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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

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

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

Respondents,

v.

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

Appellants,

APPELLANTS' REPLY BRIEF

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INTRODUCTION

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 reply to the arguments presented by Respondents Jo Ann Blackwell, Samuel Owens, and Michelene Brooks (collectively, "Plaintiffs") in this matter. Plaintiffs' arguments are misplaced and incorrect. For the reasons set forth in Defendants' Appellants' Brief, and reiterated here, the Court should issue an order reversing the circuit court, compelling Owens to arbitrate his claims against Defendants, and dismissing the claims asserted by each of the Plaintiffs.

ARGUMENTS IN REPLY

I. The circuit court erred in failing to compel Owens to arbitrate his claims pursuant to the arbitration provision in the CIGNA Agreement.

Owens's claims against Defendants, if they exist at all, are subject to mandatory arbitration. Owens's alleged claims in the Amended Complaint against Mary Black, PASI and CHSPSC are clearly derived from provisions in the agreement between Mary Black and CIGNA (Owens's health insurer), and those claims are dependent upon Owens's enforcement of those terms in the CIGNA Agreement. Under such circumstances, Owens is equitably estopped from avoiding the application of the arbitration provision in the CIGNA Agreement.

When 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 v. Hilton Head Hosp.*, 400 S.C. 281, 288, 733 S.E.2d 597, 600 (Ct. App. 2012). Whether the circuit court erred in failing to compel Owens to arbitrate his claims against Defendants is controlled by the determination of whether Owens's claims seek to take a direct benefit from the CIGNA Agreement. If the Court finds that Owens is seeking to take benefit and

enforce the CIGNA Agreement, then the Court must reverse the circuit court and compel Owens to arbitrate his claims.

To confirm that Owens does seek to enforce and to take direct benefit from the CIGNA Agreement, the Court need only review what Owens has alleged and argued. Owens makes the following allegations in the Amended Complaint demonstrating that he is attempting to take a direct benefit from and to enforce the CIGNA Agreement (a contract between Mary Black and a health insurance carrier) as a non-signatory third-party beneficiary:

> Paragraph 28: Upon information and belief, **Defendants are required by <u>their contracts with patients' health insurance carriers</u>** to submit insurance patients' medical bills directly to the carriers. . . .
>
> Paragraph 29: **Defendants are required to <u>honor a contractual discount with their patients' health insurance carriers</u>** and accept discounted payments from those health insurance carriers in full satisfaction of the patients' debts.
>
> Paragraph 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 <u>contracts with health insurance providers</u> and health plans for reduced compensation for treating patients who have health insurance**.
>
> Paragraph 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 <u>agreed to accept from patients' health insurance</u>**.

(R. 68-69) (emphasis added).

Each of these so-called factual allegations in the Amended Complaint demonstrate the *sine qua non* of Owens's claims is the alleged obligation of the Defendants created by and existing exclusively under the express CIGNA Agreement between Mary Black and CIGNA to send bills directly to the health insurance carrier, CIGNA. In other words, the essential element of Owens's entire Amended Complaint is the assertion that Defendants have a contractual obligation with the

health insurer, CIGNA, to bill patients and the insurance carrier in a certain manner. That manner of billing is controlled by the contractual agreement with the insurance carrier. In Owens's particular case, that agreement is the CIGNA Agreement.

Furthermore, in an effort to support the existence of a class of unnamed plaintiffs that he seeks to represent, Owens alleges the following are "principle common issues" between his claims and those of the purported class:

> a. **Whether Defendants entered into <u>express and/or implied agreements with various health insurance carriers</u>** providing, among other things, that health insurance claims should be promptly submitted to the carriers for payment;
>
> b. **Whether Defendants violated their <u>contracts with various health insurance carriers</u>** by not submitting medical bills to the carrier;
>
> c. **Whether Defendants violated their <u>contracts with various health insurance carriers</u>** 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 <u>contracts with various health insurance carriers</u>** by not offering a contractually agreed discount to patients covered by said policies

(R. 72-73) (emphasis added).

In support of his alleged cause of action for unjust enrichment Owens alleges, "[i]t 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**." (R. 76) (emphasis added).

In support of his alleged cause of action for injunctive relief, Owens alleges:

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

> Paragraph 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
>
> Paragraph 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**.

(R. 77).

Finally, in his brief to this Court, Owens concedes that his "success on [his claim for injunctive relief] admittedly relies on the hospital services [CIGNA] agreements. . . ." and ". . . one of Owens' claims relies on the health services [CIGNA] agreements . . . ." (Resp. Br. p. 13). Owens also argues that "he was harmed by Mary Black's failure to act in accordance with the contract" and, therefore, "he has been forced to bring this action." (Resp. Br. p. 11).

Despite the multitude of allegations in the Amended Complaint plainly predicated specifically upon the enforcement of the terms of the CIGNA Agreement, and Owens's admissions in his brief to this Court, Owens now tries to argue that his claims for unjust enrichment and tortious interference with contractual relations "do not rely upon the Mary Black services [CIGNA] agreement for recovery." (Resp. Br. p. 12). However, Owens points to no other predicate for an obligation by Defendants to submit bills directly to CIGNA other than the CIGNA Agreement.

All of Owens's allegations and admissions establish undeniably that that he is attempting to enforce and take a direct benefit from the CIGNA Agreement. That agreement contains a valid and enforceable arbitration provision. When 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.

Owens's claims, which in this case are uniquely based on the CIGNA Agreement, distinguish this case from the *Weaver v. Brookdale Senior Living, Inc.*, 847 S.E.2d 268, 271 (Ct. App. 2020) and *Wilson v. Willis*, 426 S.C. 326, 335, 827 S.E.2d 167, 172 (2019) as cited by Owens. Those cases did not involve plaintiffs attempting to take a direct benefit from a contract, or to enforce the terms of the contract, while nonetheless seeking to avoid the contract's arbitration provision.

In *Weaver*, the plaintiff's grandmother died after wandering out of a nursing home and being attacked by an alligator. The plaintiff (Weaver) filed a lawsuit in her individual capacity against the defendant nursing home (Brookdale) asserting claims for negligence, negligent infliction of emotional distress, and intentional infliction of emotional distress. *Weaver*, 431 S.C. at 227-28, 847 S.E.2d at 270-71. It was undisputed that Weaver's grandmother executed a residency agreement with Brookdale and that agreement contained an arbitration provision. *Id.* at 228, 847 S.E.2d at 271. In response to Weaver's complaint, Brookdale moved to compel Weaver's claims to arbitration pursuant to the arbitration provision in the residency agreement. *Id.* In support of its motion to compel arbitration, Brookdale argued that Weaver, a non-signatory to the residency agreement, was equitably estopped from avoiding the application of the residency agreement's arbitration provision. *Id.* The court held that Weaver's claims relied on "general tort duties owed by [Brookdale] to everyone, not any provision of the residency agreement" and the duties that Weaver was suing to enforce did not flow from the residency agreement. *Id*. at 232, 847 S.E.2d at 273. On this basis, the court found that Weaver had not exploited or otherwise sought to enforce or procure any direct benefit specifically arising from the residency agreement. *Id.* Therefore, the court affirmed the denial of Brookdale's motion to compel arbitration. *Id.*

In *Wilson*, insureds and competing insurance agents asserted claims against an insurance agent (Willis), the insurance broker who hired her, their insurance agency (Southern Risk), and

several insurance carriers that contracted with Southern Risk based upon alleged fraudulent actions related to the provision of insurance to the insured and the operation of an insurance agency. *Wilson*, 426 S.C. at 332, 827 S.E.2d at 170. Three of the insurance carriers moved to compel the entire action to arbitration based upon their agency agreements with Southern Risk which controlled only the business relationship between Southern Risk and those insurance carriers. The court found that the plaintiffs' claims did not involve them suing to enforce or obtain a benefit from the agency agreement between Southern Risk and the insurance carriers. Therefore, the court held that the doctrine of direct benefits estoppel did not apply to the plaintiffs' claims and affirmed the circuit court's denial of the carrier's motions to compel arbitration. *Id.* at 345-46, 827 S.E.2d at 177-78.

In contrast to *Weaver* and *Wilson*, Owens is specifically attempting to enforce and take direct benefit from the CIGNA Agreement. All of his claims are based upon the enforcement of the billing procedures and the negotiated rates that are created solely from the CIGNA Agreement. Unlike the claims in *Wilson* and *Weaver*, Owens has no claim that is not based upon the enforcement of the terms of the CIGNA Agreement. Therefore, Owens's claims are the exact type of claims that are subject to direct benefits estoppel. Accordingly, Owens is bound by all of the terms of the CIGNA Agreement, including its arbitration provision. The Court must reverse the circuit court and compel Owens to arbitrate his claims against the Defendants.

II. The Court should exercise its discretion to review and decide the issues of law presented by this appeal.

While in this case the appeal of the Order denying Defendants' Motion to Compel Arbitration is a matter of right, there are also compelling justifications for the Court to exercise its discretion and to decide the appeal of the other issues presented by the circuit court's order denying

Defendants' Motion to Dismiss the various claims of not only Owens but the other two Plaintiffs (Blackwell and Brooks).

It is well-established that the Court has complete discretion to review a denial of a motion to dismiss when considered with another appealable issue also before the Court. *See FOC Lawshe Ltd. P'ship v. Int'l Paper Co.*, 352 S.C. 408, 413, 574 S.E.2d 228, 231 (Ct. App. 2002). In *FOC Lawshe Limited Partnership v. International Paper Company*, 352 S.C. 408, 412, 574 S.E.2d 228, 230 (Ct. App. 2002), the court reviewed an order denying the plaintiff's motion for a temporary injunction (an immediately appealable issue) and, at the same time, exercised its discretion to review a separate order denying the defendant's motion to dismiss the plaintiff's nuisance claim. The court stated that it could review the denial of the defendant's motion to dismiss because "an order that is not directly appealable can be considered if there is an appealable issue before the court." *FOC Lawshe*, 352 S.C. at 413 n.1, 574 S.E.2d at 231, n.1 (citing *Cox v. Woodmen of World Ins. Co.*, 347 S.C. 460, 469, 556 S.E.2d 397, 402 (Ct. App. 2001)). In *FOC Lawshe*, the party appealing the motion to dismiss was not even the same party appealing the immediately reviewable order. Nevertheless, the Court of Appeals used its discretion to consider whether the circuit court erred in denying the defendant's motion to dismiss at the same time that it reviewed whether the circuit court properly denied the plaintiff's motion for TRO. In *FOC Lawshe*, the court simply stated that it could review the denial of the motion to dismiss because there was an immediately appealable issue before the court. *See id*.

Other courts exercising the same discretion have stated that a court may exercise its discretion and review the denial of the motion to dismiss when presented with other immediately appealable issues if immediate review promotes judicial economy, narrows issues for trial, or potentially avoids unnecessary litigation. *See Edge v. State Farm Mut. Auto. Ins. Co.*, 366 S.C. 511, 517, 623 S.E.2d 387, 390 (2005); *Hite v. Thomas & Howard Co.*, 305 S.C. 358, 360, 409

S.E.2d 340, 341 (1991), *overruled on other grounds by Huntley v. Young,* 319 S.C. 559, 462 S.E.2d 860 (1995); *Cox*, 347 S.C. at 469, 556 S.E.2d at 402. Specifically, in *Edge*, 366 S.C. at 517, 623 S.E.2d at 390, the court exercised its discretion to consider the defendant's (State Farm) cross-appeal of the denial of its motion to dismiss concurrently with the plaintiff's appeal of another immediately reviewable order granting a co-defendant's motion to dismiss. The court stated that it would consider State Farm's cross-appeal of the denial of its motion to dismiss because immediate review could "avoid another appeal in the future and potentially narrow the issues for trial (i.e. judicial economy)." *Edge*, 366 S.C. at 517, 623 S.E.2d at 390.

Similarly, in *State v. Bonner*, 400 S.C. 561, 567, 735 S.E.2d 525, 527-28 (Ct. App. 2012), the court exercised its discretion to review an unpreserved argument because immediate review was in the interest of judicial economy. The court explained that immediate review of an otherwise unripe issue is "in the interest of judicial economy when the issue would be raised to the court at some future time and both parties had fully briefed the issue." *Bonner*, 400 S.C. at 567, 735 S.E.2d at 527-28.

In this case, judicial economy favors immediate review of all of the issues raised by Defendants. At issue in the Motions to Dismiss are fundamental questions about whether these Plaintiffs have any cognizable claims which could justify protracted and expensive proceedings. Worse, in this case Plaintiffs purport to represent and pursue these invalid claims on behalf of a class of people. The litigation, which involves issues of medical care and billing, will also invade the rights and privacy of the alleged class members. Surely, the threshold examination of the issues as to whether such claims even exist is critical in this case to protect and promote judicial economy, the interest of justice and control of the legitimate scope of any further litigation. The Court's review of all of the issues on appeal will eliminate the need for further proceedings, regardless of forum, and such review likely will eliminate or narrow issues for trial and resolve

important issues related to the scope of claims for further litigation. In the following sections, specific examples of why such immediate review is warranted in this case are highlighted. Therefore, the proper elimination of any claim by any of the Plaintiffs will have a dramatic impact on the scope of this litigation and any trial.

Furthermore, as stated in *Edge*, 366 S.C. at 517, 623 S.E.2d at 390, judicial economy favors immediate review of an issue if that review may eliminate the need for another appeal in the future. Defendants' appeal requests the Court exercise its discretion to review questions of law arising out of the Plaintiffs' pleadings. Those issues have been briefed by all parties and are ripe for immediate consideration by this Court. Other than Plaintiffs' desire to avoid this Court deciding the legal sufficiency of their claims, there is no valid or logical reason for delay of this Court's review of the Plaintiffs' claims which fail as a matter of law on the face of the Amended Complaint.

A. The circuit court erred in failing to dismiss Owens's claims because Owens's claims do not relate back to Blackwell's filing of the original complaint, and they are time barred.

In this case, Owens does not have surviving viable claims to litigate or arbitrate. His claims are stale and barred, as a matter of law, by the applicable limitations periods. Owens was not a party to this litigation, or a plaintiff, when the action was commenced on January 20, 2017. Neither he, nor his claims were mentioned or described in any way in the Complaint filed by Blackwell on that date.

Blackwell's claims in the original complaint relate only to her individual and personal circumstances, and are each premised on the proposition that Defendants owed obligations to her based on the terms of the MedCost Agreement which was a hospital services agreement exclusively between Mary Black and the insurance provider, MedCost. (R. 23-39). Blackwell only moved to amend her complaint, and in that Amended Complaint to add Owens and Brooks as parties, on October 18, 2019. (R. 121). In her Amended Complaint, Blackwell also changed

and broadened the definition of the purported class—which had not been certified and whose unnamed putative members were not parties to this litigation. (R. 31; 52; 72).

Thus, Owens was a new party, with new claims, who was added to this lawsuit when Blackwell filed her Amended Complaint on April 24, 2020. 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. (Resp. Br. p. 23-24). Prior to his addition to the lawsuit, there was no claim for unjust enrichment based upon the enforcement of the rates negotiated in the CIGNA Agreement; there was no claim for an injunction to enforce the CIGNA Agreement; and there was no claim for tortious interference with a contractual relationship involving the purported breach of a CIGNA insurance policy. Owens's claims were not, and could not have been, a part of Blackwell's original complaint because she is not and cannot assert claims to enforce any CIGNA contract because she has alleged no relationship, contractual or otherwise, with CIGNA.

Rule 15(c), SCRCP, 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) does not apply to the addition of a new party. *See id.*; *Gause v. Smithers*, 384 S.C. 130, 133, 681 S.E.2d 607, 609 (Ct. App. 2009). Thus, the claims of a newly added plaintiff—such as Owens and Brooks—do not relate back to the date of filing of the original plaintiff's initial complaint.

According to the Amended Complaint, Owens settled his bill with the Mary Black on October 14, 2016. (R. 71). Thus, it is apparent that Owens knew or should have known of the existence of his purported claims at that time and the claims accrued no later than that date (actually even earlier) for purposes of triggering the limitations period. Blackwell filed the Motion to Amend the Complaint on October 18, 2019. (R. 121). Therefore, more than three (3) years have passed between when Owens knew or should have known of his alleged claims and when

Blackwell filed her Motion to Amend the Complaint. Because Owens's claims do not relate back to the filing of Blackwell's original complaint, his claims are plainly time barred.

B. The circuit court erred in finding that the voluntary payment doctrine was not applicable to Brooks's and Owens's causes of action based upon a purported finding that the Amended Complaint contains general allegations upon which duress may be inferred.

Prior to asserting their respective causes of action in this litigation, Brooks and Owens made voluntary payments to Mary Black to resolve the debt for the medical services provided. (R. 71-72). Under South Carolina law, an individual cannot recover payments made voluntarily (the voluntary payment doctrine). *Moody v. Stem*, 214 S.C. 45, 60, 51 S.E.2d 163, 169 (1948); *Shockley v. Wickliffe*, 150 S.C. 476, 480, 148 S.E. 476, 477 (1929). To void the application of the voluntary payment doctrine, a plaintiff must allege and prove that the payment was made under fraud, duress, or extortion. *Hardaway v. So. Ry. Co.*, 90 S.C. 475, 488-89, 73 S.E. 1020, 1025 (1912). Under the established pleading rules in the South Carolina Rules of Civil Procedure, a party must plead fraud with particularity (Rule 9(b)) and must affirmatively set forth allegations of duress and fraud (Rule 8(c)). Neither Owens, nor Brooks alleged duress as required.[1]

Thus, the allegations in the Amended Complaint are insufficient for any Plaintiff to avoid the application of the voluntary payment doctrine. In *Shockley*, 150 S.C. at 476, 148 S.E. at 477, the South Carolina Supreme Court analyzed a similar application of the voluntary payment doctrine. In *Shockley*, 150 S.C. at 476, 148 S.E. at 476-77, the plaintiff (Shockley) obtained a loan from the defendant (Burns) and secured the loan with a mortgage. Shockley repaid the loan, and the same process occurred with a second loan from Burns. *Id.* at 476, 148 S.E. at 477. After

[1] While an unpublished opinion may not hold precedential value, the reasoning applied by the Court of Appeals in *Johnson v. Estate of Smith*, No. 2006-UP-002, 2006 WL 7285544, at *3 (S.C. Ct. App. Jan. 4, 2006) (holding a plaintiff was required to specifically plead duress to avoid the enforcement of a settlement agreement related to their claims) provides additional guidance in this matter.

Burns's death, his heirs claimed to possess both mortgages and demanded payment for both loans from Shockley. *Id.* Shockley settled with the Burns' heirs; however, Shockley later found the documents demonstrating that the loan obligations were satisfied prior to the heirs' demand for payment. *Id.* Shockley sued the heirs for fraud and the heirs moved to dismiss the claims pursuant to the voluntary payment doctrine. *Id.* Shockley attempted to avoid the application of the voluntary payment doctrine on the grounds that his settlement payment was induced by mistake, fraud, or duress. *Id.* The court found that the plaintiff's payment was voluntary and was not made under duress. The *Shockley* court elaborated on the issue of what constitutes duress in circumstances where a plaintiff settles with a defendant:

> Taking the allegations of fact in the complaint to be true, as must be done upon demurrer, we find no facts which show the payment to have been involuntary. If, when demand was made upon the plaintiff for settlement of the notes by the defendants, he had refused to pay them, the defendants could not have subjected him to serious injury or risk in respect to his person or property or any right in such manner as to constitute coercion or duress; the most that they could have done was to bring suit for collection of the notes, and all that they did do, as appears from the record, was to threaten such suit. But the threat of a lawsuit does not constitute coercion or oppression. It is the business of the courts to settle disputes between litigants, and to hold that a threat of bringing suit for collection of a note is oppression would be to defeat the very purposes for which the courts were established.

Id.

In the present action, Owens and Brooks argue that their settlement payments to Mary Black were not voluntary because Mary Black had purportedly asserted liens. However, Owens and Brooks allege no facts that would support a finding that their settlement payments to Mary Black were made under duress. Because duress must be specifically plead, the circuit court erred by merely drawing the improper inference of duress, which must have been pled with specificity. *See* Rule 8, SCRCP. Accordingly, the voluntary payment doctrine applies and Owens and Brooks

are barred from pursuing further legal action related to the settlement payments they made in relation to the medical services that were provided to them.

C. The circuit court erred in failing to dismiss Blackwell's claims.

1. The circuit court erred in failing to dismiss Blackwell's claim for unjust enrichment.

Blackwell's claim for unjust enrichment fails as a matter of law because the Amended Complaint contains no allegation that Blackwell conferred any benefit to Mary Black, PASI, or CHSPSC.

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). It is a quintessential element to a claim for unjust enrichment that the plaintiff must have conferred a benefit on the defendant. Indeed, the remedy for a claim for unjust enrichment is restitution. *Inglese v. Beal*, 403 S.C. 290, 297, 742 S.E.2d 687, 690-91 (Ct. App. 2013). And restitution merely permits a plaintiff to recover the value of the benefit that the plaintiff had previously conferred to the defendant. *JASDIP Properties SC, LLC v. Est. of Richardson*, 395 S.C. 633, 640, 720 S.E.2d 485, 488 (Ct. App. 2011). Thus, if nothing was given to the defendant, then there is nothing to return and there is no available remedy. Without a remedy, the claim fails.

For the purpose of this appeal, the Court's analysis of whether the circuit court erred in failing to dismiss Blackwell's claim for unjust enrichment need go no further than to observe that Blackwell never alleges that she conferred a benefit to Mary Black, PASI, or CHSPSC. If the Court is unable to identify any allegation in the Amended Complaint that Blackwell conveyed

something of value to Mary Black, PASI, or CHSPSC, then the circuit court erred in denying the motion to dismiss.

Since review of the Amended Complaint plainly reveals there is no factual allegation that Blackwell made a payment or conferred a benefit to Mary Black (or any of the Defendants), the cause of action for unjust enrichment must be dismissed. The Amended Complaint reveals only that Mary Black conferred a benefit to Blackwell—it provided medical services to her between December 27, 2013 and January 3, 2014. (R. 65 – 70). Blackwell does not—and cannot—allege that she conferred a benefit to Mary Black because she does not allege and never did pay for that medical treatment.

Blackwell's claim for unjust enrichment fails as a matter of law. Accordingly, the Court must reverse the circuit court and dismiss Blackwell's claim for unjust enrichment.

2. Blackwell's claims fail as a matter of law because she is not a third-party with the right to enforce the MedCost Agreement.

a. The Court may consider the terms of the MedCost Agreement in reviewing the Defendants' Motion to Dismiss.

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) (incorporated 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) (integral to the complaint); *Leichling v. Honeywell Int'l, Inc.*, 842 F.3d 848, 850-51 (4th Cir. 2016) (integral to the complaint); *Goines v. Valley Cmty. Servs. Bd.*, 822 F.3d 159, 166 (4th Cir. 2016) (same); *Kensington Volunteer Fire Dep't, Inc. v. Montgomery Cty., Md.*, 684 F.3d 462, 467 (4th Cir. 2012) (same); *Philips v. Pitt Cty. Mem'l Hosp.*, 572 F.3d 176, 180 (4th Cir. 2009) (same); *Am. Chiropractic Ass'n v. Trigon Healthcare, Inc.*, 367

F.3d 212, 234 (4th Cir. 2004) (same); *Episcopal Church in S.C. v. Church Ins. Co. of Vermont*, 993 F. Supp. 2d 581, 587 (D.S.C. 2014) (same).

The MedCost Agreement is integral to Blackwell's claims because the MedCost Agreement is the contract that creates the obligation—if any exists—for Mary Black to bill MedCost directly on behalf of a MedCost insured and to bill at discounted rates established by that Agreement. There is no such obligation without the MedCost Agreement and all of Blackwell's claims are based upon the existence of such an obligation. Furthermore, the following allegations demonstrate how the MedCost Agreement is integral to Blackwell's claims and, therefore, should be properly considered in reviewing Defendants' Motion to Dismiss:

> Paragraph 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. . . .
>
> Paragraph 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.
>
> Paragraph 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**.

(R. 68) (emphasis added). The MedCost Agreement is obviously integral to Blackwell's claims and she is suing to take benefit from and to enforce its terms. Moreover, Blackwell argues to this Court that "the amended pleading set forth sufficient allegations that Ms. Blackwell was the intended third-party beneficiary of an agreement between MedCost (her insurance provider) and Mary Black . . . ." (Resp. Br. p. 31). Clearly, Blackwell argues to this Court that her pleadings set forth allegations that she is a third-party beneficiary entitled to enforce the MedCost Agreement. Thus, it is obvious that the MedCost Agreement from which she seeks to derive benefit and that

she is suing to enforce is integral to the Amended Complaint and should be considered by a court when reviewing a Rule 12(b)(6) motion to dismiss.

b. Blackwell does not have standing to sue to enforce the MedCost Agreement because that contract properly disclaims enforcement by purported third-party beneficiaries.

Blackwell alleges she has the right to enforce the terms of the MedCost Agreement for her own goals and benefit. She argues that she is an intended third-party beneficiary of the agreement. However, Blackwell is clearly 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. The MedCost Agreement plainly and directly expresses the intent of Mary Black and MedCost 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's and MedCost's intention that the contract not 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**.

(R. 258) (emphasis added).

For a court to construe and interpret the MedCost Agreement, the determinative action, is to review and give effect to the Agreement's 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 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 Blackwell lacks standing to

enforce the MedCost Agreement as a third-party beneficiary, she lacks standing to enforce the terms of the agreement and to pursue any of her alleged claims. Therefore, as a matter of law, Blackwell's claims must be dismissed. Accordingly, the circuit court erred in failing to grant the Motion to Dismiss because the express disclaimer of third-party beneficiaries in the MedCost Agreement is determinative of the claims asserted by Blackwell. She cannot pursue or succeed on claims based on the terms of the MedCost Agreement and all of her alleged claims are clearly derived therefrom.

D. The circuit court erred in failing to dismiss Brooks's claims pursuant to the Medicare Act.

In her brief, Brooks contends that the circuit court did not err in refusing to dismiss her claims because "Mary Black's argument . . . presumes that the at-fault driver in Brooks's automobile accident had a valid insurance policy from which to collect, even though this fact is not alleged anywhere in the Amended Complaint." (Resp. Br. p. 31). Brooks's argument fails because of the presumptions that a court is required to make when reviewing a pleading.

In South Carolina, there is a rebuttable presumption that the at-fault driver was covered by a valid insurance policy. A presumption exists that a person observed the law—unless there is proof to the contrary—and South Carolina law requires drivers to have automobile insurance. *See Simmons v. Atl. Coast Line R. Co.*, 250 S.C. 199, 203, 157 S.E.2d 172, 175 (1967); S.C. CODE ANN. §§ 56-10-10 to -40 and 56-10-210 to -280; S.C. CODE ANN. §§ 38-77-140, -150, and -160. To overcome the presumption that the at-fault driver had valid insurance, Brooks must allege that the at-fault driver did <u>not</u> have valid automobile insurance. Brooks fails to allege any such facts. The circuit court stated that it could not grant the motion to dismiss because it would be required to presume the at-fault driver had valid automobile insurance which is a fact that is outside the

pleadings. (R. 13). The circuit court erred because, under the law, it was required to presume the at-fault driver had valid insurance.

Whether the at-fault driver had automobile insurance is the determinative fact for all of Brooks's claims because she is alleged to be covered by Medicare and the Medicare Act requires Mary Black collect payment from an at-fault driver's insurance carrier as the primary payer and designate Medicare as the secondary payer. *See* 42 U.S.C.A. § 1395y(b)(2)(A)(ii) (designating an at-fault driver's insurance carrier as the primary payer and Medicare as the secondary payer); 42 C.F.R. § 489.20 (stating that health care providers (like Mary Black) commit to billing other primary payers (like the at-fault driver) before Medicare); *see also Parkview Hosp., Inc. v. Roese*, 750 N.E.2d 384, 389 (Ind. Ct. App. 2001); *Joiner v. Med. Ctr. E., Inc.*, 709 So. 2d 1209, 1221 (Ala. 1998). Brooks's claims are all based upon the false proposition that Mary Black acted wrongfully by not submitting the bill for services rendered to her to Medicare. However, that proposition is false and, in fact, Mary Black complied with the Medicare Act's billing procedures in its handling of the billing on Brooks's services.

Rather than taking a reasonable position and acknowledging that Mary Black complied with the Medicare law and requirements—which means the Amended Complaint erroneously asserts a claim against Mary Black for improper billing procedures—Brooks and the circuit court endorse the position that litigation of a baseless claim should continue merely because a plaintiff, apparently intentionally, failed to plead the undeniable attendant facts. This is a clear example of, and justification for this Court undertaking review of this issue immediately in the interest of judicial economy and to avoid unnecessary litigation. Indeed the necessity of immediate review is amplified in this case where Brooks has alleged that she should be allowed to represent a class of Medicare patients with the same defective claim, and for which she seeks to pursue intensive and invasive discovery related to those unnamed patients. Class discovery related to claims that

are baseless must be stopped and prevented when the claim of the named plaintiff on which it is based is meritless as a matter of law. Accordingly, Mary Black, PASI, and CHSPSC request the Court take the appropriate action and reverse the circuit court and dismiss Brooks's claims.

E. The circuit court erred in failing to dismiss the claims against CHSPSC and PASI.

Plaintiffs admit that they have not alleged that any defendant is vicariously liable for the actions of another. Neither are they asserting an amalgamation claim or attempting to pierce the corporate veil of any of the Defendants and have alleged no facts to support such theories. (Resp. Br. p. 36-37); *see also Pertuis v. Front Roe Restaurants, Inc.*, 423 S.C. 640, 655, 817 S.E.2d 273, 281 (2018) (identifying the requirements for a court to consider separate corporate entities as a single business enterprise). Instead, Plaintiffs contend Defendants "acted in concert" and each Defendant is liable for its own conduct. (Resp. Br. p. 37). However, Plaintiffs allege no facts supporting the conclusory assertion that Defendants acted in concert with one another. To survive, the Amended Complaint must allege facts against each Defendant sufficent to establish each element of each cause of action. *See* Rule 8(a), SCRCP (requiring a short plain statement of facts showing the plaintiff is entitled to relief).

The allegations against PASI and CHSPSC are limited and specious. 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.

(R. 66-67).

Other than the allegations listed above, the Amended Complaint refers to the Defendants collectively and does not provide any allegation that would allow the Defendants (or a court) to determine or distinguish the potential liability or the actual claims Plaintiffs are asserting separately against Mary Black, PASI, and CHSPSC. Rather, the remainder of the Amended Complaint contains only non-specific generalized allegations referencing PASI, CHSPSC, and Mary Black collectively as Defendants.

Courts refer to this type of pleading as an improper "shotgun pleading." *See Alexander v. S.C. Dep't of Transportation*, No. CV 3:20-4480-TLW-SVH, 2021 WL 2635446, at *2 (D.S.C. June 25, 2021). A shotgun pleading fails to satisfy the pleading standards set forth in Rule 8, SCRCP, because that type of pleading fails to identify a factual basis for holding each defendant liable. *See Addahoumi v. Pastides*, No. CV 3:16-1571-CMC-SVH, 2017 WL 4792222, at *3 (D.S.C. July 25, 2017), *report and recommendation adopted*, No. 3:16-CV-1571-CMC-SVH, 2017 WL 4773357 (D.S.C. Oct. 23, 2017) (dismissing a plaintiff's shotgun pleading because the complaint referred to the defendants in the collective and failed to identify the factual basis for holding each defendant individually liable to the plaintiff).

To survive a motion to dismiss, Plaintiffs are required to plead facts that would, if true and proved, allow a court to find each defendant liable. The Amended Complaint's collective pleading fails to meet this minimal standard. Therefore, the circuit court erred in failing to dismiss the claims against PASI and CHSPSC on the grounds that Plaintiffs failed to allege facts sufficent to

constitute a cause of action against PASI and CHSPSC. Accordingly, the Court must reverse the circuit court and dismiss the Plaintiffs' claims against CHSPSC and PASI.

CONCLUSION

For the reasons set forth in Defendants' Appellants' Brief, and reiterated here, the Court should issue an order reversing the circuit court, compelling Owens to arbitrate his claims against Defendants, and dismissing the claims asserted by each of the Plaintiffs.

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November 4, 2021
Columbia, South Carolina

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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

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

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

Respondents,

v.

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

Appellants,

APPELLANTS' CERTIFICATE OF COUNSEL

The undersigned hereby certifies on November 4, 2021, that Appellants' Final Brief and Appellants' Reply Brief comply with Rule 211(b) of the South Carolina Appellate Court Rules.

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