THE STATE OF SOUTH CAROLINA
In The Supreme Court

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; and Professional Account Services, Inc..... Petitioners.

PETITIONERS MARY BLACK HEALTH SYSTEM, LLC, d/b/a MARY BLACK MEMORIAL HOSPITAL, CHSPSC, LLC, AND PROFESSIONAL ACCOUNT SERVICES, INC.'S PETITION FOR A WRIT OF CERTIORARI

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CERTIFICATION BY COUNSEL

Counsel for Petitioners Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; CHSPSC, LLC; and Professional Account Services, Inc. certifies that a Petition for Rehearing was made and finally ruled on by the Court of Appeals on January 27, 2025.

QUESTIONS PRESENTED FOR REVIEW

I. Whether a nonsignatory to a contract who brought an action to take a benefit from the contract can avoid the enforcement of the contract's arbitration provision through strategic pleading that obscures the true nature of their claims in order to avoid application of direct benefits estoppel.

II. Whether the Court of Appeals' interpretation of common class-arbitration-waiver language in an arbitration agreement is inconsistent with decisions by the United States Supreme Court and the Federal Arbitration Act.

III. Whether the Court of Appeals erred in declining to review orders denying Defendants' motions to dismiss because the review of those claims supports the Court's analysis of the arbitration issue and judicial economy favors such review at this time.

INTRODUCTION

This petition involves one of two irreconcilable decisions issued by the same Court of Appeals panel, on the same day, based on functionally equivalent factual allegations, and addressing the same central question: whether the doctrine of direct benefits estoppel requires a plaintiff to arbitrate his/her claims against a defendant when the plaintiff brought an action to take a benefit from a contract between the defendant and a third party that contains an agreement to arbitrate such claims. In this case, the Court of Appeals—over Judge Geather's dissent—answered no. Yet, in *Bennett v. ACS Primary Care Physicians-Southeast P.C.*, 444 S.C. 458, 908 S.E.2d 110 (Ct. App. 2024), the Court of Appeals correctly answered yes.

To reach this conflicting result, the majority in this case relied on superficial differences in how the plaintiffs characterized a claim. That is, despite complaining of the same alleged wrong (a purported failure to submit bills for medical services directly to a patients' health insurance

carrier), the *Bennett* plaintiffs styled one (out of three) claims as a breach of contract claim, while Plaintiffs here styled one (out of three) claims in tort.

But this is a distinction without a difference. As Judge Geathers explained in dissent, Plaintiffs' claims seek to enforce, and cannot be determined without reference to, the terms of contracts containing an arbitration provision. Moreover, the majority's form-over-substance distinction creates inconsistency in South Carolina law, inviting inequitable results, confusion in the trial courts, and gamesmanship.

Defendants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; CHSPSC, LLC; and Professional Account Services, Inc. (collectively, "Defendants"), therefore, urge this Court to grant this petition and ensure consistency and harmony in South Carolina law.

STATEMENT OF THE CASE

A. Plaintiffs' Allegations.

Plaintiffs Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr. (collectively, "Plaintiffs") allege that Defendant Mary Black (a hospital) provided them with emergency care following motor vehicle accidents. Plaintiffs say that Mary Black and its Co-Defendant affiliates' contracts with "health insurance carriers" "required" Defendants to submit Plaintiffs' medical bills "directly to the carriers." (R. 68, ¶ 28). However, Plaintiffs allege Defendants failed to abide by the Defendants' contracts with the Plaintiffs' health insurance carriers and contrary to those contracts billed them instead, thereby depriving Plaintiffs of the allegedly discounted rates agreed upon in those contracts between the hospital and the insurance carriers. (R. 68–69, ¶¶ 26–32).

Plaintiffs allege that, by doing so, Defendants tortiously interfered with certain contractual relationships and were unjustly enriched. Plaintiffs' tort theory is that (1) Plaintiffs allegedly had contractual relationships (insurance policies) with their insurers; (2) Defendants allegedly knew or should have known of those relationships; and (3) Defendants allegedly interfered with and

disrupted those relationships by preventing Plaintiffs from receiving the benefit of those relationships (insurance policies). That benefit, according to Plaintiffs, is "the discounted amount [Defendants] agreed to accept from patients' health insurance." (R. 69, ¶ 32; *see also id.* 68, ¶ 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.")).

Plaintiffs' other claims also focus on Defendants' contracts with Plaintiffs' insurers. Under Plaintiffs' unjust enrichment theory, "payment for the services provided should have come from the [Plaintiffs'] health insurance carriers," with the amount to be paid "determined by the contracts between Defendants and patients' health insurance carriers." (R. 76, ¶ 73 (emphasis added)). Thus, Plaintiffs allege, Defendants were unjustly enriched by seeking and receiving payment from Plaintiffs. (R. 76, ¶¶ 71–72). As for their claim for injunctive relief, Plaintiffs allege that Defendants "were required" to submit Plaintiffs' medical bills "directly to their health insurers for payment" and "to honor" certain "contractually agreed-upon discounts" found in the contracts between Defendants and Plaintiffs' insurers. (R. 77, ¶¶ 76–78).

Plaintiffs style their case as a class action. In identifying the supposedly common issues, Plaintiffs mainly list purported violations of the alleged contracts between Defendants and patients' insurers. (R. 72 - 73, ¶ 57(a) ("Whether Defendants entered into express and/or implied agreements with various health insurance carriers…."); ¶ 57(b)–(e) (listing several questions about whether "Defendants violated" those alleged contracts)). By contrast, not one common issue concerns *Plaintiffs'* alleged contracts (policies) with their insurers.

B. The Court of Appeals' Majority Decision and Dissent.

Plaintiff Samuel H. Owens, Jr. alleges that his health insurer is CIGNA. (R. 71, ¶ 48). The agreement between CIGNA and Mary Black ("CIGNA Agreement") requires that any disputes

over its interpretation or performance must be resolved through individual arbitration. (R. 275–76). Defendants moved to compel Owens to arbitrate his claims pursuant to the CIGNA Agreement's arbitration provision because Owens seeks to take direct benefits from the CIGNA Agreement—the allegedly discounted rates negotiated and the obligation to bill CIGNA directly at those rates for medical services rendered—and, therefore, is bound by the agreement's arbitration provision. Defendants also moved under Rule 12(b)(6) to dismiss all Plaintiffs' claims. After the circuit court denied the motions, Defendants appealed.

On appeal, Defendants argued the circuit court erred in denying the Motion to Compel Arbitration because direct benefits estoppel binds Owens to the CIGNA Agreement's arbitration provision. When a plaintiff sues and seeks relief based on a contract containing an arbitration provision South Carolina courts have applied direct benefits estoppel to bar the plaintiff from avoiding the application of the contract's arbitration provision. *Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 288, 733 S.E.2d 597, 600 (Ct. App. 2012). Under the doctrine of direct benefits estoppel a nonsignatory may not refuse "to comply with an arbitration clause when it receives a direct benefit from a contract containing an arbitration clause." *Wilson v. Willis*, 426 S.C. 326, 340, 827 S.E.2d 167, 177 (2019) (internal quotation marks omitted). "Stated another way, under the direct benefits theory of estoppel, a nonsignatory may be compelled to arbitrate where the nonsignatory knowingly exploits the benefits of an agreement containing an arbitration clause…." *Id.*, 426 S.C. at 340–41, 827 S.E.2d at 175 (internal quotation marks and brackets omitted). Although the doctrine applies when the nonsignatory "receives benefits flowing directly from the agreement," *id.*, it also applies when the nonsignatory maintains that provisions in the agreement "*should be enforced to benefit*" it. *Id.*, 426 S.C. at 340, 827 S.E.2d at 175 (quoting *Int'l Paper Co. v. Schwabedissen Maschinen & Anlagen GMBH*, 206 F.3d 411, 418 (4th Cir. 2000)) (emphasis in

original). In other words, it is not necessary that the plaintiff already received the benefit in order for direct benefits estoppel to apply.

Here, as Defendants argued on appeal, Owens's overarching theory is that the CIGNA Agreement required Defendants to bill CIGNA directly, not him, and to bill at the rates agreed upon in the CIGNA Agreement. This theory forms the essential basis of all Owens's claims. He alleges these facts amount to Defendants having tortiously interfered with his contract with CIGNA because they deprived him of the alleged "benefit of" that relationship—namely, the alleged obligation under the CIGNA Agreement to bill CIGNA at discounted rates, rather than seeking "additional monies to which Defendants were not entitled" by billing Owens. (R. 75, ¶ 66; *see also id.* 68–69, ¶¶ 27–29, 32). Owens also alleges that Defendants were unjustly enriched by billing Owens directly rather than billing CIGNA directly at the discounted rates agreed upon pursuant to the CIGNA Agreement. Additionally, he alleges that Defendants should be ordered to follow the terms of agreements like the CIGNA Agreement.

Whatever the claim, Defendants explained, direct benefits estoppel prevents Owens from claiming he is entitled to receive a direct contractual benefit (the alleged duty to bill CIGNA at discounted rates) on the one hand, while disclaiming the contractual obligation to arbitrate such claims on the other. Relatedly, because analyzing the estoppel issue required the Court of Appeals to consider the nature of all claims, Defendants asked the Court of Appeals to review the denial of Defendants' motions to dismiss.

Despite all this, a majority of the Court of Appeals panel affirmed the circuit court's refusal to compel Owens to arbitrate his claims and refused to review the decision to deny the motions to dismiss. Nonetheless, the majority agreed that the arbitration provision in the CIGNA Agreement is binding and enforceable. (Panel Op. at 9). Yet the majority held that Owens was not estopped from avoiding the application of the CIGNA Agreement's arbitration provision. To reach this

decision, the majority ignored the fact that Owens was undeniably seeking to enforce and exploit the CIGNA Agreement to his benefit. Instead, the majority misapplied the binding authorities requiring him to arbitrate his claims pursuant to the doctrine of direct benefits estoppel, purportedly because Owens "never *alleged* in the complaint that he *received* a direct benefit from the CIGNA Agreement." (*Id.* at 10) (emphasis added). And, ignoring that Owens expressly alleged the existence of the CIGNA Agreement in the Amended Complaint, the majority stated that he "did not know about the agreement prior to this litigation." (*Id.*).

Working from these misguided premises, the majority concluded that Owens's "claims for tortious interference with contract and unjust enrichment are not pled as arising from the CIGNA Agreement." (*Id.*). The majority stated that Owens's tort claim "does not arise solely from or have to be determined in reference to the CIGNA Agreement" because "it arises out of tort law and does not refer or relate to the CIGNA Agreement even if it would not have arisen but for the agreement." (*Id.*). The majority's justification for its conclusion ignores the fact that in South Carolina there is no general duty for a healthcare provider to submit bills to a patient's health insurance carrier.[1] If any obligation exists for a healthcare provider to bill a patients' insurance carrier, then that obligation would be derived from the contracts between the healthcare provider and the insurance carrier.

Likewise, the majority held that the unjust enrichment claim "does not rely on the CIGNA Agreement." According to the majority, even though the claim expressly "refers to the CIGNA Agreement," it does not "have to be determined by refence to the CIGNA Agreement" but "could be determined in reference to Owens's insurance contract with CIGNA" although the majority

[1] *See* Argument Section B. (1) below; *Beverly v. Grand Strand Reg'l Med. Ctr., LLC*, 429 S.C. 502, 514–15, 839 S.E.2d 468, 474 (Ct. App. 2020), *aff'd*, 435 S.C. 594, 869 S.E.2d 812 (2022); *Wogan v. Kunze*, 366 S.C. 583, 605, 623 S.E.2d 107, 119 (Ct. App. 2005), *aff'd as modified*, 379 S.C. 581, 666 S.E.2d 901 (2008).

provides no basis or justification for this conclusion. (*Id.* at 11). In fact, Owens's insurance policy is not a part of the Record in this appeal. And while the majority recognized that "Owens's claim for injunctive relief does rely on the CIGNA Agreement," it concluded that Owens need not arbitrate this claim because his other two claims "do not arise from the CIGNA Agreement." (*Id.* at 11–12).

As an alternative ground for Owens to avoid arbitration, the majority interpreted a class arbitration waiver in the CIGNA Agreement to justify the conclusion that Defendants cannot compel Owens to arbitration because he already joined a class action. (*Id.* at 12). Finally, the majority declined to review any part of the denial of Defendants' Rule 12(b)(6) motions because, the majority said, they "would benefit from further factual development." (*See id.* at 12–13).

This decision was not unanimous. Agreeing with Defendants, Judge Geathers wrote in dissent that Owens may not disclaim the agreement to arbitrate. The dissent explained that "the causes of action in the Amended Complaint ... invoke [Defendants'] contractual duties to the insurance carriers with which the [Plaintiffs] also had contracts." (*Id.* at 13–14). Thus, "equity prevents" Owens "from avoiding the arbitration clause that was part of [his insurer's] agreement." *Id.* at 13 (internal quotation marks omitted). To hold otherwise "would both disregard equity and contravene the purposes underlying enactment of the Federal Arbitration Act." *Id.* at 14 (internal quotation marks and brackets omitted).

C. The *Bennett* Decision.

The same day it issued its decision here, the same panel issued a unanimous decision in *Bennett*, that one authored by Judge Geathers. The two cases are functionally indistinguishable, with striking similarities between their core allegations:

Blackwell Amended Complaint (R. 63 *et seq.*)	*Bennett* Complaint (Case No. 2021-001342, R. 37 *et seq.*)
¶ 15: "[Mary Black] provided healthcare services for Plaintiffs and the general public"	¶ 8: "Defendant … provide[s] emergency medicine services."
¶ 28: "Defendants are required by their contracts with patients' health insurance carriers to submit insurance patients' medical bills directly to the carriers."	¶ 2: "Defendant … contract[ed] with [BCBS] … ([the] 'Provider Agreement'). Under the Provider Agreement, Defendant agreed to bill BCBS directly for services rendered to patients insured through BCBS ('Insureds')."
¶ 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." ¶ 57(c): "Defendants … pursue[d] payment directly from patients[.]" ¶ 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."	¶ 4: "Defendant would bill Insureds directly at a rate higher than the negotiated BCBS rate, resulting in an increase to healthcare costs to Insureds."
¶ 57(a): "Defendants violated their contracts with various health insurance carriers by not submitting medical bills to the carrier."	¶ 4: "Defendant refused to bill BCBS for services rendered to Insureds."
¶ 67: "Defendants' actions resulted in Plaintiffs and the Class Members having paid premiums but receiving no or little benefit."	¶ 66: "Defendant's breaches have deprived Plaintiff and Class members of benefits they paid for through their health insurance with BCBS."
¶¶ 69–74: "Defendants have been unjustly enriched in that they received and retained the benefits of proceeds to which they were not entitled …. [P]ayment for the services provided should have come from the health insurance carriers … with the amount to be paid … determined by the contracts between Defendants and patients' health insurance carriers."	¶¶ 69–75: "[B]enefits were realized by Defendant through the billing of Class members directly at a rate for services that was higher than the agreed upon BCBS rate. Defendant realized the value of payments from Class members through this improper billing. Had Defendant followed the terms of the Provider Agreement, it would have received less money for these services."

As here, the *Bennett* plaintiffs alleged that the defendant healthcare provider improperly sent bills to patients rather than their health insurance carriers. Like the Plaintiffs in this case, the *Bennett* plaintiffs asserted purported causes of action for unjust enrichment and injunctive relief on behalf

of a putative class. Like the Defendants in this case, the *Bennett* defendants moved to compel arbitration because the plaintiffs were bound by an agreement to arbitrate between defendants and plaintiffs' insurers. Like the circuit court in this case, the circuit court in *Bennett* denied the motion, and the defendants appealed.

However, unlike this case, the panel held that equitable estoppel required the *Bennett* plaintiffs to arbitrate their claims pursuant to the arbitration provisions in their insurers' agreements with the defendants. *Bennett*, 444 S.C. at 469–474, 908 S.E.2d at 115–18. Judge Vinson (the majority's author here) wrote a brief concurrence. That concurrence "emphasize[d]" that the *Bennett* plaintiffs "expressly asserted that they were third-party beneficiaries" of their insurers' agreements with the defendant provider. *Bennett*, 444 S.C. at 488, 908 S.E.2d at 126 (Vinson, J., concurring).[2] The concurrence also stated—in some tension with the majority decision in this case—that the breach of contract and unjust enrichment claims in *Bennett* "arose solely" from the defendants' agreements with plaintiffs' insurers because the plaintiffs "alleged that they *did not receive* the benefit of the negotiated rates under [those agreements]." *Id.* (emphasis added); *see* Panel Op. at 10 (holding that estoppel did *not* apply because Owens "never alleged in the complaint that he received a direct benefit from the CIGNA Agreement").

D. The Petition for Discretionary Review.

No party sought review of the Court of Appeals' decision in *Bennett*, and the time for any such review passed long ago.

[2] Although not in the record because it occurred in the circuit court while this appeal was pending, Plaintiffs expressly represented in their motion for class certification that they, like the plaintiffs in *Bennett*, "contend that they are third-party beneficiaries of the agreements between their insurance companies and Mary Black." The circuit court's order certifying a class (currently the subject of a separate appeal pending in the Court of Appeals) repeated that assertion, verbatim. *See* Appellate Case No. 2024-001546, Circuit Court Order, dated Nov. 1, 2022. Thus, that basis for distinguishing *Bennett* from this case is untenable, and Plaintiffs cannot argue otherwise here.

Here, on the other hand, Defendants timely petitioned for rehearing and rehearing *en banc*. The petition identified three issues. First, the majority decision misapplied the doctrine of direct benefits estoppel and, in doing so, created a conflict with *Bennett* that will lead to inequitable results, confusion, and gamesmanship. Second, the majority's reading of the class arbitration waiver conflicts with United States Supreme Court precedent and the Federal Arbitration Act. Third, the majority's decision not to review the orders denying Defendants' motions to dismiss obscured critical flaws in Plaintiffs' allegations.

The majority denied Defendants' petition. But Judge Geathers once again dissented, stating that, for the reasons stated in his original dissent, he would have granted rehearing.

ARGUMENTS

Rule 242(b) of the South Carolina Appellate Rules of Court identifies reasons this Court might consider a writ of certiorari. These reasons include where there are novel questions of law, there is a dissent, or the decision conflicts with a decision of the United States Supreme Court. Rule 242(b), SCACR. Because each is at play here, this petition should be granted.

I. The Majority's Misapplication of Direct Benefits Estoppel Invites Inconsistency, Confusion, and Gamesmanship.

No matter how Plaintiffs style their claims for relief, their theory of liability is that they were harmed, and are entitled to recover, because Defendants did not allow Plaintiffs the benefit of the terms in the agreements between the hospital and the Plaintiffs' insurance carriers, including the benefit that Defendants bill the Plaintiffs' insurance carriers directly and at the discount rates Defendants agreed to accept pursuant to the contracts with the Plaintiffs' insurance carriers. (R. 68–69, ¶¶ 27–29, 32). Viewed properly, therefore, Plaintiffs' claims "arise solely" from those agreements and Defendants' liability "must be determined by reference to those agreements." *Wilson*, 426 S.C. 343 (internal quotation marks omitted). Thus, "equity prevents" Owens "from avoiding the arbitration clause" in the CIGNA Agreement. *Id.* (internal quotation marks omitted).

In holding otherwise, the majority misapplied the doctrine of benefits estoppel. That is, the majority allowed Owens to avoid arbitration by obscuring the true nature of his claims through artful pleading and strategic omissions. In doing so, the majority not only reached the wrong result—it created fertile grounds for confusion and gamesmanship in the application the doctrine of direct benefits estoppel. As a result, the circuit courts will likely struggle to meaningfully reconcile the outcome here with the inconsistent result in *Bennett*, and litigants seeking to avoid arbitration will use the misguided and superficial bases for the cases' divergent outcomes for improper tactical advantages. This Court, therefore, should grant this Petition.

A. The Majority Opinion Directly Conflicts with *Bennett*.

The rule of stare decisis is one of consistency. *Roof v. Charlotte, C. & A.R. Co.*, 4 S.C. 61, 62–63 (1872). By reaching inconsistent results here and in *Bennett*, the Court of Appeals invites inconsistency, conflict, and confusion in the law.

The unjust enrichment allegations in *Bennett* are functionally indistinguishable from those here. In both cases the plaintiffs allege the defendants were unjustly enriched because the defendants directly billed patients when they were contractually obligated by agreements between the defendants and the plaintiffs' insurers to bill those insurers at discounted rates. (*Compare* R. 76 ¶¶ 69–74, *with* Case No. 2021-001342, R. 46–47 ¶¶ 69–75) (see chart above).

From these allegations, all three panel members agreed in *Bennett* that the claim is "based on an alleged duty arising *solely* from the terms of the Provider Agreement." *Bennett*, 444 S.C. at 472, 908 S.E.2d at 117; *id.* at 444 S.C. at 488, 908 S.E.2d at 126 (same) (Vinson J., concurring). But here, two panel members concluded that the substantially similar claim "does not rely on the [the provider-insurer agreement]." (Panel Op. at 11). These conflicting conclusions cannot both be correct.

The majority's threadbare attempt to justify its reasoning here only amplifies the conflict. The majority—without explanation—states that the unjust enrichment claim "does not rely upon or have to be determined by reference to the CIGNA Agreement" and instead "could be determined in reference to Owens's insurance contract with CIGNA." (Panel Op. at 11).

As the majority conceded, Plaintiffs' unjust enrichment theory is expressly premised on the allegation that Defendants were not entitled to the amount they charged because the payment "should have come from the health insurance carriers of Plaintiffs …, with the amount to be paid for services provided determined by the contracts between Defendants and patients' health insurance carriers." *Id.* (quoting paragraphs 71–73 of the Amended Complaint). In other words, the unjust enrichment theory is that Defendants "should have" charged Plaintiffs' insurers, not Plaintiffs, and that the amount charged "should have" been based on the discounts set forth only in alleged agreements between Defendants and the insurers. But any alleged obligation to charge Plaintiffs' insurers (instead of Plaintiffs) necessarily turns on the allegation that Defendants had a duty to do so *under their contracts with Plaintiffs' insurers*. Thus, to hold that this theory "does not rely upon or have to be determined by reference to the CIGNA Agreement" not only conflicts with *Bennett*—it defies logic. *Id.*

The inconsistency does not end there. The two opinions are also in conflict as to how a court is to determine whether, and when, direct benefits estoppel applies. In *Bennett*, the panel recognized that direct benefits estoppel is not limited to circumstances where a nonsignatory plaintiff has *already* received a benefit from the contract containing the arbitration clause. It also applies when the nonsignatory has "maintained" that provisions of the contract "should be enforced to benefit him." *Bennett*, 444 S.C. at 470, 908 S.E.2d at 116 (quoting *Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 290, 733 S.E.2d 597, 601 (Ct. App. 2012) (quoting *Int'l* Paper, 206 F.3d at 418)). But the majority here ignored that basis for applying the doctrine and instead

focused solely on the lack of any allegation that Owens "*received* a direct benefit from the CIGNA Agreement." (Panel Op. at 10). This position makes little sense, especially given Judge Vinson's statement in his *Bennett* concurrence that, like Owens, the *Bennett* plaintiffs *also* alleged that they "did not receive the benefit of the negotiated rates" under the relevant agreements. *Bennett*, 444 S.C. at 488, 908 S.E.2d at 126.

Still more, as the panel held in *Bennett*, "the discounts and other provisions negotiated between [an insurer] and [a provider]" *are* a sufficient benefit to subject a patient to an arbitration clause in the insurer-provider contract by estoppel. 444 S.C. at 474, 908 S.E.2d at 118. Owens and his fellow Plaintiffs here mention those benefits throughout the Amended Complaint. (R. 68, ¶ 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.")); *see also* (R. 69, ¶ 32; R. 77¶¶ 77, 78, 80). Those same discounts cannot be both an allegation of a direct benefit in *Bennett* and not an allegation of a direct benefit in this case.

And there is yet another conflict between *Bennett* and the majority's holding that Owens is not estopped from avoiding the application of the CIGNA Agreement's arbitration provision because he "did not know about the agreement prior to this litigation." (Panel Op. at 10). The *Bennett* court agreed with the defendants that the plaintiffs' alleged lack of knowledge at the time of care "does not matter to the equitable estoppel analysis because [Plaintiffs] knew about the Provider Agreements when they filed their complaints." 440 S.C. at 469, 908 S.E.2d at 116. Of course, Plaintiffs also knew about the same agreements when they filed their complaint here. Indeed, Plaintiffs repeatedly allege the existence of agreements between Defendants and Plaintiffs' insurers. (R. 61-80, ¶¶ 9, 28, 29, 31, 57(b)–(e), 73, 77–78).

When an appellate court issues conflicting decisions on the same day involving essentially indistinguishable fact patterns, the law becomes uncertain. Uncertainty, in turn, invites confusion

and inconsistent results. Defendants urge the Court to quell the conflict and uncertainty by granting this Petition.

B. The Majority's Opinion Risks Rewarding Gamesmanship.

1. The majority's decision risks encouraging plaintiffs to obscure the reality of their claims and selectively omit factual allegations.

Implicit in the result here is the suggestion is that, by styling a claim in tort and not contract, a plaintiff can avoid equity. (Panel Op. at 10–11). This approach, however, instructs courts to overlook the substance of a plaintiff's claims and invites future litigants to obscure the true nature of their claims to avoid arbitration. By elevating form over substance, therefore, the majority's opinion invites gamesmanship.

To be clear, Owens's tort claim cannot be resolved without reference to the CIGNA Agreement. The claim is that, through Defendants' alleged interference, Owens has been deprived of the benefit of his contract with CIGNA. But what is that benefit? It can only be the *alleged contractual duty* for Defendants to bill CIGNA, not Owens, and to do so at the allegedly discounted rates. (R. 68–69, ¶¶ 26–32).

Under South Carolina law a healthcare provider has no general duty to submit bills to insurance providers. *See Beverly*, 429 S.C. at 514–15, 839 S.E.2d at 474; *Wogan*, 366 S.C. at 605, 623 S.E.2d at 119. Therefore, resolving Owens's tort claim requires a determination of whether the CIGNA Agreement actually imposed as duty on Defendants (1) to bill CIGNA and not Owens and (2) to do so at discounted rates. *See Bennett*, 440 S.C. at 471, 908 S.E.2d at 117 (explaining that, "in examining a claim of equitable estoppel in the arbitration context, the court must

determine the source of the defendant's duty to the plaintiff"). If not, then there could have been no interference, tortious or otherwise, in billing Owens directly.[3]

The majority, however, refused to interrogate the basis of Owens's claim and instead accepted Owens's *characterization* at face value. But as courts have long held, a claim's true nature is "unaffected by the conclusions of the pleader or by what the pleader calls it." *Bell v. Mackey*, 191 S.C. 105, 3 S.E.2d 816, 822 (1939). "[T]he essential character of the cause of action, and the remedy or relief it seeks," are "shown by the allegations of the complaint." *Id.*

Courts routinely apply this principle in the arbitration context. This Court, for example, has explained that, when deciding "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." *Zabinski v. Bright Acres Assocs.*, 346 S.C. 580, 597, 553 S.E.2d 110, 118–19 (2001). The Fourth Circuit has reached the same conclusion, explaining that a plaintiff "may not use artful pleading to avoid arbitration" by phrasing a claim "in tort" where, "at root, those claims attempt to hold [the defendant] to the terms of [a contract with an arbitration provision]." *Am. Bankers Ins. Grp., Inc. v. Long*, 453 F.3d 623, 630 (4th Cir. 2006). The central question—no matter how the claim is styled—is "whether the plaintiff has asserted claims in the underlying suit that, either literally or obliquely, assert a breach of a duty created by the contract containing the arbitration clause." *Id.* at 629; *see also OSRX Inc. v. Anderson*, No. 22-CV-1737, 2023 WL 2472417, at *7 (D.S.C. Feb. 7, 2023) ("Although Plaintiffs' remaining claims—misappropriation of trade secrets …, intentional interference with contractual relations, and intentional interference with prospective contractual relations—are

[3] This is one reason why the majority erred in not addressing the denial of Defendants' motions to dismiss (elaborated on below). If the majority's interpretation of Owens's tortious interference claim is correct and Owens is not seeking to benefit from the CIGNA Agreement, then Plaintiffs' tortious interference claim fails as a matter of law.

'phrased in tort,' the court must look to the root of the allegations in support of these claims to determine if they really arise out of the [contract]." (quoting *Long*, 453 F.3d at 630)).

Thus, despite Owens's attempt to obscure the nature of his claims by phrasing a claim in tort, estoppel applies here. And that is because, as the dissent recognized, Plaintiffs repeatedly "invoke the [Defendants'] contractual duties to the insurance carriers with which [Plaintiffs] also had contracts." (Panel Op. at 13 (Geathers, J., dissenting)).

Indeed, the essential character of Owens's claims echoes through the Amended Complaint. Plaintiffs allege, multiple times, that Defendants "contracted with patients' health insurance providers for a reduced compensation for treating patients with health insurance" (R. 65 ¶ 9; *see also id.* ¶ 31, 57(a)). They allege, multiple times, that Defendants are "*required by their contracts* with patients' health insurance carriers to submit insurance patients' medical bills directly to the carriers" and "*required to honor a contractual discount* with their patients' health insurance carriers." (R. 68, ¶¶ 28–29; *see also id.* ¶¶ 32, 57(b)–(c) (emphasis added)). This contractual discount *is* the benefit Plaintiffs seek in the litigation. (R. 69, ¶ 32; *id.* 73, ¶ 57(d)). And it arises only from the allegations that Defendants owed a contractual duty to submit bills directly to Plaintiffs' insurance carriers and receive payment under those agreements. The first mention, on the other hand, of any alleged contractual relationship between Plaintiffs and their insurers does not appear until Plaintiffs set forth the elements of their obscurely pleaded tort claim. (R. 75, ¶ 64).

Thus, whether phrased in contract, tort, or equity, the essential character of Owens's claim is, at root, that Defendants should be held to the terms of contracts like the CIGNA Agreement. *See Long*, 453 F.3d at 630 (holding that whether estoppel applies turns on whether the plaintiff alleges a breach of the contract with the arbitration clause); *see also Wilson*, 426 S.C. at 343, 827 S.E.2d at 176 (holding that equity prevents a person from avoiding arbitration if the alleged

liability "must be determined by reference to" the contract with the arbitration clause). Thus, because Owens premises his claims on the alleged terms of the CIGNA Agreement, he is subject to its arbitration provision and estopped from avoiding its application. Allowing him to avoid this result by obscuring the true nature of his claims will only work inequity and encourage gamesmanship, as future litigants seeking to evade arbitration will be encouraged to obscure the true nature of their claims and strategically omit undeniable allegations from their complaints.

2. The majority's decision risks encouraging plaintiffs to attempt to avoid arbitration by alleging meritless non-arbitrable claims.

The majority's decision also risks encouraging future litigants to allege a host of non-arbitrable claims in a gambit to avoid arbitration. The majority correctly holds that Owens's final claim for "injunctive relief" *was* subject to arbitration because it was grounded in the CIGNA Agreement. But then the majority still concluded that Owens does not have to arbitrate that claim, or any other, because "two of the three claims alleged do not arise from the CIGNA Agreement." (Panel Op. at 11–12). In other words, the majority suggests that a plaintiff can avoid arbitration if an arbitrable claim is joined by some greater number of non-arbitrable claims.

That is not the law. Indeed, it contradicts established precedent of the United States Supreme Court. *See*, *e.g.*, *KPMG LLP v. Cocchi*, 565 U.S. 18, 21 (2011) ("A court may not issue a blanket refusal to compel arbitration merely on the grounds that some of the claims could be resolved by the court without arbitration.").[4]

If the majority were correct, then cases involving arbitrable claims would be acutely vulnerable to gamesmanship. Future plaintiffs could tip the scales against arbitration merely by

[4] The majority cites *Wilson* for this proposition. (Panel Op. at 11–12 (citing *Wilson*, 426 S.C. at 342, 827 S.E.2d at 176)). But *Wilson* is not on point. There, this Court found that *none* of the claims asserted implicated equitable estoppel. *See* 426 S.C. at 342, 827 S.E.2d at 176 (noting that, while respondents "appear[ed] to rely on the fact that some of the claims asserted … would not have arisen in the absence of the [contract]," the claims did not arise from or need to be determined by reference to the contract).

also alleging non-arbitrable claims. Still more, given the risk of being found to have waived a right to arbitration, Defendants ordinarily must seek to compel arbitration early in a case, meaning they likely have no opportunity to peel back the facial allegations and must deal with the complaint as-pled. The majority's claim-counting rule risks rewarding a plaintiff who pleads a host of questionable non-arbitrable claims to extinguish the arbitrability of valid claims by resolving the arbitration issue before the claims can be tested. Because the majority appears to have overlooked this concern, its decision warrants this Court's review.

II. The Majority's Opinion Misconstrues the Plain and Unambiguous Language of the CIGNA Agreement and Is in Conflict with United States Supreme Court Precedent.

In holding that Owens cannot be compelled to arbitrate his individual claims because he filed a class action, the majority also misconstrues the CIGNA Agreement's plain language. In doing so, it runs afoul of both United States Supreme Court precedent and the Federal Arbitration Act.

As relevant here, the CIGNA Agreement's arbitration clause states that "[a]rbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement." The agreement then clarifies that, in arbitration, "the arbitrator shall be without power to conduct an arbitration on a class basis." (R. 275–76).

As reflected in multiple decisions by the United States Supreme Court, the purpose of this common language is to make clear that the parties agree to resolve their disputes through *individual* arbitration and not through class arbitration. That is, such language is normally read to reflect the parties' "intention to use individualized rather than class or collective action procedures" to resolve their disputes. *Epic Sys. Corp. v. Lewis*, 584 U.S. 497, 506 (2018). Such clauses are common because "classwide proceedings" "interfere[] with a fundamental attribute of arbitration"—"the traditionally individualized and informal nature of arbitration." *Id.* at 508. Allowing class arbitration thus "would sacrifice the principal advantage of arbitration—its informality—and make

the process slower, more costly, and more likely to generate procedural morass than final judgment." *Id.* (internal quotation marks and brackets omitted).

Yet the majority seeks to read the clause to work the opposite of its intended effect by closing the door to arbitration when one party elects to allege, or even join, a putative class action. That is, the majority holds that this language, "interpreted in its natural and ordinary sense, prevents Owens from arbitrating his claims" because it "specifically states the arbitration provision does not apply to class actions." (Panel Op. at 12).

To begin with, that is not a plausible interpretation of the provision's text. The agreement says that (1) the parties agree that "[a]rbitration shall be the exclusive remedy for the resolution of disputes arising under the [CIGNA] Agreement" and (2) the parties agree that the arbitrator lacks "power to conduct" any such arbitration "on a class basis." (R. 275–76). To say, as the majority does, that the arbitration provision "does not apply to class actions," therefore, gets it exactly backwards. The provision *precludes* class actions, by first requiring *all* disputes (whether styled as an individual or class action) to be arbitrated and by then making clear that those arbitrations cannot proceed on a class basis.

The reading advanced by the majority, on the other hand, defeats the purpose of the clause and, indeed, one of the fundamental reasons parties agree to arbitrate in the first place. *See Epic Sys.*, 584 U.S. at 508–09. Multiple federal courts have thus rejected exactly that reading. *See*, *e.g.*, *Bouskous v. J.P. Morgan Chase Bank, N.A.*, 2020 WL 8483909, at *5 (E.D. Cal. Dec. 21, 2020). Even more problematically, the reading risks defying the Federal Arbitration Act. *See, generally*, *AT&T Mobility LLC v. Concepcion*, 563 U.S. 333 (2011) (holding that similar interpretations violate the FAA by disfavoring arbitration).

In short, the majority's reading diverges from decisions of the United States Supreme Court on class arbitration and the FAA, providing another ground for granting this petition.

III. Consideration of Defendants' Motions to Dismiss Would Have Aided the Analysis of the Other Issues.

Finally, Defendants' appeal also asked the Court of Appeals to review the circuit court's denials of Defendants' motions to dismiss under Rule 12(b)(6). The majority, however, declined to take up review of the orders, giving as its sole reason that "the issues raised … would benefit from further factual development." (Panel Op. at 13).

On the contrary, the majority would have benefited from considering Defendants' Rule 12(b)(6) arguments. Among other things, those arguments help explain how the majority's decision misapprehends the arbitration issue. *See Brown v. Cnty. of Berkeley*, 366 S.C. 354, 362 n.5, 622 S.E.2d 533, 538 n.5 (2005) (allowing review of interlocutory orders when they "are companion to issues that are [immediately] reviewable" by the appellate court).

For example (and as already discussed), a close analysis of whether Plaintiffs stated a claim for tortious interference with a contract would have aided the majority's estoppel analysis. "The elements of a cause of action for tortious interference with [a] contract" include, among other things, the wrongdoer's "intentional procurement of [the relevant contract's] breach." *Camp v. Springs Mortg. Corp.*, 310 S.C. 514, 517, 426 S.E.2d 304, 305 (1993). Plaintiffs, however, do not allege *any* breach of the alleged contract between themselves and their insurers, much less that Defendants intentionally procured any such breach. Indeed, the only breaches alleged in the Amended Complaint concern the agreements between Defendants and Plaintiffs' insurers—including the CIGNA Agreement which requires such claims be compelled to arbitration. *See Long*, 453 F.3d at 630.

As this example shows, there are legal issues in common between the immediately appealable order on arbitration and the interlocutory order on the motions to dismiss. It would thus aid the Court's understanding of this case if the Rule 12(b)(6) issues were considered on appeal.

Furthermore, addressing the deep flaws in Plaintiffs' claims would prevent injustice and aid judicial economy. *Edge v. State Farm Mut. Auto. Ins. Co.*, 366 S.C. 511, 517, 623 S.E.2d 387, 390 (2005) (allowing review of interlocutory orders when "such review would avoid another appeal in the future and potentially narrow the issues for trial (i.e. judicial economy)").[5] Judicial economy and the interests of justice favor an appellate court's immediate review of these critical flaws:

- Owens's claims are barred by the statute of limitations because they do not relate back to the filing of the original complaint;
- Blackwell's claim for unjust enrichment fails because she does not allege that she conferred any benefit to Defendants;
- Blackwell lacks standing to pursue her claims because she is not an intended third-party beneficiary under the agreement between Mary Black and her health insurer (MedCost);
- Brooks's claims are governed by the Medicare Act and the law under that Act does not support the claims alleged;
- Brooks and Owens's claims fail under the voluntary payment doctrine; and
- The Amended Complaint does not state facts sufficient to constitute any viable cause of action against two Defendants, CHSPSC, or PASI.

Judicial economy favors immediate consideration of these arguments. The Motions to Dismiss were based on legal inadequacy of the claims, not on factual issues. The legal inadequacies are apparent from the face of the Amended Complaint and do not depend on future factual development. For example, Plaintiff Brooks's claims are all governed by the Medicare Act, 42 U.S.C.A. § 1395y(b)(2)(A)(ii), and the law under that Act does not support the claims

[5] Defendants moved to compel arbitration as to Plaintiff Owens *and* dismiss the other Plaintiffs' failed claims. When the circuit court denied the arbitration motion, Defendants immediately appealed. Although the case was filed as a unified putative class action, the circuit court refused to stay the case for the other Plaintiffs. Instead, it pushed the case forward, issuing orders (over Defendants' strenuous objections) certifying a class and even striking Defendants' answers. Thus, Defendants are effectively prevented from addressing the merits of these defenses with, in the majority's words, the "benefit of further factual development." (Panel Op. at 12).

alleged. The Medicare Act requires hospitals—like Mary Black—to seek payment from any applicable automobile or liability policy prior to seeking or obtaining any payment from Medicare. 42 U.S.C.A. § 1395y(b)(2)(A)(ii). Specifically, the Medicare Act states, in relevant part, that payment "*may not be made*" where "payment has been made or can reasonably expected to be made … under an automobile or liability insurance policy or plan … or under no fault insurance." (*Id.*) (emphasis added).

All of Brooks' claims are based on the allegations that she had health coverage through Medicare, and 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. Thus, her claims against Defendants are baseless because of the controlling provisions of the Medicare Act.

Other jurisdictions that have been confronted with this issue have concluded that the Medicare Act, 42 U.S.C.A. § 1395y(b)(2)(A)(ii), 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).

Judicial economy favors immediate consideration of this issue because the law is settled that the billing practices alleged by Brooks are in direct compliance with the Medicare Act and Defendants cannot be liable to Brooks in this case for doing exactly what Medicare requires of them.

Similar circumstances exist with respect to the other causes of action at issue in the Motions to Dismiss, *i.e.* Blackwell's claim for unjust enrichment when she does not allege and she made no payment and conferred no benefit on Defendants, and the tortious interference claims where Plaintiffs do not allege and there were no breaches of the relevant contracts between Plaintiffs and their insurers, and where the Amended Complaint expressly alleges voluntary settlement payments by Brooks and Owens with no allegations of duress.

In sum, granting this petition and considering these issues now would promote judicial economy, prevent wasteful litigation, and aid in this Court's understanding and disposition of estoppel and arbitration issues already before the Court.

CONCLUSION

For these reasons, Defendants request that this Court grant their Petition for Writ of Certiorari.

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February 26, 2025
Columbia, South Carolina

THE STATE OF SOUTH CAROLINA
In The Supreme Court

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 ..... Petitioners.

PROOF OF SERVICE

The undersigned hereby certifies that on February 26, 2025, a copy of **Petitioners' Petition for Writ of Certiorari** and Appendix was served on all counsel of record via email containing the above referenced document to counsels' individual AIS email addresses as follows:

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VIA HAND-DELIVERY AND E-MAIL:
The Honorable Patricia A. Howard
Clerk, South Carolina Supreme Court
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ctappfilings@sccourts.org

Re: Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly situated v. Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital, CHSPSC, LLC, and Professional Account Services, Inc.
Opinion No. 6088 (S.C. Ct. App. Filed September 18, 2024)
Appellate Case No.: 2020-001613

Dear Mrs. Howard,

In connection with the above-referenced matter and in satisfaction of the Court's filing fee requirements, please find Check No. 520071 in the amount of $250 for the Petition for Writ of Certiorari, and Check No. 520072 in the amount of $50.00 for the Motion to File Confidential Documents Under Seal.

In conjunction with the delivery of the enclosed checks, the following documents are being filed electronically with the Court:

1. Petitioners Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital, CHSPSC, LLC, and Professional Account Services, Inc.'s Petition for Writ of Certiorari and Proof of Service;

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

3. Petitioners Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital, CHSPSC, LLC, and Professional Account Services, Inc.'s Moton to File Confidential Documents Under Seal and Proof of Service.

As copied on this letter, and as evidenced by the Proofs of Service, we have filed a copy of the Petition with the Clerk of the Appellate Court, and have served all counsel of record with a copy of the same.

Should you have any questions or need anything further, please do not hesitate to contact me.

Sincerely,

s/Katon E. Dawson, Jr.

Katon E. Dawson, Jr.

KED/tlc
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