878 S.W.2d 918 (Mo. App. W.D. 1994).

C. Hoover's amended petition contains no legally-sufficient factual basis to support Hoover's contention that Mercy overcharged him in violation of the MMPA.

Hoover's amended petition fails to state a cognizable claim because Hoover fails to plead any legally-sufficient factual basis to conclude that Mercy overcharged him in violation of the MMPA.

1. Under his express contract with Mercy, Hoover is liable to Mercy for its standard charges for medical care as set forth in its chargemaster.

Mercy did not overcharge Hoover because the parties' express contract obligates Hoover to pay Mercy's standard charges as reflected in Mercy's chargemaster at the time Hoover received treatment.

a. Hoover's contract with Mercy.

Hoover entered into an express, written contract with Mercy. *See, e.g.*, *Westerhold v. Mullenix Corp.*, 777 S.W.2d 257, 263 (Mo. App. E.D. 1989) ("Contracts are created by promissory expression. The expression of the promise may be verbal or by conduct.

When the parties express their promises in explicit oral or written words, the contract is labeled: express."); *Roark Printing, Inc. v. Worm World, Inc.*, 974 S.W.2d 613, 617 (Mo. App. S.D. 1998) ("When the parties express their promises in explicit oral or written words, they create an express contract."). Hoover's contract with Mercy provides in pertinent part:

> **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to the Facility and my physicians…. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance or amounts in excess of insurance benefits.
>
> **FINANCIAL RESPONSIBILITY:** In consideration of services rendered or to be rendered to the patient designated herein at my request for this occasion of service, *I guarantee and agree to pay Facility charges for those services rendered including any amount not paid by my insurance plan*, Medicare, health service plan or health maintenance organization…. By signing the financial responsibility statement, *the patient and guarantor(s) acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health maintenance organization (or preferred provider organization) because of a failure to comply with such coverage requirements or for any other reason*….

(Appendix 1; LF 123) (emphasis added).

b. The "Facility charges" and "billed charges" that Hoover agreed to pay are determined by Mercy's chargemaster.

By accepting treatment from Mercy, Hoover accepted an obligation to pay Mercy's "Facility charges" and "billed charges" when, as happened here, his health insurance did not cover his treatment. These "Facility charges" and "billed charges" were Mercy's standard charges for medical goods and services that were applicable to all patients, were found in Mercy's chargemaster, and were established and in effect *before* Hoover received medical care from Mercy.

Under Missouri law, if a contract does not fix the exact price in advance, the contract is still enforceable if the contract provides a method to determine the price. *See Allied Disposal, Inc. v. Bob's Home Service, Inc.*, 595 S.W.2d 417, 419 (Mo. App. E.D. 1980); *see also Sedmak v. Charlie's Chevrolet, Inc.*, 622 S.W.2d 694, 694 (Mo. App. E.D. 1981) ("Failure to specify the selling price in dollars and cents did not render the contract void or voidable ... As long as the parties agreed to a method by which the price was to be determined and as long as the price could be ascertained at the time of performance, the price requirement for a valid and enforceable contract was satisfied."). Here, Hoover's contract with Mercy provides a method to determine the price—Mercy's standard rates as set forth in its chargemaster. "In the context of a contract for the provision of and payment for medical services, a hospital's chargemaster rates serve as the basis for its pricing." *Allen v. Clarian Health Partners, Inc.*, --- N.E.2d ---, 2012 WL 6608042, *3 (Ind. Dec. 19, 2012).

The nature of medical care at a hospital does not allow a patient's bill to be predetermined before the hospital visit is completed because: (a) the hospital's charges are based on the goods and services actually provided to the patient and thus cannot be predicted with certainty because the hospital cannot divine in advance all care the treating physician may order; and (b) the patient's physician, not the hospital, determines the scope of a patient's care and the goods and services needed for treatment of the patient. "[I]n a hospital setting, it is not possible to know at the outset what the cost of the treatment will be, because it is not known what treatment will be medically necessary." *Nygaard v. Sioux Valley Hosps. & Health Sys.*, 731 N.W.2d 184, 192 (S.D. 2007); *see also Cox v. Athens Reg. Med. Ctr., Inc.*, 631 S.E.2d 792, 797 (Ga. Ct. App. 2006).

> Inherent in providing medical care and treatment is the element of the unforeseen. It is common, almost expected, that a course of treatment embarked upon will, through unforeseen circumstances, be amended, altered, enhanced, or terminated altogether, and a completely new course of treatment begun. In light of this, it would be impossible for a hospital to fully and accurately estimate all of the treatments and costs for every patient before treatment has begun. It would be cumbersome, and against patients' interests, to require hospitals to seek new authorization from a patient whenever some medical circumstance requires a new course of treatment. For this reason, it is entirely reasonable and predictable that patients would agree to pay the hospital's regular rates for whatever

> services might be necessary in treating their particular ailments or afflictions.

Shelton v. Duke Univ. Health Sys. Inc., 633 S.E.2d 113, 116 (N.C. Ct. App. 2006); *see also Allen*, 2012 WL 6608042, *3; *Holland v. Trinity Health Care Corp.*, 791 N.W.2d 724, 729 (Mich. Ct. App. 2010); *DiCarlo v. St. Mary's Hospital*, 530 F.3d 255, 264 (3d Cir. 2008); *Harrison v. Christus St. Patrick Hosp.*, 430 F.Supp.2d 591, 595-96 (W.D. La. 2006).

While the exact price of Hoover's medical care at Mercy could not be determined before he received treatment, the standard rates that Mercy would charge for the specific goods and services provided to Hoover at the direction of his private physician were known and fixed in advance in Mercy's chargemaster. Thus, the price under Hoover's contract with Mercy was to be determined by reference to Mercy's standard charges after the full extent of goods and services was known.

Because Hoover came to Mercy to receive a defined surgical procedure, he could have learned in advance what Mercy's approximate charges would be for his surgery. Hoover could have asked his private physician what hospital items (e.g., dental implants) and hospital services Mercy would likely provide to Hoover at his private physician's direction. In turn, Hoover could have asked Mercy how much its charges for those hospital items and services would be, and Mercy would have told him. Hoover made no such inquiry to Mercy and apparently made no such inquiry to his private physician.

When faced with this same issue, the vast majority of courts have held that contracts containing language similar to that in Hoover's contract: (a) create an express

obligation requiring the patient to pay the hospital's standard charges as found in its chargemaster; and (b) do not entitle the patient to pay some implied, unspecified "fair and reasonable" charge. *See DiCarlo*, 530 F.3d at 263-64; *Allen*, 2012 WL 6608042, **3-4; *Holland*, 791 N.W.2d at 728-30; *Nygaard*, 731 N.W.2d at 191-92; *Cox*, 631 S.E.2d at 796-97; *Shelton*, 633 S.E.2d at 116; *Harrison*, 430 F.Supp.2d at 595-96; *Elliott Hospital v. Boerner*, No. 04-C-739, slip op. at 11 (N.H. Sup. Ct. July 15, 2005) (Appendix 34-70).

DiCarlo is instructive. In that case, the plaintiff, an uninsured patient, signed a contract that provided: "I also guarantee payment of all charges and collection costs for services rendered." 530 F.3d at 259. The plaintiff argued that "the contract between himself and [the hospital] contained an open price term and that, therefore, the law implies an agreement to pay only a reasonable price." *Id.* at 263. The court rejected this argument, reasoning:

> [T]he price term was not in fact open, and … "all charges" unambiguously can only refer to St. Mary's uniform charges set forth in its Chargemaster.… The price term "all charges" is certainly less precise than [the] price term of the ordinary contract for goods or services in that it does not specify an exact amount to be paid. It is, however, the only practical way in which the obligations of the patient to pay can be set forth, given the fact that nobody yet knows just what condition the patient has, and what treatments will be necessary to remedy what ails him or her. Besides handing the patient an inches-high stack of papers detailing the hospital's charges for each and every conceivable service, which he or she could not

> possibly read and understand before agreeing to treatment, the form contract employed by St. Mary's is the only way to communicate to a patient the nature of his or her financial obligations to the hospital.

Id. at 263-64 (emphasis added).

In *Holland*, the court followed *DiCarlo* and held that under a contract requiring the patient to pay "for all services rendered to me at the Medical Center's usual and customary charges," the patient was obligated to pay the prices stated in the hospital's chargemaster because the chargemaster contained the hospital's uniform charge to all patients. 791 N.W.2d at 728-30. This was so even though the hospital accepted discounted payments from certain payers (such as Medicare and private insurers). *Id.*

Similarly, in *Shelton*, the patient's contract obligated the patient "to the payment of the Hospital account incurred by the patient in accordance with the regular rates and terms of the Hospital at the time of the patient's discharge." 633 S.E.2d at 115. The patient contended that the contract did not contain a definite price term and, thus, a "reasonable rate" was implied by law. The court rejected the patient's contention, holding that the price term of the contract was sufficiently definite because "the rates of services contained in the 'charge master' were necessarily implied in the contract signed by plaintiff." *Id.* at 116; *see also Harrison*, 430 F.Supp.2d at 595 ("The terms of the contract are clear and unambiguous. The term 'regular rates and terms of the hospital' does not create an open-ended contract. Thus, no analysis of whether the charges were 'fair and reasonable' is required.").

Additionally, in *Nygaard*, the patients agreed in their contracts with the hospitals to pay the hospital's unspecified, pre-set charges. 731 N.W.2d at 191. The patients contended that because no price terms were itemized in their contracts, imputed in their contracts was an obligation that the hospitals would charge the patients no more than the fair and reasonable charge for medical care. *Id.* The court held that the patients' theory "fail[ed] to state a claim because the price terms were controlled by language in the contracts." *Id.* Because the hospital had pre-set charges, "the price terms were fixed and determinable, and because the contracts spoke to the issue of price, the law does not permit imputation of different, implied price terms for what patients later claimed were the reasonable value of the services provided." *Id.* The court stressed the fact that "the contract prices were fixed at a given amount prior to the execution of the contracts." *Id.* Citing several cases from other jurisdictions, the court added: "As most courts have noted in similar hospital pricing litigation, if the charges are ascertainable through reference to outside sources, there is no need to judicially impute a fair and reasonable price term." *Id.* at 192.

Most recently, the Indiana Supreme Court held in *Allen* that when the patients signed hospital forms providing that each patient "guarantees payment of the account, and agrees to pay the same upon discharge if such account is not paid by a private or governmental insurance carrier," the patients were obligated to pay the hospital's standard charges as reflected in its chargemaster. *Allen*, 2012 WL 6608042, **3-4. The court rejected the patients' contention that their promise to pay "the account" for treatment was indefinite and could not constitute a price term for the hospital's services:

"Many courts have addressed contracts similar to those of Patients' and most have held that price terms in these contracts, while imprecise, are not sufficiently indefinite to justify imposition of a 'reasonable' price standard." *Id.* at *3 (citing *DiCarlo*, *Banner Health*, *Holland*, *Shelton*, and *Nygaard*). The court concluded that "Patients' agreement to pay 'the account' in the context of Clarian's contract to provide medical services is not indefinite and refers to Clarian's chargemaster." *Id.* at *4. In turn, the court held that "we cannot impute a 'reasonable' price term into this contract." *Id.*

Hoover acknowledges that before he signed his contract, Mercy had in place a chargemaster containing its standard, pre-set charges for medical goods and services. (LF 71-73, 75, 77, 85; Hoover's Br. 9-10). These standard, pre-set charges were incorporated into Hoover's contract. The reference in the contract to Mercy's "Facility charges" and "billed charges" can only refer to Mercy's uniform set of charges found in its chargemaster, which "applies to all patients, without regard to whether the patient is insured, uninsured, or a government program beneficiary," notwithstanding the fact that Mercy accepts a variety of discounted payments negotiated by private insurers or legislatively imposed by governmental programs. *DiCarlo*, 530 F.3d at 263. Because the price term of Hoover's contract with Mercy was fixed and determinable before Hoover received treatment, that price term governs and Hoover cannot rewrite his contract to imply a different price term obligating him to pay some unspecified "fair and reasonable" value of his treatment.

Under his contract with Mercy, Hoover is liable for Mercy's standard charges for medical care as established in its chargemaster. Hoover concedes in his amended petition

that Mercy's charges to him were the standard charges established in Mercy's chargemaster at the time of his treatment. Accordingly, Mercy did not overcharge him. The Court should affirm the trial court's dismissal of Hoover's MMPA claim.

c. The cases cited by Hoover are inapposite.

In response, Hoover relies heavily on the Indiana Court of Appeals' opinion in *Allen v. Clarian Health Partners, Inc.*, 955 N.E.2d 804 (Ind. Ct. App. 2011), *vacated*, 963 N.E.2d 804 (Ind. 2012). However, the Indiana Supreme Court granted transfer, vacated the Indiana Court of Appeals' opinion, and, as discussed above, ruled that the patients in that case were obligated to pay the hospital's standard charges as reflected in its chargemaster when the patients agreed in their contracts with the hospital to pay "the account." *Allen*, 2012 WL 6608042. Hoover's contractual agreement to pay Mercy's "Facility charges" and "billed charges" is more definite that the *Allen* patients' contractual agreement to pay "the account." Thus, *Allen* (as decided by the Indiana Supreme Court) supports Mercy's position that Hoover is obligated to pay Mercy's standard, chargemaster rates.

Hoover also relies on *Doe v. HCA Health Services of Tennessee, Inc.*, 46 S.W.3d 191 (Tenn. 2001). In *Doe*, the hospital's assignment of benefits form provided: "I understand I am financially responsible to the hospital for charges not covered by this authorization." *Id.* at 197. The court held that this language was not sufficiently definite to create an enforceable contract and require the patient to pay the hospital's standard charges as reflected in its chargemaster. *Id.* at 197.

Notably, the court in *Doe* clarified: "[T]he Court's holding in this case does not invalidate all contracts that do not state a specific price; to the contrary, our holding is based upon the particular facts of this case…. Had the agreement adequately defined 'charges,' the price term of the contract would not have been indefinite." *Id.* at 197. Applying this statement from *Doe*, the Tennessee Court of Appeals subsequently held in *Woodruff v. Fort Sanders Sevier Medical Center*, 2008 WL 148951 (Tenn. Ct. App. Jan. 16, 2008), that a hospital form that obligated the patient to pay "in accordance with the Facility's rates and terms" sufficiently defined a price term and obligated the patient to pay the hospital's established rates and terms in its chargemaster. The court reasoned: "The consent form informs the patient that the [hospital] has established rates and terms in its facility where the reasonableness of the charges could be determined. Accordingly, the pricing under this contract is not indefinite." *Id.* at *3.

Like the contract in *Woodruff*, Hoover's contract with Mercy obligates him to pay Mercy's "Facility charges" and "billed charges." The contract informed Hoover that Mercy had established rates that he would be expected to pay for his treatment. The contract is sufficiently definite. Hoover is required to pay Mercy's standard charges.

Next, Hoover relies heavily on *Quinn v. BJC Health System*, 2007 WL 7308622 (Mo. Cir., City of St. Louis, Mar. 2, 2007). In that case, the trial court (Judge David Mason) cited *Doe* for the proposition that "[w]hen an agreement that a hospital patient signs that obligates the patient to pay the hospital's 'charge' or 'regular charges' fails to fix a price, courts have stated that a 'reasonable price' would be implied." 2007 WL

7308622, *6. As discussed above, Hoover's contract does fix a price for his treatment—Mercy's standard charges established in its chargemaster.

Lastly, Hoover relies on *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alternatives, Inc.*, 832 A.2d 501 (Pa. Sup. Ct. 2003). In that case, the court observed that "there [was] no express contract between the parties" (a hospital and a managed care company) because the parties' prior contract had expired. 832 A.2d at 507. As a result, the hospital could only recover against the managed care company based on a quasi-contract implied by law, which entitled the hospital to recover a "reasonable fee" for its services. *Id.* at 508.

Temple Univ. is inapposite because Hoover has an *express* contract with Mercy. *See, e.g., Westerhold v. Mullenix Corp.*, 777 S.W.2d 257, 263 (Mo. App. E.D. 1989); *Roark Printing, Inc. v. Worm World, Inc.*, 974 S.W.2d 613, 617 (Mo. App. S.D. 1998). When, as here, an express contract exists, the rights and obligations of the parties with respect to payment are governed by the express contract, not by any promise implied by law to pay reasonable compensation, because "quantum meruit has no application when an express agreement governs the parties' rights and obligations." *Goldstein and Price, L.C. v. Tonkin & Mondl, L.C.*, 974 S.W.2d 543, 550 (Mo. App. E.D. 1998) (in awarding compensation, trial court erred by applying quantum meruit instead of parties' express agreement); *see also Krupnick & Associates, Inc. v. Hellmich*, 378 S.W.2d 562, 570 (Mo. 1964) ("This express agreement with regard to the source of plaintiff's compensation negatives the existence of any agreement implied either in fact or by law to compensate them on a different basis.").

d. Hoover's contract with Mercy is not a contract of adhesion that entitles him to pay an unspecified "reasonable" charge instead of Mercy's standard charges.

Hoover further argues that he is entitled to pay some unspecified "reasonable" charge instead of Mercy's standard charges because his contract with Mercy is allegedly a contract of adhesion. However, Hoover's contract is not a contract of adhesion because Hoover does not allege that he was required to obtain treatment from Mercy or that he could not have obtained the same treatment from any of the numerous other physicians, out-patient surgery centers, ambulatory care centers, or hospitals in the St. Louis area. *See, e.g., Grossman v. Thoroughbred Ford, Inc.*, 297 S.W.3d 918, 922 (Mo. App. W.D. 2009); *State ex rel. Vincent v. Schneider*, 194 S.W.3d 853, 857 (Mo. banc 2006); *Robin v. Blue Cross Hosp. Service, Inc.*, 637 S.W.2d 695, 697 (Mo. banc 1982). Moreover, the very case cited by Hoover—*Heartland Health Systems, Inc. v. Chamberlin*, 871 S.W.2d 8 (Mo. App. W.D. 1993)—rejects his argument.[8]

[8] Hoover's reliance on *Swain v. Auto Services, Inc.*, 128 S.W.3d 103 (Mo. App. E.D. 2003), is also misplaced. In *Swain*, the court held that an arbitration agreement in an automobile service plan was an adhesive contract, but upheld the arbitration agreement except for the selection of Arkansas as the venue for arbitration. The case has nothing to do with contractual pricing.

In *Heartland*, the court held that the mother was responsible for the hospital's standard billed charges for treating her son when she signed the hospital's form containing an express promise to pay the hospital's billed charges. The court held:

> *There is nothing in the adhesion contract rule that relieves [the mother] of the terms of the contract she signed*…. The hospital was within its rights to require some responsible person to sign an agreement to pay before it rendered its services. It could withhold its services unless and until [the mother] signed the agreement. It is useless to speculate whether it would have done so, just as it useless to speculate whether [the mother] would have signed the agreement, knowing she was obligating herself to pay the hospital bill, if the hospital had withheld its services to her son until she had so done. What can be said from the evidence is that *the contract terms which obligate [the mother] to pay the hospital bill are not contrary to the reasonable expectations of the parties to the contract.*

Id. at 11 (emphasis added).

Contrary to Hoover's bald assertion (Hoover's Br. 29), it is *not* "clear from the *Heartland* opinion that the price charged in a contract of adhesion must represent the reasonable value of the services rendered." The *Heartland* case does not contain any such holding or statement. Just the opposite, the court found the mother liable for the hospital's standard, undiscounted charges. *Heartland* establishes that when a person seeks treatment from a hospital (for himself or another) and signs a contract with the

hospital agreeing to pay the hospital's charges for the treatment, the objective reasonable expectation is that the person will pay the hospital's charges as he agreed to do.

2. Hoover fails to allege a legally-sufficient factual basis that Mercy charged him more than a "reasonable" charge in violation of the MMPA.

Assuming, *arguendo*, that Hoover is obligated to pay an unspecified "reasonable" charge instead of Mercy's standard charges, Hoover fails to allege a legally-sufficient factual basis for establishing that Mercy charged him more than a "reasonable" charge in violation of the MMPA. Hoover's claim is based solely on the legally-deficient premise that Mercy's standard charges were "set arbitrarily and capriciously," were "artificial and inflated," were "discriminatory and unfair," and were "predatory and constitute price gouging" merely because Hoover did not receive the same discounts from Mercy's standard charges that certain insured and Medicare patients are entitled to by virtue of contracts negotiated between their insurers and Mercy or by operation of the Medicare statutes.[9] Hoover chose not to buy insurance that would cover the care he received at

[9] Hoover further contends that Mercy charges uninsured patients its standard charges without discounts "to subsidize the cost of rendering the same goods and services to Medicare patients and/or patients with insurance coverage." (Hoover's Br. 15). Mercy's uninsured patients, however, only paid about 7 percent of billed charges in 2010-2011. Thus, contrary to Hoover's baseless allegation, Medicare and insured patients are subsidizing the cost of providing treatment to uninsured patients, not vice versa.

Mercy. Others who choose to pay for such coverage are entitled to the benefit of discounts negotiated by their health insurance company. Although Hoover concedes that he is not legally entitled to these discounts under any contract or statute, he nevertheless contends that the varying discounted payments that Mercy accepts from certain insurers and Medicare determine the reasonable value of the medical care that he received and, consequently, the amount that he is obligated to pay to Mercy. Courts in Missouri and throughout the country have rejected Hoover's theory. This Court should do so as well.

a. Hoover has no right, contractual or otherwise, to discounts afforded to insured or Medicare patients.

In *DiCarlo*, the court explained how hospitals typically bill for medical goods and services:

> [The hospital] has a uniform set of charges (casually known as the "Chargemaster") that it applies to all patients, without regard to whether the patient is insured, uninsured, or a government program beneficiary…. [The hospital] accepts a variety of discounted payments in different situations. It negotiates differing discounts with some managed care payors and insurance companies. It accepts discounted payments if the patient is covered by a government program that legislatively imposes discounts.

530 F.3d at 263.

The same is true with Mercy. Mercy has a uniform set of charges that it applies to all patients, whether insured or not, for the same medical goods and services. Mercy does accept a variety of discounted payments in different situations.

First, some (but not all) private insurers negotiate agreements with Mercy to accept discounted payments in satisfaction of Mercy's standard charges. Mercy does not have a single uniform discount for all insured patients; instead, Mercy, like all health care providers, has myriad discounts and payment arrangements that vary from insurer to insurer and from charged item to charged item based on negotiations between Mercy and the insurer. Mercy agrees to such discounts with insurers because insurers promptly pay Mercy for covered treatment and steer their insureds to Mercy by designating Mercy as a preferred provider for treatment. These discounts are purely a matter of the contracts between Mercy and the insurers and are part of the benefits that the insurers' members become entitled to as beneficiaries of these contracts when they (or their employers) purchased their insurance from these insurers.

Hoover is not a party to or beneficiary of any contracts between Mercy and private insurers, and, accordingly, he cannot avail himself of the benefits of these contracts. *See, e.g., Prickett v. Lucy Lee Hospital, Inc.*, 986 S.W.2d 947, 948 (Mo. App. S.D. 1999) ("Only the parties to a contract are bound by its terms. Conversely, one not a party to a contract cannot enforce the contractual terms upon one of the parties to the contract."). Indeed, it would be absurd for Hoover to be entitled to take advantage of these contracts and their discounts because he would wind up better off than the insurers and their members. He would receive the benefits of these contracts even though: (a) unlike the insurers' members, he did not pay any insurance premiums to the insurers; and (b) unlike the insurers, he did not promptly pay Mercy for his medical care or steer any patients to Mercy.

Second, like virtually all hospitals, Mercy treats patients covered by Medicare. As a condition of participating in the Medicare program and treating Medicare patients, Mercy must accept the discounted payment rates imposed by the federal government. *See* 42 U.S.C. § 1395cc. These discounted payments are not freely negotiated in the market place, but are unilaterally imposed by the federal government. "[T]he rates paid by Medicare and Medicaid are dictated by law and in no way reflect upon the cost or value of the services rendered to such patients." *Eufaula Hosp. Corp. v. Lawrence*, 32 So.3d 30, 46 (Ala. 2009) (quotation omitted).

Hoover is not similarly-situated to Medicare patients because he did not qualify for Medicare at the time of his medical care at Mercy. Hoover and all other non-Medicare patients (whether covered by private insurance or uninsured) have no right to the discounts provided to Medicare patients pursuant to federal law.

b. A "reasonable" charge for medical goods and services is not based on the discounted payments that Mercy accepts from certain insurers and Medicare.

Hoover contends that he "does not claim that he is entitled to contractual 'discounts.'" (Hoover's Br. 21). Nevertheless, he argues that that the "reasonable" charge for Mercy's goods and services is based on the discounted amounts that Mercy accepts as payment in full for goods and services provided to certain insured and Medicare patients. (*Id.*) This is just a backdoor attempt by Hoover to take advantage of discounts that he is not legally entitled to. As discussed below, these discounts are irrelevant to Hoover's payment obligations to Mercy. "[S]imply because medical bills are often discounted does

not mean that the plaintiff is not obligated to pay the billed amount." *Arthur v. Catour*, 803 N.E.2d 647, 649 (Ill. App. Ct. 2004), *aff'd* 833 N.E.2d 847 (Ill. 2005).

(1) Uninsured patients are not similarly-situated to insured or Medicare patients.

In *Galvan v. Northwestern Memorial Hosp.*, 888 N.E.2d 529 (Ill. App. Ct. 2008), the Illinois Appellate Court explained some of the compelling policy reasons why uninsured patients are not entitled to be charged based on the discounted rates paid by insurers. In that case, an uninsured patient sued a hospital under the Illinois Consumer Fraud and Deceptive Practices Act for alleged overcharging and asserted virtually the same allegations that Hoover makes here—that the hospital's charges to uninsured patients were "artificially inflated," "unfair," and "deceptive" because the hospital accepted discounted payments from insurers. The court rejected all of the patient's claims, reasoning:

> *Underlying the plaintiff's claim that charging uninsured patients a higher price amounts to oppressive pricing is a suggestion that the insured and uninsured patients are similarly situated. They are not.* The plaintiff ignores the obvious difference between an insured patient and an uninsured patient. An insured patient by definition has medical insurance either paid by him directly or by his employer as a benefit. In return for the insurance premiums his insurance company contracts with a hospital for medical services at a reduced rate. The contract benefits the hospital because payment is guaranteed. There is no such guarantee from uninsured patients.

> The reality is an insured patient comes into the hospital with expenses already incurred for medical coverage. That his insurance company has been able to negotiate a reduced rate for medical services from the hospital is simply a product of doing business.… That an uninsured patient is charged a higher rate for medical services is the flip side of the revenue-stream coin. Those that have incurred the expense of medical insurance guaranteeing payment to a medical services provider receive reduced billing rates; those that have incurred no expense to guarantee payment to a medical services provider must bear the full cost for those services. While the plaintiff contends the rate he was charged was "exorbitant" and unrelated to the actual costs of the providing the medical services received, as a court of law we find no basis to address such arguments for "unfairness" as it would require we examine the billing practices in their entirety for both insured and uninsured patients, for each is a part of the revenue stream; we cannot ignore one and examine only the other.

Id. at 538-39 (emphasis added); *see also Firelands Regional Med. Ctr. v. Jeavons*, 2008 WL 4408600 (Ohio Ct. App. Sept. 30, 2008) ("Appellant cannot show that an uninsured customer is like an insured customer"); *GEICO Indemnity Ins. Co. v. Kannaday*, Case No. 06-1067-JTM (D. Kan. Oct. 11, 2007) (Appendix 28-33) (court dismissed uninsured patient's cross-claim against hospital under Kansas Consumer Protection Act for alleged overcharging because uninsured patients are not similarly-situated to insured patients; "'[S]imilarity' … requires consideration not only of the consumer's specific medical

condition, but also their status as purchasers of insurance…. The term 'similar' here should and must take into account whether the consumer is a purchaser of insurance from an insurer who has contracted for volume discounts."). Missouri trial courts have followed the reasoning of *Galvan* and rejected Hoover's contention that an uninsured patient is entitled to pay based on the discounts afforded to insured patients (through their health insurers). *See Polsgrove v. St. John's Regional Health Center*, No. 31107CC2451, slip. op. at 4-5 (Mo. Cir., Greene County, Dec. 30, 2009) (Appendix 17-22).

(2) Mercy's volume pricing discounts for certain insured and Medicare patients are lawful and/or required by federal law.

In addition, Missouri law has long permitted sellers of goods or services to provide volume pricing discounts to some buyers and not others. *See, e.g., Foremost Dairies, Inc. Thomason*, 384 S.W.2d 651, 661 (Mo. 1964) ("[V]olume pricing or quantity discounts is a practice which has been widely used in this nation throughout the history of the economy. It is economically sound and is not considered an unfair competitive practice."). Courts have recognized that "[i]nsurance volume discount contracts are an integral part of medical practice, just as negotiated volume discounts are an accepted and common aspect of most businesses." *GEICO*, Case No. 06-1067-JTM (Appendix 28-33).

> Within the health insurance industry, it is common for insurers and medical providers to enter into agreements in which the provider agrees to accept as full payment an amount less than what is billed to the insured patient. In exchange for the provider's agreeing to offer its services at a

> discounted rate, the insurer agrees to create incentives for its insureds to use the provider, thus helping to ensure a higher volume of patients for the provider.

Midwest Neurosurgery, P.C. v. State Farm Ins. Cos., 686 N.W.2d 572, 576 (Neb. 2004); *see also Woman's Clinic, Inc. v. St. John's Health Sys., Inc.*, 252 F.Supp.2d 857, 863 (W.D. Mo. 2002) (when managed care companies provide financial incentives to their members to use in-network physicians, they can "obtain greater reductions in costs from providers and receive volume discounts").

The discounted payments that Mercy accepts from certain insurers and Medicare are, in essence, volume pricing discounts. Mercy must grant such discounts to the federal government in order to participate in the Medicare program and thereby have access to the thousands of individuals covered by Medicare. Mercy must also agree to such discounts with certain insurers to become a participating provider for those insurers and thereby obtain access to the thousands of individuals who have chosen to buy health insurance. *See, e.g.*, *Coventry Health Care of Kan. v. Via Christi Health Sys. Inc.*, 176 F.Supp.2d 1207, 1214, 1222 (D. Kan. 2001) ("Insurers who direct substantially more volume to providers can negotiate a volume discount from the providers."); *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 973 (N.D. Iowa 1995), *vacated on other grounds*, 107 F.3d 632 (8th Cir. 1997) (managed care companies "shop on the basis of price and are able to induce hospitals to discount stated charges in return for the managed care payer's promise to direct a larger volume of patients to the hospital"). Mercy agrees

to these discounts based on expectations that the third-party payers will provide increased patient volume or "steerage" to it.

Just as a company that buys 100 widgets from a seller will get a better price than a company that buys only one widget from that seller, a governmental or insurance payer that "buys" Mercy's services for hundreds of patients can legitimately expect to pay less for Mercy's services than patients (such as Hoover) who buy Mercy's services only for themselves.

(3) Courts in Missouri and throughout the country have rejected Hoover's theory.

Based on the above considerations, numerous courts throughout the country have rejected Hoover's theory and held that a hospital's acceptance of discounted payments from third-party payers such as private insurers and Medicare: (a) is irrelevant to determine the reasonable value of medical goods and services; and/or (b) does not entitle a patient to pay an amount lower than the hospital's standard, undiscounted charges. *See Holland v. Trinity Health Care Corp.*, 791 N.W.2d 724, 728-30 (Mich. Ct. App. 2010); *Polsgrove*, No. 31107CC2451 (Mo. Cir., Greene County, Dec. 30, 2009) (Appendix 17-22); *Galvan*, 888 N.E.2d 529; *Firelands Regional Med. Ctr.*, 2008 WL 4408600; *Kolari v. New York Presbyterian Hospital*, 382 F.Supp.2d 562, 576 (S.D.N.Y. Mar. 29, 2005), *vacated in part on other grounds*, 455 F.3d 118 (2d Cir. 2006); *Lindholm v. Hassen*, 369 F.Supp.2d 1104, 1111 (D.S.D. 2005) ("The reasonable value of medical services is not controlled by whether a portion or all of the medical bills was … written off pursuant to an insurance agreement or by operation of law."); *Huntington Hosp. v. Abrandt*, 779

N.Y.S.2d 891, 892 (N.Y. Sup. App. Term 2004) ("The fact that lesser amounts for the same services may be accepted from commercial insurers or government programs as payment in full does not indicate that the amounts charged to [an uninsured patient] were not reasonable."); *Elliott Hospital v. Boerner*, No. 04-C-739, slip op. at 12 (N.H. Superior Ct. July 15, 2005) (Appendix 34-70) ("Simply put, the court agrees with the [hospital's] contention that the discounted rates to which the [patient] is comparing his alleged unreasonable and inflated charges arise out of different circumstances, in the context of managed care and governmental programs, and do not purport to reflect the … hospital's 'usual and customary charges[.]'"); *Parnell v. Madonna Rehabilitation Hosp.*, 602 N.W.2d 461, 463 (Neb. 1999); *Bynum v. Magno*, 101 P.3d 1149, 1157-58 (Haw. 2004) ("Other jurisdictions have applied similar rationale in deciding that the reasonable value of medical services should be determined in light of the standard rates, rather than the amount paid [by] Medicare/Medicaid."); *Munson Medical Center v. Auto Club Ins. Ass'n*, 554 N.W.2d 49, 52-53 (Mich. App. 1996); *Hillsborough County Hosp. Auth. v. Fernandez*, 664 So.2d 1071, 1072 (Fla. Ct. App. 1995).

In *Howard v. Willis-Knighton Medical Center*, 924 So.2d 1245, 1263 (La. Ct. App. 2006), the Louisiana Court of Appeals held: "The fact that [the hospital] entered into agreements with health insurers that provide for discounted rates to insured patients does not prove that the hospital's chargemaster is unreasonable with respect to uninsured patients." In *Banner Health v. Medical Sav. Ins. Co.*, 163 P.3d 1096, 1102 (Ariz. Ct. App. 2007), the Arizona Court of Appeals ruled: "There is nothing illegal or unauthorized, however, about hospitals contracting with insurers and government entities to accept

reduced payments in satisfaction of their published rates, in return for an anticipated value of business and prompt payments. Nor does the fact that hospitals routinely accept reduced payments on behalf of many patients mean that the published and billed rates are unreasonable."

In *Eufaula Hosp. Corp. v. Lawrence*, 32 So.3d 30, 46 (Ala. 2009), the Alabama Supreme Court rejected the use of discounts afforded to Medicare, Medicaid, and private insurers as a basis for determining the reasonableness of a hospital's charges in a putative class action by uninsured patients against the hospital. In *Roberts v. University of Alabama Hosp.*, 27 So.3d 512, 517-18 (Ala. Ct. Civ. App. 2008), the Alabama Court of Civil Appeals held that Medicaid, Medicare, and Blue Cross payment rates were irrelevant in determining reasonable rates for medical services because "the hospital's acceptance of lower payments from Blue Cross and Blue Shield, Medicare, and Medicaid patients stemmed from legal and contractual requirements that applied solely to those classes of patients."

Most recently, the Illinois Appellate Court rejected the uninsured patient's attempt "to present evidence to the trial court to prove" that the medical provider "routinely accepted less than the entire billed amount to show the billed amount in this case did not reflect this provider's customary charges." *Collection Professionals, Inc. v. Schlosser*, 977 N.E.2d 315, 320-21 (Ill. App. Ct. 2012). The court held:

> [I]t is not relevant whether the collateral sources of *other* patients ultimately paid less than the initially billed amount based on a contractual agreement between the medical provider and the third party. Here, it is

> undisputed a third party or collateral source did not come forward to pay any portion of [the uninsured patient's] medical charges. In addition, [the uninsured patient] specifically agreed to pay for the medical sources before she received services from these medical providers. Finally, it is undisputed that all patients are billed the same amount for these services, which was comparable to the fees charged by other medical providers in the area for the same services. This evidence satisfied plaintiff's burden of proof to demonstrate the reasonableness of the charges reflected in plaintiff's initial bill.
>
> When determining whether the billed amount reflected only usual and customary charges in this case, it was not relevant whether the medical provider seeking full payment from *this* patient may have accepted discounted payments from a collateral source toward another patient's bill, based on a contract between that collateral source and the medical provider.

Id.

Missouri appellate courts have followed this view. In *Brown v. Van Noy*, 879 S.W.2d 667, 676 (Mo. App. W.D. 1994), the court allowed a personal injury plaintiff, who was covered by Medicare, to recover the full amount of his hospital bills even though the treating hospital accepted a lower amount as payment in full due to a discount allowed to the Medicare program. After observing that "[t]o recover damages for medical expenses, those expenses must be supported by substantial evidence that the charges were reasonable and the services rendered were necessary," the court rejected the defendant's

contention that the hospital's standard charges were not reasonable merely because the Medicare program required the hospital to write off a portion of the charges. *Id.* at 676.

Hoover attempts to distinguish *Brown*, on the basis that "the standard charges in *Brown* were accepted as reasonable because their reasonableness was not challenged, not because the standard charge was automatically deemed reasonable." (Hoover's Am. Reply Br. 13). Hoover is incorrect. The court's opinion states:

> Martin City Pub alleges, for its seventh point on appeal, that the trial court erred in overruling its motion for a new trial because Mr. Brown failed to submit sufficient and competent evidence of the portion of his damages sustained due to medical expenses. *The only hint of an objection at trial was to the reasonableness of the charges.* Out of the hearing of the jury, counsel for Martin City Pub stipulated that the charges were the ordinary charges for the services provided but wanted to "make crystal clear that I claim that ordinary charges for the services provided is not the legal equivalent of reasonable."

879 S.W.2d at 676 (emphasis added). The court rejected the defendant's argument that amounts written off by the hospital and physicians as part of the plaintiff's Medicare coverage were not part of the reasonable charges that the plaintiff could recover against the tortfeasors.

Hoover argues that the amounts paid to Mercy by insurers and Medicare payers for *other patients* are competent evidence of what *he* is required to pay to Mercy. However, as discussed above, the overwhelming authority rejects this position. The

contractual or statutory discounts that *other patients* receive because of their purchase of insurance coverage or their entitlement to Medicare coverage are irrelevant to determining the reasonable value of Hoover's medical care.

(4) Hoover's legal theory rests on the erroneous premise that all insurers and governmental payers pay the same amount for the same medical care.

Additionally, Hoover's legal theory is flawed because it rests on the premise that all insurers and governmental payers would have paid the same amount to Mercy for the same medical care that he received. In turn, Hoover reasons that this one uniform amount purportedly paid by all payers should define the reasonable value of his medical care.

Hoover's premise is erroneous. The amount paid to Mercy for any particular medical good or service typically varies widely from payer to payer. There is no "uniform" discount for insurers and governmental payers.

The varying amounts paid to Mercy by all of these payers cannot simply be averaged to arrive at a "reasonable value" because that would enable Hoover to fare better than many patients covered by private insurance or governmental payers even though Hoover did not purchase insurance and is not a beneficiary of any governmental medical program. For example, assume hypothetically that Mercy would have been paid $7,000 by Payer A, $10,000 by Payer B, $14,000 by Payer C, and $17,000 by Payer D for the same medical care that Hoover received and was billed $17,339. Mercy's average payment amount from the four payers would be $12,000. If Hoover were allowed to pay this average amount ($12,000), he would pay less than what Payer C and Payer D and

their members pay. This outcome is untenable and further illustrates why the reasonable value of Hoover's medical care cannot be based on the varying discounts afforded to insurers and governmental payers for other patients.

(5) In personal injury cases, the reasonable value of medical care can be the health care provider's full billed charges and is not based on the discounts afforded to insurers and governmental payers for other patients.

In his amended reply brief before the court of appeals, Hoover relied on Section 490.715.5, RSMo, and court decisions applying that statute to support his argument that the discounted amounts that a health care provider accepts as payment in full from insurers and governmental payers for *other patients* "can be considered the reasonable value of the services provided to [an uninsured] patient." (Hoover's Am. Reply Br. 12-15; *see also* Hoover's Br. 24). Section 490.715.5 is inapplicable because the statute only applies in personal injury cases and the present case is not a personal injury case. *See, e.g., Allen v. Clarian Health Partners, Inc.*, --- N.E.2d ---, 2012 WL 6608042, *4 (Ind. Dec. 19, 2012) (declining to extend to billing disputes between medical providers and patients the court's holding in a personal injury case allowing for the admission of evidence of the discounted amount that the personal injury plaintiff's health insurer paid to the personal injury plaintiff's medical provider).

Even so, Section 490.715.5 and court decisions applying the statute do not support Hoover's argument. Just the opposite, the statute and these court decisions demonstrate

that the reasonable value of medical care can be the health care provider's full billed charges and is not based on the discounts afforded to insurers and governmental payers for other patients.

Before the legislature enacted Section 490.715.5 in 2005, a personal injury defendant could not even offer evidence of the discounted amount that a health care provider accepted as payment in full from the insurer or governmental payer for the *personal injury plaintiff*, let alone offer evidence of the discounted amounts that the provider accepted as payment in full from insurers and governmental payers for *other patients* who received similar medical care. *See Lampe v. Taylor*, 338 S.W.3d 350, 360-61 (Mo. App. S.D. 2011); *Porter v. Toys 'R' Us-Delaware, Inc.*, 152 S.W.3d 310, 320 (Mo. App. W.D. 2004). This is the collateral source rule.

In 2005, the legislature amended the collateral source rule by enacting Section 490.715.5. That statute provides:

> (1) Parties may introduce evidence of the value of the medical treatment rendered to a party that was reasonable, necessary, and a proximate result of the negligence of any party.
>
> (2) In determining the value of the medical treatment rendered, there shall be a rebuttable presumption that the dollar amount necessary to satisfy the financial obligation to the health care provider represents the value of the medical treatment rendered. Upon motion of any party, the court may determine, outside the hearing of the jury, the

> value of the medical treatment rendered based upon additional evidence, including but not limited to:
>
> (a) The medical bills incurred by a party;
>
> (b) The amount actually paid for medical treatment rendered to a party;
>
> (c) The amount or estimate of the amount of medical bills not paid which such party is obligated to pay to any entity in the event of a recovery.

Section 490.715.5.

In providing that "[t]he medical bills incurred by a party" is competent evidence of "the value of the medical treatment rendered," the Missouri legislature recognized that health care providers' full billed charges can be the reasonable value of medical care. Similarly, in applying Section 490.715.5, this Court and all three districts of the Missouri Court of Appeals have held that health care providers' full billed charges can be the reasonable value of medical care that personal injury plaintiffs may recover against tortfeasors. *Deck v. Teasley*, 322 S.W.3d 536 (Mo. banc 2010); *Klotz v. St. Anthony's Medical Center*, 311 S.W.3d 752, 771 (Mo. banc 2010); *Montgomery v. Wilson*, 331 S.W.3d 332, 338-40 (Mo. App. W.D. 2011); *Wheeler ex rel. Wheeler v. Phenix* 335 S.W.3d 504, 516-18 (Mo. App. S.D. 2011); *Berra v. Danter*, 299 S.W.3d 690, 695-98 (Mo. App. E.D. 2009).

Section 490.715.5 and these court decisions reject Hoover's position in this case. Indeed, if this Court were to accept Hoover's position and hold that the reasonable value

of medical care is based on a medical provider's discounts with insurers or the Medicare program instead of the full billed charges, personal injury plaintiffs in Missouri would recover substantially less compensation for their injuries.

Neither Section 490.715.5 nor any Missouri appellate court decision permits the plaintiff or the defendant to present evidence of the discounted amounts that a health care provider accepts as payment in full from insurers and governmental payers for other patients who are not parties to the case. Section 490.715.5(2) provides that the "rebuttable presumption that the dollar amount necessary to satisfy the *financial obligation* to the health care provider represents the value of the medical treatment rendered." (emphasis added). This "financial obligation" is the financial obligation of the *personal injury plaintiff*, not the financial obligations of other patients who receive similar medical treatment from the health care provider.

Once the presumption in Section 490.715.5(2) is rebutted, the statute permits the defendant to present evidence of "[t]he amount actually paid for medical treatment rendered to a *party*." This is the amount actually paid for the medical treatment rendered to *the personal injury plaintiff* (the "party"), not the amounts actually paid for similar medical treatment rendered by the health care provider to other patients.

In sum, parties in a personal injury case cannot base the value of the medical care rendered to the plaintiff on the discounted amounts paid for similar medical care rendered to other patients. Logic dictates that the same outcome must apply in billing and payment disputes between a health care provider and the patient. Hoover cannot base the value of his medical care on the discounted amounts that insurers or governmental payers for

other patients would have paid to Mercy for similar medical care. As a result, he fails to plead a legally-sufficient basis for establishing that Mercy overcharged him, and the trial court correctly dismissed his MMPA claim.[10]

[10] In his amended reply brief in the court of appeals (Hoover's Am. Reply Br. 14-15), Hoover asserted that Paul Venker, an attorney who allegedly represents Mercy in medical malpractices cases, authored an article in *Journal of the Missouri Bar* in which Mr. Venker discussed Section 490.715.5 and argued that "the amount paid is the best evidence of the value of medical services" and "will prevail over an amount which was said to be charged." (This article is not part of the record on appeal.) Mr. Venker did not address the value of medical treatment in disputes between patients and health care providers, and his statement about the amount paid as the best evidence of the value of medical services referred to the amount actually paid for the medical treatment provided to the *personal injury plaintiff*, not the amounts paid by other patients and their insurers for similar treatment. Regardless, in *Deck*, this Court rejected Mr. Venker's position. To the extent that Mr. Venker's bar journal article has any relevance, it should likewise be noted that Hoover's counsel, Mr. Passanante, frequently represents personal injury plaintiffs. Mr. Passanante assuredly advocates in personal injury cases that the value of his clients' medical care is the full billed charges, not the discounted amounts paid by his clients' insurers, let alone the discounted amounts paid by other patients' insurers.

c. Mercy did not violate the MMPA by charging Hoover its standard, chargemaster rate.

Assuming, *arguendo*, that Hoover is correct that he is entitled to *pay* Mercy based on the discounted amounts that Mercy would have received from insurers and Medicare, the fact that Mercy *charged* him its standard, chargemaster rate did not violate the MMPA. The MMPA provides: "The act, use or employment by any person of any deception, fraud, false pretense, false promise, misrepresentation, unfair practice or the concealment, suppression, or omission of any material fact in connection with the sale or advertisement of any merchandise in trade or commerce … is declared to be an unlawful practice." Section 407.020.1. Courts in Missouri (and throughout the country) have long allowed medical providers to charge and collect for medical care based on their standard chargemaster rates. *See, e.g.*, *Lester E. Cox Medical Centers v. Richard*, 252 S.W.3d 236 (Mo. App. S.D. 2008); *St. Luke's Episcopal-Presbyterian Hosp. v. Underwood*, 957 S.W.2d 496 (Mo. App. E.D. 1997); *Heartland Health Systems, Inc. v. Chamberlin*, 871 S.W.2d 8, 11 (Mo. App. W.D. 1993); *Cardinal Glennon Children's Hosp. v. Clardy*, 833 S.W.2d 44 (Mo. App. E.D. 1992). Similarly, as discussed above, Missouri courts have long permitted personal injury plaintiffs to recover their health care provider's full billed charges from tortfeasors. Moreover, Missouri appellate courts have never held that medical providers must grant one patient the same discounts that it affords to insurers and governmental payers for other patients. Accordingly, as a matter of law, it cannot be an "unfair practice," any form of fraud or deception, or any other violation of the MMPA (or any other law) for health care providers such as Mercy to charge their standard,

chargemaster rates. The trial court, therefore, correctly dismissed Hoover's MMPA claim.

* * *

In sum, Hoover's basis for complaining that Mercy overcharged him is that insured and Medicare patients would supposedly have paid less for the same medical goods and services that Hoover received because of the discounts these third parties receive from Mercy. This alleged fact is irrelevant and legally insufficient to establish that Mercy overcharged Hoover in violation of the MMPA. Thus, Hoover's amended petition fails to state a cognizable MMPA claim. This Court should affirm the trial court's judgment of dismissal.

C. Hoover has no ascertainable loss of money or property as a result of Defendants' alleged violation of the MMPA.

The trial court also correctly dismissed Hoover's amended petition because Hoover has not incurred any ascertainable loss of money or property as a result of Defendants' alleged violation of the MMPA. Hoover has only paid Mercy what he considers to be the reasonable value of his medical care after consulting with his attorney. (Appendix 2-3, 10-11; LF 124-25, 132-33). He has not alleged—and in light of his admissions, cannot allege—any facts demonstrating how or why the amount that he paid, $5,300, was more than the reasonable value of his medical care. As a result, Hoover fails to satisfy the damages and causation elements of an MMPA claim, and the trial court correctly dismissed his amended petition.

An ascertainable loss (damages) as a result of a violation of the MMPA (causation) is an essential element of Hoover's claim under the MMPA. *Freeman v. Health System v. Wass*, 124 S.W.3d 504, 508 (Mo. App. S.D. 2004). Section 407.025.1, RSMo, of the MMPA states in pertinent part: "Any person who purchases or leases merchandise primarily for personal, family or household purposes and thereby *suffers an ascertainable loss of money or property*, real or personal, *as a result of the use or employment by another person of a method, act or practice declared unlawful by section 407.020*, may bring a private civil action ... to recover actual damages." (emphasis added). Under Section 407.025.1, a plaintiff "must prove that he has: (1) purchased [merchandise (including medical goods and services)]; (2) for personal, family, or household purposes; and (3) suffered an ascertainable loss of money or property; (4) as a result of an act declared unlawful by section 407.020." *Hess v. Chase Manhattan Bank, USA, N.A.*, 220 S.W.3d 758, 773 (Mo. banc 2007).

1. Hoover has no ascertainable loss (damages).

Under *Freeman*, an uninsured patient fails to sufficiently plead any "ascertainable loss" and has no MMPA claim if he has not paid the hospital more than what he contends is due to the hospital. In *Freeman*, an uninsured patient was sued by a medical facility for an unpaid bill. The uninsured patient asserted a counterclaim asserting that the medical facility "charged him a higher amount than the usual and customary charges for such goods and services in the locale, after falsely representing that the stated prices were the usual and customary values for such goods and services." 124 S.W.3d at 506. He contended that the medical facility's "act of charging him, and its corresponding attempt

to collect on those charges, had caused him to suffer an ascertainable loss of money and property, and put him in jeopardy of having a judgment entered against him with its concomitant risk of adversely affecting his 'credit record.'" *Id.*

Notwithstanding these allegations, the court held that the uninsured patient failed to state *any* recognized cause of action under any legal theory—whether under the MMPA or otherwise. The court also rejected the uninsured patient's claim that he suffered an "ascertainable loss" based on the medical facility sending him a bill for its standard charges and attempting to collect the unpaid bill: "Appellant fails to cite any case that provides that the *possibility* of a judgment being entered against a party is the equivalent of suffering an ascertainable loss under the Act." *Id.* (emphasis in original).[11]

While the uninsured patient's counterclaim was framed under the MMPA, the court in *Freeman* specifically held that the patient could not state a claim under Missouri law under *any* legal theory:

> As mandated by our supreme court, we have reviewed [the uninsured patient's] counterclaim and associated pleadings to determine if the facts alleged meet the elements of a recognized cause of action, or of a cause that *might* be adopted in the case. *We find none.*

[11] Under Missouri law, nonprofit hospitals, like other creditors, are entitled to attempt to collect payment for their services. *Callaway Community Hosp. Assoc. v. Craighead*, 759 S.W.2d 253, 256 (Mo. App. W.D. 1988) (efforts of nonprofit hospital in trying to collect payment for its services did not disqualify it from tax exemption).

Id. at 508 (emphasis added) (quotations omitted).

Based on *Freeman* or its reasoning, Missouri trial courts in St. Louis County, Greene County and Missouri federal courts have repeatedly dismissed claims, identical to Hoover's claim here, in which uninsured patients alleged that hospitals overcharged them because the patients had not paid more than what they contended was due to the hospitals. *See Richardson v. SSM Health Care Corp.*, No. 07SL-CC0574 (Mo. Cir., St. Louis County, Dec. 20, 2007) (Appendix 27); *Jarvis v. SSM Health Care Corp.*, No. 05CC-5726 (Mo. Cir., St. Louis County, Sept. 11, 2006) (Appendix 26); *Stinson v. St. Anthony's Med. Ctr.*, No. 06CC-581 (Mo. Cir., St. Louis County, Sept. 5, 2006) (Appendix 25); *Meierer v. St. John's Reg. Health Ctr.*, No. 104CC4384, slip. op. at 1-2 (Mo. Cir., Greene County, Jul. 11, 2006) (Appendix 23-24); *Lester E. Cox Med. Centers v. Huntsman*, 2003 WL 22004998, 9 (W.D. Mo. Aug. 5, 2003) (summary judgment granted because patients "owe[d] the hospital more than they claim to have been overcharged, and were therefore still ahead"). As the trial court in *Meierer* observed:

> Plaintiff in this case, having satisfied $100 of a $108,000.00 invoice is "still ahead for the medical goods and services he received." This Court is compelled to follow the reasoning in *Freeman* and therefore finds the necessary element of damages missing from all counts of Plaintiff's petition.

Meierer, No. 104CC4384, slip. op. at 2 (Appendix 23-24).

Hoover concedes that "[i]n his petition, plaintiff alleges that defendant is entitled to receive a fair and reasonable amount for the medical goods and services that it

provides." (LF 85). Is it undisputed that after consulting with his current attorney, Hoover paid $5,300 to Mercy because he considered this amount to be the reasonable value of his medical care. (Appendix 2-3; LF 124-125). Thus, Hoover has no ascertainable loss because he has paid Mercy exactly what he contends it is entitled to.

In any event, Hoover, by his own admissions, concedes that the reasonable value of his health care is more than the 30.5 percent of Mercy's billed charges that he has paid. In his amended petition, Hoover alleges that the amounts paid by insurance companies are "the best evidence of the reasonable value of the goods and services." (LF 72). In his brief, Hoover relies on and cites a so-called "authority" (a law review article) that "reports that insurance companies pay about forty cents on the dollar of the chargemaster rates." (Hoover's Br. 10). Hoover has paid well less than 40 percent of Mercy's billed charges, which, according to Hoover, is the rate that insurance companies supposedly pay and "is the best evidence of the reasonable value" of medical goods and services.[12] Based on his own admissions, Hoover is "still ahead for the medical goods and services he received" and, thus, he has no ascertainable loss and no viable MMPA claim. *Freeman*, 124 S.W.3d at 508.

[12] Mercy does not agree with Hoover's contentions. Indeed, pursuant to its provider agreement with Coventry Health, Mercy would have received $12,136.10, or 70 percent of its billed charges, if Coventry Health had covered Hoover's surgery.

2. Hoover has no ascertainable loss "as a result of" Defendants' alleged violations of the MMPA (causation).

Moreover, Hoover has not sustained any ascertainable loss "as a result of" Defendants' alleged violations of the MMPA as required under Section 407.025.1 to state an MMPA claim. When Hoover finally made payments to Mercy, he had already hired an attorney and was threatening to file against Mercy the very class action lawsuit that he ultimately filed. (Appendix 10-11; LF 132-33). Indeed, on the same day (June 27, 2011) that he made the bulk ($4,300) of his payments to Mercy, he filed this lawsuit alleging that Mercy had violated the MMPA by overcharging him and misrepresenting that its billed charges were fair and reasonable. According to Hoover, he knew that Mercy had allegedly overcharged him and misrepresented that its billed charges were fair and reasonable before he made any payments to Mercy. Hoover chose to pay Mercy $5,300 because he believed it is legally entitled to that amount, not because of anything that Mercy allegedly did in violation of the MMPA. As a result, Hoover cannot establish causation and his MMPA claim fails as a matter of law. The trial court correctly dismissed Count I of Hoover's amended petition.

3. Hoover failed to plead any ascertainable loss.

Even putting aside Hoover's admissions, he still failed to state a claim upon which relief can be granted because he did not plead sufficient facts to establish that he incurred any ascertainable loss. Missouri is a "fact pleading" state, and a plaintiff is required to plead "ultimate facts" as opposed to factual or legal conclusions. *ITT Commercial Finance v. Mid-America Marine*, 854 S.W.2d 371, 379 (Mo. banc 1993). A conclusion

must be supported by factual allegations that provide the basis for that conclusion by demonstrating how or why that conclusion is reached. *Westphal v. Lake Lotowana Ass'n, Inc.*, 95 S.W.3d 144, 152 (Mo. App. W.D. 2003).

While Hoover's amended petition asserts that he "paid more for the goods sold and the services rendered than the reasonable value of the goods and services," (LF 75), this is a mere conclusion that is unsupported by any factual allegations demonstrating how or why the amount he paid was more than the reasonable value of his medical care. Indeed, Hoover's amended petition does not even allege what Mercy's charges were, what he paid to Mercy, or what, according to him, the reasonable value of his medical care was. Consequently, as the court of appeals concluded:

> The amended petition does not contain any allegations demonstrating how or why the amount that he paid, $5,300.00, was more than the reasonable value of the goods and services that he received. Plaintiff has not alleged any facts that would support a conclusion that his payment of $5,300.00 was more than the reasonable value of the goods and services that he received. As a result, he did not plead facts showing that he had suffered an "ascertainable loss."

2012 WL 2549485, *6. Hoover, therefore, failed to state a viable MMPA claim and the trial court properly dismissed his amended petition.

4. Hoover's alleged damage to his reputation and credit is not sufficiently pleaded and is not recoverable under the MMPA.

Without citation to any authority, Hoover argues that "damage to his reputation and to his credit are [sic] also ascertainable losses." (Hoover's Br. 14). Hoover's amended petition does not allege any injury to his "credit" and contains no allegations explaining how Defendants supposedly damaged his "reputation." But more fundamentally, any alleged damage to Hoover's reputation or credit is not an "ascertainable loss *of money or property*" as required under Section 407.025.1 to support an MMPA claim.

The MMPA only allows for the recovery of economic injuries. *State ex rel. Coca-Cola Co. v. Nixon*, 249 S.W.3d 855 (Mo. banc 2008) (no "ascertainable loss" existed where alleged injury was based on consumers' subjective preference against saccharin and plaintiff could not quantify any difference in the economic value between saccharin and non-saccharin Diet Coke). In *State ex rel. BP Products North America, Inc. v. Ross*, 163 S.W.3d 922, 929 (Mo. banc 2005), this Court held that injury to reputation does not involve a loss of money or property and, thus, is not a pecuniary or economic injury that can be recovered in an injurious falsehood claim. Similarly, the alleged damage to Hoover's reputation or credit[13] is not a pecuniary or economic injury and, consequently,

[13] Hoover contends that "damage to credit is a type of damage to reputation." (Hoover's Am. Reply Br. 6).

does not involve an "ascertainable loss of money or property" that can be recovered under the MMPA.

In his amended reply brief before the court of appeals, Hoover argued that damage to reputation should qualify as an "ascertainable loss of money or property" under the MMPA because, Hoover maintains, damage to reputation is recoverable in a common law fraud claim and the MMPA was intended to supplement a common law fraud claim. (Hoover's Am. Reply Br. 6). However, an MMPA claim is not coextensive with a common law fraud claim. The legislature has expressly limited standing to bring an MMPA claim to a person who "suffers an ascertainable loss of money or property." Section 407.025.1. It is axiomatic that "[t]he legislature has the power to define the remedy available if it creates the cause of action." *Sanders v. Ahmed*, 364 S.W.3d 195, 203 (Mo. banc 2012). The Court cannot rewrite the MMPA to expand its scope. *See*, *e.g.*, *Insurance Co. of State of Pa. v. Director of Revenue and Director of Ins.*, 269 S.W.3d 32, 37 (Mo. banc 2008) ("This Court cannot rewrite the statutes to extend the applicable statute of limitations or to permit extended time for filing refund requests when the statutory deadline falls on a Saturday."). Because damage to reputation or credit is not "an ascertainable loss of money or property" under the MMPA, Hoover cannot base an MMPA claim on the alleged injury to his reputation or credit, regardless of whether damage to reputation generally might be recoverable under a common law fraud claim (a claim that Hoover did not, and could not, plead).

In *Freeman*, the court held that similar types of damages allegedly resulting from the hospital's acts in sending the patient a bill for its standard charges and attempting to

collect the unpaid bill did not constitute an "ascertainable loss" under the MMPA. 124 S.W.3d at 508. The court observed: "In any event, we see no cognizable set of circumstances in this situation under which [the patient] could suffer an ascertainable loss." *Id.* Similarly, in the present case, Hoover has suffered no ascertainable loss of money or property resulting from Mercy's acts in billing him based on its standard charges and attempting to collect from him.

* * *

In sum, Hoover did not adequately plead any ascertainable loss of money or property and, in fact, he has no ascertainable loss of money or property. As a result, his MMPA claim is legally deficient. The Court should affirm the trial court's judgment of dismissal.

D. Hoover does not state a cognizable MMPA claim based on his "double-billing" and "incorrect billing" allegations.

Hoover contends that even if he has no cognizable MMPA claim based on Mercy's billing him using its chargemaster rates, he still states a cognizable MMPA claim based on: (a) Mercy's alleged billing him for good and services that Hoover allegedly paid his surgeon for ("double-billing"); and (b) Mercy's alleged charging him for different goods and services than Mercy provided to him ("incorrect billing").[14] Hoover, however, has not stated a valid MMPA claim based on these other allegations.

[14] Notably, Hoover did not even mention these purported bases for his MMPA claim in his memorandum in opposition to Defendants' motion to dismiss. (*See* LF 81-102).

The sole allegation in support of Hoover's "double-billing" theory is found in paragraph 44 of his amended petition: "The bill for the medical goods and services rendered to plaintiff Richard Hoover, M.D. included charges for goods and services for which had already been paid to the surgeon." (LF 74).[15] This bare allegation does not suffice to state an MMPA claim.

First, Hoover does not identify any of the specific medical goods and services that he was allegedly double-billed for by his surgeon and Mercy. Second, he does not allege that he has paid for any such medical goods and services more than once. Absent such an allegation, he has not sufficiently alleged that he incurred any "ascertainable loss" as required to establish an MMPA claim. Section 407.025.1; *Freeman v. Health System v. Wass*, 124 S.W.3d 504 (Mo. App. S.D. 2004).

Third, Hoover does not allege that his surgeon properly billed him for the medical goods and services that Mercy allegedly also billed him for. Absent such an allegation, Hoover's double-billing allegation is consistent with the conclusion that Mercy properly

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Instead, he asserted that the "central issue" is whether Mercy Hospitals "charge uninsured patients more than the fair and reasonable value of the medical goods sold and services rendered." (LF 84).

[15] Mercy denies this allegation. It appears that Hoover has mistakenly confused Mercy's charges for the dental implant products with his surgeon's separate charges for his surgical services in installing the dental implant products.

billed him for the goods and services at issue whereas his surgeon did not properly bill him for them, in which case Mercy has not violated the MMPA.

Hoover's "incorrect billing" theory fares no better. In paragraph 45 of his amended petition, Hoover alleges: "The bill for the medical goods and services rendered to plaintiff Richard Hoover, M.D. included charges which had been 'upcoded' to reflect the 'standard charge' for goods and services which were more expensive than the goods and services actually sold to plaintiff Richard Hoover, M.D." (LF 74). (Mercy denies this.) Hoover does not identify any of the specific goods and services that Mercy allegedly billed incorrectly as different goods and services. Moreover, he does not allege that he paid Mercy for any such goods or services that Mercy allegedly billed incorrectly. Absent such an allegation, he has not sufficiently alleged that he incurred any "ascertainable loss" as required to establish an MMPA claim. Section 407.025.1; *Freeman*, 124 S.W.3d 504.

* * *

In sum, the Court should affirm the trial court's dismissal of Hoover's MMPA claim in its entirety.

III. The trial court correctly dismissed Count II of Hoover's amended petition for punitive damages because Hoover's punitive damages claim (Count II) is not a separate cause of action and fails because Hoover's MMPA claim (Count I) fails. (Responds to Hoover's Point Two).

In addition to an MMPA claim (Count I), Hoover's amended petition contains a purported claim for punitive damages (Count II). However, "[a] punitive damage claim is not a separate cause of action, it must be brought in conjunction with a claim for actual damages." *Misischia v. St. John's Mercy Medical Center*, 30 S.W.3d 848, 866 (Mo. App. E.D. 2000). A claim for punitive damages fails if the underlying cause of action that could support a punitive damages award fails. *Kelly v. State Farm Mut. Auto. Ins. Co.*, 218 S.W.3d 517, 526 (Mo. App. W.D. 2007). Hoover's MMPA claim (Count I) fails for the reasons discussed above and, accordingly, Hoover's punitive damages claim (Count II) likewise fails. This Court, therefore, should affirm the trial court's dismissal of Count II of Hoover's amended petition.

IV. The trial court correctly dismissed Hoover's amended petition as against Mercy Health because Mercy Health is not a proper defendant in that Hoover received treatment from Mercy, not Mercy Health, and Hoover has failed to allege sufficient facts to hold Mercy Health liable for Mercy's alleged acts. (Responds to Hoover's Point Three).

Hoover received medical goods and services from, and was billed by, Mercy, not Mercy Health. Mercy Health is the indirect parent of Mercy, but Mercy is a separate company from Mercy Health. A parent company of a hospital is not liable for the hospital's actions because "[g]enerally, two separate corporations act as distinct legal entities, even if one partly or wholly owns stock in the other" and "[i]n a parent-subsidiary relationship, the parent corporation is ordinarily not liable for tortious acts of the subsidiary corporation." *Ritter v. BJC Barnes Jewish Christian Health Systems*, 987 S.W.2d 377, 384 (Mo. App. E.D. 1999) (holding that parent corporation was not liable for hospital's allegedly negligent medical care).

Hoover has alleged no facts sufficient to hold Mercy Health liable for the acts of Mercy under any legal theory. Hoover simply alleges that "each of the defendants acted as the agent, servant and employee of the other defendants, and each of them, within the scope and course of that agency and employment." (LF 66). Hoover's conclusory allegation is insufficient to hold Mercy Health vicariously liable for Mercy's alleged actions under an agency theory. *Summer Chase Second Addition Subdivision Homeowners Ass'n v. Taylor-Morley, Inc.*, 146 S.W.3d 411, 418 (Mo. App. E.D. 2004) ("Alleging that Perotti Brothers acted 'on behalf of' Taylor-Morley is merely a

conclusory statement; it does not allege facts that, if true, establish agency or respondeat superior.").

Hoover cites *Ritter* for the proposition that a parent corporation "can be liable" for the acts of its subsidiary "where it controls or influences the practice or business policy at issue to perpetuate a fraud." (Hoover's Br. 35). Hoover omits that this proposition described in *Ritter* is but one of two factors that must be proved to hold a parent liable for its subsidiary's acts under a corporate veil-piercing theory. 987 S.W.2d at 384. The other factor that must be proven is that "the corporate cloak was used as a subterfuge to defeat public convenience, to justify a wrong, or to perpetuate a fraud." *Id.* (citation omitted).

Here, Hoover has alleged no facts sufficient to pierce the corporate veil and disregard the corporate form of Mercy and thereby hold Mercy Health liable for Mercy's acts. Indeed, Hoover does not even mention that he seeks to pierce the corporate veil of Mercy.

Hoover asserts that he has stated a viable claim against Mercy Health because he alleges that Mercy Health owns and operates the hospital where he received treatment. However, he also alleges that Mercy owns and operates that same hospital. Both allegations cannot be true and, in fact, are not true. Only one of those corporate entities can own and operate the hospital. That corporate entity is Mercy, not Mercy Health. Thus, this Court should affirm the dismissal of Hoover's amended petition as against Mercy Health.

CONCLUSION

For these reasons, the Court should affirm the trial court's judgment of dismissal.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on December 28, 2012, I electronically filed the foregoing Respondents' Substitute Brief with the Clerk of the Court using the Missouri eFiling System, which sent notification of such filing to: Paul J. Passanante, Paul J. Passanante, PC & Associates, 1010 Market Street, Suite 1650, St. Louis, Missouri 63101.

/s/ Allen D. Allred

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with Rules 55.03 and 84.06, is proportionately spaced, using Times New Roman, 13 point type, and contains 20,261 words, excluding the cover, the certificate of service, the certificate of compliance required by Rule 84.06(c), and the signature block.

/s/ Allen D. Allred