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SC Court of Appeals

THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

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APPEAL FROM SPARTANBURG COUNTY  
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

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Case No. 2017-CP-42-00219  
Appellate Case No. 2020-001613

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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;  
Professional Account Services, Inc.,

Appellants,

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**RECORD ON APPEAL  
VOL. I**

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**STATE OF SOUTH CAROLINA  
COUNTY OF SPARTANBURG****IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT**

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

Plaintiffs,

v.

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

Defendants.

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

**ORDER DENYING DEFENDANTS'  
MOTION TO ALTER OR AMEND****BACKGROUND**

This matter came before the Court on Defendants' Motion to Alter or Amend, which Defendants filed on September 14, 2020. Plaintiffs filed a Response in Opposition to Defendants' Motion to Alter or Amend on October 9, 2020, and Defendants filed a Reply to Plaintiffs' Response in Opposition on October 19, 2020. Defendants moved, pursuant to Rule 59(e), SCRPC, for the Court to reconsider and alter or amend its prior order denying Defendants' Motions to Dismiss Pursuant to Rule 12(b)(6) or, in the Alternative, to Stay the Case and Compel Arbitration (hereinafter, "Defendants' Motions to Dismiss or Compel Arbitration"). The Court issued an order denying Defendants' Motions to Dismiss or Compel Arbitration on September 4, 2020.

Defendants' Motion to Alter or Amend asks the Court to modify its September 4 Order and: (1) compel Plaintiff Owens to arbitrate his claims against Defendants; (2) dismiss Plaintiff Owens's claims based on the statute of limitations; (3) reconsider its analysis of the voluntary payment doctrine; (4) dismiss Plaintiff Blackwell's unjust enrichment claim; (5) find that Plaintiff Blackwell is barred from enforcing the MedCost Agreement between Defendant Mary Black and

her health insurer as a third-party beneficiary; and (6) conclude that Plaintiffs have improperly engaged in “collective pleading.” The Court has fully considered all of Defendants’ arguments in their Motion, Plaintiffs’ arguments in opposition, and Defendants’ arguments in their reply brief, as well as the parties’ prior submissions in connection with Defendants’ Motions to Dismiss or Compel Arbitration (including the documents filed under seal by Defendants). Consistent with Rule 59(f), the Court has determined, in its discretion, that Defendants’ motion may “be determined on briefs filed by the parties without oral argument.” Rule 59(f), SCRPC. For the following reasons, Defendants’ Motion to Alter or Amend is **DENIED**.

### STANDARD OF REVIEW

“The purpose of Rule 59(e), SCRPC, to alter or amend the judgment is to request the trial judge to ‘reconsider matters properly encompassed in a decision on the merits.’” *Pye v. Estate of Fox*, 369 S.C. 555, 565–566, 633 S.E.2d 505, 510 (2006) (quoting *Arnold v. State*, 309 S.C. 157, 172, 420 S.E.2d 834, 842 (1992)). “[I]t is proper to view a Rule 59(e) motion not only as a vehicle to request the trial court ‘alter or amend the judgment,’ but also as a vehicle to seek ‘reconsideration’ of issues and arguments. A motion under Rule 59(e) long has been viewed as ‘motion for reconsideration’ despite the absence of those words from the rule.” *Elam v. S.C. Dept. of Transp.*, 361 S.C. 9, 21, 602 S.E.2d 772, 778–779 (2004). Additionally, where a movant fails to identify any issue raised, but not ruled upon in a prior motion, a motion for reconsideration is properly denied. *See Collins Music Co. v. IGT*, 353 S.C. 559, 579 S.E.2d 524 (Ct. App. 2002).

### ANALYSIS

#### **1. Plaintiff Owens should not be compelled to arbitrate his claims against Defendants.**

The Court previously rejected Defendants’ assertion that this case should be stayed and Plaintiff Owens should be compelled to arbitrate his claims against Defendants due to an agreement between CIGNA and Defendant Mary Black. Defendants’ Motion to Alter or Amend

has not convinced the Court that it should change its prior conclusion. In asking the Court to reconsider its decision on the arbitration issue, Defendants have argued the issues of equitable estoppel, whether the elective nature of the arbitration provision in the CIGNA agreement affects the analysis, and whether a disclaimer of third parties and class arbitration in that agreement renders the arbitration provision unenforceable against Plaintiff Owens.

The Court finds it significant that Plaintiff Owens is not a party to the CIGNA agreement. Under the facts and circumstances of this case, the Court concludes that the decisions of the Court of Appeals in *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 847 S.E.2d 268 (Ct. App. 2020), and of the South Carolina Supreme Court in *Wilson v. Willis*, 426 S.C. 326, 827 S.E.2d 167 (2019), are applicable and controlling. Indeed, the facts of the present case are even more compelling than those in *Weaver* or in *Wilson*. Neither direct benefits estoppel nor equitable estoppel apply to this case, and Defendants' remaining arguments for compelling arbitration are rejected.

## **2. Plaintiffs' Amended Complaint sufficiently pled facts against Defendants.**

The Court also rejects Defendants' argument that Plaintiffs have improperly pled their claims against them because some of those claims were pled collectively. The Court agrees with Plaintiffs' arguments that Defendants misconstrue either the effect of Plaintiffs' allegations or applicable South Carolina pleading standards, and concludes that, under the standards of Rule 8 and Rule 12(b)(6), SCRCF, the allegations of Plaintiffs' Amended Complaint are sufficient.

Although Defendants suggest Plaintiffs' pleadings improperly attempt to attach liability to each defendant, Plaintiffs have not alleged any defendant is vicariously liable for the actions of another, nor have Plaintiffs attempted to pierce the corporate veil of any defendant. Plaintiffs'

Amended Complaint instead alleges that these Defendants acted in concert and that each Defendant is liable for its own conduct. For these reasons, the Court concludes that Defendants' authorities are inapposite.

The Court also finds Defendants' alternative suggestion that collective pleading is prohibited or improper in South Carolina is incorrect. The Court is unaware of any case law, statute, or rule in the South Carolina Rules of Civil Procedure that prohibits "collective pleading" or somehow requires Plaintiffs to repeat allegations against individual defendants when those defendants allegedly acted in concert. Again, the Court finds that the cases Defendants cite on this point are not dispositive, and in fact, *Pro Slab, Inc. v. Argos USA Corp.*, C.A. No. 2:17-3185-BHH, 2018 WL 6985008 (D.S.C. June 28, 2018), supports Plaintiffs' position.

In *Pro Slab*, the district court cited *Connor v. Honeywell Int'l Inc.*, C.A. No. 2:12-1421-CWH, 2012 WL 6135193 (D.S.C. Nov. 13, 2012), which found collective Pleading to be proper:

In *Connor*, affiliated corporate defendants sought dismissal of the plaintiff's claims . . . by claiming that it was not clear which defendant or defendants were alleged to have committed which wrong. The court stated that it was "initially inclined to allow the plaintiff an opportunity to amend the complaint to clarify which conduct was attributable to which defendant." *Id.* at \*1. However, after the plaintiff represented that it was his view that the defendants were acting in concert . . . , the court found the complaint adequate. . . . Thus, the factual allegations in the plaintiffs' complaint in *Connor* supported the assertion that the defendants acted together. In contrast, here, Plaintiffs' amended complaint merely alleges the legal conclusion that the affiliated corporate entities were agents and/or alter egos and operated as one company, but the amended complaint contains *no factual allegations* to support that legal conclusion.

*Pro Slab, Inc.*, 2018 WL 6985008, at \*5. Additionally, the Court has considered Defendants' other cited authority and concludes it offers no support for their position. *See Scurmont LLC v. Firehouse Rest. Grp., Inc.*, C.A. No. 4:09-CV-00618-RBH, 2010 WL 11433199, at \*15 (D.S.C. May 19, 2010) (finding a lack of specific personal jurisdiction over an individual defendant because the plaintiff failed to plead facts demonstrating the defendant committed wrongful acts within South

Carolina). Accordingly, the Court did not err by finding Plaintiffs sufficiently pled the allegations in their Amended Complaint.

**3. Other provisions of the Court's September 4 Order do not require alteration.**

Defendants' remaining arguments regarding the statute of limitations, the voluntary payment doctrine, unjust enrichment, and the Med-Cost Agreement's alleged disclaimer are also rejected. The Court has fully considered those arguments and found Plaintiffs' responses to be persuasive and appropriate.

**CONCLUSION**

For all the foregoing reasons, Defendants have not convinced the Court that it should alter or amend its order denying Defendants' Motions to Dismiss or Compel Arbitration. Defendants' Motion to Alter or Amend is accordingly **DENIED**.

**IT IS SO ORDERED.**

*Judge's electronic signature page follows.*



Spartanburg Common Pleas

**Case Caption:** Jo Ann Blackwell , plaintiff, et al VS Mary Black Health System, Llc  
, defendant, et al

**Case Number:** 2017CP4200219

**Type:** Order/Other

IT IS SO ORDERED

s/ J. Mark Hayes, II #2132

Electronically signed on 2020-12-08 12:07:30 page 6 of 6

## FORM 4

STATE OF SOUTH CAROLINA  
COUNTY OF Spartanburg  
IN THE COURT OF COMMON PLEAS

## JUDGMENT IN A CIVIL CASE

CASE NO. 2017CP4200219

Jo Ann Blackwell et al  
PLAINTIFF(S)

Mary Black Health System, Llc et al  
DEFENDANT(S)

## DISPOSITION TYPE (CHECK ONE)

- ☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.
- ☐ **ACTION DISMISSED** (CHECK REASON): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled);  
☐ Other
- ☐ **ACTION STRICKEN** (CHECK REASON): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy;  
☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award;  
☐ Other
- ☐ **STAYED DUE TO BANKRUPTCY**
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (CHECK APPLICABLE BOX):  
☐ Affirmed; ☐ Reversed; ☐ Remanded;  
☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

**IT IS ORDERED AND ADJUDGED:** ☐ See attached order (formal order to follow) ☒ Statement of Judgment by the Court:

Please see below.

## ORDER INFORMATION

This order ☐ ends ☒ does not end the case.

☒ See Page 2 for additional information.

## For Clerk of Court Office Use Only

This judgment was electronically entered by the Clerk of Court as reflected on the Electronic Time Stamp, and a copy mailed first class to any party not proceeding in the Electronic Filing System on 11/04/2020 .

John Doe

NAMES OF TRADITIONAL FILERS SERVED BY MAIL

**Court Reporter:**

**E-Filing Note:** The date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgment to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.

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This matter came before the Court on a SCRCP Rule 59(e) filed by the Defendants seeking to alter or amend this Court's prior order denying the defendants' SCRCP Rule 12(B)(6) motion wherein the Defendants sought to have the case dismissed or, alternatively, stayed. The Court appreciates the quality of the briefing. As allowed by SCRCP Rule 59(f), this Court exercises its discretion to determine the present motion on the briefs filed by the parties.

After reviewing the submission made by the parties, the documents filed under seal, and considering this Court's prior order, the present motion is denied. The plaintiffs' counsel is asked to prepare and propose a formal order denying the motion. The proposed order, once reviewed, edited if necessary, signed and filed, will be the final order of this Court as to the present motion.

As is mentioned by all parties, the plaintiffs are not parties to the confidential agreement. Under the facts of the present case, Weaver more applicable and controlling. The present case is even more compelling than Weaver and Wilson that the doctrines of "direct benefits estoppel" and "equitable estoppel" are not applicable. Other provisions of the prior order also do not need alterations. The arguments offer in Plaintiff's memorandum appear appropriate. Include in the proposed order the analysis that addresses the defendant's alternative suggestion that the collective pleading is somehow deficient, prohibited, or improper. Under a 12(B) analysis, the complaint is proper.

Again, thank you for the briefing and patience while the matter was reviewed.



Spartanburg Common Pleas

**Case Caption:** Jo Ann Blackwell , plaintiff, et al VS Mary Black Health System, Llc  
, defendant, et al

**Case Number:** 2017CP4200219

**Type:** Order/Electronic Form 4

IT IS SO ORDERED

s/ J. Mark Hayes, II #2132

Electronically signed on 2020-11-04 12:11:14 page 3 of 3

## FORM 4

STATE OF SOUTH CAROLINA  
COUNTY OF SPARTANBURG  
IN THE COURT OF COMMON PLEAS

## JUDGMENT IN A CIVIL CASE

CASE NO. 2017CP4200219

Jo Ann Blackwell, et al

Mary Black Health System, LLC et al

PLAINTIFF(S)

DEFENDANT(S)

Submitted by: The Honorable J. Mark Hayes II

Attorney for : ☐ Plaintiff ☐ Defendant  
or  
☐ Self-Represented Litigant

## DISPOSITION TYPE (CHECK ONE)

- ☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.
- ☐ **ACTION DISMISSED (CHECK REASON):** ☐ Rule 12(b), SCRPC; ☐ Rule 41(a), SCRPC (Vol. Nonsuit); ☐ Rule 43(k), SCRPC (Settled); ☐ Other
- ☐ **ACTION STRICKEN (CHECK REASON):** ☐ Rule 40(j), SCRPC; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other
- ☐ **STAYED DUE TO BANKRUPTCY**
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**  
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

**IT IS ORDERED AND ADJUDGED:** ☐ See attached order (formal order to follow) ☒ Statement of Judgment by the Court:

## ORDER INFORMATION

This order ☐ ends ☒ does not end the case.

Additional Information for the Clerk : Please see the Information Below.

## INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

| Judgment in Favor of<br>(List name(s) below) | Judgment Against<br>(List name(s) below) | Judgment Amount To be<br>Enrolled<br>(List amount(s) below) |
|----------------------------------------------|------------------------------------------|-------------------------------------------------------------|
|                                              | N/A                                      | N/A                                                         |
|                                              |                                          | \$                                                          |
|                                              |                                          | \$                                                          |

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk.

**Note: Title abstractors and researchers should refer to the official court order for judgment details.**

**E-Filing Note: In E-Filing counties, the Court will electronically sign this form using a separate electronic signature page.**

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Circuit Court Judge

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Judge Code

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Date**For Clerk of Court Office Use Only**

This judgment was entered on the 4<sup>th</sup> day of September, 2020 and a copy mailed first class or placed in the appropriate attorney's box on this 4<sup>th</sup> day of September, 2020 to attorneys of record or to parties (when appearing pro se) as follows:

---

 Thomas A. Killoren Jr., Ryan Frederick McCarty,

---

 Katon Edwards Dawson Jr., James Lynn Werner

---

 Marghretta Hagood Shisko, John S. Simmons,

---

 John Belton White, Jr.

---

**ATTORNEY(S) FOR THE PLAINTIFF(S)**


---

**ATTORNEY(S) FOR THE DEFENDANT(S)**


---

**CLERK OF COURT**
**Court Reporter:**

**E-Filing Note:** In E-Filing counties, the date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgement to parties who are not E-Fileers or who are appearing pro se. See Rule 77(d), SCRPC.

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**ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.**

This matter came before the Court on various SCRPC Rule 12(b)(6) motions and a motion to stay and compel arbitration. After receiving the arguments, reviewing the materials submitted, and applying the required respective standards of review to the information presently before the Court, the motions cannot be granted. Even though the present decision predominantly is a denial under SCRPC Rule 12(b) (6) and, thus, decides no issue on its merits, the following observations are made in an effort to assist the parties in moving forward.

Plaintiffs present this case as a putative class action, pursuant to SCRPC Rule 23. Plaintiffs bring this action against Mary Black Memorial Hospital (a local hospital in Spartanburg), as well as the two entities that Plaintiffs allege are responsible for the hospital's billing of patients and filing of liens, Community Health Systems Professional Services Corporation (CHSPSC) and Professional Account Services. The class, which has not yet been certified, is currently defined as;

“All individuals who, since January 20, 2014, received any type of healthcare treatment from any entity located in South Carolina that is owned or affiliated with Defendants, while being covered by valid health insurance, and whose medical bills resulting from that treatment were not submitted to their health insurance carrier for potential payment.”

The allegations are that Defendants regularly refused to submit medical bills to patients' health insurance carriers and instead sought payment directly from the patients themselves. This was done despite the hospital's contracts with health insurance carriers to accept discounted payments from the insurance

providers in full satisfaction of their patients' debt. By circumventing their agreements with the insurance providers, it is alleged, that the hospital system attempted to optimize the amount of payment received for their services, as the hospital system could collect more from their patients if they were able to avoid their patients' health insurance providers.

The three named Plaintiffs in this action are Jo Ann Blackwell; Michelene Brooks; and Samuel Herbert Owens. Plaintiff Blackwell was injured as the result of being struck by an automobile on December 19, 2013, and Plaintiff Blackwell was a patient of Mary Black Memorial Hospital from December 27, 2013 until January 3, 2014. Plaintiff Blackwell received medical treatment at Mary Black for injuries associated with the accident. Plaintiff Brooks was injured in an automobile collision on February 26, 2016. Following the collision, on February 28, 2016, Plaintiff Brooks presented to Mary Black Memorial Hospital where she received medical treatment for injuries associated with the accident. Plaintiff Owens was injured in an automobile collision on October 9, 2015. Immediately following the collision, Plaintiff Owens was transported to Mary Black Health System Emergency Department via private vehicle, where he received medical treatment for injuries associated with the accident.

Generally, each of these Plaintiffs were treated at Mary Black Hospital as a result of and because of their accidents. Their medical bills were not sent to their respective insurance provider, despite, allegedly, each having valid health insurance. After each Plaintiff was billed for their treatment, Defendants placed a third-party lien against their personal injury recovery.

As to Defendants' claim that the present litigation should be stayed and the Plaintiff should be ordered to arbitration because the claim for monetary relief may rely upon the agreed negotiated price arising from the Hospital Services Agreement with Cigna and/or MedCost, LLC Agreement. The Court disagrees with that assertion. The Court has reviewed the Cigna "Hospital Services Agreement" (originally dated 2006) and the "MedCost Hospital Agreement" (originally dated 1991). The enforcement of an arbitration agreement is contractual in nature and for an arbitration provision to be enforceable by this Court; the provision must apply to the parties. The terms of either of the Agreements do not obligate the Plaintiff (Owens) to mandatory arbitration. The Court could not find an arbitration provision in the MedCost agreement and the arbitration provision in the Cigna Agreement (appears to not be mandatory as the word "may" is used) does not apply to the Plaintiff as the Plaintiff is not a "party" to the agreement. In accordance to the terms of the agreement, the Plaintiff is, at best, a "participant" under the agreement's terms but not a "party". Section 6.2 is the Dispute Resolution part of the agreement, which contains the arbitration language. As previously stated, any decision concerning arbitration appears discretionary and not mandatory (see section 6.2.1). Section 6.2.2 sets forth procedural details related to the arbitration "if" a party opted to initiate such proceeding. Buried within the section 6.2.2 is a sentence that appears to make arbitration the exclusive remedy. Nevertheless, section 6.2.2 goes on to be read that the arbitration provision does not apply to third parties and does not apply to "class" matters. As previously stated, the Plaintiff is not a "party" to the agreement and its provisions are not enforceable as binding on the Plaintiff. Plaintiff also raised the issue that the Cigna Agreement had expired. Even though the agreement was for a three (3) terms, it contained a year-to-year renewal. Based on the information provided to this Court, no decision could be made that the agreement was or was not in effect. If the effective date(s) of the agreement(s) is material to merit based decision, further discovery is needed. Therefore, this Court concludes that a SCRCF Rule 12 (b) analysis does not afford any of the Defendant to a stay based on the provisions of either of these agreements. This Court review analysis at his stage of these agreements was limited to the arbitration issue. Any other consideration of the agreements goes beyond a SCRCF Rule 12(b)(6) analysis.

The remaining SCRCP Rule 12(b) (6) arguments offered by the Defendants related to the pleadings. With a SCRCP Rule 12(b)(6) review, the question for the court is whether in a light most favorable to the Plaintiff, and with every doubt resolved in Plaintiff's behalf, the allegations set forth on the face of the complaint state any valid claim for relief. A court cannot sustain a 12(b)(6) motion if the facts alleged and inferences reasonably drawn therefrom would entitle the Plaintiffs to any relief on any theory of the case. Applying the 12 (b)(6) standard of review, the allegation in the amended complaint, and considering the arguments, the motion to dismiss cannot be granted. Again, the Court makes the following observation in an effort to assist the parties in moving forward.

The Court agrees with the Plaintiffs that the Amended Complaint states sufficient allegations against both CHSPSC and Professional Account services, stating that there is no prohibition on pleading facts in the way that they have done here, by referring to the Defendants collectively. Further, this Court agrees that the Amended Complaint provides sufficient notice to all Defendants of the allegations being made against them. Viewing the amended complaint as a whole, the Plaintiffs have alleged sufficient facts to state a claim for tortious interference with contractual relationship. Plaintiff theory being that the allegations in the Amended Complaint can be reasonably construed to mean that Defendants' conduct resulted in a breach of the patients' contracts with their insurers because Plaintiffs alleged they paid premiums and did not have their hospital bills paid by their insurers.

On a SCRCP Rule 12(b) (6) motion, this Court agrees that the Plaintiffs' argues claims do not fail as a matter of law under the Medicare Act. Again, Plaintiffs' theory and the factual presentation is that this Court would have to go outside the amended complaint to rule that the Defendants' were required to seek payment from any applicable liability coverage prior to seeking or obtaining payment from Medicare, it presumes facts not alleged in the Amended Complaint, in that it presumes that the at-fault driver in automobile accidents had a valid insurance policy from which to collect. Thus, Defendants' argument relies on facts outside of the pleadings. If the issue of insurance is material to a merit based decision, the issue should be developed in discovery.

Again, under a SCRCP Rule 12(b)(6) analysis, this Court is bound to accept Plaintiffs' theories of liability to the facts offered in the Amended Complaint. Therefore, this Court, at this stage, cannot accept the voluntary payment doctrine as a defense. Under a 12(b) (6) analysis, this decision is reasonable given the assertion that payments made by the Plaintiffs were not voluntary, as the Plaintiffs only settled with Mary Black after the hospital asserted unlawful liens against them. Plaintiffs strongly assert that payments made as a result of extortion are not considered voluntary.

Once again, under a SCRCP Rule 12(b)(6) analysis, this Court cannot dismiss the Plaintiffs' theory of unjust enrichment. When viewing the Amended Complaint in a light most favorable to the pleader, a reasonable factual conclusion with theory can be that the Defendants were unjustly enriched and it would be inequitable to allow them to retain the benefits of their wrongful billing practices while attempting to collect a higher amount from Plaintiffs.

This Court opinion is that any statute of limitation issue fails at this time because of its relatedness to the original filing of the complaint. Factually, the issue may or may not be significant at a future time.

Thank you all for continued cooperation and attention.



Spartanburg Common Pleas

**Case Caption:** Jo Ann Blackwell , plaintiff, et al VS Mary Black Health System, Llc  
, defendant, et al

**Case Number:** 2017CP4200219

**Type:** Order/Form 4

IT IS SO ORDERED

s/ J. Mark Hayes, II #2132

Electronically signed on 2020-09-04 16:20:35 page 5 of 5

**STATE OF SOUTH CAROLINA  
COUNTY OF SPARTANBURG**

**IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT**

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

Plaintiffs,

v.

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

Defendants.

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

**ORDER GRANTING  
PLAINTIFFS' MOTION FOR LEAVE  
TO AMEND THE COMPLAINT**

This matter came before the Court on Plaintiffs' Motion for Leave to Amend the Complaint, which Plaintiffs filed on October 18, 2019. Defendants filed a Memorandum in Opposition to Plaintiff's Motion on October 24, 2019, and Plaintiffs filed a Reply on November 12, 2019. The Court held a hearing on January 6, 2020. Counsel for all parties were present at the hearing and presented argument on Plaintiffs' Motion for Leave to Amend, as well as Defendants' Motion to Strike or, in the Alternative, to Dismiss the Amended Complaint<sup>1</sup> and Plaintiffs' Motion to Compel Defendants to respond to Plaintiffs' First Set of Interrogatories to Defendants and First Set of Requests for Production of Documents ("Plaintiffs' Discovery Requests"). Having fully considered the briefs and arguments, the Court rules as follows:

IT IS ORDERED that Plaintiffs' Motion for Leave to Amend the Complaint is GRANTED.

Pursuant to Rule 15, SCRCP, leave to amend "shall be freely given when justice so requires and

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<sup>1</sup> At the hearing, counsel for Defendants stated their Motion to Strike or, in the Alternative, to Dismiss the Amended Complaint had been rendered moot by the filing of Plaintiffs' Motion for Leave to Amend the Complaint.

does not prejudice any other party.” Rule 15(a), SCRCF; *see also Parker v. Spartanburg Sanitary Sewer Dist.*, 362 S.C. 276, 286, 607 S.E.2d 711, 716 (Ct. App. 2005) (“Leave to amend pleadings pursuant to Rule 15, SCRCF, shall be liberally and freely given when justice so requires and does not prejudice any other party.”). The Court notes that this case has been filed as a putative class action pursuant to Rule 23, SCRCF. The Court has not yet certified the class, and, therefore, any concerns raised by Defendants (if merited) can be addressed at the class certification stage. Additionally, once a class is certified, the period for the statute of limitations for purposes of a valid claim may be defined.

IT IS FURTHER ORDERED that Plaintiffs may file the Amended Class Action Complaint attached to their Motion as Exhibit A and that Defendants’ Motion to Strike or, in the Alternative, to Dismiss is DENIED AS MOOT.

IT IS ALSO ORDERED that the parties should consult on Plaintiffs’ outstanding discovery requests. If the parties are unable to reach an agreement as to the matters raised in Plaintiffs’ Motion to Compel, Plaintiffs may re-file their Motion and the Court will consider it.

*Judge’s Signature Page Follows*



Spartanburg Common Pleas

**Case Caption:** Jo Ann Blackwell , plaintiff, et al VS Mary Black Health System, Llc  
, defendant, et al

**Case Number:** 2017CP4200219

**Type:** Order/Other

IT IS SO ORDERED

s/ J. Mark Hayes, II #2132

Electronically signed on 2020-04-23 12:19:11 page 3 of 3

## FORM 4

STATE OF SOUTH CAROLINA  
COUNTY OF Spartanburg  
IN THE COURT OF COMMON PLEAS

## JUDGMENT IN A CIVIL CASE

CASE NO. 2017CP4200219

Jo Ann Blackwell et al  
PLAINTIFF(S)

Mary Black Health System, Llc et al  
DEFENDANT(S)

## DISPOSITION TYPE (CHECK ONE)

- ☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.
- ☐ **ACTION DISMISSED** (CHECK REASON): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled);  
☐ Other
- ☐ **ACTION STRICKEN** (CHECK REASON): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy;  
☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award;  
☐ Other
- ☐ **STAYED DUE TO BANKRUPTCY**
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** (CHECK APPLICABLE BOX):  
☐ Affirmed; ☐ Reversed; ☐ Remanded;  
☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

**IT IS ORDERED AND ADJUDGED:** ☒ See attached order (formal order to follow) ☐ Statement of Judgment by the Court:

See below for additional order information

## ORDER INFORMATION

This order ☐ ends ☒ does not end the case.

☒ See Page 2 for additional information.

## For Clerk of Court Office Use Only

This judgment was electronically entered by the Clerk of Court as reflected on the Electronic Time Stamp, and a copy mailed first class to any party not proceeding in the Electronic Filing System on 02/10/2020 .

All Others Similarly-Situated  
John Doe  
Samuel Owens, Jr  
Micheline Brooks

NAMES OF TRADITIONAL FILERS SERVED BY MAIL

**Court Reporter:**

**E-Filing Note:** The date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgment to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.

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Thank you all for the arguments and the briefings.

Plaintiff's attorney is asked to prepare a brief order granting the motion to amend the complaint. This court must view such request liberally. This is a class action in which the class has not yet been court certified, therefore the concerns raised by the defendant (if merited) can still be addressed. Once the class is certified, the period for the statute of limitation for purposes of a valid claim can be defined.

With the ruling above related to the motion to amend, the parties should consult on outstanding discovery. The Court's understanding is that responding further to discovery was dependent on the ruling related to amending the complaint. My law clerk will reach out to the parties to schedule a status conference. The status conference will be set just beyond 30 days from this ruling to allow the parties time to discuss, and hopefully resolve, discovery issues. If not, the Court will be available for assistance.



Spartanburg Common Pleas

**Case Caption:** Jo Ann Blackwell , plaintiff, et al VS Mary Black Health System, Llc  
, defendant, et al

**Case Number:** 2017CP4200219

**Type:** Order/Electronic Form 4

IT IS SO ORDERED

s/ J. Mark Hayes, II #2132

Electronically signed on 2020-02-10 16:19:39 page 3 of 3

**STATE OF SOUTH CAROLINA  
COUNTY OF SPARTANBURG**

Jo Ann Blackwell, individually and on  
behalf of all others similarly-situated,

Plaintiff,

v.

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

Defendants.

**IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT**

**C.A. No. 2016-CP-42-\_\_\_\_\_**

**SUMMONS**

**TO THE ABOVE NAMED DEFENDANTS:**

You are hereby summoned and required to answer the Complaint in this action, a copy of which is attached hereto and herewith served upon you, and to serve a copy of your answer to same upon the subscribed at 178 West Main Street, Post Office Box 3547, Spartanburg, South Carolina 29304, within thirty (30) days after the service of same, exclusive of the day of such service. If you fail to answer same within thirty (30) day period, the Plaintiff will apply to the Court for the relief demanded therein and judgment will be taken against you be default.

**Harrison, White, Smith & Coggins, P.C.**

s/John B. White, Jr. \_\_\_\_\_

**John B. White, Jr.**

**Wes A. Kissinger**

**Marghretta Shisko**

**Ryan F. McCarty**

PO Box 3547

Spartanburg SC 29304

864-585-5100

and

**Simmons Law Firm, LLC**

**John S. Simmons**  
**Derek A. Shoemake**  
**John L. Warren, III**  
1711 Pickens Street  
Columbia, SC 29201  
Tel: (803) 779-4600

Attorneys for Plaintiff

Spartanburg, South Carolina

January 20, 2017

**STATE OF SOUTH CAROLINA  
COUNTY OF SPARTANBURG**

**IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT**

Jo Ann Blackwell, individually and on  
behalf of all others similarly-situated,

**C.A. No. 2016-CP-42-\_\_\_\_\_**

Plaintiff,

v.

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

Defendants.

**CLASS ACTION COMPLAINT**

Plaintiff Jo Ann Blackwell, individually and on behalf of all persons similarly situated, by and through the undersigned counsel of record, state and alleges as follows:

**PARTIES, JURISDICTION, AND VENUE**

1. Plaintiff Jo Ann Blackwell, individually and as a representative of a proposed class, is a citizen and resident of Spartanburg County, in the State of South Carolina. Plaintiff was a patient of Defendant Mary Black Memorial Hospital from December 27, 2013 until January 3, 2014. Plaintiff was transferred to Mary Black Memorial Hospital following an automobile accident on December 19, 2013.

2. Defendant Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital, is a limited liability company organized, existing, and operating under the laws of the State of South Carolina and at all times herein mentioned did provide healthcare services for the Plaintiff and the public in general in Spartanburg County, South Carolina.

3. Defendant Community Health Systems, Inc. is a Delaware corporation with its principal place of business in Tennessee. On information and belief, Community Health Systems conducts business in the State of South Carolina and elsewhere and is the parent company that owns and/or operates subsidiaries which in turn operate general care hospitals in numerous states, including Mary Black Memorial Hospital in Spartanburg, South Carolina.

4. Defendant CHSPSC, LLC, formerly known as Community Health systems Professional Services Corporation is a Delaware corporation with its principal place of business in Tennessee. On information and belief, CHSPSC conducts business in the State of South Carolina and other states and has responsibility for billing of patients and liens filed within the State of South Carolina.

5. Defendant Professional Account Services, Inc. is a Tennessee corporation with its principal place of business in Tennessee. Professional Account Services is a collection firm that conducts business in the State of South Carolina and elsewhere.

6. On information and belief, Community Health Systems is or was at all relevant times the parent company of CHSPSC, Professional Account Services, and Mary Black Health System.

7. On information and belief, Community Health Systems, CHSPSC, and Professional Account Services exercise control over policies enacted by Mary Black Health System, including policies related to billing and liens, and Community Health Systems, CHSPSC, Professional Account Services, and Mary Black Health System committed the acts and omissions complained of herein jointly and in concert.

8. The John Doe Defendants are other corporations, persons, or entities who either own, operate, control, manage, or in other ways are responsible or liable parties for the named defendants herein. These John Doe Defendants are additional tortfeasors but at the time of this pleading their identities are unknown. These John Doe Defendants are as-yet unidentified tortfeasors are intended to include, without limitation, the following:

- a) All individual employees, agents, or contractors who were performing services of any kind for Mary Black Memorial Hospital during the events described herein who are or may be liable for damages to Plaintiff and the proposed Class Members;
- b) All individuals or business entities other than Mary Black Memorial Hospital who hired, employed, or supervised any individual employees, agents, or contractors who were performing the duties of accounts receivable/payable services for Mary Black Memorial Hospital;
- c) All individuals or business entities who own or control Mary Black Memorial Hospital; and
- d) All insurers of Mary Black Memorial Hospital and/or any John Doe Defendant who raise the issue of non-profit or charitable status or immunity from suit.

9. This Court has jurisdiction over the parties and the subject matter to this action, and Spartanburg County is the proper venue for this action.

10. Plaintiff brings this action on behalf of herself and all other similarly-situated individuals in the State of South Carolina as a class action.

### FACTUAL ALLEGATIONS

11. Defendants screen all patients and make a determination regarding the reason for treatment and whether there may be sources of payment other than health insurance available.

12. On information and belief, if the patient is identified as one whose medical bills may be recoverable from another source, Defendants refuse to submit that patient's medical bills to his or her health insurance carrier or submit the bills to health insurance and, sometime thereafter, remit those funds back to health insurance after receiving payment from another source.

13. Defendants engaged in these practices even though Defendants are contractually required to submit said bills to the health insurance carrier, accept the payment from health insurance in satisfaction of the bill, not seek payments from any additional sources, and hold the patient harmless from any amounts owed other than co-pays and/or deductibles.

14. While refusing to submit medical bills to the patients' health insurance carrier and accept the payment in satisfaction of the bill, Defendants routinely seek payment for the medical bills from those same patients, either directly or indirectly.

15. Defendants seek payment for medical bills through means including, for example, demanding cash payment directly from the patients, placing unlawful liens on patients' third-party tort claims, seeking medical payment benefits from the patients' auto insurers, turning patients over to collection agencies, and/or reporting patients to credit bureaus (thereby impairing the patients' credit scores).

16. Defendants pursue such course of conduct despite the patients having health insurance and being entitled to have their medical bills submitted to their health insurance carrier for payment.

17. Upon information and belief, Defendants are required by their contracts with patients' health insurance carriers to submit insurance patients' medical bills directly to the carriers. Likewise, Defendants were required to submit Plaintiff's medical bills to Plaintiff's health plan, which is self-insured through Plaintiff's employer, QS-1.

18. Defendants are required to honor a contractual discount with their patients' health insurance carriers and accept discounted payment from those health insurance carriers in full satisfaction of the patients' debts.

19. Upon information and belief, Defendants are precluded by contracts with private health insurance carriers and health plans from seeking payment for covered services from other sources, including from the patients directly, medical payment benefits from the patients' auto insurer, turning the bills over to collections, and/or filing liens against patients' property, including personal injury claims.

20. Defendants fail to inform patients at the time of treatment that they will not honor the patients' health insurance if the circumstances create the possibility of another source of recovery.

21. Defendants represent to patients (including the named Plaintiff in this case) that Defendants will submit the patients' bills to health insurance and will accept that payment in satisfaction of the patients' bills.

22. Defendants enter into contracts with patients (including the named Plaintiff in this case), which assign and authorize payment to Defendants by the patients' health insurance carriers. These agreements also indicate that Defendants will submit the patients' charges to health insurance and that the patients will only be responsible for charges not covered by the assignment of insurance benefits (*i.e.*, co-pays and deductibles).

23. Such patients are unable to submit their medical bills directly to their health insurance carriers as Defendants are the entities responsible for such submissions. Defendants are the only entities in possession of the information required to make such submissions and Defendants are the entities that have contracts with the health insurance carriers and health plans for a reduced compensation for treating patients with health insurance.

24. Through Defendants' bill collection practices, they attempt to optimize the amount received for services rendered by seeking from patients the full amount billed (or more than Defendants are entitled to for the covered treatment), rather than accepting the discounted amount it has agreed to accept from the patient's health insurance carrier.

25. By employing such a policy and business model, Defendants have unlawfully violated the rights of Plaintiff and the Class Members as described herein.

26. Further, such conduct of Defendants and their agents, for which they are directly and indirectly responsible, is outrageous, intentional, willful, wanton, and malicious, and otherwise shows a complete indifference to or conscious disregard of the

rights of Plaintiff and the Class Members such that punitive damages are appropriate and warranted under the circumstances.

27. On or about December 27, 2013, Plaintiff Jo Ann Blackwell presented to Mary Black Memorial Hospital for emergency medical services as a result of an automobile accident on December 19, 2013. Following the accident, Plaintiff was taken to Spartanburg Regional Medical Center, but on December 27, 2013, she was transferred directly to Mary Black Memorial Hospital.

28. Plaintiff was discharged from Mary Black Memorial Hospital on or about January 3, 2014.

29. Plaintiff's treatment resulted in medical charges for the treatment she received from Mary Black Memorial Hospital in the amount of \$33,093.65, which Defendants did not bill to Plaintiff's health insurance.

30. At the time of treatment, Plaintiff had valid health insurance coverage with her health plan, which is self-insured through Plaintiff's employer, QS-1.

31. At the time of treatment, Defendants did not inform Plaintiff that Defendants would not accept her health insurance. Defendants likewise did not explain that they would be seeking the balance of Plaintiff's medical bills from her personally, by billing her medical payments coverage, or by placing a lien against her third-party tort claim.

32. Defendants did not inform Plaintiff that Defendants would be pursuing a third-party lien against her personal injury recovery.

33. Defendants are required by contracts with Plaintiff's health insurance to submit medical bills of insured patients directly to the carrier for payment.

34. Plaintiff was entitled to a contractual reduction in the amount of her medical bills charged by Defendants pursuant to her insurance carrier's agreement with Defendants, and to have those bills paid by her health insurance.

35. Defendants are precluded by their contracts with Plaintiff's health insurance from seeking payment for covered benefits from other sources, including seeking payment directly from Plaintiff, seeking medical payment benefits from Plaintiff's auto insurer, turning the bills over to collections, and/or filing a lien on Plaintiff's property, such as a third-party tort claim.

36. Despite the fact that Plaintiff did not owe Defendants any debt, on February 6, 2014 Defendants sent a notice of assignment of benefits in the amount of \$33,093.65.

37. Defendants sought payment and/or asserted a lien on the third-party motorist claim through the auto insurer.

38. Defendants did not inform Plaintiff that Defendants had a contract with her health insurance that required Plaintiff's charges be submitted to health insurance for payment and that Defendants were precluded from pursuing any charges from Plaintiff and/or any asset of Plaintiff, including, but not limited to, by filing a lien on Plaintiff's third-party personal injury recovery.

39. Defendants have wrongfully sought \$16,546.83 to satisfy Defendant's lien.

### CLASS ACTION ALLEGATIONS

40. Plaintiff incorporates the preceding allegations of her Class Action Complaint by reference.

41. This action is brought as a class action pursuant to Rule 23 of the South Carolina Rules of Civil Procedure. Plaintiff brings this action on her own behalf and on behalf of all others similarly situated as a representative of the following class:

All South Carolina residents who, for the past three (3) years, received any type of healthcare treatment from any entity located in South Carolina that is owned or affiliated with Defendant Community Health Systems, while being covered by valid commercial health insurance, and whose medical bills resulting from that treatment were either not submitted to health insurance for payment or were submitted and thereafter Defendants refunded those payments to their health insurance carriers and Defendants obtained payment for those bills directly from the patient, from an auto insurer, and/or from the patient's third-party tort recovery (hereinafter, "Class Members" or the "Class").

42. The particular members of the Class are capable of being described without difficult managerial or administrative problems. The members of the Class are readily identifiable from the information and records in the possession or control of Defendants.

43. The Class consists of hundreds and perhaps thousands of individual members and is, therefore, so numerous that individual joinder of all members is impractical.

44. There are questions of law and fact common to the Class, which questions predominate over any questions affecting only individual members of the Class and, in fact, the wrongs suffered and remedies sought by Plaintiff and the other members of the Class are premised upon an unlawful scheme perpetuated uniformly upon all the Class

Members. The only material difference between the Class Members' claims is the exact monetary amount to which each member of the Class is entitled.

45. The principal common issues include, but are not limited to, the following:
- a) Whether Defendants entered into express and/or implied agreements with various health insurance carriers providing, among other things, that health insurance claims should be promptly submitted to the carriers for payment;
  - b) Whether Defendants violated their contracts with various health insurance carriers by not submitting medical bills to the carrier;
  - c) Whether Defendants violated their contracts with various health insurance carriers by pursuing recovery for services rendered by placing liens upon patients' property (such as third-party tort claims), pursuing medical payment benefits from auto insurers, pursuing payment directly from patients, and/or turning patients' accounts over to collections;
  - d) Whether Defendants violated their contracts with various health insurance carriers by not offering a contractually agreed discount to patients covered by said policies;
  - e) Whether Defendants have violated their contracts with Plaintiff and the Class Members by seeking payment for charges that were covered by valid commercial health insurance;

- f) Whether Defendants improperly refused to submit the Plaintiff's and the Class Members' medical bills to Plaintiff's and the Class Members' health insurance carriers for payment;
- g) Whether Defendants profited by refusing to submit said medical bills to said health insurance carriers for payment;
- h) Whether Defendants have been unjustly enriched at the expense of Plaintiff and the Class Members through their misconduct;
- i) Whether Defendants breached their duty of good faith and fair dealing to the Plaintiff and the Class through the misconduct described herein;
- j) Whether Defendants are liable to Plaintiff and the Class Members based on a claim on money they have received; and
- k) Whether Defendants should be enjoined from continuing their improper and unlawful billing practices as described herein.

46. Plaintiff's claims are typical of those of the Class and are based on the same legal and factual theories as outlined herein.

47. Plaintiff and her counsel will fairly and adequately represent and protect the interests of the members of the Class. Plaintiff has no claims antagonistic to those of the Class. Plaintiff has retained competent and experienced counsel who have prosecuted numerous complex actions within the State of South Carolina and across the nation. Undersigned counsel is committed to the vigorous prosecution of this action.

48. Certification of a class is appropriate in that Plaintiff and the Class Members are seeking monetary damages, common questions predominate over any

individual questions, and a class action is a superior method for the fair and efficient adjudication of this controversy. A class action will cause an orderly and expeditious administration of the claims of the Class Members. Economies of time, effort, and expense, will be promoted and uniformity of decisions will be promoted by certification of the class. Additionally, the individual Class Members are unlikely to be aware of their rights and are not in a position (either through experience or financially) to commence individual litigation against Defendants and Defendants' vast resources.

49. Certification of a class action is likewise appropriate in that inconsistent or varying adjudications with respect to individual members of the Class would establish incompatible standards of conduct for Defendants. In addition, as a practical matter, adjudications with respect to individual members of the class would be dispositive of the interests of the other members not parties to the adjudications or would, at the very least, substantially impair or impede their ability to protect their interests.

50. Defendants have acted or refused to act on grounds generally applicable to the Class as a whole, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the Class as a whole.

**COUNT I**  
**TORTIOUS INTERFERENCE WITH CONTRACTUAL RELATIONSHIP**

51. Plaintiff incorporates the preceding allegations of her Class Action Complaint by reference.

52. Plaintiff and the Class Members had a valid business expectancy and/or contractual relationship with their own health insurance providers by virtue of an express

or implied contract that Plaintiff and each individual Class Member had with their health insurance carrier.

53. Defendants knew or should have known of the business expectancies and/or contractual relationships involving Plaintiff, the Class Members, and their respective health insurance carriers.

54. Defendants intentionally and improperly interfered with and caused a disruption of the business expectancies and/or contractual relationships of Plaintiff and the Class Members by preventing them from receiving the benefit of their relationships with their respective health insurance carriers. Defendants did so without justification or privilege in a malicious attempt to obtain additional monies to which Defendants were not entitled and with reckless disregard for the damage and harm such action would have on Plaintiff and the Class Members.

55. Defendants' actions resulted in Plaintiff and the Class Members having paid premiums but receiving no or little benefit. Defendants' actions thus proximately caused Plaintiff and the Class Members damages.

56. Plaintiff and the Class Members are entitled to compensatory damages, punitive damages, and interest in amounts to be determined at trial.

## **COUNT II UNJUST ENRICHMENT**

57. Plaintiff incorporates the preceding allegations of her Class Action Complaint by reference.

58. As alleged above, Defendants have engaged in a pattern of subverting the financial interests and contractual agreements of Plaintiff and the Class Members—patients of Defendants’ hospitals—for their own pecuniary gain.

59. Defendants have been unjustly enriched in that they received and retained the benefits of proceeds to which they were not entitled and which they received in violation of South Carolina law.

60. Said benefits were conferred on Defendants by Plaintiff and the Class Members and were unlawfully obtained to the detriment of Plaintiff and the Class Members.

61. It would be unjust for Defendants to retain these funds because payment for the services provided should have come from the health insurance carriers of Plaintiff and the Class Members, with the amount to be paid for services provided determined by the contracts between Defendants and patients’ health insurance carriers.

62. Allowing Defendants to retain these benefits would violate fundamental principles of justice, equity, and good conscience.

### **COUNT III INJUNCTIVE RELIEF**

63. Plaintiff incorporates the preceding allegations of her Class Action Complaint by reference.

64. On information and belief, Defendants were required to submit Plaintiff’s medical bills to her health insurance for payment.

65. On information and belief, Defendants are required by their contracts with various other health insurance carriers to submit the medical bills of the proposed Class Members directly to those carriers for payment.

66. On information and belief, Defendants are also required to honor a contractual discount with their patients' health insurance carriers and accept discounted payments from those health insurance carriers in satisfaction of the patients' bills.

67. Nevertheless, on information and belief, Defendants failed to honor contractually agreed-upon discounts regarding Plaintiff's medical bills and those of the proposed Class Members. Defendants likewise failed to honor their contractual commitment to submit the medical bills of insured patients to those patients' insurance.

68. Defendants are, on information and belief, precluded by their contracts with private health insurance carriers from seeking payment for covered services from other sources, including from the patient directly, medical payment benefits from the patient's auto insurer, turning the bills over to collections, and/or filing liens against patients' property, including personal injury claims.

69. Through Defendants' bill collection practices, they attempt to optimize the amount received for services rendered by seeking from patients the full amount billed (or more than they are entitled to for the covered treatment), rather than accepting the discounted amount they have agreed to accept from the patient's health insurance carrier.

70. By employing such a policy and business model, Defendants are violating the terms of their health insurance provider agreements and have unlawfully violated the rights of Plaintiff and the Class Members.

71. A real and subsisting controversy exists between the parties hereto concerning the validity of Defendants' policies and procedures.

72. Plaintiff requests that this Court declare that Defendants, through their actions, policies, procedures, and misconduct as alleged herein, have violated the terms of their agreements with the various health insurance providers and said policies and procedures should be declared invalid and void as a matter of law. Further, this Court should enter a permanent injunction enjoining Defendants from engaging in their unlawful billing practices as described herein and for such other and further relief as the Court deems just and proper under the circumstances.

#### **JURY DEMAND**

73. Plaintiff, on behalf of herself and the Class Members, demands a jury trial on all issues so triable.

#### **PRAYER FOR RELIEF**

Wherefore, Plaintiff, on behalf of herself and all Class Members, respectfully prays for judgment against the Defendants as follows:

- (a) For an Order certifying that this action may be maintained as a class action and appointing Plaintiff and her counsel to represent the class;
- (b) For a declaration that Defendants' actions violated Plaintiff's and the Class Members' rights under South Carolina law as pleaded in Counts I through IV;
- (c) For all actual damages, statutory damages, punitive damages, penalties, and remedies available for the Defendants' violations of Plaintiff's and the Class Member's rights under South Carolina law;

- (d) For a declaration that Defendants, through their actions and misconduct as alleged above, have been unjustly enriched and for an order that Defendants disgorge any unlawfully gained proceeds;
- (e) For pre-judgment interest as provided by law;
- (f) For post-judgment interest as provided by law;
- (g) For declaratory relief and a permanent injunction enjoining Defendants from engaging in the unlawful billing practices as detailed in this Complaint;
- (h) For an award to Plaintiff and the Class Members of their reasonable attorneys' fees;
- (i) For an award to Plaintiff and the Class Members of their costs and expenses of this action; and
- (j) For such other and further relief as this Court may deem necessary and proper.

Respectfully submitted,

**Harrison, White, Smith & Coggins, P.C.**

s/John B. White, Jr.\_\_\_\_\_

**John B. White, Jr.**

**Wes A. Kissinger**

**Marghretta Shisko**

**Ryan F. McCarty**

PO Box 3547

Spartanburg SC 29304

864-585-5100

and

**Simmons Law Firm, LLC**

**John S. Simmons**

**Derek A. Shoemake**

**John L. Warren, III**

1711 Pickens Street

Columbia, SC 29201

Tel: (803) 779-4600

Attorneys for Plaintiff

Spartanburg, South Carolina

January 20, 2017

**STATE OF SOUTH CAROLINA  
COUNTY OF SPARTANBURG**

**IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT**

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

Plaintiffs,

v.

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

Defendants.

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

**AMENDED SUMMONS**

**TO THE ABOVE NAMED DEFENDANTS:**

You are hereby summoned and required to answer the Amended Class Action Complaint in this action, a copy of which is attached hereto and herewith served upon you, and to serve a copy of your answer to same upon the subscribed at 178 West Main Street, Post Office Box 3547, Spartanburg, South Carolina 29304, within thirty (30) days after the service of same, exclusive of the day of such service. If you fail to answer same within thirty (30) day period, the Plaintiff will apply to the Court for the relief demanded therein and judgment will be taken against you be default.

**HARRISON WHITE, P.C.**

s/John B. White, Jr.

John B. White, Jr. (S.C. Bar No. 5996)  
Thomas A. Killoren, Jr. (S.C. Bar No. 69490)  
Marghretta Shisko (S.C. Bar No. 100106)  
Griffin L. Lynch (S.C. Bar No. 72518)  
Harrison White, P.C.  
P.O. Box 3547  
Spartanburg SC 29304  
864-585-5100

and

John S. Simmons (S.C. Bar No. 10260)  
Simmons Law Firm, LLC  
1711 Pickens Street  
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Tel: (803) 779-4600

Attorneys for Plaintiffs

Spartanburg, South Carolina

June 28, 2019

**STATE OF SOUTH CAROLINA  
COUNTY OF SPARTANBURG**

**IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT**

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

Plaintiffs,

v.

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

Defendants.

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

**AMENDED CLASS ACTION COMPLAINT**

Plaintiffs Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all persons similarly situated, by and through the undersigned counsel of record, state and allege as follows:

**INTRODUCTION AND BACKGROUND**

1. Plaintiffs bring this action on behalf of themselves and others similarly situated to remedy Defendants' unlawful, unfair, and predatory service and billing practices.

2. At all times relevant to this Complaint, Defendant Mary Black Health System, LLC (referred to herein as "Mary Black") was in the business of providing healthcare services and operated Mary Black Memorial Hospital in the City of Spartanburg, Spartanburg County, South Carolina.

3. As described in more detail below, at all relevant times, Mary Black subverted the financial interests of its patients for its own benefit and profit through unlawful and predatory billing practices.

4. Upon information and belief, Mary Black had a practice of screening all patients and making an initial determination regarding the reason for treatment and whether there might be third-party recovery available to pay for such treatment. Typically, this would be where the patient presented for treatment as a result of an injury from an automobile accident.

5. If Mary Black identified the patient as one whose health expenses might be eligible for third-party recovery, Mary Black refused to submit that patient's medical bills to his or her health insurance provider.

6. The reason for this is simple. Mary Black employed this business model under the belief that if it held out on submitting an accident patient's medical bills to his or her health insurance provider, then Mary Black could receive a higher reimbursement from another source, thereby increasing its profit margin.

7. While refusing to turn over medical bills to accident patients' health insurance providers, Mary Black routinely pursued payment for the medical bills from those same patients. Mary Black did so by, among other things, demanding cash payment directly from the patients, turning over the patients to collection agencies (including, but not limited to, Defendant Professional Account Services, Inc.), and by reporting patients to credit bureaus, thereby impairing patients' credit scores.

8. Mary Black pursued such course of conduct despite the patients having health insurance and being entitled to have their healthcare expenses that were incurred at Mary Black submitted to their health insurance for payment.

9. Such patients were unable to submit their medical bills directly to their health insurance as Mary Black was the entity responsible for submitting such bills. Mary Black was the entity in possession of the information required to make such submissions, and Mary Black was the entity that contracted with patients' health insurance providers for a reduced compensation for treating patients with health insurance (i.e., provider contracts).

10. By employing such a policy and business model, Mary Black unlawfully violated the rights of Plaintiffs and the class members, as described more fully below.

11. Moreover, such conduct of Mary Black and its agents was outrageous, intentional, willful, wanton, and malicious, and otherwise showed a complete indifference to or disregard for the rights of Plaintiffs and the class members such that an award of punitive damages would be appropriate to punish and deter such wrongdoing.

### **PARTIES, JURISDICTION, AND VENUE**

12. Plaintiff Jo Ann Blackwell ("Plaintiff Blackwell"), individually and as a representative of a proposed class, is a citizen and resident of Spartanburg County, in the State of South Carolina. Plaintiff Blackwell was injured as the result of being struck by an automobile on December 19, 2013, and Plaintiff Blackwell was a patient of Mary Black Memorial Hospital from December 27, 2013 until January 3, 2014. Plaintiff Blackwell received medical treatment at Mary Black for injuries associated with the accident.

13. Plaintiff Michelene Brooks ("Plaintiff Brooks"), individually and as a representative of a proposed class, is a citizen and resident of Spartanburg County, in the State of South Carolina. Plaintiff Brooks was injured in an automobile collision on February 26, 2016.

Following the collision, on February 28, 2016, Plaintiff Brooks presented to Mary Black Memorial Hospital where she received medical treatment for injuries associated with the accident.

14. Plaintiff Samuel Herbert Owens, Jr. (“Plaintiff Owens”), individually and as a representative of a proposed class, is a citizen and resident of Spartanburg County, in the State of South Carolina. Plaintiff Owens was injured in an automobile collision on October 9, 2015. Immediately following the collision, Plaintiff Owens was transported to Mary Black Health System Emergency Department via private vehicle, where he received medical treatment for injuries associated with the accident.

15. Defendant Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital, is a limited liability company organized, existing, and operating under the laws of the State of South Carolina, and at all times relevant to this Complaint, Mary Black provided healthcare services for Plaintiffs and the general public at its locations in Spartanburg County, South Carolina.

16. Defendant CHSPSC, LLC, formerly known as Community Health Systems Professional Services Corporation, is a Delaware corporation with its principal place of business in Tennessee. On information and belief, CHSPSC regularly conducts business in the State of South Carolina and other states and has responsibility for the billing of patients and liens filed within the State of South Carolina.

17. Defendant Professional Account Services, Inc. (“PASI”) is a Tennessee corporation with its principal place of business in Brentwood, Tennessee. PASI is a collection firm that regularly conducts business in the State of South Carolina and elsewhere.

18. On information and belief, CHSPSC and PASI exercise control over policies and procedures enacted by and implemented by Mary Black Health System, including policies relating

to billing and liens, and all of these entities committed the acts and omissions complained of herein jointly and in concert.

19. Defendants are referred to collectively herein as Mary Black and/or Defendants.

20. This Court has jurisdiction over the parties to and the subject matter of this action, and venue in Spartanburg County is proper.

21. Plaintiffs bring this action on behalf of themselves and all other similarly-situated individuals in the State of South Carolina as a class action.

### **FACTUAL ALLEGATIONS**

#### ***1. Defendants' policies and practices***

22. Upon admission, Defendants screen all patients and make a determination regarding the reason for treatment and whether there may be sources of payment other than health insurance available.

23. On information and belief, if Defendants identify a patient as one whose medical bills may be recoverable from a source other than the patient's health insurance, Defendants refuse to submit that patient's medical bills to his or her health insurance provider.

24. Defendants engaged in these practices even though Defendants are required to submit patients' bills to their health insurance carriers, accept payment from health insurance in satisfaction of the bill, not seek payments from additional sources, and/or hold the patient harmless from any amounts owed other than co-pays and/or deductibles.

25. While refusing to submit medical bills to patients' health insurance carriers and accept payment from health insurance carriers in satisfaction of the bills, Defendants routinely seek payment for the medical bills from those same patients, either directly or indirectly.

26. For example, Defendants seek payment for medical bills by demanding cash payment directly from the patients, placing unlawful liens on patients' third-party tort claims, seeking medical payment benefits from patients' automobile insurers, turning patients over to collection agencies, and/or reporting patients to credit bureaus (thereby impairing patients' credit scores).

27. Defendants pursue such conduct despite the patients having health insurance and being entitled to have their medical bills submitted to their health insurance for payment.

28. Upon information and belief, Defendants are required by their contracts with patients' health insurance carriers to submit insurance patients' medical bills directly to the carriers. Defendants were likewise required to submit the medical bills of Plaintiffs and the Class Members to their health insurance.

29. Defendants are required to honor a contractual discount with their patients' health insurance carriers and accept discounted payments from those health insurance carriers in full satisfaction of the patients' debts.

30. Defendants fail to inform patients at the time of treatment that they will not submit medical bills to the patients' health insurance if the circumstances create the possibility of another source of recovery.

31. Patients are unable to submit their medical bills directly to their health insurance. Defendants are the entities responsible for such submissions and are the only entities in possession of the information required to make such submissions. Further, Defendants have contracts with health insurance providers and health plans for reduced compensation for treating patients who have health insurance.

32. Through Defendants' bill collection practices, they attempt to maximize the amount they receive for services rendered by attempting to recover amounts billed from patients rather than accepting the discounted amount they agreed to accept from patients' health insurance.

33. By employing such policies and practices, Defendants have violated the rights of Plaintiffs and the Class Members as described herein.

34. Further, such conduct of Defendants and their agents, for which they are directly and indirectly responsible, is outrageous, intentional, willful, wanton, and malicious, and otherwise shows a complete indifference to or conscious disregard of the rights of Plaintiffs and the Class Members such that punitive damages are appropriate and warranted under the circumstances.

## **2. *Plaintiff Blackwell***

35. On December 19, 2013, at approximately 8:28 a.m., Plaintiff Blackwell was walking across Daniel Morgan Avenue in Spartanburg, South Carolina, when she was struck by a vehicle. Initially, Plaintiff Blackwell was taken to the trauma department of Spartanburg Regional Medical Center, but she was transferred to Mary Black Memorial Hospital on December 27, 2013. Plaintiff Blackwell remained at Mary Black until January 3, 2014, when she was discharged.

36. At the time of her treatment, Plaintiff Blackwell had valid health insurance coverage with her health plan, which is self-insured through her employer, QS-1. Mary Black knew or should have known that Plaintiff Blackwell had valid health insurance coverage.

37. Plaintiff Blackwell's treatment at Mary Black resulted in medical charges in the amount of \$33,093.65. Defendants refused to submit Plaintiff Blackwell's bills for medical services to her health insurance for payment.

38. At the time of her treatment, Defendants did not inform Plaintiff Blackwell that Defendants would not accept her health insurance, nor did they explain that they would be seeking

the balance of Plaintiff Blackwell's medical bills from her directly and/or by pursuing a third-party lien against her personal injury recovery.

39. Upon information and belief, Plaintiff Blackwell's medical bills would have been paid had they been submitted to her health insurance for payment.

40. However, instead of turning over Plaintiff Blackwell's medical bills to her health insurance provider for payment, Defendants sought collection of Plaintiff Blackwell's account by asserting liens against Plaintiff's potential third party automobile accident claim.

### **3. *Plaintiff Brooks***

41. On February 26, 2016, Plaintiff Brooks was a passenger in a vehicle that was hit by another automobile. Plaintiff Brooks presented to the emergency room at Mary Black Hospital two days later, on February 28, 2016, complaining of injuries associated with the accident.

42. At the time of her medical treatment, Plaintiff Brooks had valid health insurance coverage through Medicare. Mary Black knew or should have known that Plaintiff Brooks had valid health insurance coverage.

43. Plaintiff Brooks's treatment at the Mary Black ER resulted in medical charges totaling \$9,982.44. Defendants refused to submit those bills for medical services to Plaintiff Brooks's health insurance for payment.

44. Upon information and belief, Plaintiff Brooks's medical bills would have been paid had they been submitted to her health insurance for payment.

45. However, instead of turning over Plaintiff Brooks's medical bills to her health insurance for payment, Defendants sought collection of Plaintiff Brooks's account by asserting liens against her third-party automobile accident claim.

46. On or about September 26, 2017, Defendants agreed to accept a 50% reduction on Plaintiff Brooks's account and settle for \$4,991.22. Defendants agreed to this reduction only after asserting a lien against Plaintiff Brooks's third-party recovery in her personal injury case and after reviewing the settlement offer for that case.

**4. *Plaintiff Owens***

47. On October 9, 2015, Plaintiff Owens was driving his vehicle when he was rear-ended by another automobile. Plaintiff Owens was transported to the emergency department at Mary Black Hospital via private vehicle following the accident, and he received medical treatment at Mary Black for injuries associated with the accident.

48. At the time of his medical treatment, Plaintiff Owens had valid health insurance coverage through Cigna. Mary Black knew or should have known that Plaintiff Owens had valid health insurance coverage.

49. Plaintiff Owens's treatment at the Mary Black ER resulted in medical charges totaling \$9,086.75. Defendants refused to submit those bills for medical services to Plaintiff Owens's health insurance for payment.

50. Upon information and belief, Plaintiff Owens's medical bills would have been paid had they been submitted to his health insurance for payment.

51. However, instead of turning over Plaintiff Owens's medical bills to his health insurance for payment, Defendants sought collection of Plaintiff Owens's account by asserting a lien against his third-party automobile accident claim.

52. On or about October 14, 2016, Defendants agreed to accept a 50% reduction on Plaintiff Owens's account and settle for \$4,543.38. Defendants agreed to this reduction only after

asserting a lien against Plaintiff Owens's third-party recovery in his personal injury case and after reviewing the settlement offer for that case.

### CLASS ACTION ALLEGATIONS

53. This action is brought as a class action pursuant to Rule 23 of the South Carolina Rules of Civil Procedure. Plaintiffs bring this action on their own behalf and on behalf of all others similarly situated as representatives of the following Class:

All individuals who, since January 20, 2014, received any type of healthcare treatment from any entity located in South Carolina that is owned or affiliated with Defendants, while being covered by valid health insurance, and whose medical bills resulting from that treatment were not submitted to their health insurance carrier for potential payment.

54. The particular members of the Class are capable of being described without difficult managerial or administrative problems. The members of the Class are readily identifiable from the information and records in the possession or control of Defendants.

55. The Class consists of hundreds and perhaps thousands of individual members and is, therefore, so numerous that individual joinder of all members is impractical.

56. There are questions of law and fact common to the Class, which questions predominate over any questions affecting only individual members of the Class and, in fact, the wrongs suffered and remedies sought by Plaintiff and the other members of the Class are premised upon an unlawful scheme perpetuated uniformly upon all the Class Members. The only material difference between the Class Members' claims is the exact monetary amount to which each member of the Class is entitled.

57. The principal common issues include, but are not limited to, the following:

- a) Whether Defendants entered into express and/or implied agreements with various health insurance carriers providing, among other things, that health insurance claims should be promptly submitted to the carriers for payment;

- b) Whether Defendants violated their contracts with various health insurance carriers by not submitting medical bills to the carrier;
- c) Whether Defendants violated their contracts with various health insurance carriers by pursuing recovery for services rendered by placing liens upon patients' property (such as third-party tort claims), pursuing medical payment benefits from auto insurers, pursuing payment directly from patients, and/or turning patients' accounts over to collections;
- d) Whether Defendants violated their contracts with various health insurance carriers by not offering a contractually agreed discount to patients covered by said policies;
- e) Whether Defendants have violated their contracts with Plaintiff and the Class Members by seeking payment for charges that were covered by valid commercial health insurance;
- f) Whether Defendants improperly refused to submit the Plaintiff's and the Class Members' medical bills to Plaintiff's and the Class Members' health insurance carriers for payment;
- g) Whether Defendants profited by refusing to submit said medical bills to said health insurance carriers for payment;
- h) Whether Defendants have been unjustly enriched at the expense of Plaintiff and the Class Members through their misconduct;
- i) Whether Defendants breached their duty of good faith and fair dealing to the Plaintiff and the Class through the misconduct described herein;

- j) Whether Defendants are liable to Plaintiff and the Class Members based on a claim on money they have received; and
- k) Whether Defendants should be enjoined from continuing their improper and unlawful billing practices as described herein.

58. Plaintiff's claims are typical of those of the Class and are based on the same legal and factual theories as outlined herein.

59. Plaintiff and her counsel will fairly and adequately represent and protect the interests of the members of the Class. Plaintiff has no claims antagonistic to those of the Class. Plaintiff has retained competent and experienced counsel who have prosecuted numerous complex actions within the State of South Carolina and across the nation. Undersigned counsel is committed to the vigorous prosecution of this action.

60. Certification of a class is appropriate in that Plaintiff and the Class Members are seeking monetary damages, common questions predominate over any individual questions, and a class action is a superior method for the fair and efficient adjudication of this controversy. A class action will cause an orderly and expeditious administration of the claims of the Class Members. Economies of time, effort, and expense, will be promoted and uniformity of decisions will be promoted by certification of the class. Additionally, the individual Class Members are unlikely to be aware of their rights and are not in a position (either through experience or financially) to commence individual litigation against Defendants and Defendants' vast resources.

61. Certification of a class action is likewise appropriate in that inconsistent or varying adjudications with respect to individual members of the Class would establish incompatible standards of conduct for Defendants. In addition, as a practical matter, adjudications with respect to individual members of the class would be dispositive of the interests of the other members not

parties to the adjudications or would, at the very least, substantially impair or impede their ability to protect their interests.

62. Defendants have acted or refused to act on grounds generally applicable to the Class as a whole, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the Class as a whole.

**COUNT I**  
**TORTIOUS INTERFERENCE WITH CONTRACTUAL RELATIONSHIP**

63. Plaintiffs incorporate the preceding allegations of this Class Action Complaint by reference.

64. Plaintiffs and the Class Members had a valid business expectancy and/or contractual relationship with their own health insurance providers by virtue of an express or implied contract that Plaintiffs and each individual Class Member had with their health insurance carrier.

65. Defendants knew or should have known of the business expectancies and/or contractual relationships involving Plaintiffs, the Class Members, and their respective health insurance carriers.

66. Defendants intentionally and improperly interfered with and caused a disruption of the business expectancies and/or contractual relationships of Plaintiffs and the Class Members by preventing them from receiving the benefit of their relationships with their respective health insurance carriers. Defendants did so without justification or privilege in a malicious attempt to obtain additional monies to which Defendants were not entitled and with reckless disregard for the damage and harm such action would have on Plaintiffs and the Class Members.

67. Defendants' actions resulted in Plaintiffs and the Class Members having paid premiums but receiving no or little benefit. Defendants' actions thus proximately caused Plaintiffs and the Class Members damages.

68. Plaintiffs and the Class Members are entitled to compensatory damages, punitive damages, and interest in amounts to be determined at trial.

## **COUNT II UNJUST ENRICHMENT**

69. Plaintiffs incorporate the preceding allegations of this Class Action Complaint by reference.

70. As alleged above, Defendants have engaged in a pattern of subverting the financial interests and contractual agreements of Plaintiffs and the Class Members—patients of Defendants' hospitals—for their own pecuniary gain.

71. Defendants have been unjustly enriched in that they received and retained the benefits of proceeds to which they were not entitled and which they received in violation of South Carolina law.

72. Said benefits were conferred on Defendants by Plaintiffs and the Class Members and were unlawfully obtained to the detriment of Plaintiffs and the Class Members.

73. It would be unjust for Defendants to retain these funds because payment for the services provided should have come from the health insurance carriers of Plaintiffs and the Class Members, with the amount to be paid for services provided determined by the contracts between Defendants and patients' health insurance carriers.

74. Allowing Defendants to retain these benefits would violate fundamental principles of justice, equity, and good conscience.

**COUNT III  
INJUNCTIVE RELIEF**

75. Plaintiffs incorporate the preceding allegations of this Class Action Complaint by reference.

76. On information and belief, Defendants were required to submit the medical bills of Plaintiffs and the proposed Class Members directly to their health insurance for payment.

77. On information and belief, Defendants were also required to honor a contractual discount with their patients' health insurance carriers and accept discounted payments from those health insurance carriers in satisfaction of the patients' bills.

78. Nevertheless, on information and belief, Defendants failed to honor contractually agreed-upon discounts regarding Plaintiffs' medical bills and those of the proposed Class Members. Defendants likewise failed to honor their contractual commitment to submit the medical bills of insured patients to those patients' insurance.

79. Defendants are, on information and belief, precluded from seeking payment for covered services from other sources, including from the patient directly, medical payment benefits from the patient's auto insurer, turning the bills over to collections, and/or filing liens against patients' property, including personal injury claims.

80. Through Defendants' bill collection practices, they attempt to optimize the amount received for services rendered by seeking from patients the full amount billed (or more than they are entitled to for the covered treatment), rather than accepting the discounted amount they have agreed to accept from the patient's health insurance carrier.

81. By employing such a policy and business model, Defendants are violating the terms of their health insurance provider agreements and have unlawfully violated the rights of Plaintiffs and the Class Members.

82. A real and subsisting controversy exists between the parties hereto concerning the validity of Defendants' policies and procedures.

83. Plaintiff requests that this Court declare that Defendants, through their actions, policies, procedures, and misconduct as alleged herein, have violated the terms of their agreements with the various health insurance providers and said policies and procedures should be declared invalid and void as a matter of law. Further, this Court should enter a permanent injunction enjoining Defendants from engaging in their unlawful billing practices as described herein and for such other and further relief as the Court deems just and proper under the circumstances.

#### **JURY DEMAND**

84. Plaintiffs, on behalf of themselves and the Class Members, demands a jury trial on all issues so triable.

#### **PRAYER FOR RELIEF**

Wherefore, Plaintiffs, on behalf of themselves and all Class Members, respectfully pray for judgment against the Defendants as follows:

- (a) For an Order pursuant to S.C.R.C.P. 23 certifying that this action may be maintained as a class action and appointing Plaintiffs and their counsel to represent the class;
- (b) For a declaration that Defendants' actions violated the rights of Plaintiffs and the Class Members under South Carolina law;
- (c) For all actual damages, statutory damages, punitive damages, penalties, and remedies available for the Defendants' violations of the rights of Plaintiffs and the Class Members under South Carolina law;

- (d) For a declaration that Defendants, through their actions and misconduct as alleged above, have been unjustly enriched and for an order requiring Defendants to disgorge any unlawfully gained proceeds;
- (e) For pre-judgment interest as provided by law;
- (f) For post-judgment interest as provided by law;
- (g) For declaratory relief and a permanent injunction enjoining Defendants from engaging in the unlawful billing practices as detailed in this Complaint;
- (h) For an award to Plaintiffs and the Class Members of their reasonable attorneys' fees;
- (i) For an award to Plaintiffs and the Class Members of their costs and expenses of this action;  
and
- (j) For such other and further relief as this Court may deem necessary and proper.

*Signature Page Follows*

Respectfully submitted,

s/John B. White, Jr.

John B. White, Jr. (S.C. Bar No. 5996)  
Thomas A. Killoren, Jr. (S.C. Bar No. 69490)  
Marghretta Shisko (S.C. Bar No. 100106)  
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864-585-5100

and

John S. Simmons (S.C. Bar No. 10260)  
Simmons Law Firm, LLC  
1711 Pickens Street  
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Tel: (803) 779-4600

*Attorneys for Plaintiffs*

Spartanburg, South Carolina

June 28, 2019

**STATE OF SOUTH CAROLINA  
COUNTY OF SPARTANBURG**

**IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT**

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

Plaintiffs,

v.

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

Defendants.

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

**AMENDED SUMMONS**

**TO THE ABOVE-NAMED DEFENDANTS:**

You are hereby summoned and required to answer the Amended Class Action Complaint in this action, a copy of which is attached hereto and herewith served upon you, and to serve a copy of your answer to same upon the subscriber at 178 West Main Street, Post Office Box 3547, Spartanburg, South Carolina 29304, within thirty (30) days after the service of same, exclusive of the day of such service. If you fail to answer same within thirty (30) day period, the Plaintiff will apply to the Court for the relief demanded therein and judgment will be taken against you be default.

**HARRISON WHITE, P.C.**

s/John B. White, Jr.

John B. White, Jr. (S.C. Bar No. 5996)  
Thomas A. Killoren, Jr. (S.C. Bar No. 69490)  
Marghretta Shisko (S.C. Bar No. 100106)  
Griffin L. Lynch (S.C. Bar No. 72518)  
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and

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1711 Pickens Street  
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Tel: (803) 779-4600

Attorneys for Plaintiffs

Spartanburg, South Carolina

April 24, 2020

**STATE OF SOUTH CAROLINA  
COUNTY OF SPARTANBURG**

**IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT**

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Samuel H. Owens, Jr., individually and on  
behalf of all others similarly-situated,

Plaintiffs,

v.

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Mary Black Memorial Hospital; CHSPSC,  
LLC; and Professional Account Services,  
Inc.,

Defendants.

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

**AMENDED CLASS ACTION COMPLAINT**

Plaintiffs Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all persons similarly situated, by and through the undersigned counsel of record, state and allege as follows:

**INTRODUCTION AND BACKGROUND**

1. Plaintiffs bring this action on behalf of themselves and others similarly situated to remedy Defendants' unlawful, unfair, and predatory service and billing practices.

2. At all times relevant to this Complaint, Defendant Mary Black Health System, LLC (referred to herein as "Mary Black") was in the business of providing healthcare services and operated Mary Black Memorial Hospital in the City of Spartanburg, Spartanburg County, South Carolina.

3. As described in more detail below, at all relevant times, Mary Black subverted the financial interests of its patients for its own benefit and profit through unlawful and predatory billing practices.

4. Upon information and belief, Mary Black had a practice of screening all patients and making an initial determination regarding the reason for treatment and whether there might be third-party recovery available to pay for such treatment. Typically, this would be where the patient presented for treatment as a result of an injury from an automobile accident.

5. If Mary Black identified the patient as one whose health expenses might be eligible for third-party recovery, Mary Black refused to submit that patient's medical bills to his or her health insurance provider.

6. The reason for this is simple. Mary Black employed this business model under the belief that if it held out on submitting an accident patient's medical bills to his or her health insurance provider, then Mary Black could receive a higher reimbursement from another source, thereby increasing its profit margin.

7. While refusing to turn over medical bills to accident patients' health insurance providers, Mary Black routinely pursued payment for the medical bills from those same patients. Mary Black did so by, among other things, demanding cash payment directly from the patients, turning over the patients to collection agencies (including, but not limited to, Defendant Professional Account Services, Inc.), and by reporting patients to credit bureaus, thereby impairing patients' credit scores.

8. Mary Black pursued such course of conduct despite the patients having health insurance and being entitled to have their healthcare expenses that were incurred at Mary Black submitted to their health insurance for payment.

9. Such patients were unable to submit their medical bills directly to their health insurance as Mary Black was the entity responsible for submitting such bills. Mary Black was the entity in possession of the information required to make such submissions, and Mary Black was the entity that contracted with patients' health insurance providers for a reduced compensation for treating patients with health insurance (i.e., provider contracts).

10. By employing such a policy and business model, Mary Black unlawfully violated the rights of Plaintiffs and the class members, as described more fully below.

11. Moreover, such conduct of Mary Black and its agents was outrageous, intentional, willful, wanton, and malicious, and otherwise showed a complete indifference to or disregard for the rights of Plaintiffs and the class members such that an award of punitive damages would be appropriate to punish and deter such wrongdoing.

### **PARTIES, JURISDICTION, AND VENUE**

12. Plaintiff Jo Ann Blackwell ("Plaintiff Blackwell"), individually and as a representative of a proposed class, is a citizen and resident of Spartanburg County, in the State of South Carolina. Plaintiff Blackwell was injured as the result of being struck by an automobile on December 19, 2013, and Plaintiff Blackwell was a patient of Mary Black Memorial Hospital from December 27, 2013 until January 3, 2014. Plaintiff Blackwell received medical treatment at Mary Black for injuries associated with the accident.

13. Plaintiff Michelene Brooks ("Plaintiff Brooks"), individually and as a representative of a proposed class, is a citizen and resident of Spartanburg County, in the State of South Carolina. Plaintiff Brooks was injured in an automobile collision on February 26, 2016.

Following the collision, on February 28, 2016, Plaintiff Brooks presented to Mary Black Memorial Hospital where she received medical treatment for injuries associated with the accident.

14. Plaintiff Samuel Herbert Owens, Jr. (“Plaintiff Owens”), individually and as a representative of a proposed class, is a citizen and resident of Spartanburg County, in the State of South Carolina. Plaintiff Owens was injured in an automobile collision on October 9, 2015. Immediately following the collision, Plaintiff Owens was transported to Mary Black Health System Emergency Department via private vehicle, where he received medical treatment for injuries associated with the accident.

15. Defendant Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital, is a limited liability company organized, existing, and operating under the laws of the State of South Carolina, and at all times relevant to this Complaint, Mary Black provided healthcare services for Plaintiffs and the general public at its locations in Spartanburg County, South Carolina.

16. Defendant CHSPSC, LLC, formerly known as Community Health Systems Professional Services Corporation, is a Delaware corporation with its principal place of business in Tennessee. On information and belief, CHSPSC regularly conducts business in the State of South Carolina and other states and has responsibility for the billing of patients and liens filed within the State of South Carolina.

17. Defendant Professional Account Services, Inc. (“PASI”) is a Tennessee corporation with its principal place of business in Brentwood, Tennessee. PASI is a collection firm that regularly conducts business in the State of South Carolina and elsewhere.

18. On information and belief, CHSPSC and PASI exercise control over policies and procedures enacted by and implemented by Mary Black Health System, including policies relating

to billing and liens, and all of these entities committed the acts and omissions complained of herein jointly and in concert.

19. Defendants are referred to collectively herein as Mary Black and/or Defendants.

20. This Court has jurisdiction over the parties to and the subject matter of this action, and venue in Spartanburg County is proper.

21. Plaintiffs bring this action on behalf of themselves and all other similarly-situated individuals in the State of South Carolina as a class action.

### **FACTUAL ALLEGATIONS**

#### **1. *Defendants' policies and practices***

22. Upon admission, Defendants screen all patients and make a determination regarding the reason for treatment and whether there may be sources of payment other than health insurance available.

23. On information and belief, if Defendants identify a patient as one whose medical bills may be recoverable from a source other than the patient's health insurance, Defendants refuse to submit that patient's medical bills to his or her health insurance provider.

24. Defendants engaged in these practices even though Defendants are required to submit patients' bills to their health insurance carriers, accept payment from health insurance in satisfaction of the bill, not seek payments from additional sources, and/or hold the patient harmless from any amounts owed other than co-pays and/or deductibles.

25. While refusing to submit medical bills to patients' health insurance carriers and accept payment from health insurance carriers in satisfaction of the bills, Defendants routinely seek payment for the medical bills from those same patients, either directly or indirectly.

26. For example, Defendants seek payment for medical bills by demanding cash payment directly from the patients, placing unlawful liens on patients' third-party tort claims, seeking medical payment benefits from patients' automobile insurers, turning patients over to collection agencies, and/or reporting patients to credit bureaus (thereby impairing patients' credit scores).

27. Defendants pursue such conduct despite the patients having health insurance and being entitled to have their medical bills submitted to their health insurance for payment.

28. Upon information and belief, Defendants are required by their contracts with patients' health insurance carriers to submit insurance patients' medical bills directly to the carriers. Defendants were likewise required to submit the medical bills of Plaintiffs and the Class Members to their health insurance.

29. Defendants are required to honor a contractual discount with their patients' health insurance carriers and accept discounted payments from those health insurance carriers in full satisfaction of the patients' debts.

30. Defendants fail to inform patients at the time of treatment that they will not submit medical bills to the patients' health insurance if the circumstances create the possibility of another source of recovery.

31. Patients are unable to submit their medical bills directly to their health insurance. Defendants are the entities responsible for such submissions and are the only entities in possession of the information required to make such submissions. Further, Defendants have contracts with health insurance providers and health plans for reduced compensation for treating patients who have health insurance.

32. Through Defendants' bill collection practices, they attempt to maximize the amount they receive for services rendered by attempting to recover amounts billed from patients rather than accepting the discounted amount they agreed to accept from patients' health insurance.

33. By employing such policies and practices, Defendants have violated the rights of Plaintiffs and the Class Members as described herein.

34. Further, such conduct of Defendants and their agents, for which they are directly and indirectly responsible, is outrageous, intentional, willful, wanton, and malicious, and otherwise shows a complete indifference to or conscious disregard of the rights of Plaintiffs and the Class Members such that punitive damages are appropriate and warranted under the circumstances.

## **2. *Plaintiff Blackwell***

35. On December 19, 2013, at approximately 8:28 a.m., Plaintiff Blackwell was walking across Daniel Morgan Avenue in Spartanburg, South Carolina, when she was struck by a vehicle. Initially, Plaintiff Blackwell was taken to the trauma department of Spartanburg Regional Medical Center, but she was transferred to Mary Black Memorial Hospital on December 27, 2013. Plaintiff Blackwell remained at Mary Black until January 3, 2014, when she was discharged.

36. At the time of her treatment, Plaintiff Blackwell had valid health insurance coverage with her health plan, which is self-insured through her employer, QS-1. Mary Black knew or should have known that Plaintiff Blackwell had valid health insurance coverage.

37. Plaintiff Blackwell's treatment at Mary Black resulted in medical charges in the amount of \$33,093.65. Defendants refused to submit Plaintiff Blackwell's bills for medical services to her health insurance for payment.

38. At the time of her treatment, Defendants did not inform Plaintiff Blackwell that Defendants would not accept her health insurance, nor did they explain that they would be seeking

the balance of Plaintiff Blackwell's medical bills from her directly and/or by pursuing a third-party lien against her personal injury recovery.

39. Upon information and belief, Plaintiff Blackwell's medical bills would have been paid had they been submitted to her health insurance for payment.

40. However, instead of turning over Plaintiff Blackwell's medical bills to her health insurance provider for payment, Defendants sought collection of Plaintiff Blackwell's account by asserting liens against Plaintiff's potential third party automobile accident claim.

### **3. Plaintiff Brooks**

41. On February 26, 2016, Plaintiff Brooks was a passenger in a vehicle that was hit by another automobile. Plaintiff Brooks presented to the emergency room at Mary Black Hospital two days later, on February 28, 2016, complaining of injuries associated with the accident.

42. At the time of her medical treatment, Plaintiff Brooks had valid health insurance coverage through Medicare. Mary Black knew or should have known that Plaintiff Brooks had valid health insurance coverage.

43. Plaintiff Brooks's treatment at the Mary Black ER resulted in medical charges totaling \$9,982.44. Defendants refused to submit those bills for medical services to Plaintiff Brooks's health insurance for payment.

44. Upon information and belief, Plaintiff Brooks's medical bills would have been paid had they been submitted to her health insurance for payment.

45. However, instead of turning over Plaintiff Brooks's medical bills to her health insurance for payment, Defendants sought collection of Plaintiff Brooks's account by asserting liens against her third-party automobile accident claim.

46. On or about September 26, 2017, Defendants agreed to accept a 50% reduction on Plaintiff Brooks's account and settle for \$4,991.22. Defendants agreed to this reduction only after asserting a lien against Plaintiff Brooks's third-party recovery in her personal injury case and after reviewing the settlement offer for that case.

**4. Plaintiff Owens**

47. On October 9, 2015, Plaintiff Owens was driving his vehicle when he was rear-ended by another automobile. Plaintiff Owens was transported to the emergency department at Mary Black Hospital via private vehicle following the accident, and he received medical treatment at Mary Black for injuries associated with the accident.

48. At the time of his medical treatment, Plaintiff Owens had valid health insurance coverage through Cigna. Mary Black knew or should have known that Plaintiff Owens had valid health insurance coverage.

49. Plaintiff Owens's treatment at the Mary Black ER resulted in medical charges totaling \$9,086.75. Defendants refused to submit those bills for medical services to Plaintiff Owens's health insurance for payment.

50. Upon information and belief, Plaintiff Owens's medical bills would have been paid had they been submitted to his health insurance for payment.

51. However, instead of turning over Plaintiff Owens's medical bills to his health insurance for payment, Defendants sought collection of Plaintiff Owens's account by asserting a lien against his third-party automobile accident claim.

52. On or about October 14, 2016, Defendants agreed to accept a 50% reduction on Plaintiff Owens's account and settle for \$4,543.38. Defendants agreed to this reduction only after

asserting a lien against Plaintiff Owens's third-party recovery in his personal injury case and after reviewing the settlement offer for that case.

### **CLASS ACTION ALLEGATIONS**

53. This action is brought as a class action pursuant to Rule 23 of the South Carolina Rules of Civil Procedure. Plaintiffs bring this action on their own behalf and on behalf of all others similarly situated as representatives of the following Class:

All individuals who, since January 20, 2014, received any type of healthcare treatment from any entity located in South Carolina that is owned or affiliated with Defendants, while being covered by valid health insurance, and whose medical bills resulting from that treatment were not submitted to their health insurance carrier for potential payment.

54. The particular members of the Class are capable of being described without difficult managerial or administrative problems. The members of the Class are readily identifiable from the information and records in the possession or control of Defendants.

55. The Class consists of hundreds and perhaps thousands of individual members and is, therefore, so numerous that individual joinder of all members is impractical.

56. There are questions of law and fact common to the Class, which questions predominate over any questions affecting only individual members of the Class and, in fact, the wrongs suffered and remedies sought by Plaintiff and the other members of the Class are premised upon an unlawful scheme perpetuated uniformly upon all the Class Members. The only material difference between the Class Members' claims is the exact monetary amount to which each member of the Class is entitled.

57. The principal common issues include, but are not limited to, the following:

- a) Whether Defendants entered into express and/or implied agreements with various health insurance carriers providing, among other things, that health insurance claims should be promptly submitted to the carriers for payment;

- b) Whether Defendants violated their contracts with various health insurance carriers by not submitting medical bills to the carrier;
- c) Whether Defendants violated their contracts with various health insurance carriers by pursuing recovery for services rendered by placing liens upon patients' property (such as third-party tort claims), pursuing medical payment benefits from auto insurers, pursuing payment directly from patients, and/or turning patients' accounts over to collections;
- d) Whether Defendants violated their contracts with various health insurance carriers by not offering a contractually agreed discount to patients covered by said policies;
- e) Whether Defendants have violated their contracts with Plaintiff and the Class Members by seeking payment for charges that were covered by valid commercial health insurance;
- f) Whether Defendants improperly refused to submit the Plaintiff's and the Class Members' medical bills to Plaintiff's and the Class Members' health insurance carriers for payment;
- g) Whether Defendants profited by refusing to submit said medical bills to said health insurance carriers for payment;
- h) Whether Defendants have been unjustly enriched at the expense of Plaintiff and the Class Members through their misconduct;
- i) Whether Defendants breached their duty of good faith and fair dealing to the Plaintiff and the Class through the misconduct described herein;

- j) Whether Defendants are liable to Plaintiff and the Class Members based on a claim on money they have received; and
- k) Whether Defendants should be enjoined from continuing their improper and unlawful billing practices as described herein.

58. Plaintiff's claims are typical of those of the Class and are based on the same legal and factual theories as outlined herein.

59. Plaintiff and her counsel will fairly and adequately represent and protect the interests of the members of the Class. Plaintiff has no claims antagonistic to those of the Class. Plaintiff has retained competent and experienced counsel who have prosecuted numerous complex actions within the State of South Carolina and across the nation. Undersigned counsel is committed to the vigorous prosecution of this action.

60. Certification of a class is appropriate in that Plaintiff and the Class Members are seeking monetary damages, common questions predominate over any individual questions, and a class action is a superior method for the fair and efficient adjudication of this controversy. A class action will cause an orderly and expeditious administration of the claims of the Class Members. Economies of time, effort, and expense, will be promoted and uniformity of decisions will be promoted by certification of the class. Additionally, the individual Class Members are unlikely to be aware of their rights and are not in a position (either through experience or financially) to commence individual litigation against Defendants and Defendants' vast resources.

61. Certification of a class action is likewise appropriate in that inconsistent or varying adjudications with respect to individual members of the Class would establish incompatible standards of conduct for Defendants. In addition, as a practical matter, adjudications with respect to individual members of the class would be dispositive of the interests of the other members not

parties to the adjudications or would, at the very least, substantially impair or impede their ability to protect their interests.

62. Defendants have acted or refused to act on grounds generally applicable to the Class as a whole, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the Class as a whole.

**COUNT I**  
**TORTIOUS INTERFERENCE WITH CONTRACTUAL RELATIONSHIP**

63. Plaintiffs incorporate the preceding allegations of this Class Action Complaint by reference.

64. Plaintiffs and the Class Members had a valid business expectancy and/or contractual relationship with their own health insurance providers by virtue of an express or implied contract that Plaintiffs and each individual Class Member had with their health insurance carrier.

65. Defendants knew or should have known of the business expectancies and/or contractual relationships involving Plaintiffs, the Class Members, and their respective health insurance carriers.

66. Defendants intentionally and improperly interfered with and caused a disruption of the business expectancies and/or contractual relationships of Plaintiffs and the Class Members by preventing them from receiving the benefit of their relationships with their respective health insurance carriers. Defendants did so without justification or privilege in a malicious attempt to obtain additional monies to which Defendants were not entitled and with reckless disregard for the damage and harm such action would have on Plaintiffs and the Class Members.

67. Defendants' actions resulted in Plaintiffs and the Class Members having paid premiums but receiving no or little benefit. Defendants' actions thus proximately caused Plaintiffs and the Class Members damages.

68. Plaintiffs and the Class Members are entitled to compensatory damages, punitive damages, and interest in amounts to be determined at trial.

## **COUNT II UNJUST ENRICHMENT**

69. Plaintiffs incorporate the preceding allegations of this Class Action Complaint by reference.

70. As alleged above, Defendants have engaged in a pattern of subverting the financial interests and contractual agreements of Plaintiffs and the Class Members—patients of Defendants' hospitals—for their own pecuniary gain.

71. Defendants have been unjustly enriched in that they received and retained the benefits of proceeds to which they were not entitled and which they received in violation of South Carolina law.

72. Said benefits were conferred on Defendants by Plaintiffs and the Class Members and were unlawfully obtained to the detriment of Plaintiffs and the Class Members.

73. It would be unjust for Defendants to retain these funds because payment for the services provided should have come from the health insurance carriers of Plaintiffs and the Class Members, with the amount to be paid for services provided determined by the contracts between Defendants and patients' health insurance carriers.

74. Allowing Defendants to retain these benefits would violate fundamental principles of justice, equity, and good conscience.

**COUNT III  
INJUNCTIVE RELIEF**

75. Plaintiffs incorporate the preceding allegations of this Class Action Complaint by reference.

76. On information and belief, Defendants were required to submit the medical bills of Plaintiffs and the proposed Class Members directly to their health insurance for payment.

77. On information and belief, Defendants were also required to honor a contractual discount with their patients' health insurance carriers and accept discounted payments from those health insurance carriers in satisfaction of the patients' bills.

78. Nevertheless, on information and belief, Defendants failed to honor contractually agreed-upon discounts regarding Plaintiffs' medical bills and those of the proposed Class Members. Defendants likewise failed to honor their contractual commitment to submit the medical bills of insured patients to those patients' insurance.

79. Defendants are, on information and belief, precluded from seeking payment for covered services from other sources, including from the patient directly, medical payment benefits from the patient's auto insurer, turning the bills over to collections, and/or filing liens against patients' property, including personal injury claims.

80. Through Defendants' bill collection practices, they attempt to optimize the amount received for services rendered by seeking from patients the full amount billed (or more than they are entitled to for the covered treatment), rather than accepting the discounted amount they have agreed to accept from the patient's health insurance carrier.

81. By employing such a policy and business model, Defendants are violating the terms of their health insurance provider agreements and have unlawfully violated the rights of Plaintiffs and the Class Members.

82. A real and subsisting controversy exists between the parties hereto concerning the validity of Defendants' policies and procedures.

83. Plaintiff requests that this Court declare that Defendants, through their actions, policies, procedures, and misconduct as alleged herein, have violated the terms of their agreements with the various health insurance providers and said policies and procedures should be declared invalid and void as a matter of law. Further, this Court should enter a permanent injunction enjoining Defendants from engaging in their unlawful billing practices as described herein and for such other and further relief as the Court deems just and proper under the circumstances.

### **JURY DEMAND**

84. Plaintiffs, on behalf of themselves and the Class Members, demands a jury trial on all issues so triable.

### **PRAYER FOR RELIEF**

Wherefore, Plaintiffs, on behalf of themselves and all Class Members, respectfully pray for judgment against the Defendants as follows:

- (a) For an Order pursuant to S.C.R.C.P. 23 certifying that this action may be maintained as a class action and appointing Plaintiffs and their counsel to represent the class;
- (b) For a declaration that Defendants' actions violated the rights of Plaintiffs and the Class Members under South Carolina law;
- (c) For all actual damages, statutory damages, punitive damages, penalties, and remedies available for the Defendants' violations of the rights of Plaintiffs and the Class Members under South Carolina law;

- (d) For a declaration that Defendants, through their actions and misconduct as alleged above, have been unjustly enriched and for an order requiring Defendants to disgorge any unlawfully gained proceeds;
- (e) For pre-judgment interest as provided by law;
- (f) For post-judgment interest as provided by law;
- (g) For declaratory relief and a permanent injunction enjoining Defendants from engaging in the unlawful billing practices as detailed in this Complaint;
- (h) For an award to Plaintiffs and the Class Members of their reasonable attorneys' fees;
- (i) For an award to Plaintiffs and the Class Members of their costs and expenses of this action;  
and
- (j) For such other and further relief as this Court may deem necessary and proper.

*Signature Page Follows*

Respectfully submitted,

s/John B. White, Jr.

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*Attorneys for Plaintiffs*

Spartanburg, South Carolina

1     STATE OF SOUTH CAROLINA             )   IN THE COURT OF  
        )   COMMON PLEAS  
 2     COUNTY OF SPARTANBURG            )   OF THE SEVENTH  
        )   JUDICIAL CIRCUIT  
 3     )     
        )     
 4     )     
        )     
 5     JO ANN BLACKWELL,                 )  
    MICHELENE BROOKS, AND             )  
 6     SAMUEL H. OWENS, JR.,            )  
    INDIVIDUALLY AND ON BEHALF        )  
 7     OF ALL OTHERS SIMILARLY          )  
    SITUATED,                            )  
        )     
 8             Plaintiffs,               )   TRANSCRIPT OF RECORD  
        )   2017-CP-42-00219  
 9     vs.                                )  
        )     
 10    MARY BLACK HEALTH SYSTEM,        )  
    LLC, d/b/a MARY BLACK             )  
 11    MEMORIAL HOSPITAL; CHSPSC,        )  
    LLC, PROFESSIONAL ACCOUNT         )  
 12    SERVICES, INC.,                    )  
        )     
 13             Defendants.                )  
        )   

14     -----

15                                         July 29, 2020  
 16                                         Spartanburg, South Carolina

17    B E F O R E:

18             HONORABLE J. MARK HAYES, II, Judge.  
 19             HONORABLE DEBRA McCASLIN, Judge

20

21                                         Julie A. Cendroski,  
 22                                         Circuit Court Reporter  
                                        Seventh Judicial Circuit

23

24

25

1 A P P E A R A N C E S

2 MARGHRETTA HAGOOD SHISKO, ESQUIRE  
For The Plaintiffs

3 JOHN B. WHITE, JR., ESQUIRE  
4 For The Plaintiffs

5 KATON EDWARDS DAWSON, JR., ESQUIRE  
For the Defendants

6 JAMES LYNN WERNER, ESQUIRE  
7 For the Defendants.

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EXHIBITS

MARKED

ENTERED

**NO EXHIBITS PROFFERED**

MOTION TO DISMISS

THE COURT: Okay. I am showing, there is our court reporter, she is on with us. I see Mr. White, Mr. Simmons, Mr. Werner. Mr. Werner, are you going to take care of all of the defendants?

MR. WERNER: I am, Judge. Katon Dawson from my office was on this. I don't know if he still is, but I'll be taking care of all of the defendants.

MR. DAWSON: I am, but I'm showing low bandwidth.

THE COURT: And as usual he uses that low bandwidth excuse, okay. Ladies and gentlemen, we also have with us Judge -- Circuit Court Judge Debra McCaslin with us. She was assigned to be with us on this case. She is going to be participating. She has been provided copies of the same information that I have.

She and I have met prior to us getting together, and we have reviewed the information that I have about the case. So if you think that I don't know anything, she really doesn't know anything because she learned it all from me. So please educate us both as anything that you would like for us to know.

MR. WERNER: Judge, I have lost your video. This is Werner.

THE COURT: Okay. Bad reception. Anybody else getting bad reception besides Mr. Werner?

1 COURT REPORTER: I am, Judge.

2 THE COURT: Julie's getting bad reception as  
3 well. Okay. These things happen. All right. Okay.  
4 Give us just a moment, let's see if we can get the  
5 technology fixed and we'll get right back to everybody.

6 MR. WERNER: Hello?

7 THE COURT: Give us one second. Give us just one  
8 second. We're running around finding a cord, so  
9 hopefully we'll get the cord in just a second and maybe  
10 that'll solve the low bandwidth problems.

11 MR. WERNER: I did hear you there, so...

12 THE COURT: Okay. You did or you didn't?

13 MR. WERNER: I did just hear that.

14 THE COURT: All right. I'm told that we are now  
15 plugged in. We're going to try to start again.

16 Again, I want to introduce Judge McCaslin. She  
17 is a Circuit Court judge from Lexington and she is with  
18 us with this case. So she is familiar, through me, with  
19 the case. She's been provided the summary that my law  
20 clerk has prepared, as well as she has access to the  
21 pleadings if she needs them. So any -- I've offered to  
22 her as well that she can help me learn about the case by  
23 asking you any question that she might have during the  
24 course of the argument. So I would ask that you please  
25 show her the same respect that y'all show me so well all

1 the time.

2 So with that being said, I'm gonna turn this over  
3 to -- Mr. Werner, are you gonna argue or are we gonna  
4 let Mr. Dawson?

5 MR. WERNER: I will do it, Judge.

6 THE COURT: All right. And I'm gonna let the  
7 court reporter know, Julie, if ever this gets to be too  
8 much and you cannot understand, just let us know and  
9 we'll stop and we'll reconvene and try to do it again,  
10 okay?

11 COURT REPORTER: Yes, sir.

12 THE COURT: Okay. Yes, sir, Mr. Werner, I'd be  
13 more than happy to hear from you.

14 MR. WERNER: Thank you, Judge. I'll try to do  
15 this as quickly and in an organized fashion, especially  
16 under these conditions. As Your Honor knows, the three  
17 defendants have each filed motions to dismiss. Those  
18 motions, of course, are attacking two things.

19 One, the efficiency of the complaint that causes  
20 of action from each of these plaintiffs on a question of  
21 whether or not the law recognizes a cause of action,  
22 such as they seek to assert. And then also, attacking  
23 them under 12(b)(6) in the sense of whether they would  
24 be stated facts sufficient to constitute one of those  
25 causes of action if it exists. So that's, obviously,

1 the focus of this ---

2 COURT REPORTER: I lost him.

3 MR. WERNER: And there are a few features that  
4 are unique to a couple of the defendants. But first  
5 let's talk about the original plaintiff, Ms. Blackwell.

6 She filed her original complaint in this case on  
7 January 20th of 2017. She then made a motion to amend  
8 that complaint, which motion was filed on October the  
9 18th, 2019, and sometime thereafter, Your Honor, granted  
10 that motion.

11 That amendment actually sought to add the two  
12 other plaintiffs and their claims to the case. Now,  
13 those claims by all three plaintiffs are for tortious  
14 interference with contractual relations, for unjust  
15 enrichment, and for injunctive relief.

16 And in their memorandum to you, all of the  
17 plaintiffs have admitted that the essence of their claim  
18 is that they assert that they are third-party  
19 beneficiaries under what are generally called the  
20 hospital service agreements. They each have slightly  
21 different names, but those are agreements between the  
22 hospital, Mary Black, and their health insurers. And  
23 they claim that they're the third-party beneficiaries  
24 under those agreements and that they are suing to  
25 enforce those to suit their claims and to seek benefits

1 under those agreements.

2 And, in particular, they're seeking to gain  
3 benefit from the payment terms and the payment  
4 discounts, which have been negotiated in the agreements  
5 between the hospital and the health insurers. So  
6 that's, that's the essence of this case. That's what  
7 their case is about.

8 Now, again, they've each alleged tortious  
9 interference. Well, what they've said is that the  
10 defendants -- and, again, we'll come back to this  
11 because it's an issue in the motion, but they don't,  
12 they don't specify what any defendant did. They just  
13 seek to call them defendants having done nothing more  
14 than basically plead their corporate existence.

15 But they argue that those defendants interfered  
16 with the business expectancies for contractual  
17 relationships preventing her, Blackwell, from receiving  
18 the benefit of her relationship with her health  
19 insurance carrier. And we've cited all the law to you,  
20 and it's, I think, well established in South Carolina.

21 A claim for tortious interference requires one of  
22 the absolutely essential elements is that the actions of  
23 the defendant must have procured the breach of a  
24 contract between the plaintiff and a third party.  
25 Without there being a contract between the plaintiff and

1 a third party, which is breached because of the actions  
2 of the defendant, there is no cause of action for  
3 tortious interference.

4           They don't even allege a breach of a contract.  
5 They say there was an interference in their  
6 expectancies, but that's not enough. That does not give  
7 rise to a cause of action for tortious interference  
8 under the law of South Carolina. They do not allege a  
9 breach of the contracts between them and their health  
10 insurers, and without that there can be no cause of  
11 action for tortious interference. That's the essence of  
12 the Motion to Dismiss for all three defendants with  
13 respect to the tortious interference claim of all three  
14 plaintiffs.

15           Now let's look at Blackwell's unjust enrichment  
16 claim. She claims to seek unjust enrichment. As Your  
17 Honor knows, under the law in South Carolina unjust  
18 enrichment is an attempt to gain the remedy of  
19 restitution. Give me back something I gave you that you  
20 don't have the right to keep in equity. There has to be  
21 a tangible value that is provided from one on behalf of  
22 the plaintiff to the defendant for which there can be  
23 restitution.

24           In the case of Blackwell, there is not even an  
25 allegation in the complaint or the amended complaint

1     that Blackwell or anyone on her behalf, provided a  
2     tangible benefit. They don't allege that there was a  
3     payment made or a settlement made with respect to her  
4     liability.

5             The closest they do when they argue this to you  
6     is say, well, Judge, they had a lien, they claimed a  
7     lien. Well, first of all, that lien expired a long time  
8     ago under the law, so there is no lien that they can be  
9     planning. But a lien isn't enough. A lien is nothing  
10    unless the lien is collected. There's no value, there's  
11    no tangible value received and retained by the  
12    defendant.

13            Without the defendant having received and  
14    retained tangible value, in this case, a payment from  
15    the plaintiff, there can be no claim of unjust  
16    enrichment by that plaintiff. Blackwell made no such  
17    payment. She doesn't even allege that she made such a  
18    payment, and she has no claim for unjust enrichment.

19            The injunctive relief claim is based entirely on  
20    their assertion and their effort to enforce the terms of  
21    the agreement between the hospital and Blackwell's  
22    insurance company. That is -- when you read the cause  
23    of action, that's exactly what they are trying to do, to  
24    enforce the payment terms, the discount terms, et  
25    cetera.

1           The problem for Blackwell is that that agreement,  
2       which she claims to be a third-party beneficiary of, and  
3       when she claims to be a third-party beneficiary who  
4       wants to take benefits under that agreement, she takes  
5       that agreement in total the way it is. And that  
6       agreement has an expressed disclaimer of third-party  
7       beneficiaries and specifically conveys the intent of the  
8       two contracting parties that no one else, no third party  
9       has the right to sue upon or to enforce that agreement.

10           And so, any claim, whether it be a claim for  
11       damages or injunctive relief, she does not have standing  
12       as a third-party beneficiary and cannot have that  
13       standing. So that's, that's the first line of argument  
14       with respect to Ms. Blackwell's claims and the basis of  
15       the Motion to Dismiss. We'll come back and touch on a  
16       few other issues more generally, but let's go to Owens,  
17       Plaintiff Owens.

18           Again, Owens was not an original plaintiff. She  
19       was nowhere mentioned in or referred to in the original  
20       complaint. The claims were -- the party was added, the  
21       claims were added in the amended complaint. That  
22       amendment adding the new plaintiffs does not relate back  
23       in time to the original complaint.

24           We've cited the law, the rules and the cases in  
25       our memorandum, and I'm not gonna sit here and just

1 reread them to you because I know Your Honor has looked  
2 at that. But Rule 15 does not allow a plaintiff to add  
3 new plaintiffs by way of amendment. And Rule 15(c)  
4 makes it clear that any addition of a new plaintiff does  
5 not relate back. Adding a new plaintiff is not  
6 correcting a misnomer or a mistake, it is literally  
7 trying to assert new claims by a new party and that does  
8 not relate back under the law to the original complaint.

9 And so in this case the allegations on the face  
10 of the complaint are that Owen made the settlement and  
11 the payment, which they use as the basis for their  
12 claims of restitution and whatnot, on October the 14th,  
13 2016. They didn't even file the Motion to Amend, which  
14 giving them the benefit of all doubts, would be the  
15 earliest date whereby they might have now tried to  
16 assert that claim until October the 18th of 2019.

17 That is outside the three-year limitation period  
18 which governs each of those causes of action. It's more  
19 than three years after the, after Owen knew or should  
20 have known that the claim existed; that the claim had  
21 accrued. And since the amendment does not relate back  
22 on the face of their own complaint that it's time  
23 barred.

24 Now, here's the other important thing about the  
25 Owen's matter. Again, and they said this point blank in

1 their response to the motion. Their claims are all  
2 based upon their contention that they are a third-party  
3 beneficiary of each of their respective agreements. To  
4 each of their respective agreements between their  
5 insurer and the hospital.

6 Well, when each of these plaintiffs tries to  
7 enforce the terms of that agreement as a third-party  
8 beneficiary and seeks to benefit from other terms in  
9 that agreement. The law in South Carolina, the Pierson  
10 case and the cases subsequent to Pierson, make it clear  
11 that the triggers direct benefit estoppel. The  
12 significance of that in this case means they have to  
13 take the burdens of that agreement, just as they seek to  
14 take the benefits of that agreement.

15 In the case of the agreement between Owens  
16 insurer and the hospital, that agreement contains an  
17 arbitration clause. That arbitration clause on its face  
18 unequivocally says that it covers all disputes. And so  
19 when Owen seeks to enforce that agreement and to make  
20 claims based on status of an alleged third-party  
21 beneficiary, those claims are subject to arbitration  
22 under that agreement and under that clause. And because  
23 of that and because of the breadth of arbitration, this  
24 case would have to be stayed and the matter referred to  
25 arbitration with the handling of those disputes.

1           So those are, again, first layer approach to the  
2     issues raised for the Motion to Dismiss in the case of  
3     Owen. I take that back. There is one more issue and  
4     that is we also have asserted and cited the case law  
5     under voluntary payment. The complaint alleges that  
6     Owen settled the claims, the claims in dispute with the  
7     hospital. When they made a voluntary payment settling  
8     those claims, under the law of South Carolina they  
9     cannot pursue further claims.

10           They didn't plead coercion or duress or fraud.  
11     Nowhere in this complaint is there even a scintilla of  
12     an allegation that those things were present. As Your  
13     Honor knows, those things would require heightened  
14     pleading. Not just ultimate facts, but they would  
15     trigger heightened pleading standards. And by not doing  
16     that, they cannot now try to survive on a contention,  
17     oh, well, the claim was made under duress. They didn't  
18     plead that.

19           And what's significant here, Judge, I gave you  
20     the date. This case was started in 2017, the beginning  
21     of 2017. I mean, we've gone long enough to even get a  
22     complaint that can state a viable claim. And it really  
23     is a case where it's time to start cleaning this out and  
24     dismissing these. So those are the issues as it relates  
25     to Owens.

1           That leaves the issues of the claims by Brooks,  
2     the plaintiff Brooks. Again, Brooks was added by an  
3     amendment, not an original plaintiff. Again, the  
4     plaintiff admits that the essence of this whole case is  
5     that pursuant to the agreements between the health  
6     insurers and the hospital. It was wrong, so say the  
7     plaintiffs, for the hospital to do anything to try to  
8     collect these debts by any means other than billing the  
9     insurer for the plaintiff and collecting exclusively  
10    from that insurer.

11           Well, the fact of the matter is, the amended  
12    complaint alleges that Brooks is a Medicare patient.  
13    Her insurance is Medicare. Well, so their argument in  
14    context of Brooks is that an agreement required the  
15    defendant to send its bill and collect its payment from  
16    Medicare or quote/unquote insurer instead of doing  
17    anything to collect that bill from the at-fault parties  
18    in the underlying acts.

19           Well, we've cited to Your Honor the Medicare  
20    statute and we've cited to you cases from other  
21    jurisdictions that have had to deal with this exact  
22    issue. And the fact of the matter is the law of  
23    Medicare provides exactly the opposite. The law of  
24    Medicare requires the hospital to, in fact, first pursue  
25    the claims against the other parties and not to submit

1 the bill directly to Medicare.

2           These defendants cannot be liable under any  
3 theory for doing what the law, the Medicare Act, and the  
4 Medicare law required them to do. And to acknowledge  
5 the Medicare, the Medicare statute is a question of law,  
6 it's a matter of law. There is nothing left for Your  
7 Honor to do but to look at that Medicare statute and to  
8 apply it and to conclude that there are no legitimate  
9 claims by Brooks based on the theories and facts that  
10 have been asserted.

11           Brooks is another one where the voluntary payment  
12 issue arose. The allegation of the complaint is that  
13 there was a voluntary payment made to settle the claim.  
14 There's no allegation that that payment was made under  
15 coercion or duress or based on fraud. And without those  
16 things having been pled and pled to meet heightened  
17 standard, there's nothing in this complaint that would  
18 allow these claims to survive.

19           Now, let me go back and just deal with sort of  
20 one other general broad issue which was raised in the  
21 motion, and that is this idea they try to simply use the  
22 word defendants without any specific allegations to say  
23 that all three of these defendants are being sued in  
24 each of these claims by each of these plaintiffs.  
25 There's no allegations, and certainly not sufficient

1   allegations to allege a conspiracy among them or an  
2   amalgamation under the law or to pierce corporate veils.

3           Merely alleging that they are in the same family  
4   of allegations doesn't get it. The law is clear about  
5   that. And we've cited, I think, that case to Your Honor  
6   in the brief we filed with you last night. There is no  
7   basis here for them to claim that they have these causes  
8   of action against the two other defendants, so called  
9   PASI and CHSPSC.

10           You know, it's one thing to try to rely on the  
11   pleadings, but you get too clever with the pleadings,  
12   Judge. I mean, on the one hand they are trying to say  
13   that they have the right to sue based on their  
14   expectancy under these agreements that are clearly just  
15   between the hospital and their health insurers; that  
16   they have a right to sue PASI and CHSPSC under those  
17   agreements when it's clear they're not parties. And  
18   then they actually come back to you and say, but they're  
19   not entitled to, they're not entitled to the benefits of  
20   those agreements when it says no third-party  
21   beneficiaries or when it says you must arbitrate.

22           Well, that's not the way the law works. If they  
23   want to allege, even though it's -- there's no basis for  
24   it, if they want to base their claim on the fact that  
25   they assert that CHSPSC and PASI are bound to that

1 agreement, then CHSPSC and PASI are entitled to all the  
2 benefits of that agreement as well, just as when they  
3 seek the benefits, they are bound to the burdens of  
4 those agreements.

5 And so, the fact of the matter is they're trying  
6 to sue two additional parties here with no, no specific  
7 allegations or factual basis. I mean, they literally  
8 use the word when they say they settled and paid these  
9 two claims, they just used the word defendants. Now,  
10 common sense belies the idea that they paid three  
11 parties. They know who they paid, they paid the  
12 hospital.

13 They didn't deliver any settlement or payment to  
14 CHSPSC or PASI, but they try to hide behind this just,  
15 oh, defendants to claim that they ought to be able to  
16 pursue unjust enrichment claims against two parties that  
17 they gave no benefits to. None of them gave any  
18 benefits to.

19 And so, respectfully, Judge, it's time to clean  
20 this thing up and it's time to dismiss these causes of  
21 action. Obviously, in the case of Brooks, the issue of  
22 arbitration is a threshold issue, and so we understand  
23 that if you agree that because of their allegations it  
24 is subject to arbitration, then the whole matter should  
25 be referred to arbitration and the rest of the issues

1     dealt with through the arbitrator. But if you maintain  
2     that they do have the right to claim third-party  
3     beneficiary status, they have to go arbitrate.

4             THE COURT: Is that it?

5             MR. WERNER: So that's, in a nutshell, that's  
6     level one of the argument, Judge.

7             THE COURT: Do you have any other levels you want  
8     to present to me before I ask a question?

9             MR. WERNER: I mean, there are a few specifics  
10    that were asserted which may be raised and I'll bring.  
11    We addressed them in our brief last night. I mean, you  
12    know, they try to argue, Judge, that there's no  
13    arbitration agreement because the agreement was dated in  
14    2006 and they don't, they don't read the whole provision  
15    that says it's continued from year to year unless  
16    terminated, according to the termination provisions.

17            They're suing under that agreement. They claim  
18    that agreement exists and then when it's time to have to  
19    arbitrate under it, oh, there's no proof that agreement  
20    exists, Judge. I mean, come on, it's disingenuous. We  
21    need to stop at this point.

22            Same thing that they've, you know, that they've  
23    -- that they've made these arguments about the payments  
24    and stuff. I mean, I think I've addressed those. And  
25    they're certainly addressed in the written material.

1 I'll address them in reply if they raise them again.

2 THE COURT: Okay. All right, well, let's --  
3 thank you very much. Okay. I'm showing that someone's  
4 got a low bandwidth, but I'm gonna proceed on because  
5 I'm not hearing the court reporter tell me that she's  
6 having issues. And so, she's shaking her head, no, she  
7 doesn't have issues.

8 So let's -- thank you, Mr. Werner. We'll move to  
9 -- I'm showing that it shows Mr. White, but there is a  
10 -- I'm showing that they're muted. Their microphone is  
11 off.

12 MR. WERNER: It's on now, Your Honor.

13 THE COURT: Yeah. Mr. Werner, if you would, just  
14 for purposes of technology, do you know how to mute your  
15 microphone?

16 MR. WERNER: I'm looking for it on here, Judge,  
17 and ---

18 THE COURT: It's not -- don't ask me to tell how  
19 because I don't know. Okay. Hang on one second. It  
20 helps with the bandwidth, Mr. Werner. Hang on.

21 MR. WERNER: I think I'm muted now. Can you hear  
22 me speaking?

23 THE COURT: I can hear you speaking. Okay. Give  
24 us one second, Mr. White and Mr. Werner. Give us one  
25 second.

1 MR. WERNER: Can you all still hear me?

2 THE COURT: Yes. Give us one second, Mr. Werner.  
3 Okay. Now, Mr. Werner, don't speak because we can't  
4 hear you. Your microphone is off now.

5 All right. Mr. White, I don't know who's gonna  
6 argue it, but we'll be more than happy to hear from you.

7 MR. WHITE: Thank you, Your Honor. Marghretta  
8 Shisko, my partner, is gonna argue this motion.

9 THE COURT: Okay. Yes, ma'am.

10 MS. SHISKO: Good morning, Your Honor. May it  
11 please the Court. So we filed a single consolidated  
12 brief in response to the three motions filed by Mr.  
13 Werner and Mr. Dawson and I think that those motions  
14 together raise a lot of similar arguments.

15 And I think I counted eight issues that they  
16 raise, but ultimately this is a Motion to Dismiss, not a  
17 Motion for Summary Judgement, but looking at whether the  
18 complaints has a short and plain statement of the facts  
19 showing that the pleader is entitled to relief for  
20 examining the sufficiency of the allegations. But I  
21 think under the pleading standards in South Carolina our  
22 amended complaint meets that standard.

23 And also, I think it's important to keep in mind  
24 as we go through these issues that we filed this as a  
25 class action complaint, so some of these arguments --

1 some of their arguments tend to ignore that. And I'm  
2 just gonna address them in the order that we addressed  
3 them in our brief, if that's all right.

4 And those issues include the sufficiency of the  
5 factual allegations against PASI and CHSPSC, whether the  
6 complaint states a claim for tortious interference;  
7 whether Ms. Brooks' claims are barred as a matter of law  
8 under the Medicare Act; the application of voluntary  
9 payment doctrine; the statute of limitations;  
10 arbitration; and the sufficiency of Ms. Blackwell's  
11 claims and whether she has standing as a third-party  
12 beneficiary.

13 With respect to the sufficiency of the  
14 allegations against PASI and CHSPSC, plaintiffs have  
15 asserted that PASI and CHSPSC, which are related to Mary  
16 Black and are the billing and collection -- or PASI is  
17 the billing and collection arm of Mary Black. They seek  
18 to enforce liens and collect on outstanding medical  
19 bills for the hospital.

20 We allege that these defendants exercise control  
21 over the wrongful policies and procedures regarding  
22 billing and liens and that a defendant's act of jointly  
23 and in concert. And that's in paragraph 18 of the  
24 amended complaint. These allegations are sufficient.

25 And, ultimately, the question is whether the

1 defendants are on notice of the allegations against  
2 them. And throughout the amended complaint we make  
3 numerous factual allegations against these defendants  
4 and they should be on notice at this point.

5 Next, they challenge the sufficiency of our  
6 allegations on just claim for tortious interference with  
7 contractual relations. And they argue that we -- that  
8 we were gonna allege a brief -- I mean a breach, but our  
9 claim is based on their interference with the insurance  
10 contracts between the insurance contracts between the  
11 insurers and the patients and they willfully refused to  
12 submit hospital bills; thereby, depriving the plaintiffs  
13 of the benefit of their insurance relationship, and we  
14 allege that they paid premiums and received little or no  
15 benefit. And at this stage that should be sufficient to  
16 allege breach to support that cause of action.

17 With respect to Plaintiff Brooks and the Medicare  
18 Act, that argument goes beyond the four corners of the  
19 complaint and presumes that the at-fault driver in her  
20 case ---

21 MR. WERNER: I don't know if anyone can hear me.  
22 We've lost audio.

23 MS. SHISKO: Pardon?

24 THE COURT: I'm sorry? Mr. Werner, say that  
25 again. I'm sorry.

1           MR. WERNER: Yeah. We lost audio probably a  
2 minute or two ago on what Marghretta was saying.

3           THE COURT: Okay. Give us just a second. Okay.  
4 Can you back up and let's -- Mr. Werner, what's the last  
5 -- I don't know whether you're taking physical notes,  
6 but if you were, what were the last notes that you took?  
7 Now he's muted. Hang on one second, Mr. Werner.

8           MR. WERNER: Sorry.

9           THE COURT: Now you're unmuted. Okay.

10          MR. WERNER: The last I heard was when she began  
11 saying that the complaint is that they interfered with  
12 the insurance by not submitting the claims. That was  
13 the essence of the last thing I heard.

14          THE COURT: Can you back up to that point?

15          MS. SHISKO: Sure.

16          THE COURT: Okay.

17          MS. SHISKO: Can you hear me now?

18          MR. WERNER: I can hear you now. I'll mute me  
19 again so I won't interfere.

20          MS. SHISKO: And can the court reporter hear me?

21          COURT REPORTER: (Indicating.)

22          THE COURT: Yes.

23          MS. SHISKO: Thank you. So, yes, our claim is  
24 based on defendant's interference with their insurance  
25 contracts with the insurance -- with the insurers. And

1 we allege that they willfully refused to submit their  
2 hospital bills at Mary Black to their respective  
3 insurance carriers for payment. And as a result, that  
4 the patients did not receive the benefits of their  
5 insurance relationships and their insurance contract;  
6 and that they paid premiums that received little to no  
7 benefit; and these allegations at this stage are  
8 sufficient to state a claim for tortious interference  
9 with contractual relation.

10           Going next to Plaintiff Brooks and the Medicaid  
11 Act -- I mean, Medicare Act, defendant's argument goes  
12 beyond the four corners of plaintiff's pleading and is  
13 improper at this stage. It presumes facts not alleged  
14 in the amended complaint. And we allege in the  
15 complaint that Brooks' medical bills would have been  
16 paid had they been submitted to her health insurance for  
17 payment. And defendant's argument would require the  
18 Court to disregard this allegation, which would be  
19 improper at the Motion to Dismiss stage.

20           The next issue is the issue of whether or not the  
21 voluntary payment doctrine applies. And defendants made  
22 that argument with respect to both defendant Brooks and  
23 Owens because both of those individuals had third-party  
24 cases and the liens that Mary Black asserted were paid  
25 from their third-party tort recovery.

1           And as an initial point, they're arguing that  
2   Owens and Brooks can't recover because their liens were  
3   paid. But then when we get to unjust enrichment with  
4   Ms. Blackwell, she can't recover because she didn't  
5   confer benefit because her lien -- Owens and Brooks'  
6   liens were paid, but Blackwell's lien was not paid and  
7   now has expired, so they want it both ways.

8           In any event, the voluntary payment doctrine does  
9   not apply because, as we argued in our brief, these  
10   payments were not truly voluntary and they certainly  
11   were not made of full knowledge of the facts. The  
12   plaintiffs had no way of knowing the terms of the  
13   agreements between the insurance companies and Mary  
14   Black. For example, the contractually reduced rate at  
15   which the hospital agreed to bill insurers for their  
16   services.

17           Then with respect to the statute of limitations  
18   against Mr. Owens, they're basically trying to make the  
19   same argument that they made when they opposed our  
20   motion to amend the complaint. And that is that  
21   Valentine does not -- the case of Valentine does not  
22   permit an amendment to add plaintiffs. This argument  
23   also ignores that we filed this case as a class action.

24           And as we previously argued, our amendment was to  
25   add new class reps, not to assert new claims, since this

1 case was filed as a class action, the claims of the  
2 members of the class would be litigated regardless of  
3 who the named reps are. And the subject of the claim is  
4 still the same. It's still the same basis for the  
5 complaint.

6 Then with respect to arbitration, they argue that  
7 Plaintiff Owens should be required to arbitrate his  
8 claims, due to the 2006 agreement that they filed under  
9 seal. That agreement was just between Mary Black and  
10 reportedly between Mr. Owens' insurers.

11 We have argued that CHSPSC and PASI are not  
12 parties to that contract and it should not be enforced  
13 to prohibit Mr. Owens' claims against them. And in any  
14 event, if the Court does decide that that provision  
15 applies and does decide to compel Owens' arbitration of  
16 Owens' claim, that doesn't mean that the entire case  
17 needs to be stayed. We can sever his claims against  
18 those -- from those against the other named plaintiffs.

19 Then finally, with respect to Ms. Blackwell, as  
20 Mr. Werner mentioned, she was the original plaintiff and  
21 she filed this suit back in January 2017. And I know  
22 there's been some delay, but a lot of that was due to  
23 this case being -- or a motion for complex designation  
24 pending in this case for quite some time.

25 But in any event, we have now amended the

1 complaint. But she was the original plaintiff and she  
2 -- her claim for unjust enrichment should also survive  
3 the Motion to Dismiss stage. We allege that Mary Black  
4 asserted a lien against her third-party accident claim  
5 and did not bill her health insurance for her medical  
6 bills.

7           And when this case was originally filed, Mary  
8 Black was actively pursuing a lien against her  
9 third-party recovery. And it would be inequitable for  
10 the defendants to retain the benefits of their wrongful  
11 billing practices while attempting to collect from -- to  
12 collect the higher amount from the plaintiffs than they  
13 would have received if they had actually billed their  
14 insurance providers like they were required to do.

15           I think that's all. I addressed that.

16           THE COURT: Okay. Give us one second, Mr.  
17 Werner, we'll be right back with you. Okay. All right.  
18 Thank you very much.

19           Yes, sir, Mr. Werner, anything in reply?

20           MR. WERNER: Just very briefly, Judge. I mean,  
21 the new argument made was, well, we've alleged this to  
22 be a class action, Judge, so essentially I think they're  
23 trying to say so all bets are off. We ought to be able  
24 to do whatever we want to do. Well, it's not a class  
25 action until they move to have it certified and Your

1 Honor determines that class can and should be certified.

2 In fact, you can't have a class action if the  
3 named plaintiffs' claims are not viable and legitimate  
4 because you can't have a class when you don't even have  
5 a class representative who has claims. So the fact that  
6 they've alleged a class action is irrelevant in  
7 assessing these grounds for Motions to Dismiss.

8 The other thing which I guess I was just struck  
9 by, and I tried to address this earlier but, you know,  
10 you heard in response to why the tortious interference  
11 claim should not be dismissed that, well, you know,  
12 Judge, they interfered with, you know, they didn't  
13 submit the bills like they should have, like they were  
14 obligated to do. Well, that's not tortious  
15 interference. Again, okay, they claim they're a  
16 third-party beneficiary, so they can claim they're a  
17 third-party beneficiary suing for breach of some  
18 contract, but that's not tortious interference.

19 Tortious interference is a specific claim based  
20 on specific conditions and they've not even alleged that  
21 those conditions exist, namely the actual procurement of  
22 a breach of a contract with a third party. Without that  
23 there can be no tortious interference claim and it  
24 doesn't exist in this case.

25 You know, the whole Medicare argument is --

1     that's a question of law, Judge. I don't care what you  
2     try to allege, if it doesn't exist in the law it can't  
3     state a claim. And Your Honor certainly has the right  
4     and the ability and, in fact, the duty to take notice of  
5     the law, and the Medicare Act could not be plainer than  
6     that they do not have the right to assert the claims for  
7     their Medicare plaintiff, as they are doing, because the  
8     Medicare Act specifically prescribes the action that my  
9     client took.

10           I think everything else is either addressed by my  
11     earlier comments or have been addressed in the brief, so  
12     I'll be glad to answer any questions, but I won't take  
13     any more of your time, Judge.

14           THE COURT: Yeah. Give us just one second.  
15     Okay. Question, clarification if you would. This  
16     question of the arbitration agreement, the -- I  
17     understand -- I know that I signed an order that you all  
18     had consented to, you all had agreed to having certain  
19     documents filed under seal.

20           Now, I have not, in all candor, I have not gone  
21     in and I have not physically taken possession of that  
22     document and ripped it open, because whenever things are  
23     filed under seal I get real nervous when I go poking  
24     around into the clerk's file, so I have not taken a look  
25     at that.

1           But according to the document that I signed, it  
2   is the document sought to be ordered sealed or the  
3   participating hospital agreement between Mary Black and  
4   MedCost, which has been identified as Exhibit A, in the  
5   Motion to Dismiss and alternatively the Motion to  
6   Compel; and the Hospital Services Agreement between Mary  
7   Black and CIGNA, indicated as Exhibit B. Those are the  
8   two documents upon which the plaintiff is contending  
9   creates this obligation of arbitration.

10           MR. WERNER: Yes, Your Honor, that's correct.  
11   I'm sorry, you said the plaintiff and ---

12           THE COURT: Sorry, the defendants contend that  
13   that's where ---

14           MR. WERNER: Well, the CIGNA agreement is the  
15   agreement that has the arbitration clause.

16           THE COURT: CIGNA, okay.

17           MR. WERNER: The MedCost agreement related to Ms.  
18   Blackwell's claim is there because that is the document  
19   that we spoke about earlier in the argument that has the  
20   expressed disclaimer of third-party beneficiaries in it.  
21   But it's only the CIGNA agreement that relates to Owen,  
22   I believe, that has the arbitration clause.

23           THE COURT: CIGNA only relates to the defendant's  
24   position is that the CIGNA agreement is the only one  
25   that relates to the other ones.

1 MR. WERNER: That's correct, Judge.

2 THE COURT: Okay. I think I understand that part  
3 now. Okay. All right. Anything briefly in reply from  
4 the plaintiffs? Anything brief.

5 MS. SHISKO: Just briefly, Your Honor. We don't  
6 object to -- or we object to the agreements being  
7 considered in the context of a 12(b)(6) motion because  
8 those are beyond the pleading.

9 THE COURT: Okay. Okay. All right. Okay.  
10 Well, thank you all very much while we worked through  
11 the technical challenges of doing this motion. I want  
12 to also thank you all for being polite to me while we  
13 had Judge McCaslin in with us and she didn't have to  
14 witness you all badgering me the way that sometimes you  
15 do.

16 I wanted to just take this as a moment for a  
17 judicial protocol or judicial option. I had to take a  
18 phone call this morning, and I say this because I am  
19 looking at, even though it's through video, I am looking  
20 at some of the best lawyers in the state of South  
21 Carolina and I know that I am probably going to be  
22 preaching to the choir when I say this.

23 I know that we're living through difficult times.  
24 I know that we are facing challenges that we have never  
25 faced, not only as a legal profession but also as a

1 community of people. And I have to deviate and say this  
2 because I had to take a phone call this morning. And  
3 the phone call was from a lawyer in my community who had  
4 been appointed yesterday to be the trustee of a lawyer  
5 who committed suicide yesterday.

6 And I asked this gentlemen, I said, do we know  
7 anything about why and he didn't know that much, but it  
8 did appear that he was frustrated and felt the pressures  
9 of the environment that we now face ourselves in dealing  
10 with this health issues, as well as having to deal with  
11 the difficulties in the practice of law.

12 I just, I wanted to point that out to you all  
13 because I want you all to reach out to this Court, reach  
14 out to your fellow lawyers, reach out to your partners,  
15 reach out to anybody that you can.

16 If you ever reach that point to where you're  
17 feeling overwhelmed or frustrated with the legal work  
18 that you do, to reach out to them. You know, there's  
19 nothing wrong with asking for help or there's nothing  
20 wrong with saying, gosh, I don't feel right about  
21 something. Because I'm really -- again, I know I'm  
22 preaching to the choir of the lawyers that I have in  
23 front of me.

24 But I would be remiss having just had that phone  
25 call and having to know that there was a lawyer out

1     there who didn't have somebody to reach out to or maybe  
2     felt like he could not reach out to us. So I want you  
3     to know the Court's here for you all. I know that every  
4     one of you would take that phone call if ever your  
5     brother or your sister ever felt like they needed it.

6             With that being said, thank you all very much for  
7     the arguments. I will take a look at the paperwork that  
8     you've submitted. I've taken a look at it already. My  
9     law clerk's taken a look at it already. As usual,  
10    excellent writing, excellent briefing, but I will get  
11    back to you all as soon as we can. But thank you all  
12    very much.

13            And, Judge, I'll reach out to you, okay?  
14    Anything else?

15            MR. WERNER: Thank you, Judge.

16            MS. SHISKO: Thank you.

17            MR. WERNER: Stay safe everyone.

18            THE COURT: You all too.

19            MR. DAWSON: Thank you.

20            (Hearing concluded at 11:20 a.m.)

21

22

23

24            --- THIS ENDS REQUESTED TRANSCRIPT ---

25

## 1 COURT REPORTER CERTIFICATE

2  
3 I, the undersigned Julie A. Cendroski, Court  
4 Reporter for the Seventh Judicial Circuit Court of the  
5 State of South Carolina, do hereby certify that to the  
6 best of my ability the foregoing is a true, accurate,  
7 and complete transcript of record of all the proceedings  
8 and evidence introduced in the hearing and/or trial of  
9 the captioned case, relative to appeal, in the Court OF  
10 General Sessions for Spartanburg County, South Carolina,  
11 on the 29th day of July, 2020.

12 I do further certify that I am neither of kin,  
13 counsel, nor interest to any party hereto.

14  
15  
16  
17  
18 s/Julie A. Cendroski  
19 Julie A. Cendroski  
20 Circuit Court Reporter  
21 Seventh Judicial Circuit  
22  
23  
24  
25

|                                        |   |                                      |
|----------------------------------------|---|--------------------------------------|
| STATE OF SOUTH CAROLINA                | ) | IN THE COURT OF COMMON PLEAS         |
| COUNTY OF SPARTANBURG                  | ) | SEVENTH JUDICIAL CIRCUIT             |
|                                        | ) |                                      |
| Jo Ann Blackwell, Michelene Brooks,    | ) | C.A. No. 2017-CP-42-00219            |
| and Samuel H. Owens, Jr., individually | ) |                                      |
| and on behalf of all others similarly  | ) |                                      |
| situated,                              | ) |                                      |
|                                        | ) |                                      |
| Plaintiffs,                            | ) | <b>DEFENDANTS' MOTION TO STRIKE</b>  |
|                                        | ) | <b>OR, IN THE ALTERNATIVE, TO</b>    |
| v.                                     | ) | <b>DISMISS THE AMENDED COMPLAINT</b> |
|                                        | ) |                                      |
| Mary Black Health System, LLC, d/b/a   | ) |                                      |
| Mary Black Memorial Hospital; and      | ) |                                      |
| CHSPSC, LLC; Professional Account      | ) |                                      |
| Services, Inc.,                        | ) |                                      |
|                                        | ) |                                      |
| Defendants.                            | ) |                                      |
|                                        | ) |                                      |

---

Defendants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; CHSPSC, LLC; and Professional Account Services, Inc. ("Defendants"), by and through undersigned counsel, hereby move the Court, pursuant to Rules 12(b)(4), 12(b)(5), 12(b)(6), 12(f), 15, and 24, of the South Carolina Rules of Civil Procedure, for an Order striking the purported Amended Complaint, or dismissing the purported Amended Complaint.

In support of this Motion, Defendants state, among other reasons, that:

1. The purported Amended Complaint is not proper and was not properly filed or served and, therefore, must be dismissed as a matter of law pursuant to Rules 12(b)(4) and 12(b)(5) and 15 of the South Carolina Rules of Civil Procedure. More than 30 days had passed since Defendants had answered the original Complaint and thus the Complaint could only be amended upon leave of Court – which leave was neither sought, nor obtained.
2. The purported Amended Complaint is not proper because it purports to add two new named Plaintiffs which is not proper and is not allowed pursuant to Rule 15.

*Valentine v. Davis*, 319 S.C. 169, 172, 460 S.E.2d 218, 219 (Ct. App. 1995). Therefore, the purported Amended Complaint must be dismissed or stricken pursuant to Rule 12(f). See *Smith v. McAlister-Smith Funeral Home, Inc.*, No. 2:11-CV-03281-DCN, 2012 WL 4378185, at \*2 (D.S.C. Sept. 25, 2012) (striking a plaintiff's improperly filed amended complaint because the plaintiff filed the amended complaint outside of the permissible time frame and without seeking leave from the court); *Regan v. City of Hanahan*, No. CV 2:16-1077-RMG, 2017 WL 1244041, at \*1 n.3 (D.S.C. Apr. 3, 2017) (striking the plaintiff's improperly filed amended complaint for failure to comply with Rule 15).

3. Neither of the two purported new named Plaintiffs sought or obtained an order allowing them to intervene in the case in accordance with Rule 24 and their joinder in the case is otherwise improper.
4. The claims of the purported new Plaintiff, Michelene Brooks, fail as a matter of law and must be dismissed pursuant to Rule 12(b)(6). According to the allegations on the face of the purported Amended Complaint, all of Ms. Brooks' claims are based on the allegations that she had health insurance coverage through Medicare and that Defendants are liable because they sought collections for her medical care costs by asserting a right to payment against the insurer for the at-fault driver in her auto accident instead of submitting the claim for her medical care costs to Medicare. However, in accordance with 42 U.S.C.A. § 1395y(b)(2)(A)(ii) (The Medicare Act), Defendants were required to seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare. Furthermore, Ms. Brooks does not allege that she exhausted her administrative remedies under the Medicare Act as she

must do prior to initiating any civil action that alleged. *See Buckner v. Heckler*, 804 F.2d 258, 259-60 (4th Cir. 1986) (dismissing a patient's claim to recover an overpayment to a hospital that resulted from duplicate payments from Medicare and the patient's automobile insurer on the grounds that the patient's claims constituted claims arising under the Medicare Act and, therefore, the plaintiff was required to exhaust his administrative remedies prior to filing suit); *Heckler v. Ringer*, 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622 (1984) (holding that exhaustion of administrative remedies is required for all claims arising under the Medicare Act, 42 U.S.C. §§ 1395-1395zz).

5. Plaintiff Blackwell's claim for unjust enrichment must be dismissed as a matter of law pursuant to Rule 12(b)(6). The Complaint does not even allege that Ms. Blackwell, or anyone on her behalf or for her benefit, made any payment or provided any value to Defendants for the medical care she received. South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: "(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its value." *Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994)

This Motion is based upon the purported Amended Complaint, the other pleadings on file, the documents referenced therein, the applicable authorities and upon such arguments and memoranda of law as may be submitted in support hereof.

s/Katon E. Dawson Jr.

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

August 19, 2019  
Columbia, South Carolina

**STATE OF SOUTH CAROLINA  
COUNTY OF SPARTANBURG**

**IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT**

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

Plaintiffs,

v.

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

Defendants.

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

**MOTION FOR LEAVE TO AMEND  
COMPLAINT**

Plaintiffs Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all persons similarly situated, respectfully submit this Motion for Leave to Amend the Class Action Complaint originally filed on January 20, 2017. Plaintiffs seek to amend the complaint to add two named plaintiffs who are asserting claims individually and on behalf of a proposed class. Plaintiffs' proposed Amended Complaint is attached hereto as Exhibit A.

Pursuant to Rule 15 of the South Carolina Rules of Civil Procedure, leave to amend "shall be freely given when justice so requires and does not prejudice any other party." Rule 15(a), SCRCPP; *see also Parker v. Spartanburg Sanitary Sewer Dist.*, 362 S.C. 276, 286, 607 S.E.2d 711, 716 (Ct. App. 2005) ("Leave to amend pleadings pursuant to Rule 15, SCRCPP, shall be liberally and freely given when justice so requires and does not prejudice any other party."). "The purpose of the rules is to secure justice, and consequently, they reduce formalities and technicalities." *Patton v. Miller*, 420 S.C. 471, 492, 804 S.E.2d 252, 263 (2017). Accordingly, "a request to amend should only be denied if one of three facts is present: the amendment would be prejudicial to the

opposing party, there has been bad faith on the part of the moving party, or amendment would be futile.” *Mayfield v. NASCAR, Inc.*, 674 F.3d 369, 379 (4th Cir. 2012) (internal quotation marks omitted); *see generally Maybank v. BB&T Corp.*, 416 S.C. 541, 565, 787 S.E.2d 498, 510 (2016) (“In construing the South Carolina Rules of Civil Procedure, our [South Carolina Supreme] Court looks for guidance to cases interpreting the federal rules.”). Since the “rule strongly favors amendments,” courts are therefore “encouraged to freely grant leave to amend.” *Parker*, 362 S.C. at 286, 607 S.E.2d at 717.

Here, the Rule 15 criteria are satisfied. Plaintiffs seek to amend the complaint to add additional named plaintiffs to pursue claims in a representative capacity, and the proposed amendment will not prejudice the defendants. *See Twelfth RMA Partners, L.P. v. Nat’l Safe Corp.*, 335 S.C. 635, 641, 518 S.E.2d 44, 47 (Ct. App. 1999) (allowing the substitution of a plaintiff through an amended complaint, reasoning that “[t]he [defendants] rely on *Valentine v. Davis* for the proposition that a plaintiff may not add a new plaintiff to a case to assert a claim against the defendant. In this case, however, no new claims are being added. The court is only changing the name of the plaintiff. The subject of the claim . . . is still the same.” (citation omitted)); *Patton*, 420 S.C. at 493, 804 S.E.2d at 263 (allowing the addition of a plaintiff in a new capacity). Additionally, Plaintiffs’ amendment to add new named plaintiffs as class representatives is not asserting any new claims. Since this case is a class action, the class members’ claims will be litigated regardless and the subject of the claim is still the same, thus the addition of the new named plaintiffs should be permitted under Rule 15.

WHEREFORE, Plaintiffs respectfully requests that the Motion for Leave to Amend be granted. (Plaintiffs’ counsel has conferred with counsel for Defendants and Defendants’ counsel does not consent.)

Respectfully submitted,

s/John B. White, Jr.

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*Attorneys for Plaintiffs*

Spartanburg, South Carolina

October 18, 2019

## EXHIBIT A

**STATE OF SOUTH CAROLINA  
COUNTY OF SPARTANBURG**

**IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT**

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

Plaintiffs,

v.

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

Defendants.

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

**AMENDED CLASS ACTION COMPLAINT**

Plaintiffs Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all persons similarly situated, by and through the undersigned counsel of record, state and allege as follows:

**INTRODUCTION AND BACKGROUND**

1. Plaintiffs bring this action on behalf of themselves and others similarly situated to remedy Defendants' unlawful, unfair, and predatory service and billing practices.

2. At all times relevant to this Complaint, Defendant Mary Black Health System, LLC (referred to herein as "Mary Black") was in the business of providing healthcare services and operated Mary Black Memorial Hospital in the City of Spartanburg, Spartanburg County, South Carolina.

3. As described in more detail below, at all relevant times, Mary Black subverted the financial interests of its patients for its own benefit and profit through unlawful and predatory billing practices.

4. Upon information and belief, Mary Black had a practice of screening all patients and making an initial determination regarding the reason for treatment and whether there might be third-party recovery available to pay for such treatment. Typically, this would be where the patient presented for treatment as a result of an injury from an automobile accident.

5. If Mary Black identified the patient as one whose health expenses might be eligible for third-party recovery, Mary Black refused to submit that patient's medical bills to his or her health insurance provider.

6. The reason for this is simple. Mary Black employed this business model under the belief that if it held out on submitting an accident patient's medical bills to his or her health insurance provider, then Mary Black could receive a higher reimbursement from another source, thereby increasing its profit margin.

7. While refusing to turn over medical bills to accident patients' health insurance providers, Mary Black routinely pursued payment for the medical bills from those same patients. Mary Black did so by, among other things, demanding cash payment directly from the patients, turning over the patients to collection agencies (including, but not limited to, Defendant Professional Account Services, Inc.), and by reporting patients to credit bureaus, thereby impairing patients' credit scores.

8. Mary Black pursued such course of conduct despite the patients having health insurance and being entitled to have their healthcare expenses that were incurred at Mary Black submitted to their health insurance for payment.

9. Such patients were unable to submit their medical bills directly to their health insurance as Mary Black was the entity responsible for submitting such bills. Mary Black was the entity in possession of the information required to make such submissions, and Mary Black was the entity that contracted with patients' health insurance providers for a reduced compensation for treating patients with health insurance (i.e., provider contracts).

10. By employing such a policy and business model, Mary Black unlawfully violated the rights of Plaintiffs and the class members, as described more fully below.

11. Moreover, such conduct of Mary Black and its agents was outrageous, intentional, willful, wanton, and malicious, and otherwise showed a complete indifference to or disregard for the rights of Plaintiffs and the class members such that an award of punitive damages would be appropriate to punish and deter such wrongdoing.

### **PARTIES, JURISDICTION, AND VENUE**

12. Plaintiff Jo Ann Blackwell ("Plaintiff Blackwell"), individually and as a representative of a proposed class, is a citizen and resident of Spartanburg County, in the State of South Carolina. Plaintiff Blackwell was injured as the result of being struck by an automobile on December 19, 2013, and Plaintiff Blackwell was a patient of Mary Black Memorial Hospital from December 27, 2013 until January 3, 2014. Plaintiff Blackwell received medical treatment at Mary Black for injuries associated with the accident.

13. Plaintiff Michelene Brooks ("Plaintiff Brooks"), individually and as a representative of a proposed class, is a citizen and resident of Spartanburg County, in the State of South Carolina. Plaintiff Brooks was injured in an automobile collision on February 26, 2016.

Following the collision, on February 28, 2016, Plaintiff Brooks presented to Mary Black Memorial Hospital where she received medical treatment for injuries associated with the accident.

14. Plaintiff Samuel Herbert Owens, Jr. (“Plaintiff Owens”), individually and as a representative of a proposed class, is a citizen and resident of Spartanburg County, in the State of South Carolina. Plaintiff Owens was injured in an automobile collision on October 9, 2015. Immediately following the collision, Plaintiff Owens was transported to Mary Black Health System Emergency Department via private vehicle, where he received medical treatment for injuries associated with the accident.

15. Defendant Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital, is a limited liability company organized, existing, and operating under the laws of the State of South Carolina, and at all times relevant to this Complaint, Mary Black provided healthcare services for Plaintiffs and the general public at its locations in Spartanburg County, South Carolina.

16. Defendant CHSPSC, LLC, formerly known as Community Health Systems Professional Services Corporation, is a Delaware corporation with its principal place of business in Tennessee. On information and belief, CHSPSC regularly conducts business in the State of South Carolina and other states and has responsibility for the billing of patients and liens filed within the State of South Carolina.

17. Defendant Professional Account Services, Inc. (“PASI”) is a Tennessee corporation with its principal place of business in Brentwood, Tennessee. PASI is a collection firm that regularly conducts business in the State of South Carolina and elsewhere.

18. On information and belief, CHSPSC and PASI exercise control over policies and procedures enacted by and implemented by Mary Black Health System, including policies relating

to billing and liens, and all of these entities committed the acts and omissions complained of herein jointly and in concert.

19. Defendants are referred to collectively herein as Mary Black and/or Defendants.

20. This Court has jurisdiction over the parties to and the subject matter of this action, and venue in Spartanburg County is proper.

21. Plaintiffs bring this action on behalf of themselves and all other similarly-situated individuals in the State of South Carolina as a class action.

### **FACTUAL ALLEGATIONS**

#### **1. *Defendants' policies and practices***

22. Upon admission, Defendants screen all patients and make a determination regarding the reason for treatment and whether there may be sources of payment other than health insurance available.

23. On information and belief, if Defendants identify a patient as one whose medical bills may be recoverable from a source other than the patient's health insurance, Defendants refuse to submit that patient's medical bills to his or her health insurance provider.

24. Defendants engaged in these practices even though Defendants are required to submit patients' bills to their health insurance carriers, accept payment from health insurance in satisfaction of the bill, not seek payments from additional sources, and/or hold the patient harmless from any amounts owed other than co-pays and/or deductibles.

25. While refusing to submit medical bills to patients' health insurance carriers and accept payment from health insurance carriers in satisfaction of the bills, Defendants routinely seek payment for the medical bills from those same patients, either directly or indirectly.

26. For example, Defendants seek payment for medical bills by demanding cash payment directly from the patients, placing unlawful liens on patients' third-party tort claims, seeking medical payment benefits from patients' automobile insurers, turning patients over to collection agencies, and/or reporting patients to credit bureaus (thereby impairing patients' credit scores).

27. Defendants pursue such conduct despite the patients having health insurance and being entitled to have their medical bills submitted to their health insurance for payment.

28. Upon information and belief, Defendants are required by their contracts with patients' health insurance carriers to submit insurance patients' medical bills directly to the carriers. Defendants were likewise required to submit the medical bills of Plaintiffs and the Class Members to their health insurance.

29. Defendants are required to honor a contractual discount with their patients' health insurance carriers and accept discounted payments from those health insurance carriers in full satisfaction of the patients' debts.

30. Defendants fail to inform patients at the time of treatment that they will not submit medical bills to the patients' health insurance if the circumstances create the possibility of another source of recovery.

31. Patients are unable to submit their medical bills directly to their health insurance. Defendants are the entities responsible for such submissions and are the only entities in possession of the information required to make such submissions. Further, Defendants have contracts with health insurance providers and health plans for reduced compensation for treating patients who have health insurance.

32. Through Defendants' bill collection practices, they attempt to maximize the amount they receive for services rendered by attempting to recover amounts billed from patients rather than accepting the discounted amount they agreed to accept from patients' health insurance.

33. By employing such policies and practices, Defendants have violated the rights of Plaintiffs and the Class Members as described herein.

34. Further, such conduct of Defendants and their agents, for which they are directly and indirectly responsible, is outrageous, intentional, willful, wanton, and malicious, and otherwise shows a complete indifference to or conscious disregard of the rights of Plaintiffs and the Class Members such that punitive damages are appropriate and warranted under the circumstances.

## **2. *Plaintiff Blackwell***

35. On December 19, 2013, at approximately 8:28 a.m., Plaintiff Blackwell was walking across Daniel Morgan Avenue in Spartanburg, South Carolina, when she was struck by a vehicle. Initially, Plaintiff Blackwell was taken to the trauma department of Spartanburg Regional Medical Center, but she was transferred to Mary Black Memorial Hospital on December 27, 2013. Plaintiff Blackwell remained at Mary Black until January 3, 2014, when she was discharged.

36. At the time of her treatment, Plaintiff Blackwell had valid health insurance coverage with her health plan, which is self-insured through her employer, QS-1. Mary Black knew or should have known that Plaintiff Blackwell had valid health insurance coverage.

37. Plaintiff Blackwell's treatment at Mary Black resulted in medical charges in the amount of \$33,093.65. Defendants refused to submit Plaintiff Blackwell's bills for medical services to her health insurance for payment.

38. At the time of her treatment, Defendants did not inform Plaintiff Blackwell that Defendants would not accept her health insurance, nor did they explain that they would be seeking

the balance of Plaintiff Blackwell's medical bills from her directly and/or by pursuing a third-party lien against her personal injury recovery.

39. Upon information and belief, Plaintiff Blackwell's medical bills would have been paid had they been submitted to her health insurance for payment.

40. However, instead of turning over Plaintiff Blackwell's medical bills to her health insurance provider for payment, Defendants sought collection of Plaintiff Blackwell's account by asserting liens against Plaintiff's potential third party automobile accident claim.

### **3. Plaintiff Brooks**

41. On February 26, 2016, Plaintiff Brooks was a passenger in a vehicle that was hit by another automobile. Plaintiff Brooks presented to the emergency room at Mary Black Hospital two days later, on February 28, 2016, complaining of injuries associated with the accident.

42. At the time of her medical treatment, Plaintiff Brooks had valid health insurance coverage through Medicare. Mary Black knew or should have known that Plaintiff Brooks had valid health insurance coverage.

43. Plaintiff Brooks's treatment at the Mary Black ER resulted in medical charges totaling \$9,982.44. Defendants refused to submit those bills for medical services to Plaintiff Brooks's health insurance for payment.

44. Upon information and belief, Plaintiff Brooks's medical bills would have been paid had they been submitted to her health insurance for payment.

45. However, instead of turning over Plaintiff Brooks's medical bills to her health insurance for payment, Defendants sought collection of Plaintiff Brooks's account by asserting liens against her third-party automobile accident claim.

46. On or about September 26, 2017, Defendants agreed to accept a 50% reduction on Plaintiff Brooks's account and settle for \$4,991.22. Defendants agreed to this reduction only after asserting a lien against Plaintiff Brooks's third-party recovery in her personal injury case and after reviewing the settlement offer for that case.

#### **4. *Plaintiff Owens***

47. On October 9, 2015, Plaintiff Owens was driving his vehicle when he was rear-ended by another automobile. Plaintiff Owens was transported to the emergency department at Mary Black Hospital via private vehicle following the accident, and he received medical treatment at Mary Black for injuries associated with the accident.

48. At the time of his medical treatment, Plaintiff Owens had valid health insurance coverage through Cigna. Mary Black knew or should have known that Plaintiff Owens had valid health insurance coverage.

49. Plaintiff Owens's treatment at the Mary Black ER resulted in medical charges totaling \$9,086.75. Defendants refused to submit those bills for medical services to Plaintiff Owens's health insurance for payment.

50. Upon information and belief, Plaintiff Owens's medical bills would have been paid had they been submitted to his health insurance for payment.

51. However, instead of turning over Plaintiff Owens's medical bills to his health insurance for payment, Defendants sought collection of Plaintiff Owens's account by asserting a lien against his third-party automobile accident claim.

52. On or about October 14, 2016, Defendants agreed to accept a 50% reduction on Plaintiff Owens's account and settle for \$4,543.38. Defendants agreed to this reduction only after

asserting a lien against Plaintiff Owens's third-party recovery in his personal injury case and after reviewing the settlement offer for that case.

### **CLASS ACTION ALLEGATIONS**

53. This action is brought as a class action pursuant to Rule 23 of the South Carolina Rules of Civil Procedure. Plaintiffs bring this action on their own behalf and on behalf of all others similarly situated as representatives of the following Class:

All individuals who, since January 20, 2014, received any type of healthcare treatment from any entity located in South Carolina that is owned or affiliated with Defendants, while being covered by valid health insurance, and whose medical bills resulting from that treatment were not submitted to their health insurance carrier for potential payment.

54. The particular members of the Class are capable of being described without difficult managerial or administrative problems. The members of the Class are readily identifiable from the information and records in the possession or control of Defendants.

55. The Class consists of hundreds and perhaps thousands of individual members and is, therefore, so numerous that individual joinder of all members is impractical.

56. There are questions of law and fact common to the Class, which questions predominate over any questions affecting only individual members of the Class and, in fact, the wrongs suffered and remedies sought by Plaintiff and the other members of the Class are premised upon an unlawful scheme perpetuated uniformly upon all the Class Members. The only material difference between the Class Members' claims is the exact monetary amount to which each member of the Class is entitled.

57. The principal common issues include, but are not limited to, the following:

- a) Whether Defendants entered into express and/or implied agreements with various health insurance carriers providing, among other things, that health insurance claims should be promptly submitted to the carriers for payment;

- b) Whether Defendants violated their contracts with various health insurance carriers by not submitting medical bills to the carrier;
- c) Whether Defendants violated their contracts with various health insurance carriers by pursuing recovery for services rendered by placing liens upon patients' property (such as third-party tort claims), pursuing medical payment benefits from auto insurers, pursuing payment directly from patients, and/or turning patients' accounts over to collections;
- d) Whether Defendants violated their contracts with various health insurance carriers by not offering a contractually agreed discount to patients covered by said policies;
- e) Whether Defendants have violated their contracts with Plaintiff and the Class Members by seeking payment for charges that were covered by valid commercial health insurance;
- f) Whether Defendants improperly refused to submit the Plaintiff's and the Class Members' medical bills to Plaintiff's and the Class Members' health insurance carriers for payment;
- g) Whether Defendants profited by refusing to submit said medical bills to said health insurance carriers for payment;
- h) Whether Defendants have been unjustly enriched at the expense of Plaintiff and the Class Members through their misconduct;
- i) Whether Defendants breached their duty of good faith and fair dealing to the Plaintiff and the Class through the misconduct described herein;

- j) Whether Defendants are liable to Plaintiff and the Class Members based on a claim on money they have received; and
- k) Whether Defendants should be enjoined from continuing their improper and unlawful billing practices as described herein.

58. Plaintiff's claims are typical of those of the Class and are based on the same legal and factual theories as outlined herein.

59. Plaintiff and her counsel will fairly and adequately represent and protect the interests of the members of the Class. Plaintiff has no claims antagonistic to those of the Class. Plaintiff has retained competent and experienced counsel who have prosecuted numerous complex actions within the State of South Carolina and across the nation. Undersigned counsel is committed to the vigorous prosecution of this action.

60. Certification of a class is appropriate in that Plaintiff and the Class Members are seeking monetary damages, common questions predominate over any individual questions, and a class action is a superior method for the fair and efficient adjudication of this controversy. A class action will cause an orderly and expeditious administration of the claims of the Class Members. Economies of time, effort, and expense, will be promoted and uniformity of decisions will be promoted by certification of the class. Additionally, the individual Class Members are unlikely to be aware of their rights and are not in a position (either through experience or financially) to commence individual litigation against Defendants and Defendants' vast resources.

61. Certification of a class action is likewise appropriate in that inconsistent or varying adjudications with respect to individual members of the Class would establish incompatible standards of conduct for Defendants. In addition, as a practical matter, adjudications with respect to individual members of the class would be dispositive of the interests of the other members not

parties to the adjudications or would, at the very least, substantially impair or impede their ability to protect their interests.

62. Defendants have acted or refused to act on grounds generally applicable to the Class as a whole, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the Class as a whole.

**COUNT I**  
**TORTIOUS INTERFERENCE WITH CONTRACTUAL RELATIONSHIP**

63. Plaintiffs incorporate the preceding allegations of this Class Action Complaint by reference.

64. Plaintiffs and the Class Members had a valid business expectancy and/or contractual relationship with their own health insurance providers by virtue of an express or implied contract that Plaintiffs and each individual Class Member had with their health insurance carrier.

65. Defendants knew or should have known of the business expectancies and/or contractual relationships involving Plaintiffs, the Class Members, and their respective health insurance carriers.

66. Defendants intentionally and improperly interfered with and caused a disruption of the business expectancies and/or contractual relationships of Plaintiffs and the Class Members by preventing them from receiving the benefit of their relationships with their respective health insurance carriers. Defendants did so without justification or privilege in a malicious attempt to obtain additional monies to which Defendants were not entitled and with reckless disregard for the damage and harm such action would have on Plaintiffs and the Class Members.

67. Defendants' actions resulted in Plaintiffs and the Class Members having paid premiums but receiving no or little benefit. Defendants' actions thus proximately caused Plaintiffs and the Class Members damages.

68. Plaintiffs and the Class Members are entitled to compensatory damages, punitive damages, and interest in amounts to be determined at trial.

## **COUNT II UNJUST ENRICHMENT**

69. Plaintiffs incorporate the preceding allegations of this Class Action Complaint by reference.

70. As alleged above, Defendants have engaged in a pattern of subverting the financial interests and contractual agreements of Plaintiffs and the Class Members—patients of Defendants' hospitals—for their own pecuniary gain.

71. Defendants have been unjustly enriched in that they received and retained the benefits of proceeds to which they were not entitled and which they received in violation of South Carolina law.

72. Said benefits were conferred on Defendants by Plaintiffs and the Class Members and were unlawfully obtained to the detriment of Plaintiffs and the Class Members.

73. It would be unjust for Defendants to retain these funds because payment for the services provided should have come from the health insurance carriers of Plaintiffs and the Class Members, with the amount to be paid for services provided determined by the contracts between Defendants and patients' health insurance carriers.

74. Allowing Defendants to retain these benefits would violate fundamental principles of justice, equity, and good conscience.

**COUNT III  
INJUNCTIVE RELIEF**

75. Plaintiffs incorporate the preceding allegations of this Class Action Complaint by reference.

76. On information and belief, Defendants were required to submit the medical bills of Plaintiffs and the proposed Class Members directly to their health insurance for payment.

77. On information and belief, Defendants were also required to honor a contractual discount with their patients' health insurance carriers and accept discounted payments from those health insurance carriers in satisfaction of the patients' bills.

78. Nevertheless, on information and belief, Defendants failed to honor contractually agreed-upon discounts regarding Plaintiffs' medical bills and those of the proposed Class Members. Defendants likewise failed to honor their contractual commitment to submit the medical bills of insured patients to those patients' insurance.

79. Defendants are, on information and belief, precluded from seeking payment for covered services from other sources, including from the patient directly, medical payment benefits from the patient's auto insurer, turning the bills over to collections, and/or filing liens against patients' property, including personal injury claims.

80. Through Defendants' bill collection practices, they attempt to optimize the amount received for services rendered by seeking from patients the full amount billed (or more than they are entitled to for the covered treatment), rather than accepting the discounted amount they have agreed to accept from the patient's health insurance carrier.

81. By employing such a policy and business model, Defendants are violating the terms of their health insurance provider agreements and have unlawfully violated the rights of Plaintiffs and the Class Members.

82. A real and subsisting controversy exists between the parties hereto concerning the validity of Defendants' policies and procedures.

83. Plaintiff requests that this Court declare that Defendants, through their actions, policies, procedures, and misconduct as alleged herein, have violated the terms of their agreements with the various health insurance providers and said policies and procedures should be declared invalid and void as a matter of law. Further, this Court should enter a permanent injunction enjoining Defendants from engaging in their unlawful billing practices as described herein and for such other and further relief as the Court deems just and proper under the circumstances.

#### **JURY DEMAND**

84. Plaintiffs, on behalf of themselves and the Class Members, demands a jury trial on all issues so triable.

#### **PRAYER FOR RELIEF**

Wherefore, Plaintiffs, on behalf of themselves and all Class Members, respectfully pray for judgment against the Defendants as follows:

- (a) For an Order pursuant to S.C.R.C.P. 23 certifying that this action may be maintained as a class action and appointing Plaintiffs and their counsel to represent the class;
- (b) For a declaration that Defendants' actions violated the rights of Plaintiffs and the Class Members under South Carolina law;
- (c) For all actual damages, statutory damages, punitive damages, penalties, and remedies available for the Defendants' violations of the rights of Plaintiffs and the Class Members under South Carolina law;

- (d) For a declaration that Defendants, through their actions and misconduct as alleged above, have been unjustly enriched and for an order requiring Defendants to disgorge any unlawfully gained proceeds;
- (e) For pre-judgment interest as provided by law;
- (f) For post-judgment interest as provided by law;
- (g) For declaratory relief and a permanent injunction enjoining Defendants from engaging in the unlawful billing practices as detailed in this Complaint;
- (h) For an award to Plaintiffs and the Class Members of their reasonable attorneys' fees;
- (i) For an award to Plaintiffs and the Class Members of their costs and expenses of this action;  
and
- (j) For such other and further relief as this Court may deem necessary and proper.

*Signature Page Follows*

Respectfully submitted,

s/John B. White, Jr.

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*Attorneys for Plaintiffs*

Spartanburg, South Carolina

STATE OF SOUTH CAROLINA )  
COUNTY OF SPARTANBURG )

IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT

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

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

Plaintiffs, )

**DEFENDANTS' MEMORANDUM IN  
OPPOSITION TO PLAINTIFFS'  
MOTION TO AMEND COMPLAINT**

v. )

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

Defendants. )

---

Defendants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; CHSPSC, LLC; and Professional Account Services, Inc. (collectively, "Defendants"), by and through undersigned counsel, hereby submit this memorandum in opposition to Plaintiffs Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr. (collectively, "Plaintiffs") Motion to Amend Complaint. Plaintiffs' Motion to Amend should be denied because Rule 15, SCRCF, does not permit the addition of new named plaintiffs—Michelene Brooks and Samuel H. Owens, Jr.—and the proposed amendments are futile.

**FACTS AND PROCEDURAL HISTORY**

On January 20, 2017, Plaintiff Blackwell filed the initial complaint in this matter based upon the following simple allegations:

1. On December 27, 2013, Plaintiff Blackwell was admitted to Mary Black Memorial Hospital (the "Hospital") following an automobile accident. [Amended Complaint ¶¶ 12, 35].
2. Plaintiff Blackwell received medical treatment and was released from the Hospital on January 3, 2014. [Amended Complaint ¶¶ 12, 35].

3. Plaintiff Blackwell alleges that she had health insurance coverage at the time she was admitted to the Hospital. [Amended Complaint ¶ 36].
4. The Hospital did not submit a claim for payment of her bill to her health insurance carrier. [Amended Complaint ¶ 37].
5. Instead, the Hospital submitted the bill for her hospital care to the liability insurance carrier for the at fault driver in her accident (State Farm). [Amended Complaint ¶ 38].

Another important fact is that neither Plaintiff Blackwell, nor her health insurer, nor State Farm, ever paid any of the bill to the Hospital.<sup>1</sup> It is interesting to note that the Complaint alleges no such payment.

With the above facts describing her situation and personal claims, Plaintiff Blackwell, nonetheless, initially alleged in the Complaint that the case should proceed as a class action with the class of plaintiffs defined to be:

All South Carolina residents who, for the past three (3) years, received any type of healthcare treatment from any entity located in South Carolina that is owned or affiliated with Defendant Community Health Systems, while being covered by valid commercial health insurance, and whose medical bills resulting from that treatment were either not submitted to health insurance for payment or were submitted and thereafter Defendants refunded those payments to their health insurance carriers and Defendants obtained payment of those bills directly from the patient, from an auto insurer, and/or from the patient's third-party tort recovery (hereinafter, "Class Members" or the "Class").

[Complaint ¶ 41].

On June 28, 2019, Plaintiff Blackwell—without consent of the Defendants or leave from the Court—filed a purported Amended Complaint. This so-called Amended Complaint attempted to add (for the first time) Michelene Brooks and Samuel H. Owens, Jr. as additional named plaintiffs. In addition to the previously unasserted individual claims and allegations for

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<sup>1</sup> The Hospital has still received no payment for the care or services rendered to Plaintiff Blackwell, and it has not filed any claims against Plaintiff Blackwell, or any insurer, to recover the amounts due.

these new “plaintiffs,” the Amended Complaint sought to amend the class definition to include the following:

All individuals who, since January 20, 2014, received any type of healthcare treatment from any entity located in South Carolina that is owned or affiliated with Defendants, while being covered by valid health insurance, and whose medical bills resulting from that treatment were not submitted to their health insurance carrier for potential payment.

[Amended Complaint ¶ 53].

In addition to the newly defined proposed class, the Amended Complaint makes the following factual allegations as to Plaintiff Owens:

1. On October 9, 2015, Plaintiff Owens was admitted to the Hospital following an automobile accident. [Amended Complaint ¶ 14, 47].
2. Plaintiff Owens alleges that at the time of his medical treatment he had valid health insurance coverage through Cigna. [Amended Complaint ¶ 48].
3. On or about October 14, 2016, Plaintiff Owens—through counsel—negotiated an agreement to settle his account for a payment of \$4,543.38. [Amended Complaint ¶ 52].

Similarly, the Amended Complaint alleges the following individual factual allegations related to Plaintiff Brooks:

1. On February 26, 2016, Plaintiff Brooks was admitted to the Hospital following an automobile accident. [Amended Complaint ¶ 41].
2. Plaintiff Brooks alleges that at the time of her medical treatment she had valid health insurance coverage through Medicare. [Amended Complaint ¶ 42].
3. On or about September 26, 2017, Plaintiff Brooks—through counsel—negotiated an agreement to settle her account for a payment of \$4,991.22. [Amended Complaint ¶ 46].

On August 19, 2019, Defendants filed a Motion to Strike or Dismiss the Amended Complaint filed at that time without motion, consent, or leave of the Court, on the grounds that (1) Plaintiffs improperly filed their purported Amended Complaint without the consent of the

Defendants or leave from the Court; (2) the purported Amended Complaint improperly attempts to add named plaintiffs which is not allowed pursuant to Rule 15, SCRCF; (3) neither of the two purported newly named Plaintiffs (Owens and Brooks) filed a Rule 24 motion to intervene; (4) Plaintiff Brooks's individual claims fail as a matter of law; and (5) Plaintiff Blackwell's claim for unjust enrichment must be dismissed as a matter of law pursuant to Rule 12(b)(6). Defendants incorporate by reference hereto all of the arguments raised in Defendants' Motion to Strike or Dismiss the Amended Complaint, except for the argument that the Motion to Amend was filed without seeking leave from the Court.

### **STANDARD OF REVIEW**

"Amendments of pleadings are controlled by Rule 15, SCRCF." *Staubes v. City of Folly Beach*, 339 S.C. 406, 413, 529 S.E.2d 543, 546 (2000). While disposition of a motion to amend is within the sound discretion of the Court, *Kelly v. South Carolina Farm Bureau Mut. Ins. Co.*, 316 S.C. 319, 450 S.E.2d 59 (Ct. App. 1994), leave to amend should not be given when granting the party's motion to amend would be futile. *Skydive Myrtle Beach, Inc. v. Horry Cty.*, 426 S.C. 175, 182, 826 S.E.2d 585, 588 (2019) (stating that a court "may deny a motion to amend if the amendment would be clearly futile"); *Coral Gables v. Palmetto Brick, Co.*, 183 S.C. 478, 191 S.E. 337, 341 (1937) (holding that an amendment to a complaint asserting a cause of action which is barred by the statute of limitations is futile).

### **ARGUMENTS**

#### **I. Rule 15 of the South Carolina Rules of Civil Procedure does not permit Plaintiff Blackwell to amend the complaint to add new parties asserting new claims in this case.**

Rule 15 does not permit the Plaintiffs to amend the complaint to add new plaintiffs asserting new claims. The Court in *Valentine v. Davis*, 319 S.C. 169, 172, 460 S.E.2d 218, 219 (Ct. App. 1995) summarized the application of Rule 15 as follows:

Rule 15, SCRCF, does not allow an existing plaintiff to add a new plaintiff to the case to assert a claim against the defendant. Rule 15(a) only permits an existing plaintiff to add, modify, delete, or change claims against an existing defendant. Rule 15(b) addresses amendments to conform to the evidence presented at trial. Rule 15(c) deals with relation back of amendments. **None of these subsections addresses a motion to add a plaintiff as contemplated in this case.**

(emphasis added). Rule 15(c) only applies to a substitution or change in a party, and “the addition of a party is not the same as a substitution or change of party.” *Jackson v. Doe*, 342 S.C. 552, 558, 537 S.E.2d 567, 570 (Ct. App. 2000).

Plaintiffs’ Motion to Amend Complaint attempts to add two new parties (Brooks and Owens) to assert new claims based on new factual allegations. The authorities in South Carolina are clear, “Rule 15 does not contemplate adding a *new* plaintiff to assert a *new* claim. . . .” *Patton v. Miller*, 420 S.C. 471, 495, 804 S.E.2d 252, 264 (2017) (emphasis added). Therefore, the Court should deny Plaintiffs’ Motion to Amend Complaint because Plaintiffs seek to impermissibly and improperly add new parties asserting new claims to the above-captioned action nearly three years after the filing of the original complaint.

**II. Plaintiff Owens’s claims are clearly futile because his claims do not relate back to the filing of the original complaint and, therefore, his claims for tortious interference with contract and unjust enrichment are barred by the applicable statutes of limitation.**

The Court should deny Plaintiffs’ Motion to Amend Complaint as it relates to Plaintiff Owens’s claims for tortious interference with contract and unjust enrichment because his claims do not relate back to the filing of the original complaint and, therefore, are barred by the applicable statute of limitations.

Rule 15(c), SCRCF, addresses whether an amendment to a complaint relates back to the filing of the original complaint. *Valentine*, 319 S.C. at 172, 460 S.E.2d at 219. The addition of a new party is not contemplated by Rule 15(c). *Gause v. Smithers*, 384 S.C. 130, 133, 681 S.E.2d

607, 609 (Ct. App. 2009). Thus, Rule 15(c) does not allow for Plaintiff Owens's claims to relate back to the filing of the original complaint because he is a newly added party asserting claims based upon his own individual facts.

Because Plaintiff Owens's claims do not related back to the filing of the original complaint, his claims for tortious interference with contract and unjust enrichment are barred by the applicable statute of limitations. According to the purported Amended Complaint, Plaintiff Owens settled his bill with the Hospital on October 14, 2016. [Amended Complaint ¶ 52]. Plaintiffs filed the Motion to Amend Complaint on October 18, 2019. Therefore, more than three (3) years have passed since Plaintiff Owens knew or should have known of his alleged claims. *See Burgess v. Elliott*, No. 3:16-CV-3325-RBH, 2017 WL 1505421, at \*3 (D.S.C. Apr. 27, 2017), *aff'd*, 696 F. App'x 125 (4th Cir. 2017) ("The applicable statute of limitations for civil actions of breach of contract, negligence, and tortious interference with contract is likewise three years."); *Graham v. Welch, Roberts & Amburn, LLP*, 404 S.C. 235, 239, 743 S.E.2d 860, 862 (Ct. App. 2013) (holding a claim for unjust enrichment was barred by the three year statute of limitations). Accordingly, the Court should deny the Plaintiffs' Motion to Amend Complaint on the grounds that such an amendment would be clearly futile because Plaintiff Owens is attempting to assert claims that are barred by the applicable statutes of limitation. *See Coral Gables*, 183 S.C. 478, 191 S.E. at 341 (holding that an amendment to a complaint asserting a cause of action which is barred by the statute of limitations is futile).

**III. Plaintiff Brooks's claims are clearly futile and fail as a matter of law, because she did not exhaust her administrative remedies prior to filing suit.**

Plaintiff Brooks' claims are futile because she has failed to allege that she exhausted her administrative remedies prior to filing suit. Plaintiff Brooks alleges that at the time of her automobile accident she was covered by Medicare. *See* Amended Complaint ¶ 42.

Exhaustion of administrative remedies is required for all claims arising under the Medicare Act. *Heckler v. Ringer*, 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622 (1984). In *Buckner v. Heckler*, 804 F.2d 258, 259-60 (4th Cir. 1986), the court dismissed a patient's claim to recover an overpayment to a hospital that resulted from duplicate payments from Medicare and the patient's automobile insurer on the grounds that the patient's claims constituted claims arising under the Medicare Act and, therefore, the plaintiff was required to exhaust all administrative remedies prior to filing suit.

Like the plaintiff in *Buckner*, Plaintiff Brooks is required to exhaust all administrative remedies prior to seeking relief in this Court. The purported Amended Complaint makes no reference to Plaintiff Brooks having exhausted all administrative remedies prior to filing the Motion to Amend Complaint. Accordingly, the Court must deny Plaintiffs' Motion to Amend Complaint on the grounds that Plaintiff Brooks's claims are clearly futile based upon her failure to exhaust all administrative remedies prior to seeking relief in this Court.

**IV. Plaintiff Brooks's claims are clearly futile and fail as a matter of law, because the Medicare Act requires a hospital to attempt to collect payment from any applicable auto or liability policy coverage prior to seeking or obtaining payment from Medicare.**

Plaintiff Brooks's claims are all based upon the Defendants' effort to collect payment under an automobile insurance policy or plan before submitting the bill to Medicare. Plaintiff Brooks's claims are all clearly futile because the Medicare Act, 42 U.S.C.A. § 1395y(b)(2)(A)(ii), requires Defendants seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare. Specifically, the Medicare Act states:

Payment under this subchapter may not be made, . . . with respect to any item or service to the extent that -- . . . (ii) payment has been made or can reasonably be expected to be made . . . under an automobile liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

42 U.S.C.A. § 1395y(b)(2)(A)(ii).

All of Plaintiff Brooks's claims are based upon Defendants' collection efforts which are in compliance with the Medicare Act. Therefore, the pursuit of Plaintiffs Brooks's claims would be clearly futile. Accordingly, the Court should deny the Plaintiffs' Motion to Amend the Complaint.

**V. Plaintiff Blackwell's claim for unjust enrichment fails as a matter of law, because she did not provide any of the Defendants with an unjust benefit.**

South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: "(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its value." *Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994). The Amended Complaint does not even allege that Plaintiff Blackwell, or anyone on her behalf or for her benefit, made any payment or provided any value to Defendants for the medical care she received. Therefore, Plaintiff Blackwell's claim for unjust enrichment fails as a matter of law and is clearly futile. Accordingly, the Court should deny the Plaintiffs' Motion to Amend Complaint.

**VI. Plaintiff Blackwell is not a member of the Amended Complaint's newly proposed class.**

Plaintiff Blackwell is not even a member of the newly proposed class. Blackwell's treatment, according to her own allegations, ended on January 3, 2014, and the proposed class is defined to include only persons receiving treatment "since January 20, 2014." See Amended Complaint ¶¶ 12, 35, 53. A class representative must be part of the class. See *Hosp. Mgmt. Assocs., Inc. v. Shell Oil Co.*, 356 S.C. 644, 664, 591 S.E.2d 611, 622 (2004). Therefore, the proposed Amended Complaint is clearly futile, because Plaintiff Blackwell is not a member of the alleged class of injured plaintiffs.

## CONCLUSION

Based on the foregoing, Defendants request that the Court DENY Plaintiffs' Motion to Amend Complaint on the grounds that (1) Rule 15 of the South Carolina Rules of Civil Procedure does not permit Plaintiff Blackwell to amend the complaint to add new parties asserting new claims; (2) Plaintiff Owens's claims for tortious interference with contract and unjust enrichment are clearly futile because those claims for are barred by the applicable statutes of limitation; (3) Plaintiff Brooks's claims are clearly futile and fail as a matter of law, because she did not exhaust her administrative remedies prior to filing suit; (4) Plaintiff Brooks's claims are clearly futile and fail as a matter of law, because the Medicare Act requires a hospital to attempt to collect payment from any applicable auto or liability policy coverage prior to seeking or obtaining payment from Medicare; (5) Plaintiff Blackwell's claim for unjust enrichment is clearly futile and fails as a matter of law, because she did not provide any of the Defendants with an unjust benefit; and (6) Plaintiff Blackwell is not a member of the Amended Complaint's newly proposed class.

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

October 24, 2019  
 Columbia, South Carolina

|                                        |   |                                          |
|----------------------------------------|---|------------------------------------------|
| STATE OF SOUTH CAROLINA                | ) | IN THE COURT OF COMMON PLEAS             |
| COUNTY OF SPARTANBURG                  | ) | SEVENTH JUDICIAL CIRCUIT                 |
|                                        | ) |                                          |
| Jo Ann Blackwell, Michelene Brooks,    | ) | C.A. No. 2017-CP-42-00219                |
| and Samuel H. Owens, Jr., individually | ) |                                          |
| and on behalf of all others similarly  | ) |                                          |
| situated,                              | ) |                                          |
|                                        | ) |                                          |
| Plaintiffs,                            | ) | <b>DEFENDANT CHSPSC, LLC’S MOTION</b>    |
|                                        | ) | <b>DISMISS PURSUANT TO RULE 12(B)(6)</b> |
| v.                                     | ) | <b>OR, IN THE ALTERNATIVE, TO STAY</b>   |
|                                        | ) | <b>THE CASE AND COMPEL</b>               |
| Mary Black Health System, LLC, d/b/a   | ) | <b>ARBITRATION</b>                       |
| Mary Black Memorial Hospital; and      | ) |                                          |
| CHSPSC, LLC; Professional Account      | ) |                                          |
| Services, Inc.,                        | ) |                                          |
|                                        | ) |                                          |
| Defendants.                            | ) |                                          |
|                                        | ) |                                          |

Defendant CHSPSC, LLC (“CHSPSC”) hereby moves to dismiss the Amended Complaint of each Plaintiff, Jo Ann Blackwell, Michelene Brooks and Samuel H. Owens’s (collectively, “Plaintiffs”), pursuant to Rule 12(b)(6) of the South Carolina Rules of Civil Procedure. Alternatively, CHSPSC moves the Court to stay the case and compel Plaintiff Owens to arbitrate his claims against CHSPSC.

**I. The Amended Complaint of each Plaintiff fails to state facts sufficient to constitute a cause of action against CHSPSC.**

**A. Plaintiffs’ Amended Complaint fails to state a claim based on a lack of factual (specific) allegations**

The entirety of the specific and individual allegations against CHSPSC are encompassed in two paragraphs:

16. Defendant CHSPSC, LLC, formerly known as Community Health Systems Professional Services Corporation, is a Delaware corporation with its principal place of business in Tennessee. On information and belief, CHSPSC regularly conducts business in the State of South Carolina and other states and has responsibility for the billing of patients and liens filed within the State of South Carolina.

18. On information and belief, CHSPSC and PASI exercise control over policies and procedures enacted by and implemented by Mary Black Health System, including policies relating to billing and liens, and all of these entities committed the acts and omission complained of herein jointly and in concert.

The Amended Complaint contains no other specific or individual allegations against CHSPSC. Rather, the remainder of the Amended Complaint contains only non-specific generalized allegations referencing Professional Account Services, Inc. (“PASI”), CHSPSC, and Mary Black Health System, LLC collectively as Defendants. There are no allegations sufficient to identify what CHSPSC did, or failed to do, which would support the assertion of each (or any) of the purported causes of action. Furthermore, there are no factual allegations which could support or form the basis for any claim to pierce the corporate veil of CHSPSC or to establish a basis for an amalgamation or conspiracy claim. *See Pro Slab, Inc. v. Argos USA Corp.*, No. CV 2:17-3185-BHH, 2018 WL 6985008, at \*5 (D.S.C. June 28, 2018), *reconsideration granted on other grounds*, No. CV 2:17-3185-BHH, 2018 WL 6985010 (D.S.C. Dec. 3, 2018) (granting the defendants’ motions to dismiss on the grounds that that the plaintiffs’ amended complaint simply lumped together members of corporate families and impermissibly ascribed liability to groups rather than to individual entities); *see also Scurmont LLC v. Firehouse Rest. Grp., Inc.*, No. 4:09-CV-00618-RBH, 2010 WL 11433199, at \*15 (D.S.C. May 19, 2010) (dismissing claims against an individual defendant because the complaint only contained general conclusory allegations against the defendants collectively and the plaintiffs failed to plead sufficient facts that an individual defendant committed any wrongful act within the State of South Carolina, let alone any wrongful act causally related to the plaintiff’s alleged injuries).

Since, the Amended Complaint contains only conclusory allegations against CHSPSC, Plaintiffs have, therefore, failed to plead ultimate facts sufficient to constitute any cause of action against CHSPSC. *See Jones v. Gilstrap*, 288 S.C. 525, 528, 343 S.E.2d 646, 648 (Ct. App. 1986)

(providing that conclusory allegations in a complaint are insufficient to survive the defendant's motion to dismiss for failure to state a cause of action). Without alleging facts related to an act or omission by CHSPSC the Amended Complaint fails on its face and the claims against CHSPSC must be dismissed as a matter of law.

**A. Plaintiffs' Amended Complaint fails to allege facts sufficient to constitute a cause of action for tortious interference with contractual relationship**

The Court should dismiss Plaintiffs' claims for tortious interference with the contractual relationship between Plaintiffs and their health insurance carriers because the generic and conclusory allegations in the Amended Complaint fail to allege the essential elements of the claim that (1) Plaintiffs' contracts with their health insurance carriers were breached and (2) that CHSPSC caused Plaintiffs' contracts with their health insurance carriers to be breached. *See Camp v. Springs Mortgage Corp.*, 310 S.C. 514, 517, 426 S.E.2d 304, 305-06 (1993) (stating that a claim for tortious interference with contract requires a plaintiff allege the following: (1) the existence of a valid contract, (2) the wrongdoer's knowledge thereof, (3) the intentional procurement of its breach, (4) the absence of justification, and (5) resulting damages). Without a breach of Plaintiffs' contracts with their health insurance carriers, there can be no recovery under a cause of action for tortious interference with a contractual relationship. *First Union Mortgage Corp. v. Thomas*, 317 S.C. 63, 73, 451 S.E.2d 907, 913 (Ct. App. 1994). Accordingly, Plaintiffs' claims for tortious interference with a contractual relationship must be dismissed as a matter of law.

**II. Plaintiff Brooks**

**A. Plaintiff Brooks's claims fail under the Medicare Act.**

All of Plaintiff Brooks's claims are based on the allegations that she had health insurance coverage through Medicare and that CHSPSC is liable because it sought collections for her medical care costs by asserting a right to payment against the insurer for the at-fault driver in her automobile accident instead of immediately and directly submitting the claim for her medical care

costs to Medicare.<sup>1</sup> However, in accordance with 42 U.S.C.A. § 1395y(b)(2)(A)(ii) (“The Medicare Act”), CHSPSC was required to seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare. *See Parkview Hosp., Inc. v. Roese*, 750 N.E.2d 384, 389 (Ind. Ct. App. 2001) (“[W]e find that Congress’s intent is clearly expressed in 42 U.S.C. § 1395y(b)(2)(A)(ii). It explicitly prohibits medical service providers from collecting payment from Medicare when payment can reasonably be expected to be made promptly under an automobile or liability insurance policy.”); *Joiner v. Med. Ctr. E., Inc.*, 709 So. 2d 1209, 1221 (Ala. 1998) (holding that an Alabama hospital had a right under the Medicare Act to obtain full payment of its charges from the proceeds of the plaintiff patient’s settlement with an automobile liability carrier, instead of filing a claim for reimbursement with Medicare). Therefore, CHSPSC may not be held liable for acting in compliance with the Medicare Act and all of Plaintiff Brooks’s claims must be dismissed as a matter of law.

**B. Plaintiff Brooks’s claims are barred by the voluntary payment doctrine.**

Plaintiff Brooks’s claims are barred by the voluntary payment doctrine. *Hardaway v. S. Ry. Co.*, 90 S.C. 475, 488-89, 73 S.E. 1020, 1025 (1912) (stating that it is an elementary principle of South Carolina law that no action will lie to recover money voluntarily paid); *Moody v. Stem*, 214 S.C. 45, 60, 51 S.E.2d 163, 169 (1948). Plaintiff Brooks alleges that “Defendants agreed to accept a 50% reduction on Plaintiff Brooks’s account and settle for \$4,991.22.” [Amended Complaint ¶ 46]. Therefore, her claims to recover the funds she voluntarily paid are barred by the voluntary payment doctrine and must be dismissed as a matter of law. *See Cross v. Ciox Health, LLC*, No. 4:19-CV-7-FL, 2020 WL 534289, at \*11 (E.D.N.C. Feb. 3, 2020) (applying similar North Carolina law and granting a motion to dismiss pursuant to Rule 12(b)(6) on the grounds that

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<sup>1</sup> CHSPSC is a separate and distinct entity from Mary Black and PASI and is not responsible for Mary Black’s billings, but the allegations of the Amended Complaint must be accepted as true *only* for the purposes of this motion under Rule 12 of the South Carolina Rules of Civil Procedure. PPAB 5649599v4.docx

the voluntary payment doctrine barred the plaintiffs' purported class claims for unjust enrichment because the plaintiffs' attorneys voluntarily paid the requested amounts to a medical records provider).

### **III. Plaintiff Blackwell**

#### **A. Plaintiff Blackwell fails to state a claim for unjust enrichment**

Plaintiff Blackwell's claim for unjust enrichment must be dismissed as a matter of law pursuant to Rule 12(b)(6). The Amended Complaint does not even allege that Plaintiff Blackwell, or anyone on her behalf or for her benefit, made any payment or provided any value to CHSPSC for the medical care she received. *See Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994) (stating that South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: "(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its value"). Accordingly, Plaintiff Blackwell's claim for unjust enrichment must be dismissed as a matter of law.

#### **B. The MedCost Agreement bars enforcement by non-signatory third-parties (like Plaintiff Blackwell).**

Plaintiff Blackwell's claims must be dismissed as a matter of law because all of her claims are derived from her alleged ability to enforce the negotiated rates for medical services in the Participating Hospital Agreement between her insurance provider (MedCost) and Mary Black, (Amended Complaint ¶¶ 28-31). The express language of that Agreement expressly denies non-signatory third-parties (like Plaintiff Blackwell) the right to sue to enforce its terms. (A copy of the Participating Hospital Agreement will be filed as **Exhibit A** to this Motion after the Court has entered an appropriate order permitting Defendants to file confidential contracts with insurance carriers under seal). Since Plaintiff Blackwell lacks standing to enforce the Participating Hospital

Agreement as a third-party beneficiary, she lacks standing to enforce the terms of the agreement and pursue any of her alleged claims. Therefore, as a matter of law, Plaintiff Blackwell's claims fail and must be dismissed.

#### **IV. Plaintiff Owens**

##### **A. Plaintiff Owens must arbitrate his claims against CHSPSC**

If the Court allows Plaintiff Owens's claims against CHSPSC to continue in any way based on the allegations that Plaintiff Owens is entitled to enforce the billing and payment terms of the Hospital Services Agreement between his alleged insurance provider (CIGNA) and Mary Black, and that CHSPSC is a party or subject to said Agreement then CHSPSC moves to compel arbitration of Plaintiff Owens's claims pursuant to the arbitration requirements of the Agreement and to stay further proceedings in this action. (A copy of the Hospital Services Agreement between CIGNA and Mary Black will be filed as **Exhibit B** to this Motion after the Court has entered an appropriate order permitting Defendants to file confidential contracts with insurance carriers under seal). Section 6.2.2 of the CIGNA Hospital Services Agreement states, "Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement." Having alleged that CHSPSC is liable for failure to comply with the terms of the agreement between Mary Black and CIGNA, Plaintiff Owens is attempting to enforce the terms of that Agreement against CHSPSC. Although CHSPSC expressly denies that it is a party to the contract between Mary Black and CIGNA, if Plaintiff Owens is allowed to proceed on claims seeking to enforce terms of that Agreement against CHSPSC, then to the extent CHSPSC is alleged to be bound by the contract between Mary Black and CIGNA, then Plaintiff Owens must individually arbitrate his claims against CHSPSC pursuant to the terms of the arbitration agreement contained within the contract between Mary Black and CIGNA.

**B. Plaintiff Owens's claims are barred by the applicable statutes of limitation.**

If the Court finds that Plaintiff Owens's claims are not subject to the arbitration provision in the Hospital Services Agreement, then the Court should dismiss Plaintiff Owens's claims for tortious interference with contract and unjust enrichment on the grounds that those claims are barred by the applicable statutes of limitation. *See Graham v. Welch, Roberts & Amburn, LLP*, 404 S.C. 235, 239, 743 S.E.2d 860, 862 (Ct. App. 2013) (holding a claim for unjust enrichment was barred by the three-year statute of limitations); *Burgess v. Elliott*, No. 3:16-CV-3325-RBH, 2017 WL 1505421, at \*3 (D.S.C. Apr. 27, 2017), *aff'd*, 696 F. App'x 125 (4th Cir. 2017) ("The applicable statute of limitations for civil actions of breach of contract, negligence, and tortious interference with contract is likewise three years."). In the Amended Complaint, Plaintiff Owens alleges he settled his bill with the Mary Black on October 14, 2016. [Amended Complaint ¶ 52]. Plaintiffs filed the Motion to Amend Complaint on October 18, 2019. Therefore, more than three (3) years have passed since Plaintiff Owens knew or should have known of his alleged claims. Accordingly, his claims are barred by the applicable statutes of limitation.

**C. Plaintiff Owens's claims are barred by the voluntary payment doctrine.**

If the Court finds that Plaintiff Owens's claims are not subject to the arbitration provision in the Hospital Services Agreement, then Plaintiff Owens's claims are barred by the voluntary payment doctrine. *See Hardaway*, 90 S.C. at 488-89, 73 S.E. at 1025; *Moody*, 214 S.C. at 60, 51 S.E.2d at 169. Plaintiff Owens alleges that "Defendants agreed to accept a 50% reduction on Plaintiff Owens's account and settle for \$4,543.38." [Amended Complaint ¶ 52]. Therefore, his claims to recover the funds he voluntarily paid are barred by the voluntary payment doctrine and must be dismissed as a matter of law. *See Cross*, 2020 WL 534289, at \*11.

## CONCLUSION

This Motion is based upon the allegations in the Amended Complaint, the controlling statutes and case law, and may be supported by such memoranda of law and arguments as are submitted to the Court and parties prior to a hearing hereon.

WHEREFORE, having shown the basis for the Motion to Dismiss or, in the alternative, compelling arbitration, CHSPSC requests the Court dismiss Plaintiffs' Amended Complaint on the grounds that Plaintiffs have failed to allege facts sufficient to constitute a cause of action, or in the alternative, compel Plaintiff Owens to arbitrate his claims against CHSPSC.<sup>2</sup>

s/Katon E. Dawson, Jr.

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*Attorneys for Defendant CHSPSC, LLC*

June 8, 2020  
 Columbia, South Carolina

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<sup>2</sup> Alternatively, CHSPSC moves the Court to enter an Order requiring Plaintiffs submit a more definite statement and allege the necessary facts to establish and identify the claims Plaintiffs are asserting against CHSPSC, rather than the collective "Defendants." See Rule 12(e), SCRCF. Presently, CHSPSC cannot reasonably be required to frame a response to Plaintiff's Amended Complaint without a more definite statement as to the facts and allegations that are being alleged against CHSPSC.

STATE OF SOUTH CAROLINA )  
COUNTY OF SPARTANBURG )

IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT

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

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

Plaintiffs, )

v. )

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

Defendants. )

**DEFENDANT MARY BLACK HEALTH  
SYSTEM, LLCs' MOTION DISMISS  
PURSUANT TO RULE 12(B)(6) OR, IN  
THE ALTERNATIVE, TO STAY THE  
CASE AND COMPEL ARBITRATION**

Defendant Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital ("Mary Black"), hereby moves to dismiss the Amended Complaint of each Plaintiff, Jo Ann Blackwell, Michelene Brooks and Samuel H. Owens's (collectively, "Plaintiffs"), pursuant to Rule 12(b)(6) of the South Carolina Rules of Civil Procedure. Alternatively, Mary Black moves the Court to stay the case and compel Plaintiff Owens to arbitrate his claims against Mary Black.

**I. The Amended Complaint of each Plaintiff fails to state facts sufficient to constitute a cause of action against Mary Black.**

**A. Failure to State a Claim for Tortious Interference with Contractual Relationship**

The Court should dismiss Plaintiffs' claims for tortious interference with the contractual relationship between Plaintiffs and their health insurance carriers because the generic and conclusory allegations in the Amended Complaint fail to allege the essential elements of the claim that (1) Plaintiffs' contracts with their health insurance carriers were breached and (2) that Mary Black caused Plaintiffs' contracts with their health insurance carriers to be breached. *See Camp v. Springs Mortgage Corp.*, 310 S.C. 514, 517, 426 S.E.2d 304, 305-06 (1993) (stating that a claim

for tortious interference with contract requires a plaintiff allege the following: (1) the existence of

a valid contract, (2) the wrongdoer's knowledge thereof, (3) the intentional procurement of its breach, (4) the absence of justification, and (5) resulting damages). Without a breach of Plaintiffs' contracts with their health insurance carriers, there can be no recovery under a cause of action for tortious interference with a contractual relationship. *First Union Mortgage Corp. v. Thomas*, 317 S.C. 63, 73, 451 S.E.2d 907, 913 (Ct. App. 1994). Accordingly, Plaintiffs' claims for tortious interference with a contractual relationship must be dismissed as a matter of law.

## **II. Plaintiff Brooks**

### **A. Plaintiff Brooks's claims fail under the Medicare Act.**

All of Plaintiff Brooks's claims are based on the allegations that she had health insurance coverage through Medicare and that Mary Black is liable because it sought collections for her medical care costs by asserting a right to payment against the insurer for the at-fault driver in her automobile accident instead of immediately and directly submitting the claim for her medical care costs to Medicare. However, in accordance with 42 U.S.C.A. § 1395y(b)(2)(A)(ii) ("The Medicare Act"), Mary Black was required to seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare. *See Parkview Hosp., Inc. v. Roese*, 750 N.E.2d 384, 389 (Ind. Ct. App. 2001) ("[W]e find that Congress's intent is clearly expressed in 42 U.S.C. § 1395y(b)(2)(A)(ii). It explicitly prohibits medical service providers from collecting payment from Medicare when payment can reasonably be expected to be made promptly under an automobile or liability insurance policy."); *Joiner v. Med. Ctr. E., Inc.*, 709 So. 2d 1209, 1221 (Ala. 1998) (holding that an Alabama hospital had a right under the Medicare Act to obtain full payment of its charges from the proceeds of the plaintiff patient's settlement with an automobile liability carrier, instead of filing a claim for reimbursement with Medicare). Therefore, Mary Black may not be held liable for acting in compliance with the Medicare Act and all of Plaintiff Brooks's claims must be dismissed as a matter of law.

**B. Plaintiff Brooks's claims are barred by the voluntary payment doctrine.**

Plaintiff Brooks's claims are barred by the voluntary payment doctrine. *Hardaway v. S. Ry. Co.*, 90 S.C. 475, 488-89, 73 S.E. 1020, 1025 (1912) (stating that it is an elementary principle of South Carolina law that no action will lie to recover money voluntarily paid); *Moody v. Stem*, 214 S.C. 45, 60, 51 S.E.2d 163, 169 (1948). Plaintiff Brooks alleges that "Defendants agreed to accept a 50% reduction on Plaintiff Brooks's account and settle for \$4,991.22." [Amended Complaint ¶ 46]. Therefore, her claims to recover the funds she voluntarily paid are barred by the voluntary payment doctrine and must be dismissed as a matter of law. *See Cross v. Ciox Health, LLC*, No. 4:19-CV-7-FL, 2020 WL 534289, at \*11 (E.D.N.C. Feb. 3, 2020) (applying similar North Carolina law and granting a motion to dismiss pursuant to Rule 12(b)(6) on the grounds that the voluntary payment doctrine barred the plaintiffs' purported class claims for unjust enrichment because the plaintiffs' attorneys voluntarily paid the requested amounts to a medical records provider).

**III. Plaintiff Blackwell**

**A. Plaintiff Blackwell fails to state a claim for unjust enrichment**

Plaintiff Blackwell's claim for unjust enrichment must be dismissed as a matter of law pursuant to Rule 12(b)(6). The Amended Complaint does not even allege that Plaintiff Blackwell, or anyone on her behalf or for her benefit, made any payment or provided any value to Mary Black for the medical care she received. *See Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994) (stating that South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: "(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its

value”). Accordingly, Plaintiff Blackwell’s claim for unjust enrichment must be dismissed as a matter of law.

**B. The MedCost Agreement bars enforcement by non-signatory third-parties.**

Plaintiff Blackwell’s claims must be dismissed as a matter of law because all of her claims are derived from her alleged ability to enforce the negotiated rates for medical services in the Participating Hospital Agreement between her insurance provider (MedCost) and Mary Black, (Amended Complaint ¶¶ 28-31). The express language of that Agreement expressly denies non-signatory third-parties (like Plaintiff Blackwell) the right to sue to enforce its terms. (A copy of the Participating Hospital Agreement will be filed as **Exhibit A** to this Motion after the Court has entered an appropriate order permitting Defendants to file confidential contracts with insurance carriers under seal). Since Plaintiff Blackwell lacks standing to enforce the Participating Hospital Agreement as a third-party beneficiary, she lacks standing to enforce the terms of the agreement and pursue any of her alleged claims. Therefore, as a matter of law, Plaintiff Blackwell’s claims fail and must be dismissed.

**IV. Plaintiff Owens**

**A. Plaintiff Owens must arbitrate his claims against Mary Black.**

If the Court allows Plaintiff Owens’s claims against Mary Black to continue in any way based on the allegations that Plaintiff Owens is entitled to enforce the billing and payment terms of the Hospital Services Agreement between his alleged insurance provider (CIGNA) and Mary Black, then Mary Black moves to compel arbitration of Plaintiff Owens’s claims pursuant to the arbitration requirements of the Agreement and to stay further proceedings in this action. (A copy of the Hospital Services Agreement between CIGNA and Mary Black will be filed as **Exhibit B** to this Motion after the Court has entered an appropriate order permitting Defendants to file confidential contracts with insurance carriers under seal). Section 6.2.2 of the CIGNA Hospital

Services Agreement states, “Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement.” Plaintiff Owens is attempting to enforce the terms of agreement between Mary Black and CIGNA against Mary Black. If Plaintiff Owens is allowed to proceed on claims seeking to enforce terms of that Agreement against Mary Black, then Plaintiff Owens must individually arbitrate his claims against Mary Black pursuant to the terms of the arbitration agreement contained within the contract between Mary Black and CIGNA.

**B. Plaintiff Owens’s claims are barred by the applicable statutes of limitation.**

If the Court finds that Plaintiff Owens’s claims are not subject to the arbitration provision in the Hospital Services Agreement, then the Court should dismiss Plaintiff Owens’s claims for tortious interference with contract and unjust enrichment on the grounds that those claims are barred by the applicable statutes of limitation. *See Graham v. Welch, Roberts & Amburn, LLP*, 404 S.C. 235, 239, 743 S.E.2d 860, 862 (Ct. App. 2013) (holding a claim for unjust enrichment was barred by the three-year statute of limitations); *Burgess v. Elliott*, No. 3:16-CV-3325-RBH, 2017 WL 1505421, at \*3 (D.S.C. Apr. 27, 2017), *aff’d*, 696 F. App’x 125 (4th Cir. 2017) (“The applicable statute of limitations for civil actions of breach of contract, negligence, and tortious interference with contract is likewise three years.”). In the Amended Complaint, Plaintiff Owens alleges he settled his bill with the Mary Black on October 14, 2016. [Amended Complaint ¶ 52]. Plaintiffs filed the Motion to Amend Complaint on October 18, 2019. Therefore, more than three (3) years have passed since Plaintiff Owens knew or should have known of his alleged claims. Accordingly, his claims are barred by the applicable statutes of limitation.

**C. Plaintiff Owens’s claims are barred by the voluntary payment doctrine.**

If the Court finds that Plaintiff Owens’s claims are not subject to the arbitration provision in the Hospital Services Agreement, then Plaintiff Owens’s claims are barred by the voluntary payment doctrine. *See Hardaway v. S. Ry. Co.*, 90 S.C. 475, 488-89, 73 S.E. 1020, 1025 (1912)

(stating that it is an elementary principle of South Carolina law that no action will lie to recover money voluntarily paid); *Moody v. Stem*, 214 S.C. 45, 60, 51 S.E.2d 163, 169 (1948). Plaintiff Owens alleges that “Defendants agreed to accept a 50% reduction on Plaintiff Owens’s account and settle for \$4,543.38.” [Amended Complaint ¶ 52]. Therefore, his claims to recover the funds he voluntarily paid are barred by the voluntary payment doctrine and must be dismissed as a matter of law. *See Cross*, 2020 WL 534289, at \*11.

### **CONCLUSION**

This Motion is based upon the allegations in the Amended Complaint, the controlling statutes and case law, and may be supported by such memoranda of law and arguments as are submitted to the Court and parties prior to a hearing hereon.

WHEREFORE, having shown the basis for the Motion to Dismiss or, in the alternative, compelling arbitration, Mary Black requests the Court dismiss Plaintiffs’ Amended Complaint on the grounds that Plaintiffs have failed to allege facts sufficient to constitute a cause of action, or in the alternative, compel Plaintiff Owens to arbitrate his claims against Mary Black.

s/Katon E. Dawson, Jr.

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 System, LLC, d/b/a Mary Black Memorial  
 Hospital*

June 8, 2020  
 Columbia, South Carolina

STATE OF SOUTH CAROLINA )  
COUNTY OF SPARTANBURG )

IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT

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

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

Plaintiffs, )

v. )

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

Defendants. )

**DEFENDANT PROFESSIONAL  
ACCOUNT SERVICES, INC.'S MOTION  
DISMISS PURSUANT TO RULE 12(B)(6)  
OR, IN THE ALTERNATIVE, TO STAY  
THE CASE AND COMPEL  
ARBITRATION**

Defendant Professional Account Services, Inc. ("PASI") hereby moves to dismiss the Amended Complaint of each Plaintiff, Jo Ann Blackwell, Michelene Brooks and Samuel H. Owens's (collectively, "Plaintiffs"), pursuant to Rule 12(b)(6) of the South Carolina Rules of Civil Procedure. Alternatively, PASI moves the Court to stay the case and compel Plaintiff Owens to arbitrate his claims against PASI.

**I. The Amended Complaint of each Plaintiff fails to state facts sufficient to constitute a cause of action against PASI.**

**A. Plaintiffs' Amended Complaint fails to state a claim based on a lack of factual (specific) allegations**

The entirety of the specific and individual allegations against PASI are encompassed in two paragraphs:

17. Defendant Professional Account Services, Inc. ("PASI") is a Tennessee corporation with its principal place of business in Brentwood, Tennessee. PASI is a collection firm that regularly conducts business in the State of South Carolina and elsewhere.
18. On information and belief, CHSPSC and PASI exercise control over policies and procedures enacted by and implemented by Mary Black Health System, including

policies relating to billing and liens, and all of these entities committed the acts and omission complained of herein jointly and in concert.

The Amended Complaint contains no other specific or individual allegations against PASI. Rather, the remainder of the Amended Complaint contains only non-specific generalized allegations referencing PASI, CHSPSC, LLC, and Mary Black Health System, LLC collectively as Defendants. There are no allegations sufficient to identify what PASI did, or failed to do, which would support the assertion of each (or any) of the purported causes of action. Furthermore, there are no factual allegations which could support or form the basis for any claim to pierce the corporate veil of PASI or to establish a basis for an amalgamation or conspiracy claim. *See Pro Slab, Inc. v. Argos USA Corp.*, No. CV 2:17-3185-BHH, 2018 WL 6985008, at \*5 (D.S.C. June 28, 2018), *reconsideration granted on other grounds*, No. CV 2:17-3185-BHH, 2018 WL 6985010 (D.S.C. Dec. 3, 2018) (granting the defendants' motions to dismiss on the grounds that that the plaintiffs' amended complaint simply lumped together members of corporate families and impermissibly ascribed liability to groups rather than to individual entities); *see also Scurmont LLC v. Firehouse Rest. Grp., Inc.*, No. 4:09-CV-00618-RBH, 2010 WL 11433199, at \*15 (D.S.C. May 19, 2010) (dismissing claims against an individual defendant because the complaint only contained general conclusory allegations against the defendants collectively and the plaintiffs failed to plead sufficient facts that an individual defendant committed any wrongful act within the State of South Carolina, let alone any wrongful act causally related to the plaintiff's alleged injuries).

Since, the Amended Complaint contains only conclusory allegations against PASI, Plaintiffs have, therefore, failed to plead ultimate facts sufficient to constitute any cause of action against PASI. *See Jones v. Gilstrap*, 288 S.C. 525, 528, 343 S.E.2d 646, 648 (Ct. App. 1986) (providing that conclusory allegations in a complaint are insufficient to survive the defendant's

motion to dismiss for failure to state a cause of action). Without alleging facts related to an act or omission by PASI the Amended Complaint fails on its face and the claims against PASI must be dismissed as a matter of law.

**B. Plaintiffs' Amended Complaint fails to allege facts sufficient to constitute a cause of action for tortious interference with contractual relationship**

The Court should dismiss Plaintiffs' claims for tortious interference with the contractual relationship between Plaintiffs and their health insurance carriers because the generic and conclusory allegations in the Amended Complaint fail to allege the essential elements of the claim that (1) Plaintiffs' contracts with their health insurance carriers were breached and (2) that PASI caused Plaintiffs' contracts with their health insurance carriers to be breached. *See Camp v. Springs Mortgage Corp.*, 310 S.C. 514, 517, 426 S.E.2d 304, 305-06 (1993) (stating that a claim for tortious interference with contract requires a plaintiff allege the following: (1) the existence of a valid contract, (2) the wrongdoer's knowledge thereof, (3) the intentional procurement of its breach, (4) the absence of justification, and (5) resulting damages). Without a breach of Plaintiffs' contracts with their health insurance carriers, there can be no recovery under a cause of action for tortious interference with a contractual relationship. *First Union Mortgage Corp. v. Thomas*, 317 S.C. 63, 73, 451 S.E.2d 907, 913 (Ct. App. 1994). Accordingly, Plaintiffs' claims for tortious interference with a contractual relationship must be dismissed as a matter of law.

**II. Plaintiff Brooks**

**A. Plaintiff Brooks's claims fail under the Medicare Act.**

All of Plaintiff Brooks's claims are based on the allegations that she had health insurance coverage through Medicare and that PASI is liable because it sought collections for her medical care costs by asserting a right to payment against the insurer for the at-fault driver in her automobile accident instead of immediately and directly submitting the claim for her medical

care costs to Medicare. However, in accordance with 42 U.S.C.A. § 1395y(b)(2)(A)(ii) (“The Medicare Act”), PASI was required to seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare. *See Parkview Hosp., Inc. v. Roese*, 750 N.E.2d 384, 389 (Ind. Ct. App. 2001) (“[W]e find that Congress’s intent is clearly expressed in 42 U.S.C. § 1395y(b)(2)(A)(ii). It explicitly prohibits medical service providers from collecting payment from Medicare when payment can reasonably be expected to be made promptly under an automobile or liability insurance policy.”); *Joiner v. Med. Ctr. E., Inc.*, 709 So. 2d 1209, 1221 (Ala. 1998) (holding that an Alabama hospital had a right under the Medicare Act to obtain full payment of its charges from the proceeds of the plaintiff patient’s settlement with an automobile liability carrier, instead of filing a claim for reimbursement with Medicare). Therefore, PASI may not be held liable for acting in compliance with the Medicare Act and all of Plaintiff Brooks’s claims must be dismissed as a matter of law.

**B. Plaintiff Brooks’s claims are barred by the voluntary payment doctrine.**

Plaintiff Brooks’s claims are barred by the voluntary payment doctrine. *Hardaway v. S. Ry. Co.*, 90 S.C. 475, 488-89, 73 S.E. 1020, 1025 (1912) (stating that it is an elementary principle of South Carolina law that no action will lie to recover money voluntarily paid); *Moody v. Stem*, 214 S.C. 45, 60, 51 S.E.2d 163, 169 (1948). Plaintiff Brooks alleges that “Defendants agreed to accept a 50% reduction on Plaintiff Brooks’s account and settle for \$4,991.22.” [Amended Complaint ¶ 46]. Therefore, her claims to recover the funds she voluntarily paid are barred by the voluntary payment doctrine and must be dismissed as a matter of law. *See Cross v. Ciox Health, LLC*, No. 4:19-CV-7-FL, 2020 WL 534289, at \*11 (E.D.N.C. Feb. 3, 2020) (applying similar North Carolina law and granting a motion to dismiss pursuant to Rule 12(b)(6) on the grounds that the voluntary payment doctrine barred the plaintiffs’ purported class claims

for unjust enrichment because the plaintiffs' attorneys voluntarily paid the requested amounts to a medical records provider).

### **III. Plaintiff Blackwell**

#### **A. Plaintiff Blackwell fails to state a claim for unjust enrichment**

Plaintiff Blackwell's claim for unjust enrichment must be dismissed as a matter of law pursuant to Rule 12(b)(6). The Amended Complaint does not even allege that Plaintiff Blackwell, or anyone on her behalf or for her benefit, made any payment or provided any value to PASI for the medical care she received. *See Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994) (stating that South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: "(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its value"). Accordingly, Plaintiff Blackwell's claim for unjust enrichment must be dismissed as a matter of law.

#### **B. The MedCost Agreement bars enforcement by non-signatory third-parties (like Plaintiff Blackwell).**

Plaintiff Blackwell's claims must be dismissed as a matter of law because all of her claims are derived from her alleged ability to enforce the negotiated rates for medical services in the Participating Hospital Agreement between her insurance provider (MedCost) and Mary Black, (Amended Complaint ¶¶ 28-31). The express language of that Agreement expressly denies non-signatory third-parties (like Plaintiff Blackwell) the right to sue to enforce its terms. (A copy of the Participating Hospital Agreement will be filed as **Exhibit A** to this Motion after the Court has entered an appropriate order permitting Defendants to file confidential contracts with insurance carriers under seal). Since Plaintiff Blackwell lacks standing to enforce the Participating Hospital Agreement as a third-party beneficiary, she lacks standing to enforce the

terms of the agreement and pursue any of her alleged claims. Therefore, as a matter of law, Plaintiff Blackwell's claims fail and must be dismissed.

#### **IV. Plaintiff Owens**

##### **A. Plaintiff Owens must arbitrate his claims against PASI**

If the Court allows Plaintiff Owens's claims against PASI to continue in any way based on the allegations that Plaintiff Owens is entitled to enforce the billing and payment terms of the Hospital Services Agreement between his alleged insurance provider (CIGNA) and Mary Black, and that PASI is a party or subject to said Agreement then PASI moves to compel arbitration of Plaintiff Owens's claims pursuant to the arbitration requirements of the Agreement and to stay further proceedings in this action. (A copy of the Hospital Services Agreement between CIGNA and Mary Black will be filed as **Exhibit B** to this Motion after the Court has entered an appropriate order permitting Defendants to file confidential contracts with insurance carriers under seal). Section 6.2.2 of the CIGNA Hospital Services Agreement states, "Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement." Having alleged that PASI is liable for failure to comply with the terms of the agreement between Mary Black and CIGNA, Plaintiff Owens is attempting to enforce the terms of that Agreement against PASI. Although PASI expressly denies that it is a party to the contract between Mary Black and CIGNA, if Plaintiff Owens is allowed to proceed on claims seeking to enforce terms of that Agreement against PASI, then to the extent PASI is alleged to be bound by the contract between Mary Black and CIGNA, then Plaintiff Owens must individually arbitrate his claims against PASI pursuant to the terms of the arbitration agreement contained within the contract between Mary Black and CIGNA.

**B. Plaintiff Owens's claims are barred by the applicable statutes of limitation.**

If the Court finds that Plaintiff Owens's claims are not subject to the arbitration provision in the Hospital Services Agreement, then the Court should dismiss Plaintiff Owens's claims for tortious interference with contract and unjust enrichment on the grounds that those claims are barred by the applicable statutes of limitation. *See Graham v. Welch, Roberts & Amburn, LLP*, 404 S.C. 235, 239, 743 S.E.2d 860, 862 (Ct. App. 2013) (holding a claim for unjust enrichment was barred by the three-year statute of limitations); *Burgess v. Elliott*, No. 3:16-CV-3325-RBH, 2017 WL 1505421, at \*3 (D.S.C. Apr. 27, 2017), *aff'd*, 696 F. App'x 125 (4th Cir. 2017) ("The applicable statute of limitations for civil actions of breach of contract, negligence, and tortious interference with contract is likewise three years."). In the Amended Complaint, Plaintiff Owens alleges he settled his bill with the Mary Black on October 14, 2016. [Amended Complaint ¶ 52]. Plaintiffs filed the Motion to Amend Complaint on October 18, 2019. Therefore, more than three (3) years have passed since Plaintiff Owens knew or should have known of his alleged claims. Accordingly, his claims are barred by the applicable statutes of limitation.

**C. Plaintiff Owens's claims are barred by the voluntary payment doctrine.**

If the Court finds that Plaintiff Owens's claims are not subject to the arbitration provision in the Hospital Services Agreement, then Plaintiff Owens's claims are barred by the voluntary payment doctrine. *See Hardaway*, 90 S.C. at 488-89, 73 S.E. at 1025; *Moody*, 214 S.C. at 60, 51 S.E.2d at 169. Plaintiff Owens alleges that "Defendants agreed to accept a 50% reduction on Plaintiff Owens's account and settle for \$4,543.38." [Amended Complaint ¶ 52]. Therefore, his claims to recover the funds he voluntarily paid are barred by the voluntary payment doctrine and must be dismissed as a matter of law. *See Cross*, 2020 WL 534289, at \*11.

## CONCLUSION

This Motion is based upon the allegations in the Amended Complaint, the controlling statutes and case law, and may be supported by such memoranda of law and arguments as are submitted to the Court and parties prior to a hearing hereon.

WHEREFORE, having shown the basis for the Motion to Dismiss or, in the alternative, compelling arbitration, PASI requests the Court dismiss Plaintiffs' Amended Complaint on the grounds that Plaintiffs have failed to allege facts sufficient to constitute a cause of action, or in the alternative, compel Plaintiff Owens to arbitrate his claims against PASI.<sup>1</sup>

s/Katon E. Dawson, Jr.

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*Attorneys for Defendant Professional  
 Account Services, Inc.*

June 8, 2020  
 Columbia, South Carolina

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<sup>1</sup> Alternatively, PASI moves the Court to enter an Order requiring Plaintiffs submit a more definite statement and allege the necessary facts to establish and identify the claims Plaintiffs are asserting against PASI, rather than the collective "Defendants." See Rule 12(e), SCRCF. Presently, PASI cannot reasonably be required to frame a response to Plaintiff's Amended Complaint without a more definite statement as to the facts and allegations that are being alleged against PASI.

**STATE OF SOUTH CAROLINA  
COUNTY OF SPARTANBURG**

**IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT**

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

Plaintiffs,

v.

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

Defendants.

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

Hon. J. Mark Hayes, II

**PLAINTIFFS' RESPONSE IN OPPOSITION TO  
DEFENDANTS' MOTIONS TO DISMISS**

Plaintiffs Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly-situated, respectfully submit this Response in Opposition to three (3) motions to dismiss filed by the defendants in this matter. Defendants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital ("Mary Black"), CHSPSC, LLC ("CHSPSC"), and Professional Account Service, Inc. ("PASI") have filed separate motions to dismiss the Amended Complaint and/or to compel Plaintiff Owens to arbitrate his claims against them. Because Defendants' motions all raise similar (if not identical) arguments, Plaintiffs are submitting a single, consolidated response in opposition to the motions to dismiss to address all arguments. For the reasons set forth herein, Defendants' motions should all be denied and Plaintiffs should be permitted to proceed with discovery that will enable them to file a motion to certify a class of similarly-situated individuals under Rule 23(a), SCRPC.

## BACKGROUND

Plaintiff Jo Ann Blackwell originally filed this case as a class action on January 20, 2017, asserting claims against Defendants, a hospital and related entities, on behalf of herself and hundreds (or possibly thousands) of potential class members. On April 24, 2020, Plaintiffs filed an Amended Class Action Complaint, which included two additional individuals, Samul H. Owens, Jr., and Michelene Brooks, as named plaintiffs. Plaintiffs are asserting causes of action for tortious interference with contractual relationship, unjust enrichment, and injunctive relief individually and on behalf of the class members against all the defendants.

The claims of the named plaintiffs and the class members (collectively, “Plaintiffs”) stem from Defendants’ policy, in cases where a potential third party might be liable for a patient’s injuries, of not submitting claims to health insurers for payment or refunding payments to health insurance carriers and then attempting to obtain payment for the patient’s medical bills directly from the patient, from an auto insurer, and/or from the patient’s third-party tort recovery. (*See* Am. Compl. ¶¶ 4–8.) Plaintiffs allege that Defendants, as a standard business practice, routinely refused to submit patients’ medical bills to their insurance providers if Defendants’ screening identified a patient as one for whom third-party recovery might be available to pay for such treatment. (*Id.* ¶¶ 4–5.) This was done so that Defendants could obtain a higher reimbursement than what might have been received from the patient’s insurance. (*Id.* ¶ 6.)

Plaintiffs contend they are third-party direct beneficiaries of the agreements between their insurance companies and Mary Black, and that Defendants interfered with Plaintiffs’ own relationships with their insurance companies by attempting to collect payments from Plaintiffs at a higher amount than what Mary Black contracted for with Plaintiffs’ insurance companies. (*See id.* ¶ 57.) Each of the named plaintiffs is an accident victim who received treatment at Mary Black

and, thereafter, Defendants refused to submit their bills to their health insurance companies for payment. (*See id.* ¶¶ 35–52.) Instead, Defendants engaged in impermissible attempts to collect directly from Plaintiffs or from Plaintiffs’ third-party tort recovery. (*See id.* ¶¶ 40, 45, 51.) The named plaintiffs are seeking to represent a class of patients whose medical bills were not submitted to their health insurance carriers for payment. (*Id.* ¶¶ 21, 53.)

Defendants Mary Black, CHSPSC, and PASI are related entities that engaged in the wrongful billing and collection practices alleged in the Amended Complaint. Mary Black is the hospital where Plaintiffs received treatment (*see id.* ¶ 2), and CHSPSC and PASI are billing and collection entities related to Mary Black (*see id.* ¶¶ 16–17). In particular, Plaintiffs allege that “CHSPSC and PASI exercise control over policies and procedures enacted and implemented by Mary Black Health System, including policies relating to billing and liens, and all of these entities committed the acts and omissions complained of herein, jointly and in concert.” (*Id.* ¶ 18.)

### MOTION TO DISMISS STANDARD

The South Carolina Rules of Civil Procedure require a complaint to contain, among other things, “a short and plain statement of the facts showing that the pleader is entitled to relief.” Rule 8(a)(2), SCRCF; *see Clark v. Clark*, 293 S.C. 415, 416, 361 S.E.2d 328, 328 (1987). “In considering a motion to dismiss a complaint based on a failure to state facts sufficient to constitute a cause of action, the trial court must base its ruling solely on allegations set forth in the complaint.” *Doe v. Marion*, 373 S.C. 390, 395, 645 S.E.2d 245, 247 (2007) (citing *Spence v. Spence*, 368 S.C. 106, 116, 628 S.E.2d 869, 874 (2006)). In deciding a motion to dismiss under Rule 12(b)(6), “[t]he question for the court is whether in the light most favorable to the plaintiff, and with every doubt resolved in his behalf, the allegations set forth on the face of the complaint state any valid claim for relief.” *Sloan Constr. Co. v. Southco Grassing, Inc.*, 377 S.C. 108, 112–13, 659 S.E.2d 158,

161 (2008) (citing *Plyler v. Burns*, 373 S.C. 637, 645, 647 S.E.2d 188, 192 (2007)). Where “the ‘facts alleged and inferences reasonably deducible therefrom would entitle the plaintiff to any relief on any theory of the case,’ then dismissal under Rule 12(b)(6) is improper.” *Id.* at 113, 659 S.E.2d at 161 (quoting *Stiles v. Onorato*, 318 S.C. 297, 300, 457 S.E.2d 601, 603 (1995)).

Additionally, a “complaint should not be dismissed merely because the court doubts the plaintiff will prevail in the action.” *Doe*, 373 S.C. at 395, 645 S.E.2d at 248 (citing *Toussaint v. Ham*, 292 S.C. 415, 416, 357 S.E.2d 8, 9 (1987)); *see also Kennedy v. Henderson*, 289 S.C. 393, 395, 346 S.E.2d 526, 527 (1986) (“[T]he complaint must be construed liberally in favor of the pleader and sustained if facts alleged, and inferences reasonably deducible therefrom, entitle the plaintiff to relief on any theory of the case.” (citing *Blandon v. Coleman*, 285 S.C. 472, 475, 330 S.E.2d 298, 300 (1985))). “At the Rule 12 stage, therefore, the first decision for the trial court is to decide only whether the pleading states a claim.” *Skydive Myrtle Beach, Inc. v. Horry Cty.*, 426 S.C. 175, 180, 826 S.E.2d 585, 588 (2019). Plaintiffs are “entitled to litigate the validity of [their] pleading without having to convince the trial court of the merits of [their] underlying claim.” *Id.* Additionally, when a case raises a novel question of law, dismissal under Rule 12(b)(6) is improper. *See Chestnut v. AVX Corp.*, 413 S.C. 224, 228, 776 S.E.2d 82, 84 (2015) (reversing dismissal of a negligence claim that raised the novel issue of “stigma damages”).

## ARGUMENT

Defendants are attempting to have this case dismissed prior to engaging in discovery on the merits of the class allegations (other than some limited, early discovery regarding Plaintiff Blackwell’s claims) by attacking the claims of the named plaintiffs. Because the Amended Complaint adequately states claims on behalf of the individuals named plaintiffs and the class members,

the Court should deny Defendants' motions and permit Plaintiffs to litigate the validity of their claims on the merits.

**1. Plaintiffs' Amended Complaint states sufficient factual allegations against both PASI and CHSPSC.**

Both PASI and CHSPSC argue that the Amended Complaint lacks "specific or individual allegations" against them and should be dismissed on that basis. (See PASI Mot. 1–3; CHSPSC Mot. 1–3.) However, as set forth above, the South Carolina Rules of Civil Procedure merely require a plaintiff to set forth "a short and plain statement of the facts showing that the pleader is entitled to relief." Rule 8(a)(2), SCRPC. Additionally, the purpose of the South Carolina Rules of Civil Procedure is "to secure justice, and . . . reduce formalities and technicalities." *Patton v. Miller*, 420 S.C. 471, 492, 804 S.E.2d 252, 263 (2017) (quoting James F. Flanagan, *South Carolina Civil Procedure* 3 (2d ed. 1996)). They are "designed to discourage battles over mere form and to sweep away needless procedural controversies that either delay a trial on the merits or deny a party his day in court because of technical deficiencies." *Id.* at 493, 804 S.E.2d at 263 (quoting 4 Charles Alan Wright et al., *Federal Practice and Procedure* § 1029 (4th ed. 2015)).

Here, the allegations in the Amended Complaint as to both PASI and CHSPSC meet the pleading requirements. Plaintiffs have asserted facts and allegations against all Defendants, and often refer to the defendants collectively in the Amended Complaint. (See Am. Compl. 22–34 (alleging all defendants engaged in wrongful conduct).) There is no prohibition on pleading facts in this manner in South Carolina. See Rule 8(e)(1), SCRPC ("Each averment of a pleading shall be simple, concise, and direct. No technical forms of pleading or motions are required."); *Patton*, 420 S.C. 493, 804 S.E.2d at 263 (observing that it is "entirely contrary to the spirit of the . . . Rules of Civil Procedure for decisions on the merits to be avoided on the basis of . . . mere technicalities" (quoting *Foman v. Davis*, 371 U.S. 178, 181 (1962))). Additionally, Plaintiffs allege that PASI and

CHSPSC exercised control over the wrongful policies and procedures regarding billing and liens and that the defendants acted “jointly and in concert.” (Am. Compl. ¶ 18.) Because the Amended Complaint provides sufficient notice to all Defendants of the allegations being made against them, the Court should reject the arguments of PASI and CHSPSC that the allegations against them are factually insufficient.

**2. Plaintiffs have alleged sufficient facts to state a claim for tortious interference with contractual relationship.**

“[A]n action for tortious interference protects the property rights of the parties to a contract against unlawful interference by third parties.” *Dutch Fork Dev. Group II, LLC v. SEL Props., LLC*, 406 S.C. 596, 604, 753 S.E.2d 840, 844 (2012) (quoting *Threlkeld v. Christoph*, 280 S.C. 225, 227, 312 S.E.2d 14, 15 (Ct. App. 1984)). The elements of a claim for tortious interference with contractual relations are: “(1) existence of a valid contract; (2) the wrongdoer’s knowledge thereof; (3) his intentional procurement of its breach; (4) the absence of justification; and (5) resulting damages.” *Id.* (quoting *Camp v. Springs Mortg. Corp.*, 310 S.C. 514, 517, 426 S.E.2d 304, 305 (1993)). Here, Plaintiffs allege a claim for tortious interference with a contractual relationship based on Defendants’ knowledge of their contractual relationship with their health insurance providers and Defendants’ willful refusal to submit Plaintiffs’ and Class Members’ hospital bills for payment by their insurance. (See Am. Compl. ¶¶ 63–68.) As a result of Defendants’ wrongful conduct, Plaintiffs and Class Members did not “receiv[e] the benefit of their relationships with their respective health insurance carriers” and Plaintiffs and the Class Members “paid premiums but receiv[ed] no or little benefit.” (*Id.* ¶¶ 66, 67.) Plaintiffs allegations are sufficient to state a claim for tortious interference with contractual relations.

Defendants argue this cause of action should be dismissed because “[w]ithout a breach of Plaintiffs’ contracts with their health insurance carriers, there can be no recovery under a cause of

action for tortious interference with a contractual relationship.” (Mary Black Mot. 3.) However, Defendants fail to construe the allegations in the light most favorable to Plaintiffs, and they read Plaintiffs’ allegations too narrowly. The allegations in the Amended Complaint can be reasonably construed to mean that Defendants’ conduct resulted in a breach of patients’ contracts with their insurers because Plaintiffs alleged they paid premiums and did not have their hospital bills paid by their insurers. Defendants’ argument that Plaintiffs failed to allege facts sufficient to constitute a cause of action for tortious interference should be rejected.

### **3. Plaintiff Brooks’s claims do not fail under the Medicare Act as a matter of law.**

Defendants argue that Plaintiff Brooks’s claims fail as a matter of law because, pursuant to 42 U.S.C.A. § 1395y(b)(2)(A)(ii), they “were required to seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare.” (Mary Black Mot. 2; PASI Mot. 3–4; CHSPSC Mot. 3–4.) However, this argument is improper at this stage of the action because it presumes facts not alleged in the Amended Complaint. *See Charleston Cty. Sch. Dist. v. Harrell*, 393 S.C. 552, 559, 713 S.E.2d 604, 608 (2011) (“It is a well-settled principle that in resolving a Rule 12(b)(6) motion to dismiss, the court is limited to a consideration of the allegations contained within the four corners of the complaint.”). Defendants’ argument presumes that the at-fault driver in Brooks’s automobile accident had a valid insurance policy from which to collect, but this is not alleged anywhere in the Amended Complaint. Instead, the Amended Complaint merely alleges that Brooks was involved in an automobile accident and had valid health insurance coverage through Medicare, which would have paid her medical bills had they been submitted for payment. (Am. Compl. ¶¶ 41–44.) Defendants’ argument not only relies on a fact outside Plaintiffs’ complaint, but it would also require the Court to disregard the allegation in the Amended Complaint that “Plaintiff Brooks’s medical bills would have been paid had they been

submitted to her health insurance for payment.” (Am. Compl. ¶ 44.) Because this is contrary to the Court’s scope of review in deciding a Rule 12(b)(6), SCRCF, motion for dismissal, Defendants’ argument must be rejected. *See Harrell*, 393 S.C. at 559, 713 S.E.2d at 608; *Sloan Constr. Co.*, 377 S.C. at 112–13, 659 S.E.2d at 161.

**4. The voluntary payment doctrine does not bar the claims of either Plaintiff Brooks of Plaintiff Owens.**

Defendants also make the same arguments that the voluntary payment doctrine bars the claims of both Plaintiff Brooks and Plaintiff Owens. (See Mary Black Mot. 3, 5–6; PASI Mot. 4–5, 7; CHSPSC Mot. 4–5, 7.) Their arguments rely on two South Carolina cases, *Hardaway v. S. Railway Co.*, 90 S.C. 475, 73 S.E. 1020 (1912), and *Moody v. Stem*, 214 S.C. 45, 51 S.E.2d 163 (1948), and a North Carolina federal district court case, *Cross v. Ciox Health, LLC*, 38 F. Supp. 3d 572, 590 (E.D.N.C. 2020), which is currently on appeal to the Fourth Circuit Court of Appeals. None of these authorities require dismissal of Plaintiffs’ claims, and the voluntary payment doctrine is inapplicable here for several reasons.

First, any payments Brooks and Owens made to Mary Black were not voluntary. *See Hardaway*, 73 S.E. at 1025 (“[A] party cannot by direct action, or by way of set-off or counterclaim, recover money *voluntarily* paid with a full knowledge of all the facts, *and without any fraud, duress, or extortion*, although no obligation to make such payment existed.” (emphasis added)). As Plaintiffs alleged in their complaint, Brooks and Owens only settled with Mary Black after the hospital asserted unlawful liens against the plaintiffs’ recoveries for their personal injuries. (See Am. Compl. ¶¶ 26, 46, 52.) In addition, Plaintiffs alleged Mary Black “[sought] payment for medical bills by demanding cash payment directly from the patients, placing unlawful liens on patients’ third-party tort claims, seeking medical payment benefits from patients’ automobile insurers,

turning patients over to collection agencies, and/or reporting patients to credit bureaus (thereby impairing patients' credit scores)." (*Id.* ¶ 26.)

As is shown by these allegations, Mary Black coerced and extorted its patients into making payments the hospital should have billed to the patients' insurers. No payments made under these circumstances can be considered voluntary. *See Cross*, 438 F. Supp. 3d at 590 (stating a payment is involuntary when there is "some actual or threatened exercise of power possessed, or believed to be possessed, by the party exacting or receiving the payment over the person or property of another, for which the latter has no other means of immediate relief than by making the payment" (quoting *Big Bear of N. Carolina, Inc. v. City of High Point*, 294 N.C. 262, 266, 240 S.E.2d 422, 424 (1978))); 70 C.J.S. *Payment* § 103 ("Recovery may be allowed where the payment of an unlawful demand has been obtained by taking undue advantage of the payor's situation, where it has been made to prevent an injury to property rights, or where it was made to release a person or property from detention or to prevent an immediate seizure of person or property." (footnotes omitted)); *id.* ("Where a person is compelled, through the necessity of protecting his or her business interests, or under a business necessity to free or protect property from some duress or lien, to pay an unlawful demand, the payment is compulsory and may be recovered." (footnotes omitted)).

Additionally, Owens and Brooks did not make the payments to Mary Black "with full knowledge of all the facts." *Hardaway*, 73 S.E. at 1025. Specifically, the plaintiffs acted without knowledge of the contractual obligations Mary Black had in relation to the plaintiffs' insurers, including the requirement to seek compensation from the insurers for services rendered to patients, the prohibition on seeking compensation from patients (except for co-payments and other certain allowed fees), and the discounted compensation rates the hospital was obligated to accept from the

insurers. In extracting the payments from Owens and Brooks, Mary Black also deceptively failed to inform them that, pursuant to its contracts with the insurers, they were under no obligation to compensate the hospital. Consequently, the voluntary payment doctrine is further inapplicable. *See Moody*, 214 S.C. at 53, 51 S.E.2d at 165 (“That cannot be said with propriety to be voluntarily done, where a formal assent thereto is induced by *mistake*, or procured by fraud or deception, as to facts material to control the operation of the will therein, any more than where such formal assent is extorted by the application of a *force* which fetters and obstructs its free working.” (emphasis in original)); 70 C.J.S. *Payment* § 103 (“A payment is not voluntary if the payor reasonably and in good faith believes in his or her obligation or personal interest in making the payment.”); *see, e.g., Freeman v. J.L.H. Investments, LP*, 414 S.C. 362, 383, 778 S.E.2d 902, 913 (2015) (“Freeman paid the closing fee without full knowledge of what comprised the fee. . . . Accordingly, we find that Hendrick's reliance on the voluntary payment doctrine is misplaced.”).<sup>1</sup>

**5. The statute of limitations does not bar Plaintiff Owens’s claims.**

Defendants all make an identical argument that “the Court should dismiss Plaintiff Owens’s claims for tortious interference with contract and unjust enrichment on the grounds that those claims are barred by the applicable statutes of limitations.” (Mary Black Mot. 5; PASI Mot. 7; CHSPSC Mot. 7.) This Court should reject Defendants’ argument because Plaintiff Owens’s claims relate back to the filing date of the original complaint in this matter, which was January 20, 2017. His claims arise out of the same conduct set forth in the original class action complaint—

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<sup>1</sup> While Defendants argue here that Brooks’s and Owens’s claims are barred because they made payments to Mary Black, they argue elsewhere in their Motions that Blackwell’s claims are barred for precisely the opposite reason—because she *did not* make any payments to Mary Black. In doing so, Defendants advance the untenable position that claims arising out of their improper billing practices are barred when payments to the hospital are both made and not made, thereby attempting to foreclose all relief for their conduct.

Defendants' wrongful billing practices. See Rule 15(c), SCRCP ("Whenever the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleadings, the amendment relates back to the date of the original pleading."). So, even if the applicable statute of limitations started running on October 14, 2016, when "Defendants agreed to accept a 50% reduction on Plaintiff Owens's account and settle for \$4,543.38," (Am. Compl. ¶ 52), because his claims as set forth in the Amended Complaint relate back to the original date of filing, they are timely.

**6. Plaintiff Owens should not be required to arbitrate his claims.**

Defendants also argue Owens must arbitrate his claims against all Defendants due to an arbitration clause in a purported 2006 contract between Mary Black and CIGNA, Owens's insurer. As an initial matter, neither CHSPSC nor PASI are parties to the contract. Moreover, because the contract does not confer any direct benefits on CHSPSC or PASI, neither is an intended third-party beneficiary of the contract. See *Helms Realty, Inc. v. Gibson-Wall Co.*, 363 S.C. 334, 340, 611 S.E.2d 485, 488 (2005) ("A third-party beneficiary is a party that the contracting parties intend to directly benefit."); Restatement (Second) of Contracts § 302(1) (1981) (providing "a beneficiary of a promise is an intended beneficiary if recognition of a right to performance in the beneficiary is appropriate to effectuate the intention of the parties"); *Bob Hammond Const. Co. v. Banks Const. Co.*, 312 S.C. 422, 425, 440 S.E.2d 890, 892 (Ct. App. 1994) (finding "[t]he mere fact that [a party] might ultimately and indirectly benefit from [a] contract between [other parties] is not sufficient" to confer status as an intended beneficiary). At most, CHSPSC and PASI may be incidental beneficiaries to the contract, and as such, they lack standing to enforce any arbitration agreement contained therein. See *Trancik v. USAA Ins. Co.*, 354 S.C. 549, 553, 581 S.E.2d 858, 861 (Ct. App. 2003) ("South Carolina contract law carries a presumption that an individual who is not a party to

a contract lacks privity to enforce it.”); *cf. Bob Hammond Const. Co.*, 312 S.C. at 424, 440 S.E.2d at 891 (“[I]f a contract is made for the benefit of a third person, that person may enforce the contract if the contracting parties intended to create a direct, rather than an incidental or consequential, benefit to such third person.”).

Additionally, the contract Defendants produced to Plaintiffs and filed with the Court was executed in July 2006 and had an initial term of only three years. Owens’s claim against Defendants, however, did not accrue until at least October 2015, over nine years later. (See Am. Compl. ¶ 14.) Defendants have produced no proof, whether by affidavit or other documentary evidence, demonstrating that the 2006 contract was operative at the time Owens’s claim accrued and, consequently, that he could possibly be bound by the contract’s arbitration clause. *See Jackson Mills, Inc. v. BT Capital Corp.*, 312 S.C. 400, 404, 440 S.E.2d 877, 879 (1994) (stating a “valid ground[] upon which to challenge [an] arbitration clause” is that “the controversy arose out of events occurring subsequent to expiration of the arbitration agreement”). Accordingly, compelling arbitration at this stage in the litigation is unwarranted. If the Court declines to deny Defendants’ motion to compel arbitration with prejudice, Plaintiffs respectfully ask the Court to either deny the motion without prejudice or hold the motion in abeyance pending the completion of discovery relevant to this issue. *See, e.g., Towles v. United HealthCare Corp.*, 338 S.C. 29, 34, 524 S.E.2d 839, 842 (Ct. App. 1999) (noting “[t]he circuit court . . . denied United’s motion to compel arbitration ‘with leave to refile it after completing discovery in this action’”); *S.C. Pub. Serv. Auth. v. Great W. Coal (Kentucky), Inc.*, 312 S.C. 559, 561, 437 S.E.2d 22, 24 (1993) (noting the circuit court “held the motion for arbitration in abeyance pending discovery and denied the motion to dismiss”).

#### **7. Plaintiff Blackwell’s claim for unjust enrichment should not be dismissed.**

“‘Restitution is a remedy designed to prevent unjust enrichment.’ Unjust enrichment is an equitable doctrine, akin to restitution, which permits the recovery of that amount the defendant has

been unjustly enriched at the expense of the plaintiff.” *Ellis v. Smith Grading & Paving, Inc.*, 294 S.C. 470, 474, 366 S.E.2d 12, 14 (Ct. App. 1988) (citation omitted) (quoting *Stanley Smith & Sons v. Limestone College*, 283 S.C. 430, 434, 322 S.E.2d 474, 478 (Ct. App. 1984)). “A party may be unjustly enriched when it has and retains benefits or money which in justice and equity belong to another.” *Dema v. Tenet Physician Servs.-Hilton Head, Inc.*, 383 S.C. 115, 123, 678 S.E.2d 430, 434 (2009). Here, Defendants argue Plaintiff Blackwell’s unjust enrichment claim fails because there are no allegations “that Plaintiff Blackwell, or anyone on her behalf or for her benefit, made any payment or provided any value to [Defendants] for the medical care she received.” (Mary Black Mot. 3; PASI Mot. 5; CHSPSC Mot. 5.)

Viewing the Complaint as a whole, and in favor of the pleader, Plaintiff Blackwell has adequately pleaded a claim for unjust enrichment. Plaintiffs allege that all Defendants have been unjustly enriched because it would be inequitable to allow them to retain the benefits of their wrongful billing practices while attempting to collect from Plaintiffs a higher amount than they would have received if they had billed Plaintiffs’ insurance companies. The fact that Plaintiffs allege Defendants “assert[ed] liens against Plaintiff Blackwell’s potential third party automobile accident claim,” (Am. Compl. ¶ 40), is sufficient for purposes of the pleading stage, and Plaintiff Blackwell’s unjust enrichment claim should be allowed to proceed. *Cf. Beverly v. Grand Strand Reg’l Med. Ctr., LLC*, 429 S.C. 502, 516, 839 S.E.2d 468, 475 (Ct. App. 2020) (noting that Plaintiff’s complaint “alleges affirmative inequitable conduct seeking to deprive her of the benefit of her funds”).

#### **8. Plaintiff Blackwell has standing as a third-party beneficiary.**

Defendants also argue that Plaintiff Blackwell may not “enforce the negotiated rates for medical services in the Participating Hospital Agreement between her insurance provider

(MedCost) and Mary Black” because, according to Defendants, language in “that Agreement expressly denies non-signatory third-parties (like Plaintiff Blackwell) the right to sue to enforce its terms.” (Mary Black Mot. 4; PASI Mot. 5; CHSPSC Mot. 5.)

Defendants’ argument relies on a provision in a contract which is outside the pleading and should be rejected on that basis alone. *See generally O’Laughlin v. Windham*, 330 S.C. 379, 498 S.E.2d 689, 691 (Ct. App. 1998) (“A ruling on a 12(b)(6) motion to dismiss must be based *solely* upon allegations set forth on the face of the complaint.”). Additionally, even if it were proper for the Court to consider the Participating Hospital Agreement at this stage (which it is not), Defendants do not identify the precise language of the provision and have not established that the Agreement was in effect and applied at the time Plaintiff Blackwell’s claims arose. Discovery on these (and other) issues is warranted, and the Court should reject Defendants’ arguments that Plaintiff Blackwell lacks standing.

Even assuming, for the sake of argument, that any contract between a plaintiff’s insurance company and Mary Black contains language purporting to exclude members as third-party beneficiaries or prohibiting members from suing to enforce its terms, that would not be dispositive. “Under South Carolina law, it is well settled that a nonparty may enforce contractual terms that intentionally provide her direct benefits.” *Beverly*, 429 S.C. at 506, 839 S.E.2d at 470. And, in *Beverly*, a case that involved similar allegations by a patient against a hospital, the contract between the patient’s insurance company, Blue Cross Blue Shield (BCBS), and the hospital contained language expressly stating, “This Agreement is not intended to, and shall not be construed to make any person or entity a third party beneficiary.” *Id.* at 508, 839 S.E.2d at 471. Notwithstanding this language, the Court of Appeals concluded that the agreement as a whole should be

examined to determine whether the contract intended to benefit members in the insurance plan.

See *id.* at 509–13, 839 S.E.2d at 472–73. The Court of Appeals explained:

Beverly argues and we agree the PPO here is intended to benefit its participants. Grand Strand gained access to BCBS's expansive membership along with guaranteed reimbursements from BCBS in exchange for accepting both reduced payments as well as the responsibility of submitting Members' claims to BCBS. BCBS gained greater cost control in exchange for promising prompt payment for Grand Strand's services and touting Grand Strand's PPO provider status to Members. Beverly's allegations that Grand Strand's failure to submit Beverly's bill to BCBS and refusal to bill her at the reduced reimbursement rate state a claim that Grand Strand breached its contract in denying Beverly benefits arising from the Agreement. Therefore, the circuit court erred in dismissing Beverly's breach of contract claim.

*Id.* at 513, 839 S.E.2d at 473.

Here, Plaintiffs have set forth sufficient allegations that they were the intended third-party beneficiaries of agreements between their insurance providers and Mary Black, and under those agreements, Mary Black agreed to accept a reduced amount of payment for its hospital services. Plaintiffs also allege Defendants failed to submit their hospital bills to their insurance companies as required. Defendants' argument that Plaintiff Blackwell lacks standing as a third-party beneficiary should be rejected.

### CONCLUSION

Based upon the foregoing, the Court should deny all of Defendants' Motions to Dismiss and further deny Defendants' motions to compel Plaintiff Owens to arbitrate his claims.

*Signature Page Follows*

Respectfully submitted,

s/John B. White, Jr.

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July 24, 2020

STATE OF SOUTH CAROLINA )  
COUNTY OF SPARTANBURG )

IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT

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

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

Plaintiffs, )

v. )

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

Defendants. )

**DEFENDANTS’ MEMORANDUM OF  
LAW IN SUPPORT OF THE MOTION  
TO DISMISS PURSUANT TO RULE  
12(B)(6) OR, IN THE ALTERNATIVE,  
TO STAY THE CASE AND COMPEL  
ARBITRATION**

Defendants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital (“Mary Black”), CHSPSC, LLC (“CHSPSC”), Professional Account Services, Inc. (“PASI”) (collectively, “Defendants”) submit this Reply Memorandum in support of their respective Motions to Dismiss and to Compel Arbitration in the captioned matter, and to debunk the Plaintiffs’ Response in Opposition to the Motions – which Response lacks merit and is utterly misplaced. For ease of reference, Defendants will address Plaintiffs’ arguments in the order they were presented.

**1. Plaintiff’s Amended Complaint utterly fails to state facts sufficient to constitute any viable cause of action against CHSPSC or PASI.**

Plaintiffs’ conclusory lumping together of “all Defendants” is insufficient to meet their pleading burden and state a claim against PASI or CHSPSC. *See SD3, LLC v. Black & Decker (U.S.) Inc.*, 801 F.3d 412, 422-23 (4th Cir. 2015) (“[T]he complaint must forecast that factual showing, and if it fails to allege particular facts against a particular defendant, then the defendant must be dismissed.”).

The entirety of the specific and individual allegations against PASI and CHSPSC are encompassed in three paragraphs of the Amended Complaint:

16. Defendant CHSPSC, LLC, formerly known as Community Health Systems Professional Services Corporation, is a Delaware corporation with its principal place of business in Tennessee. On information and belief, CHSPSC regularly conducts business in the State of South Carolina and other states and has responsibility for the billing of patients and liens filed within the State of South Carolina.
17. Defendant Professional Account Services, Inc. ("PASI") is a Tennessee corporation with its principal place of business in Brentwood, Tennessee. PASI is a collection firm that regularly conducts business in the State of South Carolina and elsewhere.
18. On information and belief, CHSPSC and PASI exercise control over policies and procedures enacted by and implemented by Mary Black Health System, including policies relating to billing and liens, and all of these entities committed the acts and omission complained of herein jointly and in concert.

The Amended Complaint contains no other specific or individual allegations against PASI or CHSPSC. Rather, the remainder of the Amended Complaint contains only non-specific generalized allegations referencing PASI, CHSPSC, and Mary Black collectively as Defendants. There are no allegations sufficient to identify what PASI or CHSPSC did, or failed to do, which would support the assertion of each (or any) of the purported causes of action. Furthermore, there are no factual allegations which could support or form the basis for any claim to pierce the corporate veil of PASI or CHSPSC or to establish a basis for an amalgamation or conspiracy claim. *See Pro Slab, Inc. v. Argos USA Corp.*, No. CV 2:17-3185-BHH, 2018 WL 6985008, at \*5 (D.S.C. June 28, 2018), *reconsideration granted on other grounds*, No. CV 2:17-3185-BHH, 2018 WL 6985010 (D.S.C. Dec. 3, 2018) (granting the defendants' motions to dismiss on the grounds that that the plaintiffs' amended complaint simply lumped together members of corporate families and impermissibly ascribed liability to groups rather than to individual entities); *see also Scurmont LLC v. Firehouse Rest. Grp., Inc.*, No. 4:09-CV-00618-RBH, 2010 WL 11433199, at \*15 (D.S.C. May 19, 2010) (dismissing claims against an individual defendant because the complaint only

contained general conclusory allegations against the defendants collectively and the plaintiffs failed to plead sufficient facts that an individual defendant committed any wrongful act within the State of South Carolina, let alone any wrongful act causally related to the plaintiff's alleged injuries).

Since, the Amended Complaint contains only conclusory allegations against PASI and CHSPSC, Plaintiffs have, therefore, failed to plead ultimate facts sufficient to constitute any cause of action against PASI and CHSPSC. *See Jones v. Gilstrap*, 288 S.C. 525, 528, 343 S.E.2d 646, 648 (Ct. App. 1986) (providing that conclusory allegations in a complaint are insufficient to survive the defendant's motion to dismiss for failure to state a cause of action). Without alleging facts related to an act or omission by PASI or CHSPSC the Amended Complaint fails on its face and the claims against PASI and CHSPSC must be dismissed as a matter of law.

**2. Plaintiffs' Amended Complaint utterly fails to allege facts sufficient to constitute a cause of action for tortious interference against any Defendant.**

A claim for tortious interference with contract requires the Plaintiffs allege (1) the existence of a valid contract, (2) Defendants' knowledge thereof, (3) Defendants' intentional procurement of a breach of the contract, (4) the absence of justification for the breach of the contract, and (5) resulting damages. *Camp v. Springs Mortgage Corp.*, 310 S.C. 514, 517, 426 S.E.2d 304, 305-06 (1993). In this case, the Plaintiffs acknowledge that the contracts in issue are those between themselves and their respective health insurers. Without a breach of Plaintiffs' contracts with their health insurance carriers, there can be no recovery under a cause of action for tortious interference with a contractual relationship against Defendants. *First Union Mortgage Corp. v. Thomas*, 317 S.C. 63, 73, 451 S.E.2d 907, 913 (Ct. App. 1994)

Plaintiffs' Amended Complaint does not allege an actual breach of any of the relevant contracts. The Amended Complaint contains only bald and unsupported allegations that Plaintiffs did not receive the benefit of their individual health insurance contracts. However, the failure to

receive a benefit of a contract is not a breach of a contract. Plaintiffs do not even assert their individual contracts with their health insurance carriers were breached. *Eldeco, Inc. v. Charleston Cty. Sch. Dist.*, 372 S.C. 470, 482, 642 S.E.2d 726, 732 (2007) (“In the absence of a breach of a contract, [the plaintiff] cannot prove the required elements of its cause of action for tortious interference with contractual relations.”). Thus, Plaintiffs’ conclusory and vague pleadings with not even an allegation that the third-party contract was breached, are insufficient to state a claim for tortious interference with a contractual relationship. Accordingly, Plaintiffs’ claims for tortious interference with a contractual relationship must be dismissed as a matter of law.

3. **Plaintiff Brooks fails to state facts sufficient to constitute a claim against any Defendant because Brooks’ claim is governed by the Medicare Act and the law under that Act does not support the claim alleged.**

When the applicable law does not recognize or sanction the claim alleged, dismissal of that claim pursuant to Rule 12(b)(6) is appropriate. In this case, in their own words in the Response in Opposition to the Motions to Dismiss, Plaintiffs admit:

The claims of the named plaintiffs and the class members (collectively, “Plaintiffs”) stem from Defendants’ policy, in cases where a potential third party might be liable for a patient’s injuries, of not submitting claims to health insurers for payment or refunding payments to health insurance carriers and then attempting to obtain payment for the patient’s medical bills directly from the patient, from an auto insurer, and/or from the patient’s third-party tort recovery. (See Am. Compl. ¶¶ 4–8.) Plaintiffs allege that Defendants, as a standard business practice, routinely refused to submit patients’ medical bills to their insurance providers if Defendants’ screening identified a patient as one for whom third-party recovery might be available to pay for such treatment. (*Id.* ¶¶ 4–5.) This was done so that Defendants could obtain a higher reimbursement than what might have been received from the patient’s insurance. (*Id.* ¶ 6.)

Plaintiffs contend they are third-party direct beneficiaries of the agreements between their insurance companies and Mary Black, and that Defendants interfered with Plaintiffs’ own relationships with their insurance companies by attempting to collect payments from Plaintiffs at a higher amount than what Mary Black contracted for with Plaintiffs’ insurance companies. (See *id.* ¶ 57.) Each of the named plaintiffs is an accident victim who received treatment at

Mary Black and, thereafter, Defendants refused to submit their bills to their health insurance companies for payment. (*See id.* ¶¶ 35–52.) Instead, Defendants engaged in impermissible attempts to collect directly from Plaintiffs or from Plaintiffs’ third-party tort recovery. (*See id.* ¶¶ 40, 45, 51.)

Plaintiff Brooks’ claims against Defendants must be dismissed because all of her claims fail, as a matter of law, under the Medicare Act, 42 U.S.C.A. § 1395y(b)(2)(A)(ii). All of Plaintiff Brooks’ claims are based on the allegations that she had health insurance coverage through Medicare and that Defendants are liable because they sought collections for her medical care costs by asserting a right to payment against the insurer for the at-fault driver in her automobile accident instead of immediately and directly submitting the claim for her medical care costs to Medicare.

The Medicare Act requires hospitals—like Mary Black—to seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare. 42 U.S.C.A. § 1395y(b)(2)(A)(ii). Specifically, the Medicare Act states:

Payment under this subchapter may not be made . . . with respect to any item or service to the extent that . . . (ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State **or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.**

*Id.* (emphasis added).

Other jurisdictions that have been confronted with this issue have concluded that 42 U.S.C. § 1395y(b)(2)(A)(ii) explicitly prohibits medical service providers from collecting payment from Medicare when payment can reasonably be expected to be made under an automobile or liability insurance policy. *See Parkview Hosp., Inc. v. Roese*, 750 N.E.2d 384, 389 (Ind. Ct. App. 2001) (“[W]e find that Congress’s intent is clearly expressed in 42 U.S.C. § 1395y(b)(2)(A)(ii). It explicitly prohibits medical service providers from collecting payment from Medicare when payment can reasonably be expected to be made promptly under an automobile or liability insurance policy.”); *Joiner v. Med. Ctr. E., Inc.*, 709 So. 2d 1209, 1221 (Ala. 1998) (holding that

a hospital had a right under the Medicare Act to obtain full payment of its charges from the proceeds of the plaintiff patient's settlement with an automobile liability carrier, instead of filing a claim for reimbursement with Medicare). In short, Defendants cannot be liable to Brooks in this case for doing exactly what Medicare requires of them. Brooks' entire premise for liability fails and her claims must be dismissed as a matter of law.

**4. Plaintiffs Brooks' and Owens' claims are barred as a matter of law under the voluntary payment doctrine.**

It is a long standing and elementary principle of South Carolina law that no action will lie to recover money voluntarily paid. *Hardaway v. S. Ry. Co.*, 90 S.C. 475, 488-89, 73 S.E. 1020, 1025 (1912); *Moody v. Stem*, 214 S.C. 45, 60, 51 S.E.2d 163, 169 (1948).

Recently, in *Cross v. Ciox Health, LLC*, No. 4:19-CV-7-FL, 2020 WL 534289, at \*11 (E.D.N.C. Feb. 3, 2020), the North Carolina District Court applied the voluntary payment doctrine to bar a plaintiff's class action claim based upon allegations that the Plaintiff was overcharged for medical records. In *Cross*, the plaintiff alleged that she requested medical records from the hospital that treated her, that she was overcharged for those records, and her attorney paid those charges on her behalf. *Cross*, 2020 WL 534289, at \*3. The District Court granted the defendant's Motion to Dismiss pursuant to Rule 12(b)(6) on the grounds that the plaintiff's claims were barred by the voluntary payment doctrine. The District Court held:

Here, where it is alleged that defendant provided an itemized bill showing charges for the medical records, and where it is alleged that plaintiffs' attorney proceeded to pay the bills as requested, payment thus was made by plaintiffs with full knowledge of all the facts pertinent to their instant claims. Accordingly, the voluntary payment doctrine bars their claims for unjust enrichment.

Moreover, the Court found that the plaintiff did not meet the standard for avoiding the application of the voluntary payment doctrine based on "coercion or duress" because "they have alleged their attorney both requested and paid for the medical records."

In this case, Plaintiffs make no allegations of fraud, duress or coercion in connection with the voluntary payments. In fact, while Plaintiffs seek to hide the facts in their Complaint, the voluntary payments were negotiated and made by the same attorneys now representing Plaintiffs.

5. **Plaintiff Owens' claims are barred as a matter of law by the applicable limitations period.**

When the instant action was commenced on January 20, 2017, Owens was not a Plaintiff or party in the case, and there were no allegations about him or his situation. Plaintiff Blackwell moved to amend her 2017 Complaint on October 18, 2019, and in that Motion to Amend sought to add Owens as a new Plaintiff in the case for the first time.

However, Rule 15 does not permit the original Plaintiff to amend the complaint to add new plaintiffs asserting new claims. The Court in *Valentine v. Davis*, 319 S.C. 169, 172, 460 S.E.2d 218, 219 (Ct. App. 1995) summarized the application of Rule 15 as follows:

Rule 15, SCRCF, does not allow an existing plaintiff to add a new plaintiff to the case to assert a claim against the defendant. Rule 15(a) only permits an existing plaintiff to add, modify, delete, or change claims against an existing defendant. Rule 15(b) addresses amendments to conform to the evidence presented at trial. Rule 15(c) deals with relation back of amendments. **None of these subsections addresses a motion to add a plaintiff as contemplated in this case.**

(emphasis added). Rule 15(c) only applies to allow relation back of an amendment in a substitution or change in a party, and “the addition of a party is not the same as a substitution or change of party.” *Jackson v. Doe*, 342 S.C. 552, 558, 537 S.E.2d 567, 570 (Ct. App. 2000).

Plaintiffs' Motion to Amend the Complaint added two new parties (Brooks and Owens), to assert new claims based on new factual allegations. The authorities in South Carolina are clear, “Rule 15 does not contemplate adding a *new* plaintiff to assert a *new* claim. . . .” *Patton v. Miller*, 420 S.C. 471, 495, 804 S.E.2d 252, 264 (2017) (emphasis added).

Rule 15(c), SCRCF, addresses whether an amendment to a complaint relates back to the filing of the original complaint. *Valentine*, 319 S.C. at 172, 460 S.E.2d at 219. Since the addition of a new plaintiff is not contemplated by Rule 15(c), *Gause v. Smithers*, 384 S.C. 130, 133, 681 S.E.2d 607, 609 (Ct. App. 2009), Rule 15(c) does not allow for Plaintiff Owens's claims to relate back to the filing of the original complaint, because he is a newly added party asserting claims based upon his own individual facts.

Because Plaintiff Owens' claims do not relate back to the filing of the original complaint, his claims for tortious interference with contract and unjust enrichment are barred by the applicable statute of limitations. According to the purported Amended Complaint, Plaintiff Owens settled his bill with the Hospital on October 14, 2016 [Amended Complaint ¶ 52], and his claims accrued. Plaintiffs filed the Motion to Amend Complaint on October 18, 2019. Therefore, more than three (3) years passed between the time Plaintiff Owens knew or should have known of his alleged claims, and any possible action to commence his claims. See *Burgess v. Elliott*, No. 3:16-CV-3325-RBH, 2017 WL 1505421, at \*3 (D.S.C. Apr. 27, 2017), *aff'd*, 696 F. App'x 125 (4th Cir. 2017) ("The applicable statute of limitations for civil actions of breach of contract, negligence, and tortious interference with contract is likewise three years."); *Graham v. Welch, Roberts & Amburn, LLP*, 404 S.C. 235, 239, 743 S.E.2d 860, 862 (Ct. App. 2013) (holding a claim for unjust enrichment was barred by the three year statute of limitations). Because it is clear from the face of the Amended Complaint that Owens did not commence his claim within the three year limitation period, his complaint fails as a matter of law and must be dismissed.

**6. Plaintiff Owens must be compelled to arbitrate his claims.**

If the Court allows Plaintiff Owens's claims against Defendants to continue in any way based on the allegations that Plaintiff Owens is entitled to enforce the billing and payment terms of the Hospital Services Agreement between his alleged insurance provider (CIGNA) and Mary

Black (the “CIGNA Agreement”), then Plaintiff Owens must be compelled to arbitrate his claims against Defendants pursuant to the arbitration requirements of the Agreement and to stay further proceedings in this action.<sup>1</sup>

“The question of the arbitrability of a claim is an issue for judicial determination.” *Zabinski v. Bright Acres Assocs.*, 346 S.C. 580, 596, 553 S.E.2d 110, 118 (2001). The policy of the United States and the State of South Carolina is to favor the arbitration of disputes. *Zabinski*, 346 S.C. at 596, 553 S.E.2d at 118. A motion to compel arbitration, when there is an arbitration clause in the written contract, should be granted unless the arbitration clause in question is not susceptible to any interpretation which would apply to the asserted dispute. *Tritech Elec., Inc. v. Frank M. Hall & Co.*, 343 S.C. 396, 399, 540 S.E.2d 864, 865 (Ct. App. 2000). “To decide whether an arbitration agreement encompasses a dispute, a court must determine whether the factual allegations underlying the claim are within the scope of the broad arbitration clause, regardless of the label assigned to the claim.” *Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 287, 733 S.E.2d 597, 600 (Ct. App. 2012) (quoting *Zabinski*, 346 S.C. at 597, 553 S.E.2d at 118). “Any doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration.” *Id.* (quoting *Zabinski*, 346 S.C. at 597, 553 S.E.2d at 118).

Section 6.2.2 of the CIGNA Agreement states:

Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement.

All of Plaintiff Owens’s claims arise from the CIGNA Agreement and his efforts to derive benefit from that Agreement and to enforce it against each of the Defendants. All of Plaintiff Owens’s claims relate to his alleged ability to enforce the terms of the CIGNA Agreement and receive the negotiated rates for the medical services Mary Black provided to him. Any doubt as

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<sup>1</sup> A copy of the Hospital Services Agreement between CIGNA and Mary Black has been filed under seal as **Exhibit B** to this Motion.

to whether Plaintiff Owens's claims are within the scope of the CIGNA Agreement's broad arbitration provision must be resolved in favor of arbitration. *Landers v. Fed. Deposit Ins. Co.*, 402 S.C. 100, 109, 739 S.E.2d 209, 213 (2013).

Although Plaintiff Owens is a non-signatory to the CIGNA Agreement, because he seeks to enforce the Agreement and to derive benefit from its terms, he is bound by its valid and enforceable arbitration clause. The doctrine of direct benefits estoppel prevents the non-signatory from claiming he is not bound by the arbitration agreement when he is attempting to receive a direct benefit from a contract containing an arbitration clause. *Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 295-96, 733 S.E.2d 597, 604 (Ct. App. 2012). Thus, for Plaintiff Owens to assert, or derive any benefit from the CIGNA Agreement, he must be bound by the provision therein requiring arbitration. Accordingly, if Plaintiff Owens is allowed to proceed on claims seeking to enforce terms of the CIGNA Agreement against Defendants, then Plaintiff Owens must individually arbitrate his claims against Defendants pursuant to the terms of the arbitration agreement contained within the CIGNA Agreement.

Plaintiffs argument that the Agreement containing the arbitration provision is not valid or applicable in this case is ridiculous. As Plaintiffs could no doubt read, the CIGNA Agreement expressly provided in Section 5.1:

5.1 Term. This agreement shall be for an initial term of 3 years . . .  
Thereafter, this Agreement shall continue from year to year unless  
terminated pursuant to the Termination provision.

Plaintiff Owens bases the claim on the existence and applicability of that Agreement. He alleges it to exist and apply and there is nothing indicating it was terminated. Owens is bound by the Arbitration Agreement since he seeks the benefit of the other terms of the Agreement.

7. **Plaintiff Blackwell's Amended Complaint fails to state facts sufficient to constitute a counsel action against any Defendant for Unjust Enrichment.**

South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: “(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its value.” *Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994). Blackwell does not, and cannot plead any payment made to any Defendant, or any actual benefit conferred upon any Defendant. Therefore, no claim for unjust enrichment can exist.

**8. Plaintiff Blackwell is not an intended third-party beneficiary under the agreement between Mary Black and her health insurer.**

Plaintiff Blackwell’s claims are all premised upon her contention that she is a third-party beneficiary of the MedCost Agreement between Mary Black and her health insurer. She alleges she has the right to enforce the terms of that Agreement for her own goals and benefit. However, Blackwell is not a party to that MedCost Agreement and she is not an intended third-party beneficiary who can sue to enforce that Agreement for her own benefit.

In South Carolina, there is a presumption that a contract is not enforceable by a person who is not a party to the contract, and the expressed intent of the parties to the contract shall govern the interpretation of that contract. *See Windsor Green Owners Ass’n, Inc. v. Allied Signal, Inc.*, 362 S.C. 12, 17, 605 S.E.2d 750, 752 (Ct. App. 2004). It is well settled that the law presumes that parties contract exclusively for their own benefit. *See Ancrum v. Camden Water, Light & Ice Co.*, 82 S.C. 284, 295, 64 S.E. 151, 155 (1909). In order to overcome this presumption, a non-signatory third-party must show that the parties to a contract intended the third-party to be a direct beneficiary of the contract. *Touchberry v. City of Florence*, 295 S.C. 47, 48–49, 367 S.E.2d 149, 150 (1988). However, “[n]o third-party beneficiary status is created absent an intent by the parties to confer a substantial benefit on [a non-signatory third-party].” *Windsor Green Owners Ass’n, Inc.*, 362 S.C. at 19, 605 S.E.2d at 753 (emphasis added).

The line between a direct intended third-party beneficiary of a contract and an incidental or consequential third-party beneficiary is first drawn by examining the clear intent expressed by the actual parties to the contract. Absent an expression that the actual contracting parties clearly intended to directly benefit the third-party, that third-party is merely an incidental beneficiary with no right to enforce the contract. *See TC X, Inc. v. Commonwealth Land Title Ins. Co.*, 928 F. Supp. 618, 623 (D.S.C. 1995), *aff'd*, 86 F.3d 1152 (4th Cir. 1996) (applying South Carolina law to a claim for breach of a title insurance policy). Therefore, the necessary first step in determining whether a party is an intended direct third-beneficiary of a contract is to ascertain and give legal effect to the language of the contract on the issue of intent. *Whitlock v. Stewart Title Guar. Co.*, 399 S.C. 610, 614, 732 S.E.2d 626, 628 (2012) (“The cardinal rule of contract interpretation is to ascertain and give legal effect to the parties’ intentions as determined by the contract language.” (citation omitted)).

When the parties to a contract include an express third-party beneficiary disclaimer, as they did in the MedCost Agreement, a court is bound to find the parties did not intend to convey a direct benefit to third parties or to create a right for such third parties to enforce or sue upon the contract. *See Lightsey v. Toshiba Corp.*, No. 9:18-CV-190, 2019 WL 5872168, at \*3 (D.S.C. Mar. 4, 2019) (applying New York law and finding that “[d]ismissal of a third-party-beneficiary claim is appropriate where the contract rules out any intent to benefit the claimant. . . .”).<sup>2</sup>

The MedCost Agreement plainly and directly expresses Mary Black and MedCost’s intent to bar third-parties from enforcing the MedCost Agreement. This intent is unequivocally stated in

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<sup>2</sup> While not binding precedent because it is an unpublished opinion, in *Atherton v. Tenet Healthcare Corp.*, No. 2005-UP-362, 2005 WL 7084013, at \*4 (Ct. App. May 25, 2005) the Court of Appeals held the third-party disclaimer in the contract at issue in that case conveyed an unambiguous expression of the parties’ intent to exclude third-parties from being able to enforce its terms and that such an expression of intent was controlling. The application and enforceability of third-party beneficiary disclaimers in hospital services agreements has not been directly addressed in a published opinion in South Carolina.

Section 10.9 of the MedCost Agreement, which expressly and definitively states Mary Black and MedCost's intention that the contract was not to be construed to have any third-party beneficiaries:

This Agreement is entered into by and between the parties hereto for their benefit. There is no intent by either party to create or establish a third party beneficiary status or rights in a Covered Person, Employer, subcontractor, or other third party to this Agreement, except as such rights are expressly created and as set forth herein, and no such third party shall have any rights to enforce any right to enjoy any benefit created or established under this Agreement.

Review of the plain and unambiguous language must result in a finding that Mary Black and MedCost did not express, and did not have, an intent to allow Plaintiff Blackwell to enforce the MedCost Agreement as a third-party beneficiary. In fact, they expressed the clear and unambiguous intent that neither she, nor others, were third-party beneficiaries with such rights. Since Plaintiff Blackwell lacks standing to enforce the MedCost Agreement as a third-party beneficiary, she lacks standing to enforce the terms of the agreement or to pursue any of her alleged claims. Therefore, as a matter of law, Plaintiff Blackwell's claims must be dismissed.

Blackwell's attempt to rely on the decision by a panel of the court of appeals in *Beverly v. Grand Strand Regional Medical Center*, 429 S.C. 502, 839 S.E. 2d 468 (Ct. App. 2020), is not applicable. First, the petition for writ of certiorari in that case is still pending. Second, in that case the panel asserted that there were certain specific provisions in the agreement in issue which created the third party rights asserted, notwithstanding the disclaimer of third party beneficiaries. In this case, there are no allegations of provisions creating or conveying third party rights.

### **CONCLUSION**

Based on the foregoing, Defendants request the Court dismiss Plaintiffs' Amended Complaint on the grounds that Plaintiffs have failed to allege facts sufficient to constitute a cause

of action, or in the alternative, compel Plaintiff Owens to arbitrate his claims against Defendants.

s/Katon E. Dawson, Jr.

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Hospital*

July 28, 2020  
Columbia, South Carolina

STATE OF SOUTH CAROLINA )  
COUNTY OF SPARTANBURG )

IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT

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

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

Plaintiffs, )

**DEFENDANTS' MOTION TO ALTER  
OR AMEND**

v. )

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

Defendants. )

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Defendants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital (“Mary Black”), CHSPSC, LLC (“CHSPSC”), and Professional Account Services, Inc. (“PASI”) (collectively, “Defendants”) by and through undersigned counsel, hereby move the Court pursuant to Rule 59(e) of the South Carolina Rules of Civil Procedure for an Order altering, amending, or vacating the order denying Defendants’ Motion to Dismiss Pursuant to Rule 12(B)(6) or, in the Alternative, to Stay the Case and Compel Arbitration (the “Motion”). Defendants respectfully submit that the Order contains conclusions of law that the evidence in the record does not support and that overlook or misapprehend controlling law.

**I. The Court erred in failing to compel Plaintiff Samuel Owens to arbitrate his claims against Defendants.**

**A. Plaintiff Samuel Owens is equitably estopped from avoiding the arbitration provision in the CIGNA Agreement because he is seeking to take a direct benefit from that Agreement.**

The Court erroneously concluded that the terms of the CIGNA Agreement do not apply to Plaintiff Owens. South Carolina courts have repeatedly recognized that non-signatories who are attempting to enforce contracts to which they are not a party are bound by all of the terms of the

contracts they are seeking to enforce—including the arbitration provisions. *See Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 290, 733 S.E.2d 597, 601 (Ct. App. 2012) (applying direct benefits estoppel to compel a nonsignatory doctor to arbitrate his claims against a hospital pursuant to the arbitration provision in the hospital’s contract with another entity because the doctor sought to take direct benefits from that contract in his lawsuit). Plaintiff Owens’ claims against Defendants are based upon the alleged contractual requirement that Mary Black submit his hospital bills to his alleged insurance provider (CIGNA). *See* Amended Complaint ¶ 28 (“Defendants are required by their contracts with patients’ health insurance carriers to submit insurance patients’ medical bills directly to the carriers.”). Plaintiff Owens is not a signatory to the CIGNA Agreement. Thus, Plaintiff Owens is a non-signatory who is attempting to enforce and to derive benefit from the terms of an agreement to which he is not a party.

When Plaintiff Owens (a non-signatory to the CIGNA Agreement) seeks to take direct benefits from the CIGNA Agreement, and to enforce the terms contained therein, the doctrine of direct benefits estoppel binds him to all of the terms within the CIGNA Agreement—including the arbitration provision. *See Pearson*, 400 S.C. at 290, 733 S.E.2d at 601. Under the direct benefits estoppel framework “[a] nonsignatory is estopped from refusing to comply with an arbitration clause ‘when it receives a ‘direct benefit’ from a contract containing an arbitration clause.’” *Id.* at 290, 733 S.E.2d at 601 (quoting *Int’l Paper Co. v. Schwabedissen Maschinen & Anlagen GMBH*, 206 F.3d 411, 418 (4th Cir. 2000)). “‘To allow [a plaintiff] to claim the benefit of the contract and simultaneously avoid its burdens would both disregard equity and contravene the purposes underlying enactment of the Arbitration Act.’” *Id.* (quoting *Int’l Paper*, 206 F.3d at 418).

Direct benefits estoppel applies regardless of whether Plaintiff Owens is a signatory to the CIGNA Agreement. *See Thompson v. Pruitt Corp.*, 416 S.C. 43, 59, 784 S.E.2d 679, 688 (Ct. App. 2016) (“[A] party may be estopped from asserting that the lack of his signature on a written

contract precludes enforcement of the contract's arbitration clause when he has consistently maintained that other provisions of the same contract should be enforced to benefit him." (citation omitted)). To hold otherwise would be to disregard the doctrine of direct benefits estoppel and permit Plaintiff Owens to enforce the terms of the CIGNA Agreement while simultaneously permitting him to avoid compliance with the other terms of the CIGNA Agreement—including the arbitration provision. *See Pearson*, 400 S.C. at 295, 733 S.E.2d at 604 ("[A] party may not rely on the contract when it works to its advantage, and repudiate it when it works to its disadvantage."). Thus, the Court's finding that the CIGNA Agreement "does not apply to the Plaintiff as Plaintiff is not a 'party'" to the Agreement is an error of law that must be corrected.

Moreover, any analysis as to whether Plaintiff Owens should be required to arbitrate his claims must be reviewed and decided in the context of the absolutely clear and unquestionable policy, of both South Carolina and the United States, favoring the arbitration of disputes and "any doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration." *Landers v. Fed. Deposit Ins. Corp.*, 402 S.C. 100, 108, 739 S.E.2d 209, 213 (2013); *see also Zabinski v. Bright Acres Assocs.*, 346 S.C. 580, 596, 553 S.E.2d 110, 118 (2001). The Court's analysis of the arbitration provision in the CIGNA Agreement appears to have ignored the policy favoring arbitration in South Carolina.

**B. The fact that the arbitration may be elective does not permit the Court to deny Defendants' Motion to Compel Arbitration.**

Contrary to the Court's statements, resolution of disputes in arbitration does not need to be identified as the exclusive remedy to be binding and enforceable upon a demand from a proper party.

In *MailSource, LLC v. M.A. Bailey & Associates Inc.*, 356 S.C. 370, 373, 588 S.E.2d 639, 640-41 (Ct. App. 2003), the Court of Appeals analyzed a similar elective arbitration provision and found the circuit court erred in failing to compel the plaintiff to arbitrate its claims against the

defendant. In *MailSource*, the Court stated that the principal agreement “required the parties to attempt in good faith to settle any disputes first through consultation and negotiation, and then by mediation. If those attempts failed, the agreement provided ‘either party may demand that the dispute be arbitrated. . . .’” 356 S.C. 370, 373, 588 S.E.2d at 341. After the plaintiff filed an action against the defendant, the defendant moved the circuit court to compel arbitration. The court held that while the elective nature of the arbitration provision may be unique, nevertheless, the circuit court erred in refusing to compel the plaintiff to arbitrate its claims against the defendant. *Id.* at 377, 588 S.E.2d at 643.

Like the circuit court in *MailSource*, this Court erred in denying Defendants’ Motion to Compel Arbitration of Plaintiff Owens’ claims. The elective nature of the arbitration provision in the CIGNA Agreement does not alter a proper analysis of a demand for arbitration pursuant to an enforceable agreement to arbitrate. The CIGNA Agreement states that either party may demand arbitration and, like the defendant in *MailSource*, Defendants made a proper demand for arbitration in response to the Amended Complaint. Accordingly, the Court should alter or amend its order and find Plaintiff Owens is required to arbitrate his claims against Defendants.<sup>1</sup>

**C. The disclaimer of third-parties and class arbitration does not alter the necessary conclusion that Plaintiff Owens is obligated to arbitrate his claims against Defendants.**

The CIGNA Agreement’s express statement that an arbitration conducted pursuant to the Agreement will not include class claims or third-parties does not render the arbitration provision unenforceable against Plaintiff Owens. South Carolina Courts and the United States Supreme Court have recognized the principle that parties may not arbitrate class claims unless the agreement

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<sup>1</sup> Defendants further note that the Court’s reference to the elective language in the arbitration provision and its impact on the issues in this case was raised *sua sponte* for the first time by the Court in its order. This language or its impact on the Defendants’ motion was not raised as an issue by the Plaintiffs.

to arbitrate expressly states that the parties agreed to arbitrate such claims. *See Grant v. Chevrolet*, No. 2017-001897, 2020 WL 4661330, at \*2 (S.C. Ct. App. Aug. 12, 2020) (applying the reasoning of the United States Supreme Court in *Lamps Plus, Inc. v. Varela*, 139 S. Ct. 1407, 1412, 203 L. Ed. 2d 636 (2019) and *Stolt-Nielsen S.A. v. AnimalFeeds Int'l Corp.*, 559 U.S. 662, 673, 130 S. Ct. 1758, 1768, 176 L. Ed. 2d 605 (2010) to find that an arbitration provision must expressly state that the parties agree to arbitrate class issues, otherwise a party will be required to arbitrate their claims alone and the class claims may not proceed). Thus, the inclusion of express language stating that an arbitration will not include class claims is permissible and proper, and such language does not render the arbitration provision unenforceable. To the contrary, such language is directly enforceable and expresses a clear intent that the arbitration of claims pursuant to the arbitration provision in the CIGNA Agreement will only involve Plaintiff Owens and the parties that he is attempting to enforce the agreement against—Defendants.

**II. In the alternative, the Court erred in failing to dismiss Plaintiff Owens' claims on the grounds that they are barred by the applicable statute of limitations.**

The Court erred in finding that Plaintiff Owens' claims should not be dismissed pursuant to the applicable statutes of limitations. As a matter of law, Plaintiff Owens' claims do not relate back to the filing of the original complaint and, therefore, his claims are barred by the applicable statutes of limitation. While the Court erred in allowing the amendment to add new plaintiffs in the first place, that does not change the law that the claims for the new plaintiffs do not relate back to the date of the filing of the original complaint.

Rule 15(c) of the South Carolina Rules of Civil Procedure addresses the relation back of amendments to a complaint for the purpose of applying the statute of limitations. Rule 15(c) does not permit the relation back of a new claim filed by a new plaintiff that was added to a case pursuant to an amended complaint. *See Valentine v. Davis*, 319 S.C. 169, 172, 460 S.E.2d 218, 219 (Ct. App. 1995). Rule 15(c) only applies, and may only validate a relation back argument, to a

substitution or change in a party. “[T]he addition of a party is not the same as a substitution or change of party.” *Jackson v. Doe*, 342 S.C. 552, 558, 537 S.E.2d 567, 570 (Ct. App. 2000). The addition of a new party is not contemplated by Rule 15(c), and does not relate back. *Gause v. Smithers*, 384 S.C. 130, 133, 681 S.E.2d 607, 609 (Ct. App. 2009).

Thus, Rule 15(c) does not allow for Plaintiff Owens’s claims to relate back to the filing of the original complaint because he is a newly added plaintiff asserting claims based upon his own individual facts. Specifically, Plaintiff Owens’ claims are new and different from Plaintiff Blackwell’s original claims because his claims arise out of a different automobile accident, he is covered by a different insurance carrier (which results in his claims being affected by his contract with his insurance carrier and his insurance carrier’s contract with Mary Black), and he actually paid to settle his debt to Mary Black. Therefore, the Court erred in finding that Plaintiff Owens’ claims relate back to the filing of original complaint and are not barred by the applicable statutes of limitation. Accordingly, the Court should alter or amend its order and dismiss all of Plaintiff Owens’s claims because his claims do not relate back to the filing of the original complaint and, as is evident on the face of the Amended Complaint, are barred by the applicable statutes of limitation.

### **III. The Court’s analysis of the application of the voluntary payment doctrine contains improper and incendiary assertions based on facts not pled and arguments not presented to the Court.**

As an initial matter, Defendants take great umbrage with the Court’s statement (or at least implication) that the payments made on behalf of Plaintiff Owens and Plaintiff Brooks were “a result of extortion.” It is improper and frankly alarming that the Court would make such an accusation against the Defendants when no such allegation has been made and none could ever be supported by the facts.

In reviewing a Motion to Dismiss pursuant to Rule 12(b)(6) the Court considers the facts alleged in a light most favorable to the non-moving party; however, the Court is not permitted to create facts and allegations to avoid the application of an affirmative defense. The Court's improper statement that the payments made on behalf of Plaintiff Owens and Plaintiff Brooks were the result of "extortion" is wholly improper. The parties to this case are undeniably aware that counsel for Plaintiff Owens and Plaintiff Brooks negotiated settlements with Mary Black and voluntarily paid the settlement amounts negotiated. If Plaintiffs Owens or Plaintiff Brooks—or their counsel—intended to dispute the billing practices of Defendants, then they should have raised their concerns before negotiating a settlement of the hospital bills that are now in dispute. Allowing these claims to proceed based on the Court's assumption of new facts, and an intentional failure by the Plaintiffs to include in their pleadings all the necessary facts, is improper and should not be permitted by courts in this state.

**IV. The Court erred in failing to dismiss Plaintiff Blackwell's claim for unjust enrichment, because Plaintiff Blackwell does not allege she conferred any benefit to Defendants.**

In ruling on a motion to dismiss the Court is to construe the facts in favor of the non-moving party; however, this standard does not permit the Court to ignore the absence of critical facts.

South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: "(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its value." *Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994).

The Amended Complaint contains **no factual allegation** that (a) Plaintiff Blackwell made a payment or conferred a benefit to Mary Black (or any of the Defendants), (b) Mary Black realized

a benefit conferred upon it by Plaintiff Blackwell, or (c) the retention of a benefit by Mary Black would be unjust. Rather, review of the Amended Complaint's allegations reveals only that Mary Black conferred a benefit to Plaintiff Blackwell—it provided medical services to her between December 27, 2013 and January 3, 2014. Plaintiff Blackwell does not—and cannot—allege that she conferred a benefit to Mary Black—because she never paid for that medical treatment.

The Court's order does not identify any benefit conferred by Plaintiff Blackwell to the Defendants. The Court, in its Order, is guilty of the same error perpetuated by the Amended Complaint; namely, an unfounded and unsubstantiated, conclusory joinder of generic Plaintiffs and generic Defendants in its general conclusion. This is exactly why collective pleading is improper and results in erroneous analysis. The Amended Complaint does not contain any allegation that Plaintiff Blackwell conferred a benefit upon Defendants and, therefore, it is not possible for the Defendants to have unjustly retained any benefit. The Court's Order fails to identify any allegation that could be construed to permit any other finding, because no such allegation exists in the Amended Complaint. Therefore, the Court should alter or amend its order and find Plaintiff Blackwell failed to state a claim for unjust enrichment.

**V. The Court failed to address the argument that Plaintiff Blackwell is barred from enforcing the terms of the MedCost Agreement pursuant to the Agreement's express disclaimer of third-party beneficiaries.**

Plaintiff Blackwell's claims are all premised upon her contention that she is a third-party beneficiary of the MedCost Agreement between Mary Black and her health insurer. She alleges she has the right to enforce the terms of that Agreement for her own goals and benefit. However, Plaintiff Blackwell is not a party to the MedCost Agreement and she is not an intended third-party beneficiary who can sue to enforce that Agreement for her own benefit.

As raised in the Motion to Dismiss, the MedCost Agreement plainly and directly expresses Mary Black and MedCost's intent to bar third-parties from enforcing the MedCost Agreement.

This intent is unequivocally stated in Section 10.9 of the MedCost Agreement, which expressly and definitively states Mary Black and MedCost's intention that the contract was not to be construed to have any third-party beneficiaries:

This Agreement is entered into by and between the parties hereto for their benefit. There is no intent by either party to create or establish a third party beneficiary status or rights in a Covered Parson, Employer, subcontractor, or other third party to this Agreement, except as such rights are expressly created and as set forth herein, and no such third party shall have any rights to enforce any right to enjoy any benefit created or established under this Agreement.

The Court's Order does not address or decide this issue raised in the Motion, despite the law clearly establishing that the Court's determinative step in reviewing the MedCost Agreement is to review and give effect to its plain and unambiguous language. *See Whitlock v. Stewart Title Guar. Co.*, 399 S.C. 610, 614, 732 S.E.2d 626, 628 (2012) ("The cardinal rule of contract interpretation is to ascertain and give legal effect to the parties' intentions as determined by the contract language." (citation omitted)). The plain and unambiguous language of the MedCost Agreement compels the finding that Mary Black and MedCost did not express, and did not have, an intent to allow Plaintiff Blackwell to enforce the MedCost Agreement as a third-party beneficiary. *See Windsor Green Owners Ass'n, Inc. v. Allied Signal, Inc.*, 362 S.C. 12, 19, 605 S.E.2d 750, 753 (Ct. App. 2004) ("No third-party beneficiary status is created absent an intent by the parties to confer a substantial benefit on [a non-signatory third-party]."). Since Plaintiff Blackwell lacks standing to enforce the MedCost Agreement as a third-party beneficiary, she lacks standing to enforce the terms of the agreement and pursue any of her alleged claims. Therefore, as a matter of law, Plaintiff Blackwell's claims must be dismissed. Accordingly, the Court erred in failing to address this issue because it is determinative of the claims asserted by Plaintiff Blackwell.

**VI. The Court erred in permitting Plaintiffs to collectively plead claims against the Defendants.**

The Court's refusal to find that such a style of collective pleading is improper is an error. The Court's decision ignores the well-established law in South Carolina that corporations are not liable for each other's obligations merely because of some type of centralized control or mutual purposes. *See Pertuis v. Front Roe Restaurants, Inc.*, 423 S.C. 640, 654, 817 S.E.2d 273, 280 (2018), *reh'g denied* (Aug. 16, 2018); *see also Pro Slab, Inc. v. Argos USA Corp.*, No. CV 2:17-3185-BHH, 2018 WL 6985008, at \*5 (D.S.C. June 28, 2018), *reconsideration granted on other grounds*, No. CV 2:17-3185-BHH, 2018 WL 6985010 (D.S.C. Dec. 3, 2018) (granting the defendants' motions to dismiss on the grounds that that the plaintiffs' amended complaint simply lumped together members of corporate families and impermissibly ascribed liability to groups rather than to individual entities); *Scurmont LLC v. Firehouse Rest. Grp., Inc.*, No. 4:09-CV-00618-RBH, 2010 WL 11433199, at \*15 (D.S.C. May 19, 2010) (dismissing claims against an individual defendant because the complaint only contained general conclusory allegations against the defendants collectively and the plaintiffs failed to plead sufficient facts that an individual defendant committed any wrongful act within the State of South Carolina, let alone any wrongful act causally related to the plaintiff's alleged injuries). Allowing Plaintiffs to collectively plead claims against the Defendants is the equivalent of allowing Plaintiffs to pierce the corporate veil without the need to plead facts to support piercing the corporate veil. Plaintiffs are not permitted to simply collectively accuse the Defendants of wrongdoing without pleading the facts necessary to permit Defendants to share such liability. Therefore, the Court erred in finding Plaintiffs adequately plead facts to state claims against CHSPSC and PASI.

**CONCLUSION**

Based on the foregoing, Defendants request the Court alter or amend its Order and dismiss Plaintiffs' Amended Complaint on the grounds that Plaintiffs have failed to allege facts sufficient

to constitute a cause of action, or in the alternative, compel Plaintiff Owens to arbitrate his claims against Defendants.

s/James Lynn Werner

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September 14, 2020  
Columbia, South Carolina

**STATE OF SOUTH CAROLINA  
COUNTY OF SPARTANBURG**

**IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT**

Jo Ann Blackwell, Michelene Brooks, and  
Samuel H. Owens, Jr., individually and on be-  
half of all others similarly-situated,

Plaintiffs,

v.

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

Defendants.

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

Hon. J. Mark Hayes, II

**PLAINTIFFS' RESPONSE IN OPPOSI-  
TION TO DEFENDANTS' MOTION TO  
ALTER OR AMEND**

Incorporating all arguments from their previously filed memorandum of law, Plaintiffs Jo Ann Blackwell; Michelene Brooks; and Samuel H. Owens, Jr.; individually and on behalf of all others similarly-situated, respectfully submit this Response in Opposition to Defendants' Motion to Alter or Amend this Court's September 4, 2020 Order denying Defendants' Motions to Dismiss. Because there is no evidence the Court has misunderstood or failed to fully consider or rule upon any issue raised by Defendants, the Court should deny the motion and allow the matter to proceed to discovery. Defendants merely reiterate the same arguments raised in their prior memorandum and at the hearing and provide no basis for reconsideration or amendment of the Court's Order. *See, e.g., Collins Music Co. v. IGT*, 353 S.C. 559, 579 S.E.2d 524 (Ct. App. 2002) (where movant merely repeated the same arguments found in its memorandum and failed to identify any issue raised but not ruled upon, motion for reconsideration was properly denied).

## ARGUMENT

### 1. The Court correctly found that Owens should not be compelled to arbitrate his claims against Defendants.

In addition to the reasons advanced in Plaintiffs' Response in Opposition to Defendants' Motions to Dismiss, compelling Owens to arbitrate his claims against Defendants would be improper because equitable estoppel is inapplicable under these circumstances and the arbitration clause, by its own terms, does not encompass Plaintiffs' claims.

Defendants' reliance on equitable estoppel to enforce the arbitration clause as to Owens, a nonparty to the CIGNA agreement, is misplaced. Defendants cite *Pearson v. Hilton Head Hospital*, 400 S.C. 281, 733 S.E.2d 597 (Ct. App. 2012), to support their argument; however, *Pearson* is easily distinguished from this action. There, the plaintiff, while also a nonparty to the contract at issue containing an arbitration clause, "received a benefit due to the contract, in that he was able to work at the Hospital and receive payment for his work." *Id.* at 296, 733 S.E.2d at 605; *see also id.* at 296–97, 733 S.E.2d at 605 ("If not for that contract, then Dr. Pearson would have had to make separate arrangements with the Hospital in order to work there. He *knowingly accepted* benefits of the contract between the Hospital and Locum. Accordingly, Dr. Pearson benefitted from that contract and should not be able to disclaim the arbitration agreement contained in it." (emphasis added)).

Here, however, Plaintiffs have not received or accepted any corresponding benefit from the hospital service agreements Mary Black entered into. In fact, it is because the exact opposite has taken place—Plaintiffs were harmed by Defendants' failure to act in accordance with the contract—that Plaintiffs have been forced to bring this action against Defendants. *See id.* at 291, 733 S.E.2d at 602 ("Generally, these cases involve non-signatories who, *during the life of the contract*, have embraced the contract despite their non-signatory status but then, during litigation, attempt

to repudiate the arbitration clause in the contract.” (emphasis added) (quoting *E.I. DuPont de Nemours & Co. v. Rhone Poulenc Fiber & Resin Intermediates, S.A.S.*, 269 F.3d 187, 200 (3d Cir. 2001))); accord 6 C.J.S. Arbitration § 18.

The South Carolina Court of Appeals recently addressed a similar scenario in *Weaver v. Brookdale Senior Living, Inc.*, where it held that a nursing home’s insistence that “direct benefits estoppel” required arbitration of a granddaughter’s claims was unsupported by the law. 847 S.E.2d 268, 271 (S.C. Ct. App. 2020). In *Weaver*, a granddaughter brought suit after her grandmother died on the grounds of a nursing home after wandering away. *Id.* The granddaughter discovered her body, maimed and dismembered, in a retention pond, and as a result, asserted claims for negligent and intentional infliction of emotional distress. *Id.* The nursing home argued “direct benefits estoppel funnels the [granddaughter’s] claims to arbitration because her ability to sue [the nursing home] stems from [her grandmother’s] residency agreement, which includes the arbitration agreement.” *Id.* at 272. The Court of Appeals disagreed, holding “this argument is easily scotched, for direct benefits estoppel is not implicated simply because a claim related to or would not have arisen but for a contract’s existence.” *Id.* The court noted that the daughter “ha[d] not exploited or otherwise sought to enforce or benefit from the residency agreement, any more than a pedestrian run over by a truck has benefited from the contract for the purchase of the truck.” *Id.* at 273. Declining to apply the doctrine of direct benefits equitable estoppel, the Court noted that “the heart of the theory ‘is that the party entitled to invoke the principle was misled to his injury.’” *Id.* at 274 (quoting *Rodarte v. Univ. of S.C.*, 419 S.C. 592, 601, 799 S.E.2d 912, 916 (2017)). Finding no evidence of such conduct, the Court held there was no agreement to arbitrate between the parties and affirmed the denial of the motion to compel arbitration. Here, as in *Weaver*, Plaintiffs did not mislead Defendants or cause them any injury. In fact, as stated above, the opposite has taken place.

Similarly, in *Wilson v. Willis*, numerous insureds brought suit against their insurance agent, the insurance broker who hired the agent, the insurance agency, and the insurers whose policies the agency sold. 426 S.C. 326, 331, 827 S.E.2d 167, 170 (2019). The plaintiff insureds alleged the agent, among other things, “forg[ed] insurance documents, [took] cash payments, and convert[ed] the payments to her own use, resulting in the Insureds having either no coverage or reduced coverage.” *Id.* at 332, 827 S.E.2d at 170. Several insurers filed motions to compel arbitration based on arbitration clauses contained in contracts between the insurers and the agency. *Id.* at 332–33, 827 S.E.2d at 170–71. The insurers argued that “equitable estoppel should preclude [the plaintiffs’] assertion of their nonsignatory status because [their] claims were premised on duties that would not exist but for the Agency Agreement [the insurers] had with [the agency].” *Id.* at 333, 827 S.E.2d at 171. In upholding the circuit court’s denial of the insurers’ motions, however, the Supreme Court distinguished *Pearson*:

We agree with [Plaintiffs] that the circumstances in *Pearson* are distinguishable. Unlike Dr. Pearson, [Plaintiffs] did not embrace the Agency Agreement during the life of the contract and then, during litigation, attempt to repudiate the arbitration clause in the contract. It is undisputed that [Plaintiffs] were never aware of the existence of the contract until they brought their tort actions against [the insurers].

*Id.* at 342, 827 S.E.2d at 176. Rather than using *Pearson* as a guidepost, Plaintiffs respectfully submit that *Weaver* and *Wilson* are much more similar to the circumstances of this case and are controlling as to this issue.

In addition to the complete lack of prior benefits, any future benefit that may be conferred on Plaintiffs is insufficient to mandate arbitration. As Defendants acknowledged in their Motion, equitable estoppel is only available to enforce an arbitration clause when a nonsignatory receives a “direct benefit” from the contract containing the arbitration clause. *See* Defendants’ Motion to Alter or Amend, at 2. However, Plaintiffs will not receive any direct benefit from the CIGNA

hospital service agreement even if they are ultimately successful in this litigation. “It is important to distinguish direct benefits from indirect benefits because when the benefits to a nonsignatory are merely indirect, arbitration cannot be compelled.” *Wilson*, 426 S.C. at 343, 827 S.E.2d at 176. “A benefit is direct if it flows directly from the agreement.” *Id.* “In contrast, any benefit derived from an agreement is indirect where the nonsignatory exploits the contractual relationship of the parties, but does not exploit (and thereby assume) the agreement itself.” *Id.*

Here, Plaintiffs’ claims for unjust enrichment and tortious interference with a contractual relationship are grounded on independent South Carolina law and do not rely on the hospital service agreements for recovery. Accordingly, any benefit conferred due to the existence of the agreements would be indirect at best, and those claims provide Defendants no support in their attempt to compel arbitration. *See id.* at 343, 827 S.E.2d at 176 (“[D]irect benefits estoppel is not implicated simply because a claim relates to or would not have arisen ‘but for’ a contract’s existence.”); *id.* (“When a claim depends on the contract’s existence and cannot stand independently—that is, the alleged liability ‘arises solely from the contract or must be determined by reference to it’—equity prevents a person from avoiding the arbitration clause that was part of that agreement. But ‘when the substance of the claim arises from general obligations imposed by state law, including statutes, torts and other common law duties, or federal law,’ direct-benefits estoppel is not implicated even if the claim refers to or relates to the contract *or would not have arisen ‘but for’ the contract’s existence.*” (quoting *Jody James Farms, JV v. Altman Grp., Inc.*, 547 S.W.3d 624, 637 (Tex. 2018))); *see, e.g., id.* at 342, 827 S.E.2d at 176 (“General principles of South Carolina law form the basis for most of [Plaintiffs’] claims. For example, [Plaintiffs’] allegation that [the insurers] possibly conspired with [the agent] and others to commit fraud is misconduct that does not arise from the contract.”).

Plaintiffs’ remaining claim for injunctive relief similarly does not warrant compelling arbitration. Although Plaintiffs’ success on that claim admittedly relies on the hospital service agreements, the relief sought—enjoining Defendants from engaging in unlawful billing practices in contravention of the agreements—will confer no direct benefit on Plaintiffs. Any benefit resulting from the successful litigation of this claim will inure to future patients. Such an indirect and insubstantial benefit is insufficient to support Defendants’ attempt to compel arbitration. *See Equitable estoppel—Generally*, 1 Domke on Com. Arb. § 13:9 (“A nonsignatory who has received a direct benefit from a contract containing an arbitration clause may be estopped from refusing to comply with that arbitration clause. This approach does not apply if the claimed benefits are insubstantial or indirect, nor does it apply if the claim merely relates to the contract.” (footnote omitted)). Moreover, the fact that only one of Plaintiffs’ claims relies on the health service agreements further weighs against enforcement of the arbitration clause. *See Wilson*, 426 S.C. at 342, 827 S.E.2d at 176 (denying arbitration and noting “[g]eneral principles of South Carolina law form the basis for *most* of Petitioners’ claims” (emphasis added)).

Next, the Court correctly found in its Order denying dismissal that Defendants’ argument fails because the CIGNA agreement’s arbitration clause does not encompass Plaintiffs’ claims.<sup>1</sup> The clause is limited to “disputes between the parties,” and only CIGNA and Mary Black were parties to the agreement. The provisions of the arbitration clause also repeatedly refer to actions a

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<sup>1</sup> Despite Defendants’ argument regarding the elective nature of the arbitration clause, *see* Defendants’ Motion to Alter or Amend, at 3–4, the Court did not rely on this fact in determining the arbitration clause was inapplicable to Plaintiffs. *See* Form 4 Order dated Sept. 4, 2020, at 4 (“[T]he arbitration provision in the Cigna Agreement . . . does not apply to the Plaintiff as the Plaintiff is not a ‘party’ to the agreement. In accordance [with] the terms of the agreement, the Plaintiff is, at best, a ‘participant’ under the agreement’s terms but not a ‘party’. . . . As previously stated, the Plaintiff is not a ‘party’ to the agreement and its provisions are not enforceable as binding on the Plaintiff.”). Accordingly, Defendants’ argument on this point is immaterial.

“party,” “the parties,” or “Hospital” may take, which indicates that it was not intended to encompass Plaintiffs’ claims. The agreement does not define “party,” so in interpreting the agreement, the ordinary definition of the term (which does not include Plaintiffs) should be used. *See Plain meaning*, 11 Williston on Contracts § 32:3 (4th ed.) (“The plain, common, or normal meaning of language will be given to the words of a contract unless the circumstances show that in a particular case a special meaning should be attached to them.” (footnote omitted)); *Party*, Black’s Law Dictionary (11th ed. 2019) (“Someone who takes part in a transaction <a party to the contract>.”). Moreover, any ambiguity as to whether “party” encompasses Plaintiffs should be resolved against Defendants. *See Contra proferentem: Ambiguities are interpreted against the drafter*, 11 Williston on Contracts § 32:12 (4th ed.) (“[I]t is a generally accepted principle that any ambiguity in that language will be interpreted against the drafter.”).

The agreement does define “Participant” as “any individual . . . who is eligible and enrolled to receive Covered Services.” This definition encompasses Plaintiffs, so if CIGNA and Mary Black intended to include Plaintiffs’ claims in the scope of the arbitration clause, they could have used that term. Plaintiffs acknowledge that one sentence of the arbitration clause states more generally, “Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement.” However, the clause also explicitly excludes “arbitration on a class basis” and states “an arbitration conducted under this provision shall not be consolidated with an arbitration involving . . . third parties.” Read as a whole, the clause demonstrates the contracting parties’ intent not to include claims by “Participants,” and any limited, specific language to the contrary should not override this interpretation. *See The contract is to be read as a whole; the “four corners” rule*, 11 Williston on Contracts § 32:5 (4th ed.) (“A contract will be read as a whole and every part will be read with reference to the whole.”).

Because the arbitration clause, by its own terms, does not encompass Plaintiffs' claims, it cannot be enforced to compel Plaintiffs into arbitration. *See Weaver*, 847 S.E.2d at 271 ("To compel Weaver to arbitrate her claims, Appellants must demonstrate (1) there is a valid arbitration agreement, and (2) the claims fall within its scope."); 6 C.J.S. Arbitration § 18 ("[T]he doctrine of equitable estoppel is not applicable to compel arbitration, where the arbitration agreement is specifically limited to the parties who have executed the agreement, or the provision is not broad enough to indicate an intent to arbitrate with a person who did not sign the agreement." (footnote omitted)); *Hilton Head Resort Four Seasons Ctr. Horizontal Prop. Regime Council of Co-Owners, Inc. v. Resort Inv. Corp.*, 311 S.C. 394, 398, 429 S.E.2d 459, 462 (Ct. App. 1993) ("Where there has been no agreement to arbitrate, a party cannot be forced into compulsory arbitration.").

Here, as in *Weaver* and *Wilson*, applying equitable estoppel would be improper because Plaintiffs have not done, or failed to do, any act related to the execution or performance of the CIGNA agreement, and Defendants have in no way been prejudiced by Plaintiffs' conduct during the time periods covered by their claims or related to this litigation. *See Parker v. Parker*, 313 S.C. 482, 487, 443 S.E.2d 388, 391 (1994) ("Equitable estoppel occurs where a party is denied the right to plead or prove an otherwise important fact because of something which he has done or failed to do."); *id.* ("The essential element of estoppel is prejudice to the party raising the defense."). Furthermore, public policy cautions against allowing Defendants to engage in misconduct and then hide that conduct from the Court's scrutiny by enforcing an arbitration clause with respect to a nonparty. *See Wilson*, 426 S.C. at 342, 827 S.E.2d at 176 ("[Plaintiffs'] allegation that [the insurers] possibly conspired with [the agent] and others to commit fraud is misconduct that does not arise from the contract. To hold otherwise would arguably allow [the insurers] to commit unfair trade practices and conspire to destroy the businesses of other insurance agencies while shielding

themselves from the possibility of a jury trial with an arbitration clause agreed to only by the conspiring parties.”).

Finally, Defendants’ argument that “any analysis as to whether Plaintiff Owens should be required to arbitrate his claims must be reviewed and decided in the context of the absolutely clear and unquestionable policy . . . favoring the arbitration of disputes” is not applicable in this context. See Defendants’ Motion to Alter or Amend, at 3. “[T]he presumption in favor of arbitration applies to the scope of an arbitration agreement; it does not apply to the existence of such an agreement or to the identity of the parties who may be bound to such an agreement.” *Wilson*, 426 S.C. at 337, 827 S.E.2d at 173 (quoting *Carr v. Main Carr Dev., LLC*, 337 S.W.3d 489, 496 (Tex. App. 2011)). “Even the exceptionally strong policy favoring arbitration cannot justify requiring litigants to forego a judicial remedy when they have not agreed to do so.” *Id.* (quoting *Carr*, 337 S.W. at 496). In fact, “because arbitration, while favored, exists solely by agreement of the parties, a presumption *against* arbitration arises where the party resisting arbitration is a nonsignatory to the written agreement to arbitrate.” *Id.* at 337–38, 827 S.E.2d at 173.

## **2. The Court correctly found Owens’ claims are not barred by the statute of limitations.**

Defendants argue Owens’ claims are barred by the statute of limitations because they do not relate back to the date Plaintiffs filed their original Complaint. However, in doing so, Defendants repeat the same arguments they advanced in their Memorandum in Opposition to Plaintiffs’ Motion to Amend Complaint, which this court has already declined to address until after class certification is adjudicated. See Order Granting Plaintiffs’ Motion for Leave to Amend the Complaint, dated Apr. 23, 2020, at 2 (“[O]nce a class is certified, the period for the statute of limitations for purposes of a valid claim may be defined.”). The Court reiterated its position in its recent Order denying Defendants’ Motion to Dismiss. See Form 4 Order dated Sept. 4, 2020, at 4 (“This

Court[’s] opinion is that any statute of limitation issue fails at this time because of its relatedness to the original filing of the complaint. Factually, the issue may or may not be significant at a future time”). On this basis alone, the Court should reject Defendants’ continuing attempts to force the Court to rule on this issue now.

Nonetheless, Defendants’ argument also fails on the merits. Defendants rely on Rule 15(c), SCRCP, and *Valentine v. Davis*, 319 S.C. 169, 460 S.E.2d 218 (Ct. App. 1995), neither of which supports their position. They contend “Rule 15(c) does not permit the relation back of a new claim filed by a new plaintiff that was added to a case pursuant to an amended complaint.” Defendants’ Motion to Alter or Amend, at 5. However, Rule 15(c) does not prohibit the addition of plaintiffs in an amended complaint. Instead, it provides that “[w]henver the *claim or defense* asserted in the amended pleading arose out of the conduct, transaction or occurrence set forth or attempted to be set forth in the original pleadings, the amendment relates back to the date of the original pleading.” Rule 15(c) (emphasis added). Here, the claims in Plaintiffs’ Amended Complaint are materially unchanged from those in the original Complaint and certainly “arose out of the conduct, transaction or occurrence set forth or attempted to be set forth in the original pleadings.” *Id.* In fact, Rule 15(c) explicitly allows the relation back of claims when the party against whom the claim is asserted is changed. *See id.* (“An amendment changing the party against whom a claim is asserted relates back if the foregoing provision is satisfied and” the party has notice or knowledge of the action.). Accordingly, Defendants’ reliance on Rule 15(c) is misplaced.

Defendants’ reliance on *Valentine* is similarly misplaced. Not only does that case not address the relation back of claims when parties are added or substituted in an amended complaint, but subsequent case law stands in stark opposition to Defendants’ position. In *Patton v. Miller*, the plaintiff initially filed an action in her capacity as “next friend” to her daughter, and she later

moved to amend her complaint to change her capacity from next friend to her individual capacity. 420 S.C. 471, 477, 479, 804 S.E.2d 252, 255–56 (2017). On appeal from the denial of the motion, the Supreme Court found,

[Plaintiff’s] individual claim . . . satisfies Rule 15(c) because it is the exact claim she made in the representative capacity. In fact, there is no difference between the old claim and the new claim except the capacity of the person bringing it. Therefore, [the] amended claims . . . relate back to the [initial date of] filing and comply with the statute of limitations.

*Id.* at 494, 804 S.E.2d at 264. The *Patton* court also addressed and distinguished *Valentine*, stating that opinion “stands only for the proposition that Rule 15 does not contemplate adding a new plaintiff to assert a new claim.” *Id.* at 495, 804 S.E.2d at 264 (emphasis added). Here, however, Plaintiffs’ amended complaint asserts the same claims as those contained in the original complaint. There are no new claims; instead, Plaintiffs merely “amend[ed their] complaint to assert the same claim in a new capacity.” *Id.* at 496, 804 S.E.2d at 265; *see also Twelfth RMA Partners, L.P. v. Nat’l Safe Corp.*, 335 S.C. 635, 641, 518 S.E.2d 44, 47 (Ct. App. 1999) (“[Defendants] rely on *Valentine v. Davis*, 319 S.C. 169, 460 S.E.2d 218 (Ct.App.1995) for the proposition that a plaintiff may not add a new plaintiff to a case to assert a claim against the defendant. In this case, however, no new claims are being added. The court is only changing the name of the plaintiff. The subject of the claim . . . is still the same.”). In adding additional putative class representatives as plaintiffs, Defendants suffer no prejudice—they will be forced to defend the same claims, asserted by the same class of plaintiffs, only represented by two additional named class representatives.

Additionally, Plaintiffs’ reading of Rule 15(c) to allow the relation back of Owens’ claims is consistent with the purpose of the rule:

Rule 15(c) is based on the concept that once litigation involving particular conduct or a given transaction or occurrence has been instituted, the parties are not entitled to the protection of the statute of limitations against the later assertion by

amendment of defenses or claims that arise out of the same conduct, transaction, or occurrence as set forth in the original pleading.

*Patton*, 420 S.C. at 496–97, 804 S.E.2d at 265 (quoting *Thomas v. Grayson*, 318 S.C. 82, 88, 456 S.E.2d 377, 380 (1995)).

**3. Defendants misconstrued the Court’s analysis of the voluntary payment doctrine and provide no basis for alteration or amendment of the Order denying dismissal.**

Defendants’ objection to the Court’s ruling regarding the voluntary payment doctrine is unwarranted and results from a misconstruction of, and overreaction to, the Court’s language. In relevant part, the Court ruled,

Under a 12(b) (6) analysis, [the] decision [not to dismiss due to the voluntary payment doctrine] is reasonable given the assertion that payments made by the Plaintiffs were not voluntary, as the Plaintiffs only settled with Mary Black after the hospital asserted unlawful liens against them. Plaintiffs strongly assert that payments made as a result of extortion are not considered voluntary.

Form 4 Order dated Sept. 4, 2020, at 4. Contrary to Defendant’s protestations, this does not amount to a statement, implication, or accusation *by the Court* “that the payments made on behalf of Plaintiff Owens and Plaintiff Brooks were ‘a result of extortion.’” Defendants’ Motion to Alter or Amend, at 6. Instead, the Court merely restated *Plaintiffs’* assertion that the payments were coerced, and Plaintiffs’ assertion was supported by allegations in their Amended Complaint. *See* Response in Opposition to Defendants’ Motions to Dismiss, at 9 (referencing ¶¶ 26, 46, and 52 of the Amended Complaint: “As is shown by these allegations, Mary Black coerced and extorted its patients into making payments the hospital should have billed to the patients’ insurers.”).

The Court properly found Plaintiffs’ allegations, along with the inferences reasonably drawn from those allegations, were sufficient to defeat dismissal with respect to the voluntary payment doctrine, and it did not “create facts and allegations” as Defendants claim. Defendants’ Motion, at 7. *See Brazell v. Windsor*, 384 S.C. 512, 515, 682 S.E.2d 824, 826 (2009) (“If the facts and inferences drawn from the facts alleged in the complaint, viewed in the light most favorable to

the plaintiff, would entitle the plaintiff to relief on any theory, then the grant of a motion to dismiss for failure to state a claim is improper.”).

**4. The Court correctly ruled dismissal of Blackwell’s unjust enrichment claim was inappropriate.**

Plaintiffs reassert in full the arguments made in their Response in Opposition to Defendants’ Motions to Dismiss and maintain that the Court properly denied dismissal of Blackwell’s unjust enrichment claim. Viewing the Complaint as a whole, and in favor of the pleader, Plaintiff Blackwell has adequately pleaded a claim for unjust enrichment. Plaintiffs allege that all Defendants have been unjustly enriched because it would be inequitable to allow them to retain the benefits of their wrongful billing practices while attempting to collect from Plaintiffs a higher amount than they would have received if they had billed Plaintiffs’ insurance companies. The fact that Plaintiffs allege Defendants “assert[ed] liens against Plaintiff Blackwell’s potential third party automobile accident claim,” Amended Complaint ¶ 40, is sufficient for purposes of the pleading stage, and Plaintiff Blackwell’s unjust enrichment claim should be allowed to proceed. *Cf. Beverly v. Grand Strand Reg’l Med. Ctr., LLC*, 429 S.C. 502, 516, 839 S.E.2d 468, 475 (Ct. App. 2020) (noting that Plaintiff’s complaint “alleges affirmative inequitable conduct seeking to deprive her of the benefit of her funds”).

**5. The Court addressed Defendants’ argument regarding Blackwell and the alleged Med-Cost disclaimer of third-party beneficiaries, correctly finding it was beyond the proper scope of a motion to dismiss.**

In reasserting this argument, Defendants continue their attempt to ignore the scope of review for dismissal and improperly interject unpled facts into the Court’s analysis. As Plaintiffs previously noted, Defendants’ argument relies on facts and allegations that do not appear in the Complaint and are taken from a contract that has not been proven to be in force at times relevant to this action. See Response in Opposition to Defendants’ Motions to Dismiss, at 14.

Notwithstanding Defendants' claim that this issue was not addressed, the Court did rule on this issue when it stated its review of the hospital service agreements "was limited to the arbitration issue. Any other consideration of the agreements goes beyond a SCRCF Rule 12(b)(6) analysis." Form 4 Order dated Sept. 4, 2020, at 3. This is an unequivocal ruling on the issue that correctly found Defendants' argument is premature. Accordingly, reconsideration on this ground is unnecessary.

**6. The Court did not err by finding Plaintiffs' Complaint sufficiently pled facts against Defendants to support their claims.**

Defendants argue Plaintiffs' "style of collective pleading is improper," but in doing so, they misconstrue either the effect of Plaintiffs' allegations or applicable South Carolina pleading standards. First, Defendants suggest Plaintiffs' pleadings improperly attempt to attach liability to each defendant; however, Plaintiffs have not alleged any defendant is vicariously liable for the actions of another, nor have Plaintiffs attempted to pierce the corporate veil of any defendant. Instead, Plaintiffs alleged in their Complaint that Defendants acted in concert with one another, and each defendant's liability is the result of its own conduct (although such conduct may mirror that of the other defendants). Accordingly, Defendants' cited authority is inapposite. *See Pertuis v. Front Roe Restaurants, Inc.*, 423 S.C. 640, 654, 817 S.E.2d 273, 280 (2018) (adopting the single business enterprise theory of corporate liability), *reh'g denied* (Aug. 16, 2018); *Pro Slab, Inc. v. Argos USA Corp.*, No. CV 2:17-3185-BHH, 2018 WL 6985008, at \*5 (D.S.C. June 28, 2018) (rejecting the plaintiffs' pleadings, which attempted to establish an agency or alter ego relationship between defendant companies, because the plaintiffs "offer[ed] no *factual allegations* to support" such relationships), *reconsideration granted on other grounds*, No. CV 2:17-3185-BHH, 2018 WL 6985010 (D.S.C. Dec. 3, 2018).

Defendants' alternative suggestion that collective pleading is prohibited or improper in South Carolina is equally incorrect. Defendants cannot point to any case law, statute, or rule of civil procedure prohibiting collective pleading or requiring a plaintiff to repeat allegations against individual defendants when the defendants acted in concert. The cases Defendants cite on this point are not dispositive, and in fact, *Pro Slab* supports Plaintiffs' position. There, the court cited *Connor v. Honeywell Int'l Inc.*, No. CIV.A. 2:12-1421-CWH, 2012 WL 6135193 (D.S.C. Nov. 13, 2012), which found collective Pleading to be proper:

In *Connor*, affiliated corporate defendants sought dismissal of the plaintiff's claims . . . by claiming that it was not clear which defendant or defendants were alleged to have committed which wrong. The court stated that it was "initially inclined to allow the plaintiff an opportunity to amend the complaint to clarify which conduct was attributable to which defendant." *Id.* at \*1. However, after the plaintiff represented that it was his view that the defendants were acting in concert . . . , the court found the complaint adequate. . . . Thus, the factual allegations in the plaintiffs' complaint in *Connor* supported the assertion that the defendants acted together. In contrast, here, Plaintiffs' amended complaint merely alleges the legal conclusion that the affiliated corporate entities were agents and/or alter egos and operated as one company, but the amended complaint contains *no factual allegations* to support that legal conclusion.

*Pro Slab, Inc.* 2018 WL 6985008, at \*5. Defendants' other cited authority similarly offers no support to their position. See *Scurmont LLC v. Firehouse Rest. Grp., Inc.*, No. 4:09-CV-00618-RBH, 2010 WL 11433199, at \*15 (D.S.C. May 19, 2010) (finding a lack of specific personal jurisdiction over an individual defendant because the plaintiff failed to plead facts demonstrating the defendant committed wrongful acts within South Carolina). Accordingly, the Court did not err by finding Plaintiffs sufficiently pled the allegations in their Complaint.

### CONCLUSION

Based upon the foregoing, the Court should deny Defendants' Motion to Alter or Amend and adhere to its previously-entered Order denying Defendants' Motions to Dismiss.

Respectfully submitted,

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Spartanburg, South Carolina  
October 9, 2020

STATE OF SOUTH CAROLINA )  
COUNTY OF SPARTANBURG )

IN THE COURT OF COMMON PLEAS  
SEVENTH JUDICIAL CIRCUIT

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

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

Plaintiffs, )

**DEFENDANTS' REPLY TO  
PLAINTIFF'S RESPONSE IN  
OPPOSITION TO THE MOTION TO  
ALTER OR AMEND**

v. )

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

Defendants. )

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Defendants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital (“Mary Black”), CHSPSC, LLC (“CHSPSC”), and Professional Account Services, Inc. (“PASI”) (collectively, “Defendants”) hereby submit this Reply to Plaintiffs Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr.’s (collectively, “Plaintiffs”) Response in Opposition to Defendants’ Motion to Alter or Amend. For the reasons stated in Defendants’ Motion to Alter or Amend, as well as those points and authorities set forth herein, Defendants’ Motion to Alter or Amend should be granted.

**I. A Rule 59(e) Motion to Alter or Amend provides the Court with a proper avenue to amend an interlocutory order.**

Defendants’ Motion to Alter or Amend properly requests the Court alter or amend the prior order denying the Motion to Dismiss and/or Compel Arbitration. A Rule 59(e) motion to alter or amend is “a vehicle to seek ‘reconsideration’ of issues and arguments.” *Elam v. S.C. Dep’t of Transp.*, 361 S.C. 9, 21, 602 S.E.2d 772, 778 (2004). In a motion to alter or amend, a party may “ask the court to reconsider its decision even if it means rehashing all or part of an argument previously presented.” *Id.* at 21, 602 S.E.2d 772, 778-79; *see Arnold v. State*, 309 S.C. 157, 420

S.E.2d 834 (1992) (“purpose of Rule 59(e), SCRCp, to alter or amend the judgment is to request the judge to reconsider matters properly encompassed in a decision on the merits”).

The *Collins Music Co. v. IGT*, 353 S.C. 559, 560-61, 579 S.E.2d 524, 524 (Ct. App. 2002) case cited by Plaintiffs does not stand for the proposition that a court may not reconsider previously ruled upon arguments in deciding a Rule 59(e) Motion to Alter or Amend. That case involved a party who timely filed and served post-trial motions pursuant to Rule 50(b) and Rule 59 and then subsequently filed a Rule 59 motion that restated the same arguments previously raised in the other Rule 59 post-trial motions. *Id.* The issue in that case was the timing of the filing of the Notice of Appeal—not the proper scope of review of a Rule 59(e) Motion to Alter or Amend.

## **II. Plaintiff Owens’s claims are subject to the arbitration requirement in the CIGNA Agreement.**

### **A. Plaintiff Owens is admittedly seeking to enforce and to take a benefit from the CIGNA Hospital Services Agreement.**

Plaintiff Owens undeniably bases his claims on the proposition that he is entitled to the direct benefits of the billing terms and procedures and the discounted billing rates created by the CIGNA Agreement with Mary Black. Those payment terms do not exist or arise from any other source. As admitted by Plaintiff Owens in his response to the Defendants’ Motion to Alter or Amend, “Plaintiffs’ success on [their claim for injunctive relief] admittedly relies on the hospital services agreement.” [Plaintiffs’ Response p. 6]. This admission resolves the question of whether Plaintiff Owens is attempting to enforce and take a direct benefit from the CIGNA Agreement—which contains a valid and enforceable arbitration provision. Thus, when Plaintiff Owens bases his claims on a purported entitlement to the benefits of those billing terms and discounted rates arising from the CIGNA Agreement, the doctrine of direct benefits estoppel binds him to all of the terms of the CIGNA Agreement—including the arbitration provision. *See Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 290, 733 S.E.2d 597, 601 (Ct. App. 2012).

Plaintiff Owens falsely argues, with no support, that his claims are “grounded on independent South Carolina law;” however, Plaintiff Owens points to no law that creates an obligation for Mary Black to submit bills directly to CIGNA or for Mary Black to bill Plaintiff Owens at the discounted rates agreed to between Mary Black and CIGNA in the CIGNA Agreement.

Plaintiff Owens’s claims for unjust enrichment and tortious interference with contractual relations likewise are premised on his assertions to take a direct benefit of the CIGNA Agreement. For example, Plaintiff Owens claims Defendants were unjustly enriched by retaining any other payment for his medical services, because, according to Plaintiff Owens, Defendants should have billed and accepted payment pursuant to the terms of the CIGNA Agreement and at the discounted rates from CIGNA. Any obligation for Mary Black to bill and accept payment from CIGNA was created solely by the agreement between CIGNA and Mary Black. There is no other source or independent legal duty for such terms.

Plaintiff Owens’s claims which are uniquely based on the CIGNA Agreement distinguishes this case from the *Weaver v. Brookdale Senior Living, Inc.*, 847 S.E.2d 268, 271 (S.C. Ct. App. 2020) and *Wilson v. Willis*, 426 S.C. 326, 335, 827 S.E.2d 167, 172 (2019) cases cited by Plaintiffs. Those cases did not involve plaintiffs attempting to take a direct benefit from a contract, or to enforce the terms of the contract while also avoiding the contract’s arbitration provision.

Plaintiff Owens specifically argues to the Court that he was “harmed by a failure to act in accordance with the contract.” [Plaintiffs’ Response p. 2]. This is simply another express acknowledgment that Plaintiff Owens’s claims seek to enforce the CIGNA Agreement and recover for a purported injury that he alleges was caused by a failure to act in accordance with the CIGNA Agreement. Therefore, Plaintiff Owens’s claims are the exact type of claims that are subject to direct benefits estoppel. Accordingly, Plaintiff Owens is bound by all of the terms of the CIGNA

Agreement, including its arbitration provision, and the Court must compel Plaintiff Owens to arbitrate his claims against the Defendants.

**B. The arbitration provision in the CIGNA Agreement applies and requires the Court to compel a non-signatory, like Plaintiff Owens, to arbitrate his claims pursuant to the CIGNA Agreement's arbitration provision when he seeks to enforce and to take benefit from the other provisions of that Agreement.**

Plaintiffs are certainly correct in finally admitting that they are not parties to the Hospital Service Agreements between Mary Black and their health insurance companies. Since Plaintiffs are not parties to those Agreements, they have no rights under those Agreements and no rights to sue to enforce the terms of those Agreements.

However, Plaintiffs are attempting to enforce the terms of those Agreements and to sue Mary Black to gain benefit from the terms of those Agreements. Having admitted they are not parties to the Agreements, the sole basis for pursuing the claims is on the premise they are direct beneficiaries of those Agreements. While Defendants vehemently dispute that Plaintiffs are, or can be, direct beneficiaries of those Agreements, if Plaintiffs pursue claims dependent on that status, they are then bound by all of the other terms of the Agreement for which they claim beneficiary status. This means they are bound by the arbitration provisions—and, specifically, Plaintiff Owens is bound by the arbitration terms in the CIGNA Agreement.

In a case with similar operative facts and issues, *Benton v. Vanderbilt University*, 137 S.W.3d 614, 619 (Tenn. 2004), the Tennessee Supreme Court addressed a non-signatory plaintiff's ("Benton") claim against a hospital ("Vanderbilt") based upon the hospital's alleged billing practices. The court specifically addressed the plaintiff's obligation to arbitrate under the agreement from which plaintiff sought to derive the claim rights. Benton was insured by Blue Cross Blue Shield ("BCBS"), and Vanderbilt Hospital provided medical services to Benton after Benton suffered injuries in an automobile accident. *Id.* at 616. Vanderbilt and BCBS had a

hospital services agreement between them like the CIGNA Agreement. The agreement provided that Vanderbilt would bill BCBS for the medical services rendered to BCBS insureds (like Benton) at discounted rates. *Id.* Benton later filed a lawsuit against the at-fault driver for the personal injuries he suffered in the accident, but Vanderbilt then sought to collect the amount of the hospital expenses that had not been paid by BCBS and filed a statutory Notice of Hospital Lien against any monetary recovery that Benton might receive from the at-fault driver (a collection practice that is known as balance billing). *Id.* As a result of Vanderbilt's collection actions, Benton filed a complaint asserting claims against Vanderbilt for abuse of process, breach of contract, and violation of the Tennessee Consumer Protection Act on the grounds that Vanderbilt had agreed to accept payment in full from BCBS based on the hospital services agreement between Vanderbilt and BCBS. *Id.* In response to the Complaint, Vanderbilt moved to compel Benton to arbitrate his claims pursuant to the arbitration provision in the contract between Vanderbilt and BCBS. *Id.* On appeal, the Tennessee Supreme Court held that Benton was a third-party beneficiary attempting to enforce the contract between Vanderbilt and BCBS and Benton was bound by all of that agreement's terms—including the arbitration provision. *Id.* at 620. Accordingly, the Tennessee Supreme Court compelled Benton to arbitrate his claims against Vanderbilt pursuant to the hospital services agreement between BCBS and Vanderbilt. *Id.*

Significantly, in that case Benton argued that he was not subject to the arbitration provision because it only applied to the "parties to the agreement" and he was not a party to the agreement between Vanderbilt and BCBS. *Id.* at 619. The Tennessee Supreme Court rejected this argument and agreed with the courts of Alabama, Pennsylvania, and Maryland, all of which relied on *Williston on Contracts* as well as the Restatement (Second) of Contracts, to find that as a third-party beneficiary attempting to enforce the hospital services agreement is a "party" to that agreement for the purpose of enforcing the agreement's arbitration provision. *Id.*

Like the plaintiff in *Benton*, Plaintiff Owens's claims are based upon the fundamental assertion that Defendants are obligated by the terms of the hospital services agreement to bill his health insurance provider (CIGNA) at discounted rates, and Defendants may not seek to recover payment for the medical services rendered to Plaintiff Owens through his recovery from an at-fault driver's insurance carrier. Plaintiff Owens's claims are absolutely and fundamentally dependent upon the alleged obligation that Defendants bill CIGNA at discounted rates, and not attempt any billing to, or collection from Plaintiff Owens. That obligation—if it exists at all—is created by the CIGNA Agreement between Mary Black and CIGNA. Therefore, as a third-party beneficiary seeking to enforce the CIGNA Agreement, Plaintiff Owens is subject to all the terms and conditions of the CIGNA Agreement (including the arbitration provision). Accordingly, the Court must alter or amend its order denying Defendants' Motion to Compel Arbitration and compel Plaintiff Owens to arbitrate his claims against Defendants pursuant to the CIGNA Agreement's arbitration provision.

**III. Plaintiff Owens's claims do not relate back to Plaintiff Blackwell's filing of the original complaint and are barred by the applicable statute of limitations and should be dismissed.**

**A. Plaintiff Owens is a new plaintiff, asserting new claims, based on new facts and, therefore, his claims do not relate back to Plaintiff Blackwell's filing of the original complaint.**

This matter was originally filed by Plaintiff Blackwell on January 20, 2017. Plaintiff Blackwell's claims relate to her personal circumstances, as alleged, and she sought to represent a "class" of similarly situated persons. Her claims are each premised on the idea that Mary Black owed obligations to her based on the agreement between Mary Black and her health insurance provider (MedCost). It is fundamental that a plaintiff cannot pursue claims for a class of persons in different circumstances from herself. *See Bailey v. Patterson*, 369 U.S. 31, 32-33, 82 S. Ct. 549, 550, (1962) (stating that a named plaintiff "cannot represent a class of whom they are not a part.");

see also *In re Glob. Crossing, Ltd. Sec. Litig.*, 313 F. Supp. 2d 189, 207 (S.D.N.Y. 2003) (“It is well established that a plaintiff seeking to represent a class must be a member of the class he purports to represent.”). Thus, Plaintiff Blackwell can only be the representative of a class of persons covered by MedCost or the agreement between Mary Black and MedCost. Neither Plaintiff Owens, nor Plaintiff Brooks, have any connection to MedCost or the MedCost Agreement and they could not be members of the class Plaintiff Blackwell allegedly represents. Thus, when Plaintiff Owens was added as a party to this case on April 24, 2020, when Plaintiff Blackwell amended her original complaint to add Plaintiff Owens as a named plaintiff, he brought new claims into the case. The issue presently before the Court is whether Plaintiff Owens’s claims relate back to Plaintiff Blackwell’s filing of the original complaint. They do not and cannot.

Rule 15(c) of the South Carolina Rules of Civil Procedure governs the relation back of a pleading. *Jackson v. Doe*, 342 S.C. 552, 558, 537 S.E.2d 567, 570 (Ct. App. 2000). Rule 15(c) and its relation back provision only apply, and may only validate a relation back argument, to a substitution or change in a party. *Id.* “[T]he addition of a party is not the same as a substitution or change of party.” *Id.* The addition of a new party is not contemplated by Rule 15(c), and does not relate back. *Gause v. Smithers*, 384 S.C. 130, 133, 681 S.E.2d 607, 609 (Ct. App. 2009).

Plaintiff Owens is a new party, with new claims, added to this lawsuit on April 24, 2020. Plaintiff Owens’s addition to this lawsuit expanded the litigation, not only to his separate claims, but also a new putative class to include patients covered by CIGNA health insurance policies. Plaintiff Owens asserts new claims based upon the application and enforcement of the CIGNA Agreement, to which Blackwell has no relation. Plaintiff Owens’s claims were not, and could not have been, a part of Plaintiff Blackwell’s original complaint.

Plaintiff Owens is not a substitute Plaintiff for Blackwell, and he is not a change from Blackwell. The argument that his claims are “materially unchanged from those in the original

Complaint” and “arose out of the conduct, transaction or occurrence set forth or attempted to be set forth in the original pleadings” is patently false. [Plaintiffs’ Response p. 10]. Plaintiff Owens could not even have been a member of the putative class alleged by Plaintiff Blackwell. Plaintiff Blackwell does not have standing to represent Plaintiff Owens, or his claims which are derived from the CIGNA Agreement. Plaintiff Blackwell does not have standing to enforce the CIGNA Agreement because she is not covered by a CIGNA health insurance policy and she is not a third-party beneficiary of the CIGNA Agreement. The United States Supreme Court and South Carolina courts have repeatedly recognized that a named plaintiff must have standing to represent the unnamed class members and must possess the same interest and have suffered the same injury as the unnamed class members. *See Bailey*, 369 U.S. at 32-33, 82 S. Ct. at 550; *E. Tex. Motor Freight Sys., Inc. v. Rodriguez*, 431 U.S. 395, 403 (1977) (collecting cases); *Berry v. McLeod*, 328 S.C. 435, 447 n.2, 492 S.E.2d 794, 800 n.2 (Ct. App. 1997); *Edisto Fleets, Inc. v. S.C. Tax Comm’n*, 256 S.C. 350, 354, 182 S.E.2d 713, 714 (1971). Plaintiff Blackwell lacks the ability to pursue the claims now asserted by Plaintiff Owens.

Therefore, the addition of Plaintiff Owens to this litigation added new claims that are being asserted by a new party. Claims asserted by parties added to a case do not relate back to the original filing of the complaint. *See Jackson*, 342 S.C. at 558, 537 S.E.2d at 570; *Gause*, 384 S.C. at 133, 681 S.E.2d at 609. Accordingly, Plaintiff Owens’s claims are barred by the applicable statutes of limitation because his claims do not relate back to Plaintiff Blackwell’s filing of the original complaint.

#### **IV. Plaintiff Blackwell does not allege she conferred a benefit to Defendants.**

It is not disputed that South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: “(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under

conditions that make it unjust for him to retain it without paying its value.” *Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994).

Plaintiff Blackwell’s claim for unjust enrichment—according to the Amended Complaint and Plaintiffs’ Response in Opposition to the Motion to Alter or Amend—is based upon the allegation that Defendants “assert[ed] liens against Plaintiff Blackwell’s potential third party automobile accident claim.” [Plaintiffs’ Response P. 13; Amended Complaint ¶ 40]. However, a claim for unjust enrichment seeks to have a defendant return a benefit that would be inequitable for the defendant to retain. *Columbia Wholesale*, 312 S.C. at 261, 440 S.E.2d at 130. Plaintiff Blackwell cannot state a claim for unjust enrichment unless she can and does allege that she actually conferred a benefit that can and must be returned. She has utterly failed to make such an allegation. Indeed, she cannot make such an allegation because she never did confer any benefit upon Mary Black or the other Defendants. There is no factual allegation in either of Plaintiff Blackwell’s Complaints that Defendants retain possession of anything belonging to Plaintiff Blackwell. The only allegation by Plaintiff Blackwell is that Defendants asserted a lien against her potential third-party automobile accident claim. [Plaintiffs’ Response P. 13; Amended Complaint ¶ 40]. A lien does not transfer a property interest. *See Horry Cty. v. Ray*, 382 S.C. 76, 83-84, 674 S.E.2d 519, 523-24 (Ct. App. 2009) (“An equitable lien is neither an estate or property in the thing itself, nor a right to recover the thing” (citation and internal quotation marks omitted)); *Matter of Hinson*, 20 B.R. 753, 758 (Bankr. D.S.C. 1982) (a judgment lien “does not operate to give a judgment creditor a property interest in specific property” and “does not constitute a taking of property”). Thus, the mere existence of a lien is not a conference of benefit.

Plaintiff Blackwell makes no allegations through which the Court could award her restitution—the remedy for a claim for unjust enrichment—because Plaintiff Blackwell has conferred nothing to the Defendants and Defendants owe nothing to Plaintiff Blackwell.

Therefore, Plaintiff Blackwell's claim for unjust enrichment fails as a matter of law and the Court should alter or amend its Order to dismiss Plaintiff Blackwell's claim for unjust enrichment.

**V. The Court failed to address the argument that Plaintiff Blackwell is barred from enforcing the terms of the MedCost Agreement pursuant to the Agreement's express disclaimer of third-party beneficiaries.**

Defendants' Motion to Dismiss and/or Compel Arbitration raised the argument that Plaintiff Blackwell's claims fail because she is not a third-party beneficiary with the right to enforce the MedCost Agreement. The Court's order denying Defendants' Motion to Dismiss and/or Compel Arbitration failed to address this argument despite the fact that the entirety of Plaintiff Blackwell's claims are dependent upon Mary Black's contract with MedCost and her alleged ability to enforce its terms. The Court's order denying Defendants' Motion to Dismiss and/or Compel Arbitration states that "[t]he allegations are that Defendants regularly refused to submit medical bills to patients' health insurance carriers and instead sought payment directly from the patients themselves. This was done despite the hospital's contracts with health insurance carriers . . . ." Thus, the MedCost Agreement is clearly integral to the Amended Complaint and essential to all of Plaintiff Blackwell's claims.

In reviewing a motion to dismiss pursuant to Rule 12(b)(6), the Court may consider a document that is incorporated into the complaint, attached to the complaint, or integral to the complaint. See *Carolina First Corp. v. Whittle*, 343 S.C. 176, 190 n.7, 539 S.E.2d 402, 410 n.7 (Ct. App. 2000) (incorporate by reference); *Brazell v. Windsor*, 384 S.C. 512, 516, 682 S.E.2d 824, 826 (2009) (incorporate by reference); *HHHunt Corp. v. Town of Lexington*, 389 S.C. 623, 629-30, 699 S.E.2d 699, 701-02 (Ct. App. 2010) (attached to the complaint); *Patterson v. Witter*, 425 S.C. 213, 235, 821 S.E.2d 677, 689 (2018) (reviewing a Rule 23 demand letter that was not attached or incorporated into the Amended Complaint and citing *L-7 Designs, Inc. v. Old Navy, LLC*, 647 F.3d 419, 422 (2d Cir. 2011) which explains that a complaint may be "deemed to include

any written instrument attached to it as an exhibit, materials incorporated in it by reference, and documents that, although not incorporated by reference, are ‘integral’ to the complaint”); *see also* 61A Am. Jur. 2d Pleading § 529 (“A court may also consider an undisputedly authentic document that a defendant attaches as an exhibit to a motion to dismiss if the plaintiff’s claims are based on the document.”).

Plaintiff Blackwell alleges she has the right to enforce the terms of the MedCost Agreement for her own goals and benefit. However, Plaintiff Blackwell is not a party to the MedCost Agreement and she is not an intended third-party beneficiary who can sue to enforce that Agreement for her own benefit. As raised in the Motion to Dismiss, the MedCost Agreement plainly and directly expresses Mary Black and MedCost’s intent to bar third-parties from enforcing the MedCost Agreement. The Court’s Order does not address or decide this issue raised in the Motion, despite the law clearly establishing that the Court’s determinative step in reviewing the MedCost Agreement is to review and give effect to its plain and unambiguous language. *See Whitlock v. Stewart Title Guar. Co.*, 399 S.C. 610, 614, 732 S.E.2d 626, 628 (2012).

The plain and unambiguous language of the MedCost Agreement compels the finding that Mary Black and MedCost did not express, and did not have, an intent to allow Plaintiff Blackwell to enforce the MedCost Agreement as a third-party beneficiary. *See Windsor Green Owners Ass’n, Inc. v. Allied Signal, Inc.*, 362 S.C. 12, 19, 605 S.E.2d 750, 753 (Ct. App. 2004). Since Plaintiff Blackwell lacks standing to enforce the MedCost Agreement as a third-party beneficiary, she lacks standing to enforce the terms of the agreement and pursue any of her alleged claims. Therefore, as a matter of law, Plaintiff Blackwell’s claims must be dismissed. Accordingly, the Court erred in failing to address this issue because it is determinative of the claims asserted by Plaintiff Blackwell.

### **CONCLUSION**

Based on the foregoing, Defendants request the Court alter or amend its Order and dismiss Plaintiffs' Amended Complaint on the grounds that Plaintiffs have failed to allege facts sufficient to constitute a cause of action, or in the alternative, compel Plaintiff Owens to arbitrate his claims against Defendants.

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