THE STATE OF SOUTH CAROLINA
In the Supreme Court

QUESTIONS OF LAW CERTIFIED FROM
DISTRICT OF SOUTH CAROLINA

By Order of The Honorable Margaret B. Seymour,
District Court Judge for the District of South Carolina

Appellate Case No: 2013-000273

Diane Kirven, on behalf of herself and all others similarly situated, ... Plaintiff,

v.

Central States Health & Life Company of Omaha and Philadelphia
American Life Insurance Company ..... Defendants.

FINAL BRIEF OF DEFENDANTS

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I. Can the definition of "actual charges" contained within S.C. Code Ann. § 38-71-242 be applied to insurance contracts executed prior to the statute's effective date?

II. Can the South Carolina Department of Insurance mandate the application of the "actual charges" definition in S.C. Code Ann. § 38-71-242 to policies already in existence on the statute's effective date by prohibiting an insurance company from paying claims absent the application of that definition?

INTRODUCTION

The two questions of law certified by this Court center on the proper application of S.C. Code § 38-71-242 (the "Statute"), which supplies a definition of "actual charges" for "any . . . specified disease insurance policy issued to any resident of this State" that relies on that term without express definition thereof. Plaintiff Diane Kirven's ("Kirven") "Cancer and Specified Disease" policy (the "Policy"), which was purchased from Defendant Central States Health & Life Company of Omaha ("CSO") and later assumed by Defendant Philadelphia American Life Insurance Company ("Philadelphia American"), falls squarely within the Statute's purview.

Kirven's Policy, which renewed monthly, relied on the term "actual charges" without express definition and conformed to state law upon renewal. The benefit claims at issue in this case were submitted by Kirven under her Policy after the effective date of the Statute (the "Effective Date") and after the South Carolina Department of Insurance ("SCDOI") mandated that Defendants "may not pay any claim or benefit" to Kirven "in excess of the amount specified in [the Statute]."

True retroactive application of the Statute is not at issue in this case: Kirven's Complaint was filed after the Effective Date; the Policy explicitly conformed to South Carolina law when Kirven renewed it after the Effective Date; and the only benefit claims at issue are those submitted after the Effective Date.[1] The salient question is whether

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[1] For these reasons, the posture of this case is distinctly different from that of the *Ward v. Dixie National Life Insurance Co.* litigation to which Kirven repeatedly refers in her brief. (*See e.g.*, Kirven Brief, pp. 3-7, 13-14). In 2003, the *Ward* litigation was initiated seeking judicial interpretation of the term "actual charges," and in 2007, the Fourth Circuit found the term to be ambiguous. *Ward v. Dixie National Life Ins. Co*, 257 F. Appx. 620, 627 (4th Cir. 2007) ("*Ward I*"). In 2008, as a response to the *Ward I* opinion, the South Carolina Legislature enacted the Statute to provide an "actual charges"

application of the Statute's definition to an existing policy that conformed to State law upon monthly renewal constitutes a retrospective application that violates the state and federal constitutions.

Inherent to Kirven's postulate is the implication that her Policy was static, *i.e.* incapable of ever being amended, such that the Statute could never dictate payment of benefits under her Policy. Not only does this argument contravene the Statute's express

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definition for those policies that included no express definition thereof. At that time, the *Ward* litigation was still pending.

In 2010, the Fourth Circuit considered the propriety of retroactive application of the Statute to the *Ward* litigants, and it concluded that the Statute could not apply to either the *Ward* litigants (in particular) or any benefit claims submitted for payment *before* the Statute's Effective Date (in general). *Ward v. Dixie National Life Ins. Co.*, 595 F.3d 164, 174-76 (4th Cir. 2010)("*Ward II*")(declining to "overturn the adjudication of *Ward I*" because the Statute's application to "any claim or benefits" did not indicate legislative intent to reach the *Ward* litigants whose benefit claims were submitted for payment pre-Statute and resolved judicially pre-Statute). *Ward II* considered true retroactive application of the Statute to claims made years before the Statute was enacted:

> If applied to this case, the South Carolina statute would operate retroactively. It took effect on June 4, 2008—at least six years after defendants' underpayment of "actual charges" to the policyholders gave rise to the suit, about five years after the commencement of the suit, and almost one year after this court resolved the meaning of "actual charges" in *Ward I*. Applying the statute here would reach back to alter the legal consequences of those events taking place before the statute went into effect. Significantly, application of the statute here would disrupt the rights and duties of the parties as adjudicated in *Ward I*.

Ward II, 595 F.3d at 173-74.

In this case, however, application of the Statute would not attach new legal consequences to claims that arose before the June 4, 2008 Effective Date. Kirven's claims and those of all the class members she purports to represent undisputedly were submitted for payment *after* the Effective Date. Kirven's proposed class definition only includes "persons insured at any time from August 21, 2008 to the present." (Appx. Ex. 1, Complaint, p. 2). Because the filing of Kirven's Complaint and submission of all claims at issue in this case occurred *after the Effective Date of the Statute*, the issue is not retroactivity and *Ward II* is inapposite. Kirven appears to acknowledge, at least in part, that her theory of retroactivity differs from the *Ward* litigation. (Kirven Brief, p. 14 n.3).

application to "any . . . specified disease insurance policy issued" *regardless of inception date*, it ignores the express provisions of her Policy in particular. Notably, Kirven's Brief addressing the certified questions sidesteps the renewal and conformity provisions of her Policy altogether – terms of the Policy to which she agreed and terms mandating application of the Statute to her claims.

Kirven's constitutional arguments also hinge on the presumption that she has a contractual right to payment of benefits in a manner violative of the Statute. The Policy, which is supplemental not primary, only entitles Kirven to payment of the contractually-undefined "actual charges" for certain cancer treatments; it does not mandate what constitutes "actual charges" or the manner in which they are paid. Kirven wrongly posits that the Policy entitles her to payment of the amount *initially billed* by her medical providers – an amount that differs significantly from the discounted payment *ultimately accepted* by those providers in many cases (in accordance with their pre-negotiated agreements with primary insurers).[2] That is not a right afforded by the Policy, nor were Defendants obligated for the life of the Policy to overpay benefits equaling billed amounts Kirven herself was never obligated to pay. No contractual right has been impaired by Defendants' compliance with a legislatively-mandated definition for a term undefined by Kirven's Policy.

[2] Kirven's position is that the Policy entitled her to payment of monies that were theoretically billed to her but that, in reality, she never owed. In essence, the monies sought are nobody's "actual charges" because Kirven was never obligated to pay that amount!

STATEMENT OF THE CASE

Kirven filed suit on August 15, 2011 in the Columbia Division of the United States District Court for South Carolina seeking a declaratory judgment regarding the term "actual charges" in her Policy and requesting class certification and class relief for those she believes to be similarly situated. The District Court has not considered the merits of certification, although it appears the purported class may encompass as few as twenty-five (25) and as many as twenty-eight (28) other polices.[3]

The parties have engaged in limited factual discovery and agree that the two certified questions before this Court are potentially dispositive of the case. The parties jointly requested certification of the dual questions, and on February 5, 2013, the District Court entered its Order of Certification. This Court accepted the certified questions on March 8, 2013.

STATEMENT OF FACTS

A. CSO Issues The Kirven Policy.

The underlying facts of this case are relatively undisputed. Effective January 2000, Kirven purchased the Policy from CSO, which was issued on Form Number CO2 SC as Policy No. 0250069329. (Appx. Ex. 2, pp. DEF 001 – DEF 0042).[4] A rider, Form 8159 Rev. entitled "Benefit Adjustment Rider," accompanied the Policy (among others)

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[3] A total of twenty-five (25) to twenty-eight (28) policies have had reductions based on the statute. The total amount in dispute for "actual" v. "billed" for all twenty-eight (28) policies in controversy is approximately $452,841.00 dollars. (Appx. Ex. 3, S. Bookwalter Depo. p. 17 ll. 1-25; Depo. Ex. 2 (p. DEF 0547); Depo. Ex. 3 (p. DEF 0743)).

[4] By separate motion filed contemporaneously herewith (with Plaintiff's consent), Defendants have requested that the Court admit the exhibits contained in the Appendix as part of the Record in this matter.

and is the catalyst for Kirven's "actual v. billed" complaint. (Appx. Ex. 2, p. DEF 0023-0024)(the "8159 Rider").

B. Philadelphia American Assumes The Kirven Policy From CSO.

In September 2005, CSO assigned a number of policies, including Kirven's, to Philadelphia American. Both corresponded with Kirven on September 21, 2005 regarding the assumption. (Appx. Ex. 2, pp. DEF 004-006). Both offered Kirven the opportunity to object to the assumption. (Appx. Ex. 2, pp. DEF 004-006). Having received no objection by December 31, 2005, CSO transferred Kirven's Policy.

On January 13, 2006, Philadelphia American notified Kirven of the assumption and the new number it had assigned to her Policy, which was Policy No. 6515069329. (Appx. Ex. 2, pp. DEF 007-008). Kirven continued paying her regular monthly premiums to Philadelphia American. Kirven's Policy remains in force.

C. The Governing Policy's Terms And 8159 Rev. Rider.

1. Only Specified Diseases Are Covered.

Kirven's Policy is a supplemental cancer and specified disease policy. The Policy is not a major medical expense or hospitalization policy, and it only provides supplemental coverage for specific diseases such as cancer. The Policy provides certain enumerated or fixed benefits for the various treatments listed therein – and nothing else. The insured's medical provider does not submit an Explanation of Benefits form ("EOB") for the charges. Instead, the claim is submitted by the insured herself, and benefits are paid directly to the insured, not the provider, notwithstanding of the absence or presence of other coverage.

The Policy specifies, in emphasized language, that it "ONLY PROVIDES

BENEFITS *FOR A LOSS* DUE TO CANCER AND SPECIFIED DISEASE." (Appx. Ex. 2, p. DEF 009)(italics added; capitalization in original). The Policy also requires "[w]ritten proof of loss" for the payment of a claim. (Appx. Ex. 2, p. DEF 0020 – Part J - HOW TO FILE A CLAIM)(the "Proof of Loss Provision").

2. The Policy Renewed Each Month.

Kirven chose to pay her premiums on a monthly basis, rather than annually or quarterly. (Appx. Ex. 2, pp. DEF 0011; DEF 0031). CSO issued the Policy based on her selection. The Policy expressly states that it renews upon receipt of each monthly premium. (Appx. Ex. 2, p. DEF 0009 – Part C - RENEWAL AGREEMENT)(the "Renewal Agreement").

The Policy is a "guaranteed renewable" policy subject to limited conditions outlined in the Policy, including Kirven's payment of a timely premium each month, Defendants' right to adjust the premium rate if changed "for all policies like yours in your state," (Appx. Ex. 2, pp. DEF 0009 - Part D - PREMIUM CHANGE)(the "Premium Change Provision"), and specific other provisions outlined in the "CONTINUATION OF COVERAGE" and "TERMINATION OF COVERAGE" provisions, (Appx. Ex. 2, pp. DEF 0019-0020). Provided that those limited conditions are met, the Policy renews by its terms in accordance with the premium frequency selected (here, monthly).

3. Kirven Was Provided 30 Days In Which To Examine The Policy.

Because it was important that Kirven was satisfied with the Policy and that it met her expectations and insurance needs, Kirven was afforded a 30-day period in which to examine the Policy. (Appx. Ex. 2, p. DEF 0009 – Part B – 30-DAY RIGHT TO EXAMINE POLICY). If not satisfied, she could have returned it for a full refund.

(Appx. Ex. 2, p. DEF 0009 – Part B).

4. The Policy Conformed To State Statutes.

The Policy contains a "Conformity With State Statutes" provision, which provides:

> **CONFORMITY WITH STATE STATUTES**: The provisions of this policy conform with the laws of the state in which you reside on the policy effective date. If any do not, they are hereby amended so they do conform.

(Appx. Ex. 2, p. DEF 0021) (the "Conformity Provision"). Working in tandem with the Renewal Agreement, the Conformity Provision incorporates the law of South Carolina into the policy by amendment. Hence, the Policy was amended to conform to all statutes each time it renewed, or as here, monthly.

5. Policy Amendment By Rider 8159 Rev.

The basic form of the Policy contains a "Radiation" provision which appears on Page 7 of the Policy. (Appx. Ex. 2, p. DEF 0016 – RADIATION, *et al.*). However, the 8159 Rider specifically amended this provision, and it is this Rider that contains the phrase "actual charges" applicable to the claims at issue in this litigation. (Appx. Ex. 2, p. DEF 0023).

No express definition of "actual charges" appears in the Policy. When adjusting Kirven's claims, the "actual charges" analysis is only necessary in conjunction with certain "radiation or chemotherapy" related charges. The salient language appears in the section entitled "Radiation, Radio-Active Isotopes Therapy, or Immunotherapy" as follows:

> *We will pay 50% of the actual charges.* The *maximum benefit will be $50,000 per calendar year* with no lifetime maximum for the following [sic 4] treatment techniques provided they are used for the purpose of

modification of or destruction of cancerous tissue.

(Appx. Ex. 2, p. DEF 0023)(emphasis added).

Charges for other medical expenses unrelated to radiation or chemotherapy are evaluated under other provisions of the Policy and are not at issue here. The only claims about which Kirven complains were those adjusted pursuant to the 8159 Rider and any associated claims for chemotherapy. Accordingly, only the language of the Rider is at issue or the subject of any scrutiny.

D. The General Assembly Passes § 38-71-242 And SCDOI Issues Bulletin 2008-15 Mandating Compliance Therewith.

1. The General Assembly Passes The Statute In Response To *Ward I*.

SCDOI was concerned with the Fourth Circuit's pronouncement in *Ward I* (outlined in detail in footnote 1, *supra*), which was viewed as permitting an insured to reap a windfall payment of the difference between the "billed" charges and the "actual" charges – a difference the insured was never obligated to pay. Accordingly, SCDOI sought redress from the General Assembly and worked with State Senator C. Bradley Hutto's office to pass a bill that would eliminate this windfall.

The General Assembly responded by passing § 38-71-242, which became effective on June 4, 2008. The Statute defines "actual charges" as that amount that the healthcare provider agreed to accept as payment, whether under a network or other agreement, a TPA Agreement, or Medicare/Medicaid. S.C. Code Ann. § 38-71-242(A)(1) & (2). The lowest amount is to be paid. The Statute's application encompasses both individual and group specified-disease insurance policies, S.C. Code Ann. § 38-71-242(B), and it forbids the insurer from paying, after the Effective Date of June 4, 1008, any claim or benefit in excess of the statutory "actual charges" definition

(unless the policy otherwise defines that term). S.C. Code Ann. § 38-71-242(C).

2. SCDOI Issues Bulletin Number 2008-15.

After the Statute's passage, SCDOI issued Bulletin Number 2008-15 dated August 28, 2008, which was directed to insurers to whom the Statute applies. (Appx. Ex. 4, pp. DEF 0473-0475)(the "Bulletin"). The Bulletin explained that the Statute codified SCDOI's long-standing interpretation of "actual charges" (and similar terms found in supplemental cancer policies) by requiring that the *insured suffer some out-of-pocket loss* to receive payment of a benefit. (Appx. Ex. 4, pp. DEF 0473-0475). The requirement of an actual loss was designed to avoid a windfall to the insured in the form of payments greater than the sums the insured actually paid to a healthcare provider. (Appx. Ex. 4, pp. DEF 0473-0475). According to SCDOI, allowing such a windfall to persist unchecked would lead to increased premiums and fraudulent conduct, such as "deliberate" inflating of medical bills solely for the purposes of collecting greater benefits under the supplemental policy. (Appx. Ex. 4, p. DEF 0474).

Notably, the Bulletin expressly instructed that *no insurer or issuer subject to the Statute* was to pay any claim or benefit in excess of the statutorily-mandated actual charges amount. (Appx. Ex. 4, p. DEF 0474). To ensure compliance, *each insurer was required to transmit a notice in a form approved by SCDOI* to each named insured informing him or her of the Statute's content.

Philadelphia American complied by submitting a notice to SCDOI for approval. Once SCDOI approval was received, Philadelphia American transmitted the Notice to

each of its affected policy holders.[5] The Kirven Policy was subject to the Statute, and Philadelphia American issued the Notice to Kirven on August 21, 2008. (Appx. Ex. 5, pp. DEF 0245-0246)(the "Notice"). Kirven never complained of the Notice or its contents prior to filing suit.

E. The Difference Between "Billed" And "Actual" Charges.

Before the advent of HMO's, PPO's and other agreements between healthcare providers and insurance carriers, the bill received for services rendered represented the actual amount the patient was obligated to pay to satisfy the debt; hence, the term "billed charges."

Over time and in an effort to either lower or prevent the exponential rise of healthcare costs, healthcare providers entered into agreements that established a negotiated fee for care and treatment of certain diseases or conditions. The intent was to reduce the cost of healthcare services, and thereby, ultimately lower the patient's obligation. Simply stated, the patient received a reduction to the amount that a healthcare provider normally charged absent the negotiated amounts; hence the term "actual charges."

With that change, charges for which a patient was ultimately responsible began appearing in the EOB. A provider would complete an EOB using a code identifying the

[5] Prior to the assumption of Kirven's Policy by Philadelphia American, CSO settled a class action suit in the United States District Court of South Dakota entitled *Bergonzi v. Central States Health and Life Company of Omaha*, Case No. C2-4096 (filed July 3, 2003) which involved a number of the supplemental policies that Philadelphia American assumed from CSO. After the Statute was enacted, Philadelphia American determined that the Statute did not apply to the policies covered by *Bergonzi*, since the Statute expressly exempted policies covered by a final judgment issued before June 4, 2008 by a court of competent jurisdiction. The policies involved in the *Bergonzi* litigation fell within that exemption, and because those policy holders were not affected by the Statute, they were not issued the notice.

procedure or treatment and the associated charge for each code. Then, the provider sent the EOB to the patient's insurance carrier for review/payment. The EOB outlines the "actual charges" charged by the provider and represents the amount the patient must pay in satisfaction for the services rendered, or as SCDOI denominated it, "the out-of-pocket loss."

The EOB represents the total charges that a patient - like Kirven - must pay either by insurance or from her own resources to satisfy her obligation to the healthcare provider. This amount is referred to as the "actual charges." Quite often the amount listed in the EOB is less than the amount normally charged by the physician.

The amount Kirven seeks in this case is the spread between the full amount billed by the provider and the lesser amount charged on the EOB. Kirven has never been required to pay the "billed amount" nor has she suffered any out-of-pocket loss associated with this amount. The amounts were "billed" to her theoretically but never owed by her. The Statute defines "actual charges" so that this windfall is eliminated.

F. Only Eight (8) Of Kirven's Claims Are Affected By The Statute.

Kirven's overarching allegations in this case give the impression that Philadelphia American, after assumption of her Policy, completely reversed course in the payment of all her claims. Such is not the case. Kirven has submitted over 170 individual charges for reimbursement since the reoccurrence of her cancer in 2009,[6] including charges for oral administration of chemotherapy. Philadelphia American has adjusted and paid those

[6] In 2009, after the Statute's Effective Date and after Philadelphia American directly informed Kirven that the Statute would impact payment of benefits under her Policy such that "any claims submitted for expenses incurred on or after June 4, 2008 will be paid in accordance with [the Statute]," (Appx. Ex. 5, p. DEF 0245), Kirven's cancer returned.

charges according to the benefits provided by her Policy. Kirven has lodged no complaint regarding those claims or the amounts paid.

Only eight (8) of her claims are for radiation/chemotherapy and subject to the 8159 Rider and the Statute's "actual charges" mandate.[7] Those eight (8) claims total $45,838.00, although the Policy (pursuant to the 8159 Rider) provides payment for 50% of those eligible chemotherapy claims.[8] Therefore, if Kirven's argument is correct, she would be entitled to 50% of the chemotherapy charges billed to her, for a total of $22,919.00.

On the other hand, if Philadelphia American is correct in its application of the "actual charges" Statute, Kirven is entitled to benefits equaling 50% of the actual charges for which she is responsible – a total of $14,309.12. The total amount in controversy, *i.e.,* the difference between Kirven's "billed charges" and the actual charges for which she is responsible is $8,609.88.

G. Kirven's Putative Class Action Complaint.

Applying the mandatory definition found in the Statute, and pursuant to the Notice, Philadelphia American requested a copy of the EOB's that Kirven has received for the eight (8) claims for chemotherapy charges. (Appx. Ex. 6, pp. DEF 0052-

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[7] During discovery Philadelphia American produced Kirven's claims file containing records of all claims submitted, including the nature of each and the amount paid. The charges for radiation have been or will be paid at 50% based on the 8159 Rider. All her claims for radiation and chemotherapy have been paid at the 50% benefit absent the application of "actual charges," with the exception of eight (8) claims for chemotherapy administered during the period from December 2, 2009 to May 24, 2010. Given the sensitive nature of this medical information, Defendants have not attached supporting documentation hereto (although it can be made available if the Court wishes to review it).

[8] Kirven has not contested the 50% application as prescribed by the 8159 Rider.

0056)("EOB Requests").

Kirven did not provide the EOB's. Instead, she filed suit seeking payment of the billed amounts listed on the face of each invoice, instead of the actual charges the physician would accept as final payment. It is undisputed that Kirven is obligated to pay only the latter.

ARGUMENT

I. The Definition Of "Actual Charges" Contained Within S.C. Code Ann. § 38-71-242 Can Be Applied To Insurance Contracts Executed Prior To The Statute's Effective Date.

Retroactivity is the gravamen of Kirven's campaign to discourage application of the Statute to her Policy. Yet, she neglects to explain how retroactivity – much less unconstitutional retroactivity - ensues under the circumstances of *this* case: when the Statute's mandatory definition of "actual charges" is applied to claims submitted after its Effective Date under a monthly-renewing Policy that expressly conformed to South Carolina statutes and contained no "actual charges" definition of its own. Such a prospective application raises none of the potential constitutional difficulties or concerns identified in *Ward II*. *See* footnote 1, *supra*. Neither the doctrine of retroactivity, nor the related doctrines Kirven also raises – "constitutional avoidance" and violation of the Contract Clause – prevent the Statute's application to her Policy.

A. The Statute Applies Prospectively, Not Retroactively, To The Policy.

Setting aside Kirven's generalized concerns about the Statute, "retroactivity" is not implicated under the circumstances of this Policy's language. By the Policy's express terms, South Carolina law was incorporated by amendment each time the Policy renewed, which was monthly. Renewal of the Policy effectuated a new contract subject to the laws in existence at that time. Upon Kirven's first renewal after the June 4, 2008 Effective Date, her Policy became subject to the Statute. Hence, application of the Statute to Kirven's Policy was *prospective*, not retroactive.

1. The Policy Terms Governing Renewal And Conformity Are Clear, Unambiguous, And Inextricably Intertwined.

The Statute applies prospectively to the Policy because Kirven's policy was a new contract upon renewal that expressly conformed with the Statute's required definition. The terms governing renewal and conformity are clearly and ambiguously articulated in the Policy. It is undisputed that the Policy renewed upon payment and receipt of each premium which was, pursuant to Kirven's wishes, on a monthly basis. (Appx. Ex. 2, pp. DEF 0011, DEF 0031; DEF 0009 – Part C ("[Philadelphia American] will renew your policy each time you send us the premium.")). The Policy further provides that it "may be renewed only as stated in the Renewal Agreement, . . . [and] [e]ach time this policy is renewed, the new term begins when the old term ends." (Appx. Ex. 2, p. DEF 0021 – TERM OF COVERAGE). In other words, a new and independent insurance contract was entered into each time Kirven paid her monthly premium. It is further undisputed that the Policy terms expressly provide that it will conform with state statutes to incorporate South Carolina law by amendment:

> **CONFORMITY WITH STATE STATUTES**: The provisions of this policy conform with the laws of the state in which you reside on the policy effective date. If any do not, they are hereby amended so they do conform.

(Appx. Ex. 2, p. DEF 0021 – CONFORMITY WITH STATE STATUTES).

In 2009, after the Statute's Effective Date and after Philadelphia American directly informed Kirven that the Statute would impact payment of benefits under her Policy such that "any claims submitted for expenses incurred on or after June 4, 2008 will be paid in accordance with [the Statute]," (Appx. Ex. 5, p. DEF 0245), Kirven's cancer returned. It is undisputed that the eight claims in contention in this case did not arise

until December 2009 – over twelve months after passage of the Statute and eleven months after Kirven was notified that the Statute undoubtedly governed benefits under her Policy. (Appx. Ex. 1, ¶¶ 26-27).

Kirven's premium was due on the first day of each month. (Appx. Ex. 2, p. DEF 0011). Accordingly, with knowledge of the Statute's application and before December 2009 when her cancer returned, Kirven renewed her Policy approximately 15 times.

2. The Renewal And Conformity Provisions Must Be Read Cohesively.

Working in tandem with the Renewal Agreement, the Conformity Provision amends the Policy by incorporating South Carolina law when the Policy renews. Thus, when the law applicable to the Policy changes in South Carolina, the provisions of the Policy change to reflect that law. To find otherwise vitiates the express terms of Policy, which are unambiguous and must be read as a cohesive whole.

Under South Carolina law, insurance policies are subject to the general rules of contract construction. *See B.L.G. Enterprises, Inc. v. First Financial Ins. Co.*, 334 S.C. 529, 535, 514 S.E.2d 327, 330 (1999). When – as is the case here – the language used in an insurance policy is unambiguous, clear and explicit, the courts must enforce that language in accordance with its plain meaning. *See Fritz-Pontiac-Cadillac-Buick v. Goforth*, 312 S.C. 315, 318-19, 440 S.E.2d 367, 369-70 (1994). The policy terms define an insurer's obligation, and those terms cannot be enlarged by judicial construction or "tortured" to extend coverage that the parties never intended. *MGC Management of Charleston, Inc. v. Kinghorn Ins. Agency,* 336 S.C. 542, 549, 520 S.E.2d 820, 823 (Ct. App. 1999).

Importantly, "[a]ll of the policy provisions should be considered, 'and one may not, by pointing out a single sentence or clause, create an ambiguity.'" *Stewart v. State Farm Mut. Auto. Ins. Co.*, 341 S.C. 143, 150-51, 533 S.E.2d 597, 601 (Ct. App. 2000)(quoting *Yarborough v. Phoenix Mut. Life Ins. Co.*, 266 S.C. 584, 592, 225 S.E.2d 344, 348 (1976)). Accordingly, "[t]he meaning of a particular word or phrase is not determined by considering the word or phrase by itself, but by reading the policy as a whole and considering the context and subject matter of the insurance contract." *Stewart*, 341 S.C. at 150-51, 533 S.E.2d at 601.

> Presumably, all portions of a contract are inserted for a purpose . . . . Therefore, the court must consider the entire contract between the parties to determine the meaning of its provisions, and that construction will be adopted which will give effect to the whole instrument and each of its various parts, so long as it is reasonable to do so.

MGC Management, 336 S.C. at 548, 520 S.E.2d at 823 (internal citations omitted).

When Kirven's Policy is read as a whole, it is clear that the Renewal Agreement and Conformity Provision are inextricably intertwined such that renewal of the Policy conforms Policy terms to ensure compliance with South Carolina law in existence at that time. Various other courts have addressed this same issue. The Fifth Circuit and the Georgia Supreme Court have held that "statutory provisions" are, in effect, 'read into' all insurance contracts to which they apply, and form integral parts thereof." *Imperial Enters., Inc. v. Fireman's Fund Ins. Co.*, 535 F.2d 287, 290 (5th Cir. 1976); *Kelly v. Lloyd's of London*, 336 S.E.2d 772, 776 (Ga. 1985); *E.g. Stangl v. Occidental Life Ins. Co. of N.C.*, 804 F. Supp. 2d 1224, 1232-34 (W.D. Okla. 2011) (rejecting claim that interpretation of state statute defining actual charges was unconstitutional when policy provided that it was "automatically amended to comply with state law").

3. Each Renewal Of The Policy Effectuated A New Policy That Incorporated The Law In Existence At The Time Of Renewal.

Moreover, this Court has already established that the renewal of a policy like Kirven's - which permits the policy terms to change upon renewal - is a *new contract* that becomes subject to the relevant laws in effect at the time of renewal. Kirven's Policy is a "guaranteed renewable" policy subject to limited conditions outlined in the Policy, including, as particularly applicable here, Defendants' right to adjust the premium rate if changed "for all policies like yours in your state." (Appx. Ex. 2, pp. DEF 0009 - Part D - PREMIUM CHANGE)(the "Premium Change Provision"). Provided that other narrow conditions outlined in the Policy are met, including Kirven's timely payment of the premium, the Policy renews by its terms monthly as each premium is paid. This court considered markedly similar policy provisions in *Webb v. South Carolina Ins. Co.*, 305 S.C. 211, 407 S.E.2d 635 (1991), and concluded that each policy renewal resulted in the creation of a new contract.

In *Webb,* a declaratory judgment action concerning an injured plaintiff's entitlement to Uninsured Motorist (UIM) coverage, this Court considered whether renewals of a policy initially applicable for a six-month term (and renewed for three more six-month terms) were new contracts or mere continuations of the initial contract's terms. *Webb,* 305 S.C. at 213-14; 407 S.E.2d at 635-36. Distinguishing between, on the one hand, policies mandating that the same terms remain in effect upon renewal and, on the other hand, policies permitting a change in terms upon renewal (as Kirven's does), this Court established a bright line rule:

> We hold that unless (1) the expiring policy mandates the same terms shall remain in effect and (2) the terms of the policy do not change upon renewal, renewal is a new contract . . . . Absent a mandatory provision in

> the expiring policy extending its terms, the fact that a renewal continues in effect the same terms as the expiring policy is not dispositive. *Conversely, where the terms of the policy are in fact changed upon renewal, the renewal is a new contract irrespective of the provisions in the expiring policy regarding renewal.*

Webb, 305 S.C. at 213-14; 407 S.E.2d at 635-36 (emphasis added); *see also Knight v. State Farm Mut. Auto. Ins. Co.*, 374 S.E.2d 520, 522 (Ct. App. 1988) ("The general rule is that the renewal of a policy for a fixed term is in effect a new contract and must contain all the essentials of a valid contact.").

Because the policy at issue in *Webb* "specifically contemplate[d] upon renewal a renegotiation of an essential term of the contract, the premium rate , . . . [this Court found that the renewal] constitutes a new contract." *Webb,* 305 S.C. at 214; 407 S.E.2d at 636 (overruling *Simpson v. State Farm Mut. Ins. Co.*, 403 S.E.2d 167 (Ct. App. 1991) which held that renewal is a mere continuation even if the renewal allows for adjustment of the premium). Thus, "South Carolina law holds that a renewal of an insurance contract is a new contract unless the policy requires both parties to renew and no terms of the policy (including the premium) are changed from year to year." *In re Georgetown Steel Co., LLC*, 318 B.R. 313, 331 (Bankr. D.S.C. 2004) (citing *Webb*, 407 S.E.2d at 636); *Cf. Hudson v. Reserve Life Ins. Co.*, 245 S.C. 615, 618, 141 S.E.2d 926, 927-28 (1965) (holding that the accident and health policy applicable in that case was not a new contract upon renewal when none of the essential terms of the policy were subject to change upon renewal, including the premium which was initially $1.50/month and remained fixed at $1.50/month throughout the policy life when renewed). Only a single "essential term" of the contract need be subject to change to establish the renewal as a "new contract." *Webb,* 305 S.C. at 214; 407 S.E.2d at 636.

Thus, this Court has unequivocally held that, where an insurance policy specifically contemplates a new premium upon renewal – as Kirven's policy does here – then the renewal of that policy is a new contract subject to all relevant laws in effect at the time. The adjustable premium rate dispositive in *Webb* is also dispositive here. Notably, although the policy involved in *Webb* was a UIM policy, the rule established by *Webb* was not limited to that context. Indeed, the scope of the rule is broad and applicable regardless of the type of insurance involved: the Court of Appeals has relied on the *Webb* renewal rule in the context of workers' compensation insurance. *Crews v. W.R. Crews, Inc.*, 390 S.C. 15, 24, 699 S.E.2d 189, 194 (Ct. App. 2010)(citing *Webb* and rejecting an argument to the contrary); *accord, In re Georgetown*, 318 B.R. at 331 (applying *Webb* to a workers' compensation case). *Webb* remains the law in South Carolina for determining whether any insurance policy becomes a new contract upon renewal, and other courts have applied it accordingly. *But cf. Montague v. Dixie Nat. Life Ins. Co.*, 2010 WL 2428805, at *3-4 (D.S.C. 2010)(limiting the *Webb* rule and declining to apply it in the context of a supplemental policy).[9]

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[9] Other similarities between the *Webb* policy and the Kirven Policy further align *Webb* with this case: (1) both policies were guaranteed renewable; (2) both were in effect for a fixed term that began and ended with each premium payment and could be renewed without further consent by the insurer so long as limited conditions were satisfied; (3) both "expired" at the end of the term absent renewal by the policyholder; (4) both apportioned to the insurer the right to increase the premium amount on renewal; and (5) both obligated the insurer to renew the policy upon satisfaction of the limited conditions outlined therein. *Webb*, 305 S.C. at 213-14; 407 S.E.2d at 636. In *Webb*, this Court clarified the scope of the renewal rule established in *Knight v. State Farm Mut. Auto. Ins. Co.*, 297 S.C. 20, 374 S.E.2d 520 (Ct. App. 1988), by holding that a renewal constitutes a new contract even when the insurer *is obligated* to renew the policy, just so long as at least one essential term of the policy can change upon renewal. *Cf. Knight*, 297 S.C. at 23, 374 S.E.2d at 522 (observing that "[n]othing in the record suggests there was a provision in the insurance policy that obligated either party to continue the policy after its . . . expiration date"); *Hodge v. Nat'l Fid. Ins. Co.*, 221 S.C. 33, 42, 68 S.E.2d 636, 639

This Court has made clear that the *availability of any potential change* in policy terms upon renewal – here, the right to adjust the premium – renders the policy a new contract subject to the laws in existence at the time of that renewal – here, the Statute's mandated "actual charges" definition. And in this case, it is doubly so because the premium amount was not the only provision subject to change under Kirven's Policy. The "Conformity Provision" itself signals that the renewed Policy was not only subject to change – *but indeed would change* – if necessary to conform the Policy's terms to South Carolina law. There can be little doubt that, regardless of whether the premium rate fluctuated under Kirven's Policy, the parties contemplated and expected a change in Policy terms upon renewal if - and when - such a change was necessary to comply with State law.

4. Kirven Renewed Her Policy With Knowledge That The Statutorily-Mandated "Actual Charges" Definition Would Govern Payment Of Her Benefits.

Kirven cannot maintain that she was not aware such a change could occur upon renewal. Even setting aside the conclusive presumption that Kirven was aware of the Statute and its application to her Policy through the Conformity Provision, she certainly was aware of the Statute's impact on her Policy when Philadelphia American sent her the SCDOI-approved Notice on August 21, 2008. (Appx. Ex. 5, pp. DEF 0245-0246). Yet, Kirven still chose to renew her Policy thereafter, this time with undeniable knowledge and consent that the Statute would impact payment of her claims. Indeed, Kirven has renewed her Policy each and every month since the 2008 Notice, and her Policy still remains in effect.

(1952)(holding that the policy "could not be renewed or continued without the consent of both parties").

As a consequence of entering into a new and independent insurance contract after the Effective Date of the Statute, and on a monthly basis thereafter, Kirven's Policy became subject to, and continues to be governed by, the statutory definition of "actual charges." It is difficult to see how prospective application to the renewed Kirven Policy - particularly over such a long period of time - can implicate a retrospective constitutional concern. It is even more difficult to envision a constitutional infringement when Kirven repeatedly chose to renew her Policy with knowledge that the Statute limited her benefits to the actual charges she was obligated to pay her providers.

5. Courts In Other Jurisdictions, Under Similar Circumstances, Have Considered The Application Of An Intervening Statute To Be Prospective, Not Retroactive.

Kirven's case is not unique, as the propriety of "actual charges" statutes continues to be an issue litigated across the county. Many courts presented with similar circumstances have concluded that "constitutional" retroactivity is not implicated when a supplemental insurance policy, like Kirven's, is renewed after the "actual charges" statute's effective date. Rather, application of an intervening statute to a renewed policy results in a proper, prospective application. *Stangl*, 804 F. Supp. 2d at 1232-34 (rejecting claim that interpretation of state statute defining actual charges was unconstitutional when applied to insurance policy renewed after statute's effective date); *Lindley v. Life Investors Ins. Co. of Am.*, 2010 WL 723670, at *11-12 (N.D.Okla. Feb. 22, 2010)(same); *McLaughlin v. Am. Fid. Assurance Co.*, 2010 WL 2507523, at *6-10 (W.D.Okla. June 16, 2010)(same). *Cf. Bell Care Nurses Registry, Inc. v. Cont'l Cas. Co.*, 25 So. 3d 13, 16 (Fla.Ct.App. 2010)(applying state interpretive statute to policy renewed after statute's effective date). *But cf. Montague*, 2010 WL 2428805, at *3-4. Leading insurance

commentators agree. *E.g.*, 12 *J. Applemann, Insurance Law and Practice*, § 7041, at 175-176 (1981)("[W]here an existing policy is renewed, although the results vary, the better rule is to regard the [intervening] statute as applicable.").

This case is no different. The Policy language unambiguously provides that the Policy conforms to applicable State law upon renewal. Regardless, the renewal of Kirven's Policy was a new contract that would have incorporated existing state law even absent the Conformity Provision. The express language of the Policy evidences the parties' intent and expectation that the Statute would govern the payment of Kirven's claims, as does Kirven's renewal of the Policy after receiving direct notice that the Statute applies.

B. Nevertheless, Even If This Court Concludes That Application Of The Statute To Kirven's Policy Requires A Constitutional Analysis, Kirven's Concerns Are Unfounded.

Applying the Statute to Kirven's Policy (and others like it) in the prospective manner outlined above relieves the "grave concerns" expounded by Kirven's Brief without wading into the thick of an unnecessary and complicated constitutional analysis. (Kirven Brief, p. 15). By focusing on the express provisions of *the Policy*, the statutory definition is "read into" the Policy because the Policy terms contemplate that very result. There is simply no need for a separate constitutional analysis concerning the propriety of retroactivity, constitutional avoidance, or whether the Contract Clause has been violated. This Court need not look any further than the Policy terms themselves in order to resolve the certified questions.

Nevertheless, assuming *arguendo* that this Court chooses to consider the merits of Kirven's constitutional concerns (which it need not do), even a retrospective application

is constitutional here. As a general principle, "[t]his Court has a very limited scope of review in cases involving a constitutional challenge to a statute." *Joytime Distribs. & Amusement Co. v. State*, 338 S.C. 634, 640, 528 S.E.2d 647, 650 (1999). "All statutes are presumed constitutional and will, if possible, be construed so as to render them valid." *Id.* "A legislative enactment will be declared unconstitutional only when its invalidity appears so clearly as to leave no room for reasonable doubt that it violates a provision of the constitution." *Id.* That is not the case here.

1. The Plain Language Of The Statute Evidences Its Intent To Apply To Policies Like Kirven's Without Regard To The Date Of Issuance, Rendering The Doctrine Of Constitutional Avoidance And The Presumption Against Retroactivity Inapplicable.

Kirven's constitutional arguments necessitate a paradigm shift to the doctrine of retroactivity, moving the focus from the plain language of the Policy to the plain language of the Statute. Kirven's Brief appropriately identifies the threshold inquiry as one of legislative intent in enacting the Statute, and she maintains that the Statute cannot be accorded retrospective effect unless required by express words in the Statute or implied from the language used therein. (Kirven Brief, pp. 10-13).

Even so, the language of the Statute cannot be viewed in a vacuum to determine whether it illustrates legislative intent, as Kirven suggests. Rather, the analysis must be framed appropriately for the Policy at issue *here*. The appropriate inquiry is not, "does the Statute contain any express provision of retroactivity at all?" (*See, e.g.*, Kirven Brief, pp. 11-14). Such a generalized inquiry implicates the timing of submission of claims under the Policy, which were at issue in *Ward II* but are undisputedly not at issue in this case. The proper question tailored for the circumstances of this case is "did the General

Assembly intend the Statute to govern claims filed after its Effective Date under certain specified disease policies initially issued before the Effective Date?" The clear answer to this question is "yes."

The Statute does not temporally limit the issuance date of the policies it governs; to the contrary, the Statute expressly avoids a temporal limitation by applying to "any . . . specified disease insurance policy issued to any resident of the State" lacking an actual charges definition. S.C. Code Ann. § 38-71-242(B). While Kirven is correct that the Statute evidences no intent to reach *claims* filed before its Effective Date, (Kirven Brief, pp. 13-15)(citing the *Ward II* discussion that the Statute does not cover "conduct that occurred" prior to the Effective Date), the same cannot be said for *policies* issued before the Effective Date. Use of the past-participle "issued" reveals the Statute's intent to reach policies in existence when the Statute was enacted. Kirven's Policy clearly falls within the scope required, or at the least implied, by the Statute's language.

Given an obvious legislative intent for the Statute to apply to policies like Kirven's that were in existence when it was enacted, this Court need not consider the doctrine of constitutional avoidance or the presumption against retroactivity. These "judicial default rules" are not applicable in this case. [10]

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[10] Quite tellingly, the *Montague* opinion to which Kirven cites in support of her Contract Clause argument, (Kirven Brief, pp. 18-20), categorically rejected these very arguments upon which she now relies:

> The intent of the South Carolina General Assembly determines whether a state statute will have prospective or retrospective application . . . [and] both the federal and South Carolina courts utilize a presumption against statutory retroactivity as a means of giving effect to legislative intent . . . . First, the court must determine whether the legislature expressly prescribed the statute's temporal reach . . . [and i]f so, the presumption against retroactivity does not apply . . . . Of course, if the General

2. Application Of The Statute To Kirven's Policy Does Not Violate The Contract Clause Of Either The Federal Or State Constitutions.

The Statute's application to Kirven's Policy and other similar policies does not violate the state or federal Contract Clauses (collectively referred to as the "Contract Clause"). South Carolina's constitution provides:

> No bill of attainder, ex post facto law, *law impairing the obligation of contracts*, nor law granting any title of nobility or hereditary emolument, shall be passed, and no conviction shall work corruption of blood or forfeiture of estate.

S.C. Const. art. I, § 4 (emphasis added); *see also* U.S. Const. art. I, § 10 (also prohibiting the impairment of contracts). As an initial matter, Kirven's Policy falls outside of the scope of the Contract Clause, which applies only to already-existing contracts, not future contracts. *Ogden v. Saunders*, 25 U.S. (12 Wheat.) 213, 295–96, 6 L.Ed. 606 (1827); *see also Texaco, Inc. v. Short*, 454 U.S. 516, 531 (1982)("[A] statute cannot be said to impair a contract that did not exist at the time of its enactment."). As argued extensively in

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> Assembly expressly prescribed the statute's temporal reach to cover the matters being litigated, *then there is no need to resort to judicial default rules*. Because the court finds that the General Assembly expressly and unequivocally prescribed section 38–71–242's temporal reach, *the presumption against retroactivity and the doctrine of constitutional avoidance do not arise in this case*.
>
> ...
>
> [T]he court finds that the General Assembly did expressly prescribe the statute's temporal reach to cover the claims presented by the Plaintiffs, as it clearly expressed its intent for insurers of specified disease policies to pay post-June 4, 2008 benefits based on the legislatively-established definition of "actual charges".
>
> ...
>
> [O]nce the General Assembly makes its intention clear, the court is no longer to ascribe to default judicial rules.

Montague, 2011 WL 2294146, at *4-8 (emphasis added).

Section I.A., *supra,* the Statute's application to the Kirven Policy is prospective rather than retroactive because each renewal after the Statute's Effective Date constituted a new contract incorporating the statutory definition by amendment. It is for this reason that the Contract Clause is not even implicated here; the contracts at issue are new contracts executed after the Statute's Effective Date.

Even assuming, *arguendo*, that Kirven's Policy is an "existing contract" to which the Contract Clause applies, no constitutional violation results from application of the Statute. Evaluation of a potential Contract Clause violation includes: "(1) whether there is a contractual relationship; (2) whether the change in the law impairs that contractual relationship; (3) and whether the impairment is substantial." *Hodges v. Rainey,* 341 S.C. 79, 93, 533 S.E.2d 578, 585 (2000); *see also Gen. Motors Corp. v. Romein*, 503 U.S. 181, 186 (1992). If there has been a substantial impairment, the inquiry becomes whether the Statute is reasonable and necessary to effectuate a legitimate legislative purpose considering the following factors: "(1) whether an emergency exists justifying the impairment; (2) whether the law was enacted to protect a basic societal interest, rather than a favored group; (3) whether the law is narrowly tailored to the emergency at hand; (4) whether the imposed conditions are reasonable; and (5) whether the law is limited to the duration of the emergency." *Ken Moorhead Oil Co. v. Federated Mut. Ins. Co.,* 323 S.C. 532, 545, 476 S.E.2d 481, 488–89 (1996).

No Contract Clause violation has occurred in this case because the Statute does not substantially impair the contractual relationship between Kirven and Defendants; no vested right is affected by the Statute's application to Kirven's Policy. Moreover, Kirven has not shown that the Statute lacks a significant and legitimate public purpose or is

otherwise unreasonable or inappropriate.

Before delving into the Contract Clause analysis, Defendants address Kirven's claim that this case presents a "constitutional infirmity . . . even more serious" than this Court's analysis in *Harleysville Mut. Ins. Co. v. State*, 401 S.C. 15, 736 S.E.2d 651 (2012). (Kirven Brief, p. 20). Comparison of the Statute in this case to the occurrence-defining statute enacted by the General Assembly in response to the *Crossmann* litigation is misguided. (Kirven Brief, pp. 19-20). The statutes are readily distinguished by their scope. Unlike the occurrence-defining statute which retroactively defined a policy term across the board, *see* S.C. Code Ann. § 38-61-70, the General Assembly narrowly tailored this Statute to encompass *only those policies that lack a definition for actual charges.*

By exempting policies with express definitions of the term defined in the Statute, it supplements - rather than replaces - existing terms. It does not change a contractual right; it merely defines the right. On the other hand, the occurrence-defining statute's global application gave rise to this Court's concern that "[w]hile . . . it is within the legislature's power to statutorily define the meaning of 'occurrence,' it violates the Contract Clause to apply this new definition retroactively as it substantially impairs pre-existing contracts *by materially changing their terms*." *Harleysville*, 401 S.C. at 30-31, 736 S.E.2d at 658 (emphasis added). This Statute's limited application to only those policies that lack a definition in the first instance safeguards against that risk. Against that backdrop, Defendants turn to the Contract Clause analysis.

a. No Substantial Impairment Can Exist For Kirven's Alleged Right To Receive Amounts That She Was Never Obligated To Pay To Her Provider.

It is fatal to Kirven's claim of "substantial impairment" that she was never obligated to pay the amounts that she seeks.[11] The difference between the charges initially billed to her and the charges she actually owes (the latter of which entitles her to benefits under the Policy) is a fictional amount for which no loss can be identified. Those theoretical amounts will never be owed by Kirven. They are, in essence, no one's "actual charges."

1. No Vested Right Is At Stake.

Most courts that have considered Contract Clause challenges to similar policies under similar facts have reiterated the requirement that any substantial impairment must involve a *vested* right. For example, in *Stangl*, the District Court reasoned that:

> Plaintiff had a contractual right to payment of benefits under his policy, but the contractual right was to receive payment for his "actual expenses' of cancer treatment, which term was undefined in the policy. The fact that Plaintiff may have expected or even reasonably expected that "actual expenses" equated to the billed amount based upon the manner in which the Defendant has been paying him does not mean he had a *contractual right* to payments equaling billed amounts he had no obligation for nor does it mean that application of [the Oklahoma "actual charges" statute] ... constituted a substantial impairment.

Stangl, 804 F. Supp. 2d at 1237 (emphasis added). *See also Lindley,* 2010 WL 723670, at *11-12 (stating that although the state statute defining "actual charges" was "inconsistent with plaintiff's expectation, this does not show that the statute is a substantial impairment to a vested contractual right"); *McLaughlin*, 2010 WL 2507523, at *5-6 (same); *Energy*

[11] There is no dispute that the Policy establishes a contractual relationship and that the Statute affects the amounts that Kirven desires to receive thereunder. Accordingly, the Contract Clause analysis centers on the question of "substantial impairment."

Reserves Grp., Inc. v. Kansas Power & Light Co., 459 U.S. 400, 411 (1983) ("[S]tate regulation that restricts a party to gains it reasonably expected from the contract does not necessarily constitute a substantial impairment."). "It is difficult to see how denying [Kirven] additional funds that [s]he does not owe to h[er] medical providers deprives h[er] of a substantial right under the Policy." *Lindley*, 2010 WL 723670, at *8.

Because no "vested contractual right" is at stake, there can be no substantial impairment thereof. Payment of benefits equal to billed amounts that Kirven will never owe is not, as Kirven suggests, "a 'vested or substantial right' that goes to 'the right to collect some particular amount.'" (Kirven Brief, p. 11 n. 2). In fact, her contractual right was not to collect a particular amount at all, as the term "actual charges" remained undefined in the Policy. To conclude otherwise would obviate the Policy's requirement that benefits be paid *for a loss.* (*See* Appx. Ex. 2, p. DEF 009 (stating that the Policy "only provides benefits for a loss due to cancer and specified disease" (emphasis omitted)); p. DEF 0020 – Part J (requiring "[w]ritten proof of loss" for the payment of a claim)).

2. No Alteration Of A Reasonable Expectation Has Occurred.

Under South Carolina law, "[f]or purposes of Contract Clause analysis, a statute can be said to impair a contract when it alters the reasonable expectations of the contracting parties." *Hodges*, 341 S.C. at 94, 533 S.E.2d at 585–86. No alteration of a reasonable expectation has occurred in this case. The Statute's definition was not a "deviation from [contract] terms," *Henry v. Alexander*, 186 S.C. 17, 194 S.E. 649, 652 (1937), nor an "attempt[]to make material alterations in the character [or] terms" of the Policy, *Superior Motors, Inc. v. Winnebago Indus., Inc.*, 359 F.Supp. 773, 777 (D.S.C.

1973). The term "actual charges" is not defined in the Policy, and Kirven had no agreement with either Defendant as to the meaning of "actual charges" or how payments therefor would be determined. Defendants were not prohibited from altering their interpretation of "actual charges" and indeed were obligated to do so after passage of the Statute.

It is perplexing how Defendants' reliance on a legislatively-mandated definition could impair a reasonable expectation when, by the express terms of the Policy, the parties *anticipated and agreed* that such reliance would occur by virtue of the Renewal Agreement and Conformity Provision. Mere expectation is insufficient; South Carolina law requires that the expectation be reasonable. A belief that benefits would be paid according to a phantom amount disproportionate to the actual loss does not suffice. Kirven possessed no vested right to payment of benefits in that manner, and her expectation thereof was not reasonable.

Moreover, the only *reasonable* expectation that Kirven could have after renewal of her Policy post-Statute (and certainly after receipt of Philadelphia American's Notice advising of the Statute) is that her claims would be paid in accordance with the statutory definition rather than the *Ward I* definition. Kirven suggests that the Statute can never apply to her Policy because it "would alter the manner in which the Defendants have paid 'actual charges' benefits for the decade preceding the [S]tatute." (Kirven Brief, p. 16).[12] Kirven's argument presumes that her Policy is forever static, and that benefits must

[12] It is worthy of note that even before Kirven purchased her Policy, SCDOI defined "actual charges" to be obligated charges rather than billed charges: "'[t]he term 'actual charge' in industry-wide standards is the amount that you are *legally obligated to pay for a specific service.*'" *Ward I*, 257 F. App'x at 625 (quoting correspondence from SCDOI to Ward)(emphasis in original).

always be paid in the exact manner as they were on the date of her initial contract – even if that manner is not guaranteed by the Policy, even if that manner violates South Carolina law, even if her Policy contemplates amendments to correspond with changing law, and even if new contracts by renewal govern her relationship with Defendants. Such an extreme position is akin to a unyielding "coverage by estoppel" that prevents even permissible alterations contemplated by the Policy's express language. That is not the law.

Kirven has a right under the Policy to receive the "actual charges" for her cancer treatment and she is entitled to receive the full amount of her loss – the amount she is actually obligated to pay his medical providers. She is not entitled to monies she never owed, nor can Defendants be forced to perpetuate overpayment of claims simply because "that is the way it has always been done." Under these circumstances, the Policy terms are not substantially impaired by applying a mandatory statutory definition of a previously-undefined term to a renewing Policy that decreed conformity with state law.

b. South Carolina Has A "Significant And Legitimate" Public Purpose For Enacting The Statute.

This Court need not consider the purpose behind enactment because the Contract Clause analysis terminates upon a finding that no right has been substantially impaired. *E.g. Stangl*, 804 F. Supp. 2d at 1238 (declining to address significant and legitimate" injury because interpretation of "actual charges" under the statute did not substantially impair any contractual right). Nevertheless, a legitimate purpose exists for a state to enact a statute that prevents one party from reaping a windfall profit under an insurance policy. *Energy Reserves Grp.*, 459 U.S. at 412. The guard against higher premiums and fraudulent claims is a worthy legitimate purpose. *See Philadelphia Am. Life Ins. Co. v.*

Buckles, 350 F. App'x 376, 380 (11th Cir. 2009) (explaining the potential windfall created by payment of a benefit "based on a fictional amount . . . [which] lead[s] to an absurd result" such as, in that case, payment of a windfall billed sum that exceeded the actual cost of the services *by over $3 million*); *Lindley*, 2010 WL 723670, at * 8 ("The additional payments are a windfall unnecessary to cover his actual medical expenses, and is likely to lead to increase premiums for both him, and all insureds so the carrier could continue to pay the higher billed amount").

The statutory definition ensures that Kirven and others do not receive a windfall based on fictitious amounts they are not obligated to pay. The general purpose of an insurance policy is indemnity which protects the insured from bearing the cost of a loss. Its purpose is not to permit the insured to profit beyond the loss amount. This check on the payment of extra-contractual benefits ensures lower premiums and increases the availability and affordability of supplemental coverage for South Carolina citizens.

In the final analysis, the definition of "actual charges" contained within the Statute can be applied to insurance contracts executed prior to its Effective Date without encroaching on constitutional parameters. The Statute applies to Kirven's Policy (and others like it) prospectively in accordance with the express Policy terms, relieving the "grave concerns" Kirven raises without necessitating a complicated constitutional analysis. Even if this Court engages in a constitutional analysis of the propriety of retroactivity, constitutional avoidance, or whether the Contract Clause has been violated, the application of the Statute to Kirven's Policy passes muster.

II. To The Extent The Court Finds That The "Actual Charges" Definition Contained Within S.C. Code Ann. § 38-71-242 Cannot Be Applied To Policies Like Kirven's, The South Carolina Department Of Insurance Should Not Be Permitted To Compel Compliance With The Statute.

There is no substantive difference between the language of the Statute and the language of the Bulletin issued by SCDOI, which largely quotes from the Statute. (Appx. Ex. 4, pp. DEF 0473-0475). SCDOI is charged by statute with ensuring "that all laws of this State governing insurers or relating to the business of insurance are faithfully executed and mak[ing] regulations to carry out this title and all other insurance laws of this State, the enforcement or administration of which is not otherwise specifically provided for . . . ." S.C. Code Ann. § 38-3-110(2). Bulletins like the one at issue here are the means by which SCDOI communicates with those entities it has been charged to regulate.[13]

Although interpretive Insurance Department bulletins may not have the force of law, *Garris v. Cincinnati Ins. Co.*, 311 S.E.2d 723, 725 (1984) ("An Interpretive Bulletin is not binding on the courts."), this Bulletin extends beyond mere interpretation. First, the Bulletin reiterates, under the heading entitled "Compliance With S.C. Code Ann. § 38-71-242," the statutory mandate for insurers of specified disease policies: unless the policy contains a definition of "actual charges," insurers *may not* pay claims in excess of the statutory "actual charges" definition. (Appx. Ex. 4, p. DEF 0474). The Bulletin restates, almost verbatim, the Statute that the Department is charged to enforce. *See* S.C.

[13] It is undisputed that this Bulletin did not fill in gaps created by the Statute, although other South Carolina statutes require or permit the director to supplement the law by promulgating a bulletin. *See, e.g.*, S.C. Code Ann. § 38-5-180 ("The director or his designee shall outline via bulletin or order the information required in such an application."); S.C. Code Ann. § 38-33-50 ("the Director of the Department of Insurance shall, by regulations and/or policy bulletin, implement the provisions of this item.").

Code Ann. § 38-3-110(2).

In addition to reiterating the statutory mandate, the Bulletin also contains a mandate of its own. The second paragraph under the "Compliance" heading relies on the word "shall" to require that specified disease policy insurers "transmit a notice, in a form approved by the Department, to the named insured or beneficiary of each such policy informing him or her of the [statutory definition]." (Appx. Ex. 4, p. DEF 0475). Neither transmittal of the notice, nor prior approval of the notice by SCDOI, were optional.

Even if the Bulletin was not promulgated under the Administrative Procedures Act, it compelled specified disease insurers to issue a policyholder notice approved by SCDOI. This requirement of notice to all current policy holders is consistent with the Statute's clear intent to govern all supplemental policies issued to residents of South Carolina *regardless of issuance date*. The breadth of the Bulletin begs the question: if the Statute was not meant to apply to all policy-holders, then why was notice required for them?

To the extent this Court determines that the Statute does not apply to Kirven's Policy or other similar policies, Defendants request that the Court make clear that SCDOI is not entitled to enforce the Statute – by this Bulletin or otherwise – in a manner contrary to that holding.

CONCLUSION

For all of the reasons outlined above, this Court should answer the certified questions as follows: (1) the definition of "actual charges" contained within S.C. Code Ann. § 38-71-242 can be applied to insurance contracts executed prior to the Statute's effective date; and (2) to the extent that the "actual charges" definition contained within

S.C. Code Ann. § 38-71-242 cannot be applied to policies like Kirven's, the South Carolina Department Of Insurance should not be permitted to compel compliance with the Statute.

Respectfully submitted,

June 6, 2013

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THE STATE OF SOUTH CAROLINA
In the Supreme Court

QUESTIONS OF LAW CERTIFIED FROM
DISTRICT OF SOUTH CAROLINA

By Order of The Honorable Margaret B. Seymour,
District Court Judge for the District of South Carolina

Appellate Case No: 2013-000273

Diane Kirven, on behalf of herself and all others similarly situated, ... Plaintiff,

v.

Central States Health & Life Company of Omaha and Philadelphia
American Life Insurance Company ..... Defendants.

CERTIFICATE OF COMPLIANCE

The undersigned counsel hereby certifies that Defendants' Final Brief complies with Rule 211(b) of the South Carolina Appellate Court Rules and the August 13, 2007 Order of the South Carolina Supreme Court.

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v.

Central States Health & Life Company of Omaha and Philadelphia American Life Insurance Company ..... Defendants.

PROOF OF SERVICE

I, Sandy Moore, the undersigned employee of Gallivan, White & Boyd, P.A., attorneys for the Defendants, do hereby certify that I have served a copy of the foregoing **Defendants' Final Brief**, in connection with the above-referenced case by hand-delivering a copy of same on June 6, 2013 to the following addresses:

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