THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas
J. Mark Hayes, II, Circuit Court Judge

C.A. No. 2017-CP-42-00219

Appellate Case No. 2020-001613

Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly situated, ... Respondents,

v.

Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; CHSPSC, LLC; and Professional Account Services, Inc., ... Appellants.

RETURN TO PETITION FOR REHEARING

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INTRODUCTION

Incorporating all arguments and statements contained within their Final Brief, Respondents Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr. (collectively, "Insureds") hereby submit this Return pursuant to the Court's request. Because Appellants Mary Black Health System, LLC d/b/a Mary Black Memorial Hospital, CHSPSC, LLC, and Professional Account Services, Inc. (collectively, "Providers") have failed to identify anything the Court overlooked or misapprehended in its opinion, *Blackwell v. Mary Black Health Sys., LLC*, Op. No. 6088 (S.C. Ct. App. filed Sept. 18, 2024) ("*Blackwell* opinion"), the Petition for Rehearing and Suggestion for Rehearing *en banc* should be denied.

At heart, Providers ask this Court to ignore the allegations of the operative complaint in order to reach a different conclusion and compel Mr. Owens to arbitration, mixing proverbial "apples and oranges" in a strained attempt to marry the decision in *this* case with the same panel's decision in an entirely different case.[1] But Providers' arguments are without merit and are legally incorrect. The opinion in this case and the *Bennett* opinion are neither inconsistent nor irreconcilable, and the record does not support Providers' argument that the complaints at issue concern "virtually identical allegations."

In the *Blackwell* opinion, a majority of the panel properly affirmed the lower court's denial of the motion to compel arbitration against Mr. Owens, a CIGNA insured. Mr. Owens was not a party to Mary Black's hospital services contract with CIGNA ("the CIGNA Agreement"), his claims do not fall within the terms or scope of the agreement's arbitration provision, and there was no evidence in the record that he ever relied on the CIGNA Agreement or received any benefit

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[1] *Bennett v. ACS Primary Care Physicians-Se. P.C.*, Op. No. 6089 (S.C. Ct. App. filed Sept. 18, 2024) (*remittitur*) (hereafter "the *Bennett* opinion").

therefrom.[2] Indeed, despite Providers' argument to the contrary, the facts are the facts and the pleadings are the pleadings—the allegations in the Amended Complaint ("Complaint") do not assert that Mr. Owens's claims arise solely from the CIGNA Agreement, nor does the Complaint contain a breach of contract claim alleging that Mary Black breached its contract with CIGNA.[3]

For these reasons, the Petition for Rehearing should be denied, and the Court should similarly decline the suggestion for rehearing *en banc*. Consideration by the full court is not necessary "to secure or maintain uniformity of its decisions," and these proceedings do not involve questions of "exceptional importance." Rule 219(a), SCACR. Instead, the *Blackwell* opinion (and the *Bennett opinion*, for that matter) both address a scenario regularly reviewed by South Carolina appellate courts: a non-signatory to an arbitration agreement brings a lawsuit that relates, however tangentially, to a contract containing an arbitration agreement and a motion to compel the non-signatory to arbitration is filed; following the denial of the motion to compel, along with the denial of various Rule 12 motions to dismiss, an appeal follows from both the denial of the motion to compel and the admittedly interlocutory orders denying the Rule 12 motions. Since the Court thoughtfully and thoroughly considered and rejected the issues presented by Providers in their appeal, the Petition for Rehearing should be denied.

ARGUMENT

The appellate courts grant petitions for rehearing to correct points that the court "overlooked or misapprehended." Rule 221(a), SCRCP. But the purpose of a rehearing petition is not to address

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[2] In fact, the evidence is that Mr. Owens did not even know of the CIGNA Agreement's existence.

[3] As the panel explained in the *Bennett* opinion, the operative complaints at issue in *Bennett* contained such a cause of action and alleged that plaintiffs were third-party beneficiaries of the hospital's participating provider agreements with the insurance companies, in addition to asserting that those plaintiffs received direct benefits from the provider agreements. (*See Bennett* Op. at 3, 5–6, 8.)

"points the lawyers of losing parties overlooked themselves" or to permit "the case [to be] tried in the Court of Appeals a second time." *Checker Yellow Cab Co. v. Checker Cab & Parcel Serv., Inc.*, 287 S.C. 608, 612, 340 S.E.2d 549, 552 (Ct. App. 1986); *see also Kennedy v. S.C. Ret. Sys.*, 349 S.C. 531, 532, 564 S.E.2d 322, 322 (2001) (same). Additionally, hearing an appeal *en banc* is disfavored, and the Court of Appeals ordinarily does not exercise its discretion to accept rehearing *en banc* unless "consideration by the full court is necessary to secure or maintain uniformity of its decisions" or the appeal "involves a question of exceptional importance." Rule 219(a), SCRCP; *see Williamston v. Middleton*, 383 S.C. 490, 494, 681 S.E.2d 867, 869 (2009). The Court did not make a mistake in the *Blackwell* opinion by affirming the trial court's denial of Providers' motion to compel arbitration and declining to review the denial of their Rule 12 motions. The *Blackwell* opinion likewise can be reconciled with the Court's decision in the *Bennett* case, and this appeal does not present a "question of exceptional importance" that would require rehearing *en banc*. The Court should deny Appellants' Petition for Rehearing and Suggestion for Rehearing *En Banc*.

I. The *Blackwell* Opinion did not overlook or disregard any material fact or legal principle in affirming the denial of Providers' motions.

Providers seek rehearing in an effort to overturn the *Blackwell* opinion and the majority's reasoning therein, in effect urging the evisceration of a long line of cases addressing the equitable estoppel doctrine in the arbitration context. *See Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 733 S.E.2d 597 (Ct. App. 2012); *Wilson v. Willis*, 426 S.C. 337, 827 S.E.2d 167 (2019); *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 847 S.E.2d 268 (Ct. App. 2020). The Court should reject such an attempt and deny the Petition.

As an initial matter, these arguments were previously raised by Providers and rejected by

a majority of the *Blackwell* panel and therefore do not constitute a valid basis for rehearing.[4] (*See Blackwell* Op. at 8–10). Here, the Complaint asserts three causes of action against Providers: tortious interference with contract (specifically, Plaintiffs' individual health insurance policies); unjust enrichment; and injunctive relief. "The character of an action is primarily determined by the allegations contained in the complaint." *Stoneledge at Lake Keowee Owners'' Ass'n v. Clear View Constr., LLC*, 413 S.C. 615, 620, 776 S.E.2d 426, 429 (Ct. App. 2015) (internal quotation marks omitted). Providers urge this Court to adopt the dissent's reasoning to hold that because Mr. Owens's claims relate to or arguably would not have arisen "but for" the CIGNA Agreement's existence, direct benefits estoppel requires arbitration of his claims. In so doing, Providers effectively seek the Court's reversal of *Weaver v. Brookdale Senior Living* (and the cases cited therein) and ask the Court to recharacterize Owens's claims as breach of contract claims and write in third-party beneficiary allegations where none exist.

Providers insist that "Plaintiffs' claims [are], at root, that Defendants should be held to the terms of their contracts Plaintiffs' health insurance carriers" and that the contractual discounts

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[4] In the Final Brief of Appellants, Providers asserted (wrongly) that Mr. Owens "seeks to enforce the terms of a contract between the hospital and his insurance carrier as a non-signatory, third-party beneficiary of that contract," and that "his claims all involve his effort to enforce terms of [the CIGNA agreement] and to derive direct benefit therefrom." (App. Br. 6, 12). While the panel found that the claim for injunctive relief—i.e., Mr. Owens's attempt to stop Providers from continuing its "refusal to bill" policy and extorting money from patients other than himself—did rely upon the CIGNA agreement, the panel also found that his other claims arose from his own health insurance policy with CIGNA. (*Blackwell* Op. at 9). Mr. Owens and the other plaintiffs allege that they had a valid business expectancy and/or contractual relationship with their own health insurance providers, which Providers intentionally and improperly interfered with by preventing them from receiving the benefit of those relationships. (*See* R. pp. 75–76 (Am. Compl. at ¶¶ 64–74)). Put another way, Insureds allege that they paid premiums for health insurance policies but received no benefits therefrom because Providers intentionally interfered with the policies in an effort to obtain greater compensation for services rendered from the insureds directly—a practice referred to as Providers' "refusal to bill" policy. As noted at oral argument, this practice did in fact result in Providers making more money than they would have obtained from submitting Insureds' medical bills to their health insurance carriers.

contained in the providers' agreements with various insurance carriers "*is* the benefit Plaintiffs seek in the litigation." (Pet. at 9). In fact, such assertions are untrue, misleading, and invite the Court to disregard the allegations in the Complaint. What the Insureds want are the benefits accorded to them under their own health insurance policies, for which they have paid premiums and received promises in return.[5] The Complaint clearly sets out these allegations, and the majority of the panel properly relied on them in reaching its decision. (*See* R. pp. 64, 73, 75–76 (Am. Compl. at ¶¶ 5–8, 57(e)–(g), 63–74)). The Court thus correctly affirmed the lower court, noting that Mr. Owens received no benefit from the CIGNA Agreement and never availed himself of the Agreement.

Having affirmed the order denying Providers' motion to compel Mr. Owens to arbitration, the panel properly declined to address the denial of their Rule 12(b)(6) motions. Providers' argument, at its core, seeks to do away with the traditional role of the trial court and overturn long-standing precedent by asking this Court not only to ignore the operative complaint when considering motions to compel arbitration, but also when considering Rule 12 motions. In essence, Providers seek to displace the role of by the trial court by "leapfrogging" over the trial court to obtain appellate review of an unappealable, interlocutory order. The panel correctly declined to endorse such an approach. (*See Blackwell* Op. at 11 (declining to address the denial of Providers' Rule 12(b)(6) motions)). *Cf. S.C. Baptist Hosp. v. S.C. Dep't of Health & Env't Control*, 291 S.C.

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[5] Providers focus on the discounted rates for services rendered, as established by their contracts with health insurance carriers, but they utterly neglect to acknowledge that Insureds are seeking and allege that they are entitled to have their hospital bills submitted to their health insurance carrier *regardless of the outcome*. This myopic focus on the purported discounts contained in the CIGNA Agreement, instead of on the "refusal to bill" policy which Insureds contend represents a practice better known as extortion, reflects Providers' continued attempts to distract from the business practice at issue, which they contend represents the "mere assertion of a lien," App. Br. 27, and fail to recognize the practical implications of the practice. *See e.g.*, Rule 1.15(e), RPC, Rule 407 SCACR.

267, 353 S.E.2d 277 (1987) (declining to consider interlocutory appeal when the decision-maker has not yet had an opportunity to decide the merits of the case and consideration by the appellate court would be premature); *Berkeley Cnty. Sch. Dist. v. Hub Int'l Ltd.*, 944 F.3d 225, 233 (4th Cir. 2019) (in reviewing denial of motion to compel arbitration, court must accept as true the allegations of the operative complaint that relate to the "underlying dispute between the parties"); *Justice v. The Pantry*, 335 S.C. 572, 576, 518 S.E.2d 40, 42 (1999) (reiterating requirement that "[t]he trial court and this [C]ourt on appeal must presume all well pled facts to be true" and acknowledging "[t]he grant of a motion to dismiss for failure to state facts sufficient to constitute a cause of action cannot be upheld if facts alleged in the complaint and inferences reasonably deducible therefore, if proven, would entitle the plaintiff to relief on any theory of the case" (quoting *Morrow Crane Co. v. T.R. Tucker Constr. Co.*, 293 S.C. 427, 429, 373 S.E.2d 701, 702 (Ct. App. 1988))).

II. The *Blackwell* Opinion does not conflict with the decision in the *Bennett* case.

The Court's decision in the *Bennett* case held that the plaintiff-insureds were equitably estopped from avoiding arbitration provisions in provider agreements between their health insurance and healthcare providers, but that decision and the *Blackwell* opinion can be reconciled. (*See Bennett* Op. at 9.) The opinion in *Bennett* held that equitable estoppel applied because the plaintiffs' allegations established that their claims for relief all arose solely from the provider agreements. (*See, e.g.*, *id.* at 6 ("Bennett pled all of her claims as being based on an alleged duty arising *solely* from the terms of the Provider Agreement."); *id.* at 7 ("[A]ll of Gasser's claims were pled as being based on an alleged duty arising *solely* from the Provider Agreement.")). Additionally, the Court concluded that the plaintiffs were equitably estopped because of "admissions in their respective complaints that they received direct benefits from the Provider Agreements preclude them from avoiding the arbitration provisions in these agreements." (*Id.* at 9). Thus, just like the *Blackwell* opinion, the Court reached its decision in

the *Bennett* case after thoroughly analyzing the allegations in the plaintiffs' complaints. (*See id.* at 2, 6–7, 9).

That the decision in *Bennett* reached a different conclusion about the application of the equitable estoppel doctrine than the *Blackwell* opinion under similar facts does not mean that the decisions conflict or cannot be reconciled. The different outcomes result from differences in how the plaintiffs framed their cases in the pleadings, and it is well established that plaintiffs are the "architects of their own complaint." *Morrow v. Fundamental Long-Term Care Holdings, LLC*, 412 S.C. 534, 773 S.E.2d 144, 146 (2015); *see also Damico v. Lennar Carolinas, LLC*, 437 S.C. 596, 615, 879 S.E.2d 746, 757 (2022) ("[T]he plaintiff is the master of his own complaint . . . ."). Further, equitable estoppel is an equitable doctrine "designed to prevent injustice," and its application depends on the circumstances and equitable considerations, even in the arbitration context. *Wilson v. Willis*, 426 S.C. 326, 345, 827 S.E.2d 167, 177 (2019). Because of this, courts that have addressed the doctrine in reviewing arbitration orders unsurprisingly have reached different conclusions about its application based on the facts and the claims set forth in the pleadings. *See id.* at 342–45, 827 S.E.2d at 176–77; *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 230–32, 847 S.E.2d 268, 272–73 (Ct. App. 2020); *Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 296–97, 733 S.E.2d 597, 605 (Ct. App. 2012).

Although Providers argue that *Blackwell* and *Bennett* have the same "core allegations," they cherry pick allegations from the complaints and ignore that here (unlike in *Bennett*) Mr. Owens did not allege he benefited from the CIGNA Agreement, and his claims do not arise *solely* from that contract. (*Blackwell* Op. at 8; *see Bennett* Op. at 7.) Instead, the Complaint alleges that Providers' challenged business practice deprived the plaintiffs of the benefit of

their own insurance contracts and alleges claims arising out of South Carolina tort law. (*See Blackwell* Op. at 8–9; R. p. 75–76). That Providers disagree with the conclusion reached in this case does not mean the decisions are "conflicting and irreconcilable" or that they have created "an immediate conflict in the law of equitable estoppel." Courts addressing the doctrine in future cases are well-equipped to conduct the circumstance-specific analysis that was performed in both *Blackwell* and *Bennett*. This Court should decline Providers' hyperbolic attempt to create a conflict where none in fact exists.

III. This appeal does not present any exceptional or significant issues that the Court should address *en banc*.

A. Unfounded concerns of Artful Pleading and Gamesmanship Do Not Support Rehearing.

Providers' assertions that the *Blackwell* opinion will sow confusion and represent an endorsement of "artful pleading" and "gamesmanship" to avoid arbitration are entirely overblown. The idea that "artful pleading"—i.e., a well-pleaded complaint drafted by able counsel—is a detriment to the practice of law contravenes the long-acknowledged truth that writing well is one of the lawyer's most critical skills. In fact, our courts have long recognized the critical importance of artful pleading, disparaged here by Providers. *Cf. Layne v. Int'l Brotherhood of Elec. Workers*, 271 S.C. 346, 349, 247 S.E.2d 346, 351 (1978) (holding that while the Plaintiff's complaint "*suffers from a lack of artful pleading*," such deficiency would not be viewed as fatal to Plaintiff's claims (emphasis added)); *Dunlap v. Lindau Chems.*, C.A. No. 3:17-cv-0504-CMC-TER (D.S.C. Apr. 26, 2017) (holding that although plaintiff's allegations, originally filed in the Richland County Court of Common Pleas, were "*perhaps not the most artfully pleaded*," they were still sufficient to state a claim for violation of the ADA (emphasis added)).

The allegation that the *Blackwell* opinion will encourage or promote gamesmanship by encouraging future litigants seeking to avoid equitable estoppel "to strategically omit undeniable

allegations from their complaints" and "allege multiple non-arbitrable claims, even if those extra non-arbitrable claims lack merit," (Pet. at 10–12), similarly does not warrant rehearing. The trial courts, not the appellate courts, are best positioned to address gamesmanship in pleadings (and other litigation misconduct), and parties seeking to enforce arbitration provisions have the right to immediately appeal the denial of an arbitration motion.[6]

B. The *Blackwell* Opinion Does Not Misconstrue the Plain Language of the CIGNA Agreement or Conflict with the United States Supreme Court.

In addition to concluding that Mr. Owens's claims did not arise from the CIGNA Agreement, the *Blackwell* Opinion concluded that, "*even if*" they did, the Agreement's plain language prevented Mr. Owens from arbitrating his claims against Providers because it expressly prohibits class-wide arbitration. (*Blackwell* Op. at 10 (emphasis added)). The CIGNA Agreement supports this interpretation.

The CIGNA Agreement's dispute resolution provisions apply to "disputes between the parties arising with respect to the performance or interpretation of the Agreement," and the parties to the Agreement were CIGNA insurance and Mary Black Hospital. (R. p. 275; *see id.* at 263–64). Mr. Owens and other CIGNA insureds who received medical treatment at Mary Black Hospital, however, were not parties to the Agreement. Instead, these individuals fall within the Agreement's definition of "Participant"—"any individual . . . who is eligible and enrolled to receive Covered Services." (R. p. 264.) While the Agreement does not define "party" or "parties," the usual, ordinary meaning is "[o]ne who takes part in a transaction." *Party*, *Black's Law Dictionary* (11th ed. 2019); *see Arredondo v. SNH SE Ashley River Tenant, LLC*, 433 S.C. 69, 79, 81, 856 S.E.2d

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[6] In their Petition, Providers include matters outside the Record on Appeal. (*See* Pet. 14 n.3). To the extent the Court elects to consider these matters, Insureds respectfully submit that the trial court's orders that were entered after Providers filed this appeal provide a comprehensive history of this litigation.

550, 556, 557 (2021) (applying the "plain, ordinary, and popular meaning" to undefined terms in a contract). Further, the dispute resolution provisions repeatedly refer "a party" and "parties," while separately using the defined term "Participant" once. (*See* R. p. 275–76, §§ 6.2.1, 6.2.2). The language used in the Agreement thus indicates an intent not to apply to a non-party "Participant" such as Mr. Owens.

Although the Agreement states that arbitration is "the exclusive remedy for the resolution of disputes arising under this Agreement," it further provides that:

> The parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision shall not be consolidated with an arbitration involving other hospitals or third parties, and that the arbitrator shall be without power to conduct an arbitration on a class basis.

(R. p. 276). Interpreting this language and the CIGNA Agreement as a whole, the panel correctly concluded that a non-signatory, non-party to the Agreement could not arbitrate his claims. *See generally Silver v. Aabstract Pools & Spas, Inc.*, 376 S.C. 585, 591, 658 S.E.2d 539, 542 (Ct. App. 2008) ("[T]he court must consider the contract as a whole, rather than deciding whether phrases in isolation could be interpreted in various ways . . . . [T]he intention of the parties and the meaning are gathered primarily from the contents of the writing itself, or, as otherwise stated, from the four corners of the instrument . . . .").

Further, the Panel's contractual interpretation of the language and provisions in the CIGNA Agreement does not conflict with the U.S. Supreme Court's opinion in *Epic Systems Corp. v. Lewis*, 584 U.S. 497 (2018). The *Epic* case is easily distinguishable because it involved claims brought by employees (individually and on behalf of others similarly situated), and the employees were signatories to agreements with their employers that contained arbitration provisions. *See id.* at 502–03. Here, in contrast, Mr. Owens did not sign or know about the CIGNA Agreement, and he did not have an employer/employee relationship with Providers. While parties to an agreement

can certainly agree to resolve their disputes through individual arbitration, Providers are incorrect that *Epic* required the Panel to conclude that a non-signatory, non-party had waived his right to bring claims on a class basis.

CONCLUSION

Providers' petition does not establish that the *Blackwell* opinion overlooked or misapprehended any important fact or legal principle, and the different conclusions reached in *Blackwell* and *Bennett* result from differences in how those cases were pled. The Court should neither rehear this matter nor accept Providers' suggestion for *en banc* review to address issues that should be handled by the trial courts.

Respectfully submitted,

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PROOF OF SERVICE

The undersigned hereby certifies that on December 16, 2024, Respondents' *Return to Petition for Rehearing* was served on all counsel of record via email containing the above referenced document to counsels' individual AIS email addresses as follows:

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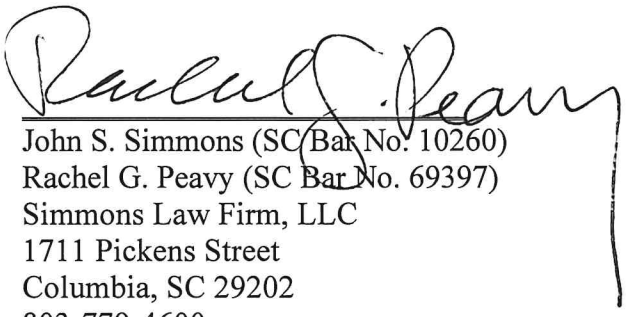

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