

STATE OF SOUTH CAROLINA

COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS

FIFTEENTH JUDICIAL CIRCUIT

STEPHANIE A SMITH on behalf of
herself and all others similarly situated,

Plaintiff,

v.

PROGRESSIVE HALCYON
INSURANCE COMPANY, n/k/a
PROGRESSIVE DIRECT INSURANCE
CO., PROGRESSIVE MAX, and
PROGRESSIVE CASUALTY
INSURANCE,

Defendants.

Case No. 2010-CP-26-10502

[DEFENDANTS' PROPOSED]
ORDER ON MOTION FOR
RECONSIDERATION AND TO ALTER
OR AMEND THE COURT'S ORDER
GRANTING CLASS CERTIFICATION

This matter is before the Court on Defendants' Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification (the "Motion"). After considering the parties' written submissions, hearing oral argument on the Motion, and conducting a rigorous analysis of the facts and law, the Court GRANTS the Motion, VACATES its February 14, 2013 Order (the "Order"), and DENIES Plaintiff's Motion for Class Certification.

BACKGROUND

I. Plaintiff's Insurance Policy And Med-Pay Claim

Between January and June 2009, Plaintiff was insured under an automobile insurance policy issued by Defendant Progressive Max (the "Policy"). Plaintiff was not insured by, and did not otherwise have any relationship with, with any other Progressive entity, including Progressive Casualty or Progressive Direct.¹ Among other things, Plaintiff's Progressive Max

¹ Except when referring to a specific Defendant, the Court collectively refers to Defendants as "Progressive."

Policy provided coverage for med-pay claims, subject to the terms and conditions set forth in the Policy, along with any exclusions. Specifically, the Policy provided that, if Plaintiff paid the med-pay premiums, Progressive would "pay the reasonable expenses incurred for necessary medical services received within three years from the date of a motor vehicle accident because of bodily injury: 1. sustained by an insured person; and 2. caused by that motor vehicle accident." Policy, Part II, Insuring Agreement. The Policy further provided that Progressive, or someone acting on its behalf, would determine "whether the expenses for medical services are reasonable," and whether the services provided were "necessary." *Id.*

In February 2009, Plaintiff was injured in an automobile accident and subsequently, through her attorney, made a med-pay claim under the Policy. The Progressive claims adjuster handling Plaintiff's claim, Ms. Dorothy Lange, examined Plaintiff's claim in light of her Policy language and determined what "reasonable" expenses Plaintiff had "incurred" for "necessary" medical services arising from her automobile accident. *Aff. of D. Lange* ¶ 6. In doing so, Ms. Lange determined that Plaintiff was entitled to reimbursement for all of her out-of-pocket medical payments, deductibles, and co-payments. *Id.* In addition, Ms. Lange determined that Plaintiff was entitled to reimbursement of all payments that her private health insurer, Blue Cross, had paid Plaintiff's medical providers. *Id.*

The only amount Ms. Lange deducted from Progressive's payment to Plaintiff was the difference between the amounts Plaintiff's medical providers originally billed for their services and the amount Blue Cross actually paid, pursuant to its third-party contracts with the medical providers. *Id.* ¶ 7. Ms. Lange deducted this amount because she determined that because neither Plaintiff nor Blue Cross actually paid those amounts, they were not expenses that Plaintiff had "incurred." *Id.* ¶¶ 7, 8.

II. Progressive's Med-Pay Adjustment Methodology

While Progressive only reduced Plaintiff's med-pay reimbursement based on the medical expenses it determined she did not "incur," Progressive reduces other South Carolina med-pay claims for a number of reasons. The record shows that Progressive adjusts med-pay claims based on at least 39 Policy provisions to determine whether insureds are owed the full amounts they request. For example, Progressive may pay a class member less than the total amount the class member was billed because some of the medical services the insured obtained did not occur "within three years from the date" of the motor vehicle accident in question. *See* Policy, Part II, Insuring Agreement. Likewise, Progressive may not have paid the insured the full amount billed because in adjusting the claim, Progressive ascertained that (i) the insured did not sustain "bodily injury," (ii) the bodily injury sustained was not the result of the "motor vehicle accident" at issue, or (iii) the insured was not, in fact, injured. *See id.*

Perhaps most crucially, pursuant to insuring agreement in the Policy, Progressive only reimburses insureds the "reasonable" amounts they incur for medical treatment.² Policy, Part II,

² As discussed below, Plaintiff disputes this point, arguing that "Progressive has never declined or reduced a claim based upon the reasonable and necessary clause within the policy." Pl.'s Supp. Br. in Opp'n to Defs.' Mot. for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification ("Plaintiff's Supplemental Brief"), at 2. But the evidence Plaintiff cites does not support this assertion. Instead, the adjusters whose testimony Plaintiff cites uniformly testified only that they could not recall specific instances in which they personally adjusted med-pay claims based on reasonableness – not that Progressive uniformly does not or "has never" adjusted med-pay claims by first determining whether the amounts are reasonable. *See* Dep. of L. Felton at 16:1-7 ("Q. Have you ever determined whether an expense is reasonable? A. If something is something I don't understand, I will talk to my manager about it. Q. Do you recall any situations where you had to determine – A. No, I don't."); Dep. of K. Braden at 12:20-24 ("Q. Can you ever recall in the last 18 months of adjusting claims for South Carolina claimants or any other claimants whether you determined that a medical service was not necessary? A. I don't recall."); Dep. of E. Dennis at 26:19-22 ("Q. In your four years with the med pay unit, have you taken any South Carolina Med Pay bill and not paid it because it was unreasonable or unnecessary? A. I don't recall."); Dep. of R. Cole at 25:10-12 ("Q. Have you ever returned a bill or reduced a bill because it was unreasonable or unnecessary? A. I don't

Insuring Agreement. To determine whether the amount an insured seeks is "reasonable,"

Progressive's employees use software called Mitchell DecisionPoint. See Dep. Tr. of P.

Goodchild (corporate representative) at 31:15-32:21, 45:24-46:4; see also Dep. Tr. of R. Cole at 9:2-21 (testifying that claims must "go through Mitchell first" to determine whether the charges are "usual and customary"); Once the DecisionPoint software audits the medical bill, the adjuster must review the audit and approve the amount to be reimbursed. Dep. of P. Goodchild (individually) at 18:1-9. The Progressive employee responsible for supervising med-pay claims in South Carolina, Peter Goodchild, explained how this process works:

Q. What happens where there is a reduction to a doctor's bill? Say the bill is \$1,000 and Mitchell says, 'Well, I think it should be \$400,' you don't know how that is calculated or determined, you don't know the nuts and bolts of Mitchell's programming?

But what happens, does the check just get spit out or – the Mitchell allowed amount?

A. The adjuster would approve that amount that was allowed for payment, and they would issue that payment.

Id.

III. Plaintiff's Claims, the Court's February 14 Order, and Progressive's Motion

Plaintiff contends that Progressive breached the Policy terms and violated South Carolina law by reimbursing her the amounts she and her health insurer actually paid for her medical expenses, rather than the amounts her medical providers billed. Second Am. Compl. ¶¶ 13, 17, 18. Plaintiff asserts claims against Progressive for breach of contract, unjust enrichment, bad faith, and unfair claims practices/tortious interference. *Id.* ¶¶ 53-74. She also seeks a declaratory

recall."); Dep. of D. Lange (August 3, 2011) at 78:10-13 (testifying that she personally has not determined that a medical bill she received in connection with a med-pay claim was unreasonable).

judgment. *Id.* ¶¶ 47-52. Plaintiff asserts her claims on behalf of herself and a purported class. *Id.* ¶ 24.

On February 14, 2013, the Court entered an Order certifying a class, which the Court defined as follows:

All insureds of Progressive Halcyon Insurance Company n/k/a Progressive Direct, Co., Progressive Max, and Progressive Casualty who (1) submitted claims to any of the Progressive Insurance Companies, including Progressive Casualty, under the med pay provision of the respective South Carolina policies during the time period of November 8, 2007 to the date of this Order, and (2) whose claims were adjusted by Progressive Casualty, and (3) who did not receive payment in the amount of their medical bills, and (4) whose med pay policy limits were not exceeded.

Id. at 13.

On February 22, 2013, Progressive timely filed its Motion, arguing that the Court should reconsider its Order because Plaintiff cannot meet the criteria for class certification set forth in SCRCP 23(a). On May 24, 2013, Progressive submitted a memorandum of law in support of the Motion. On May 29, 2013, the Court heard oral argument from the parties.

Thereafter, the parties filed several additional briefs addressing some of the issues raised in Progressive's Motion and during oral argument. On May 30, 2013, Plaintiff filed her Supplemental Brief. On June 5, 2013, Progressive filed a response to Plaintiff's Supplemental Brief. On June 19, 2013, Plaintiff filed another brief, styled Plaintiff's Memorandum in Reply to Defendants' Memorandum of Law in Support of Defendants' Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification ("Plaintiff's Supplemental Reply"). In that brief, Plaintiff proposed that the Court alter the definition of the class certified in the Order to add a fifth condition of membership. Specifically, Plaintiff proposed the following revised class definition:

All insureds of Progressive Halcyon Insurance Company n/k/a Progressive Direct Co., Progressive Max, and Progressive Casualty who (1) submitted claims to any of the Progressive Insurance Companies, including Progressive Casualty, under the med pay provision of the respective South Carolina policies during the time period of November 8, 2007 to the date of this Order, and (2) whose claims were adjusted by Progressive Casualty, and (3) who did not receive payment in the amount of their medical bills, (4) whose med pay policy limits were not exceeded, and (5) *whose file or claim contains documentation or reference to proper health insurance.*

Pl.'s Supp. Reply at 4 (emphasis added). On July 17, 2013, Progressive filed its Reply Memorandum In Further Support of Defendants' Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification ("Defendants' Reply"), in which Progressive argued, among other things, that Plaintiff's new proposed definition would not remedy the flaws Progressive contends render this case unsuitable for class treatment. Defs.' Reply at 5-6.

Having considered the parties' oral arguments and written submissions, and having further reviewed the evidentiary record, the Court finds this matter ripe for disposition.

DISCUSSION

"[A] class action is 'an exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only.'" *Broussard v. Meineke Discount Muffler Shops, Inc.*, 155 F.3d 331, 345 (4th Cir. 1998) (citation omitted).³ As a result, the proponent of class certification bears the burden of proving all five prerequisites set forth in SCRCP 23:

³ Plaintiff argues that the Court should not consider federal precedent because South Carolina takes a "more expansive view of the class action device." See Pl.'s Supp. Reply at 1-2. But Plaintiff does not explain why this purported divergence matters in this case. The chief distinction between SCRCP 23 and Federal Rule of Civil Procedure 23 is that SCRCP 23 does not contain the predominance requirement set forth Federal Rule 23(b)(3). See *Guazia v. South Carolina State Plastering, LLC*, 390 S.C. 562, 576, 703 S.E.2d 197, 204 (S.C. 2010). Progressive, however, does not argue that Plaintiff has not satisfied this predominance requirement. Instead, Progressive argues that Plaintiff has not satisfied her burden under SCRCP

- 1) The class must be "so numerous that joinder of all members is impracticable";
- 2) There must be "questions of law or fact common to the class";
- 3) The "claims or defenses of the representative parties [must be] typical of the claims or defenses of the class";
- 4) "[T]he representative parties [must] fairly and adequately protect the interests of the class"; and
- 5) "[T]he amount in controversy [must] exceed[] one hundred dollars for each member of the class."

Gardner v. South Carolina Dep't of Rev., 353 S.C. 1, 20-21, 577 S.E.2d 190, 200 (S.C. 2003).

The purpose of these requirements is to "effectively 'limit the class claims to those fairly encompassed by the named plaintiff's claims.'" *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2550 (2011) (construing Federal Rule 23(a)). Failure to establish even one of the requirements requires the Court to deny class certification. *Waller v. Seabrook Island Property Owners Ass'n*, 300 S.C. 465, 467, 388 S.E.2d 799, 800-801 (1990). Moreover, as a threshold matter, the proponent of class certification must propose an adequate class definition. *Anselmo v. West Paces Hotel Group, LLC*, No. 9-09-cv-2466-MBS, 2011 WL 1049195, at *18 (D.S.C. Mar. 18, 2011); see also *Solo v. Bausch & Lomb, Inc.*, Nos. 2-06-MN-77777-DGN, 2-06-GV-02716-DCN, 2009 WL 4287706, at *3 (D.S.C. Sept. 25, 2009) ("Although not specifically mentioned in the rule, the definition of the class is an essential prerequisite to maintaining a class action") (quoting *Roman v. ESB, Inc.*, 550 F.2d 1343, 1348 (4th Cir. 1976)).

23(a), which is materially identical Federal Rule 23(a). Accordingly, the Court finds that it is appropriate to consider federal cases construing Federal Rule 23(a) in analyzing whether Plaintiff has met her burden under SCRCP 23(a). See *Gardner v. Newsome Chevrolet-Buick*, 304 S.C. 328, 330-31, 404 S.E.2d 200, 201 (1991); see also *Middleton v. SunStar Acceptance Corp.*, No. 98-CP-07-1131, 2000 WL 33385388, at *3 n.3 (S.C. Comm. Pl. Jan. 13, 2000) ("As the South Carolina Reporter's Notes indicate, South Carolina's Rule 23 is drawn principally from Federal Rule 23. Citations to federal case law and the federal rules are based on the principal that interpretations of the federal rule provide guidance in interpreting the South Carolina rule absent material differences.") (internal citations omitted)).

To determine whether the class certification proponent has discharged her burden, the Court must conduct a "rigorous analysis" of the relevant facts. *Waller*, 300 S.C. at 467, 388 S.E.2d at 801. After conducting such an analysis, this Court concludes that Plaintiff has not met her burden of demonstrating the proposed class meets the adequacy, commonality, or typicality requirements of SCRCP 23(a). In addition, the Court concludes that class definition Plaintiff proposed in her Supplemental Reply does not adequately address the flaws Progressive identified, which renders this case unsuitable for class treatment.

I. Plaintiff Has Not Demonstrated Adequacy.

Plaintiff has not demonstrated that she would fairly and adequately represent the members of the class for two reasons. First, Plaintiff does not have a viable individual claim and thus cannot prosecute claims on behalf of the class members. Second, Plaintiff's individual circumstances cause her interests to diverge from those of the class members.

A. Plaintiff She Has No Viable Individual Claims.

Under South Carolina law, a named plaintiff must have a viable individual claim against the defendant to have standing to represent a purported class. *See Gardner*, 353 S.C. at 23 n.14, 577 S.E.2d at 200; *Ferguson v. Charleston Lincoln Mercury, Inc.*, 349 S.C. 558, 566, 564 S.E.2d 94, 98 (2002). The basis for Plaintiff's claims is that Progressive allegedly did not pay her the amount she "incurred" for medical expenses because it paid her the amount her health insurer actually paid for those services, as opposed to what her medical providers billed. Second Am. Compl. ¶ 18. Under South Carolina law and the plain language of the Policy, however, Plaintiff did not "incur" expenses that her medical providers billed but that her health insurer did not actually pay. *See* Policy, Part II, Insuring Agreement (providing that Progressive would pay only

amounts Plaintiff "incurred"); *Gordon v. Fid. & Cas. Co. of N. Y.*, 238 S.C. 438, 441, 120 S.E.2d 509, 510 (1961).

Interpreting virtually identical policy language, the South Carolina Supreme Court has held that an insured does not "incur" expenses when the insured has "no obligation . . . to pay for the treatment" she receives. *Gordon*, 238 S.C. at 441, 120 S.E.2d at 510. In April 2013, a federal district court sitting in South Carolina and interpreting South Carolina law reached the same conclusion. See *Barker v. Washington Nat'l Ins. Co.*, No. 9:12-cv-1901-PMD, 2013 WL 1767620, at *5 (D.S.C. Apr. 24, 2013). In *Barker*, the plaintiff was insured under a "Limited Benefit Health Coverage" insurance policy, which provided that the insurer would pay the plaintiff's "expenses incurred," pursuant to certain policy terms. *Id.* at *1. After obtaining medical services, the plaintiff – a Medicare beneficiary – submitted claims to the insurer based on the amounts his medical provider billed for the services he obtained. *Id.* The insurer, however, only reimbursed the plaintiff for the amounts Medicare actually paid, in accordance with the contract between Medicare and the provider. *Id.* at *2. The plaintiff sued the insurer, alleging that this method of reducing his claim was improper. *Id.* But the court disagreed, holding that the plaintiff did not "incur" the difference between what the medical provider billed and what the third-party payor paid. See *id.* at **6-7. Instead, the court held that the plaintiff "was never obligated to pay more than the amount that the hospital had agreed to accept as full payment under Medicare." *Id.* at *6. To the contrary, the court reasoned that "the benefits available under the policy are limited to those expenses for which the plaintiff was obligated to pay." *Id.* at *7.

This case is no different than *Barker*. In both cases, the plaintiff's insurer was required only to reimburse the plaintiff for medical expenses actually "incurred." Likewise, in both cases, the plaintiff's third-party payor (in *Barker*, Medicare; here, Blue Cross) had an arrangement with

the plaintiff's medical provider under which the third-party payor paid the medical provider an amount less than the total amount the medical provider billed. Finally, in both cases, the plaintiff undisputedly reimbursed the plaintiff the full amount that his or her third-party payor actually paid his or her medical provider. See Dep. Tr. of S. Smith at 55:12-56:15 (testifying that Plaintiff has no medical expenses outstanding associated with her insurance claim). Because the facts of this case are materially identical to the facts in *Barker*, the outcome likewise should be the same. Plaintiff did not "incur" the difference between what her medical provider billed and what Blue Cross paid, and she thus is not entitled to recover that amount from Progressive.

Making this determination now, in considering whether class certification is appropriate, is neither inappropriate nor premature. To the contrary, the South Carolina Supreme Court has made clear that a named plaintiff in a purported class action does not adequately represent the interests of the absent class members when the named plaintiff lacks a viable individual claim against the defendant. See *Ferguson*, 349 S.C. at 566, 564 S.E.2d at 98 (holding that purported class action cannot proceed when sole named plaintiff dies before class certification and thus has no viable claim against defendant); see also *Gardner*, 353 S.C. at 23 n.14, 577 S.E.2d at 201 (rejecting plaintiff's request to accept "juridical links doctrine" in class action context because doctrine "runs counter to this Court's previous decisions which hold that a plaintiff may not sue a defendant unless the plaintiff has suffered an injury at the hands of the defendant"). This precedent is consistent with persuasive federal authority. See, e.g., *McClain v. South Carolina Nat'l Bank*, 105 F.3d 898, 903 (4th Cir. 1997) (affirming denial of class certification because named plaintiff did not suffer damages caused by defendant and thus had no viable claim). Moreover, ruling on the legal sufficiency of Ms. Smith's claim now, in connection with deciding whether she can adequately represent the proposed class, will resolve Plaintiff's individual claim

without implicating the Due Process concerns associated with binding the absent class members. See Fed. R. Civ. P. 23 advisory cmte. note (2003) ("The party opposing the class may prefer to win dismissal or summary judgment as to the individual plaintiffs without certification and without binding the class that might have been certified.").

Because Plaintiff has no viable claim against Progressive in her own right, she cannot adequately represent the purported class. See *Broussard*, 155 F.3d at 345 (stating that Rule 23 is not a device by which plaintiffs can "strike [defendants] with selective allegations, which may or may not have been available to named plaintiffs").

B. Plaintiff Is An Inadequate Class Representative For Additional Reasons.

Upon further consideration of the record, the Court holds that Plaintiff also is not an adequate class representative for additional reasons. First, Plaintiff cannot represent class members who were insured by Progressive Casualty or Progressive Direct, rather than Progressive Max. It is undisputed that Progressive Max was the only Progressive company that issued an insurance policy to Plaintiff, who had no relationship – contractual or otherwise – with Progressive Casualty or Progressive Direct. Aff. of Michael R. Uth ¶ 5 (attached as Ex. D). As the South Carolina Supreme Court wrote in *Gardner*, "a plaintiff may not sue a defendant unless the plaintiff has suffered an injury at the hands of the defendant." 353 S.C. at 23 n.14, 577 S.E.2d at 201 (citing *Edisto Fleets, Inc. v. South Carolina Tax Comm'n*, 256 S.C. 350, 182 S.E.2d 713 (1971); *Furman Univ. v. Livingston*, 244 S.C. 200, 136 S.E.2d 254 (1964)). Because Plaintiff indisputably suffered no injury "at the hands of" Progressive Casualty or Progressive Direct, she cannot assert claims against Progressive Casualty or Progressive Direct and thus cannot represent a class including insureds of Progressive Casualty or Progressive Direct. See *Gardner*, 353 S.C. at 23 n.14.

Second, Plaintiff also is an inadequate class representative because she is a former Progressive Max policyholder, but she seeks to represent a class of current policyholders. As a former policyholder, Plaintiff has no standing to seek prospective relief, such as a declaratory judgment. See *Newman v. Richland Cnty. Historic Preservation Cmte.*, 325 S.C. 79, 74 (1997) (holding that plaintiff lacked standing to assert declaratory judgment claim because she had no "personal stake in the subject matter of [the] lawsuit"). Her interests, therefore, diverge from those of the class members she seeks to represent.

II. Plaintiff Did Not Satisfy Her Burden Of Demonstrating Commonality.

The South Carolina Supreme Court has held that "[c]ommonality is met only where the class shares a determinative issue." *Gardner*, 353 S.C. at 21-22, 577 S.E.2d 190, 201. In cases where the "factual differences" between class members' claims "are the crux of a predominant legal issue," commonality does not exist. *Id.* Put differently, to satisfy the commonality requirement, a plaintiff seeking class certification must affirmatively prove the class members "suffered the same injury" and share a "common contention" that "is capable of classwide resolution - which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Wal-Mart Stores*, 131 S. Ct. at 2551; see also *id.* ("Rule 23 does not set forth a mere pleading standard."). "A question is not common if its resolution turns on a consideration of the individual circumstances of each class member." *Burton v. Chrysler Grp. LLC*, No. 8:10-cv-00209-MGL, 2012 WL 7153877, at *3 (D.S.C. Dec. 21, 2012). The commonality requirement thus "ensure[s] that only those plaintiffs . . . who can advance the same factual and legal arguments may be grouped together as a class." *Broussard*, 155 F.3d at 340. As the leading scholar of South Carolina civil procedure has observed:

The commonality requirement is a condition of class action status, but common questions alone are not sufficient. The class action must be a better procedural mechanism for resolving the litigation than joinder of named parties or individual cases. The court should first determine the existence of common questions, and then whether they are sufficiently central to justify the class action.

James F. Flanagan, South Carolina Civil Procedure § 23.B.3 (2010).

Plaintiff contends that she has satisfied her burden of demonstrating commonality because the central question in this case – whether Progressive improperly reduced med-pay reimbursements by paying insureds less than the full amounts their medical providers billed – is a common issue. Based on the Court's review of the evidence, however, the answer to that question is not common; instead, it will vary depending on each class member's unique circumstances. Moreover, at least two of the claims that Plaintiff purports to assert on behalf of the absent class members cannot be resolved on a classwide basis because their viability necessarily turns on individualized circumstances.

A. The Class Does Not Share a Determinative Issue.

Plaintiff alleges that Progressive paid her less than the amount she was billed because it paid her the amount her health insurer contracted with her healthcare provider to pay for the services rendered. See Second Am. Compl. ¶ 18. Consequently, Plaintiff's claim that Progressive wrongly paid her less than the full amount she was billed turns on whether the expenses Plaintiff "incurred" in connection with receiving medical services were, as Plaintiff alleges, the full amount she was billed; or, as Progressive contends (and this Court holds), the amount her health insurer actually paid.

Progressive has demonstrated, however, that the class certified in the February 14 Order is not limited to Progressive insureds whom Progressive paid less than the amounts they were billed as a result of third-party payor contracts with their providers. Indeed, upon further review of the record, Plaintiff presented no evidence to show that the actual members of the class

predominantly would be such insureds. Rather, the proposed class includes all Progressive insureds in South Carolina whom Progressive paid less than the total amounts the insureds were billed, regardless of the reasons for the difference.⁴ See Feb. 14 Order at 13. The evidence shows that Progressive has made such “reduced” payments for a number of other reasons grounded in the Policy’s terms, depending on the circumstances surrounding each class member’s claim, and there is no evidence as to how many different circumstances actually are reflected in the members of the class. Thus, Plaintiff has failed to meet her burden of showing that her central contention in this case – that Progressive underpays med-pay benefits to South Carolina insureds with health insurance in breach of the Policy or in violation of South Carolina law – is common to the class the Court certified in the Order.

1. Whether Expenses Are Reasonable And Services Are Necessary Depends On Individualized Facts.

Both the class certified in the Order and the class Plaintiff now proposes would include insureds who, unlike Plaintiff herself, allegedly were paid less than the total amounts their medical providers billed because Progressive determined that the billed amounts were not “reasonable” or that the services provided were not “necessary.” *Id.* ¶¶ 28-29; Policy Part II, Insuring Agreement (stating that Progressive “will pay the reasonable expenses incurred for necessary medical services”); see, e.g., See Dep. Tr. of P. Goodchild (corporate representative) at 31:15-32:21, 45:24-46:4; Dep. of P. Goodchild (individually) at 18:1-9; Dep. Tr. of R. Cole at 9:2-21 (testifying that claims must “go through Mitchell first” to determine whether the charges are “usual and customary”); Dep. Tr. of E. Zancr at 29:14-31:13 (discussing Progressive determination of “reasonable expenses” for “necessary medical services”), 46:12-16 (stating that

⁴ As discussed below, the revision to the class definition proposed in Plaintiff’s Supplemental Reply does not affect this conclusion.

based on plain language of policy, Progressive will pay "reasonable expenses incurred for necessary medical service within three years"), 63:4-5 (stating that Progressive would pay insured "[w]hatever we were - reasonable and necessary amount that [insured was] legally obligated to pay"). Determining whether Progressive was entitled to pay those class members amounts less than they were billed depends on the interpretation of different Policy terms than those implicated by Plaintiff's claim - namely, "reasonable" and "necessary," rather than "expenses incurred." See Dep. Tr. of D. Lange at 21:18-21, 25:1-4 (stating that claims adjustment requires review of actual policy language) (attached as Ex. F); Dep. Tr. of E. Zaner at 27:16-28:3 (same). Progressive employs the DecisionPoint software to determine whether expenses are "reasonable." Dep. Tr. of P. Goodchild (corporate representative) at 31:15-32:21, 45:24-46:4.

Plaintiff argues that the Court need not concern itself with this issue because, according to Plaintiff, Progressive does not, in fact, make determinations regarding the reasonableness of medical expenses or the necessity of medical services when adjusting med-pay claims. See Pl.'s Supp. Br. at 2; Pl.'s Supp. Reply at 2-3. In other words, Plaintiff argues that Progressive simply ignores the provision of its own Policy that permits it to reduce payments to its insureds based on the reasonableness of the expenses. For this unusual proposition, Plaintiff cites testimony from several adjusters stating that they do not recall specific instances in which they personally made reasonableness determinations. See Dep. of L. Felton at 16:1-7 ("Q: Have you ever determined whether an expense is reasonable? A: If something is something I don't understand, I will talk to my manager about it. Q: Do you recall any situations where you had to determine - A: No, I don't."); Dep. of K. Braden at 12:20-24 ("Q: Can you ever recall in the last 18 months of adjusting claims for South Carolina claimants or any other claimants whether you determined

that a medical service was not necessary? A. I don't recall."); Dep. of E. Dennis at 26:19-22 ("Q. In your four years with the med pay unit, have you taken any South Carolina Med Pay bill and not paid it because it was unreasonable or unnecessary? A. I don't recall."); Dep. of R. Cole at 25:10-12 ("Q. Have you ever returned a bill or reduced a bill because it was unreasonable or unnecessary? A. I don't recall."); Dep. of D. Lange (August 3, 2011) at 78:10-13 (testifying that she personally has not determined that a medical bill she received in connection with a med-pay claim was unreasonable).

The evidence Plaintiff cites is not convincing. None of these witnesses testified that Progressive categorically does not – or did not, within the class period – make determinations about the reasonableness of expenses or the necessity of services when it adjusts med-pay claims in South Carolina. The fact that certain individual adjusters did not personally recall specific incidences of performing such tasks, among the thousands or tens of thousands of adjustments they each have performed, is both unsurprising and not compelling. This is especially so in light of the unequivocal language in the Policy stating that Progressive will make such determinations and the uncontroverted evidence from Progressive's supervisor of med-pay claims in South Carolina that Progressive makes these determinations as a matter of policy." Dep. Tr. of P. Goodchild (corporate representative) at 31:15-32:21, 45:24-46:4.

Because Plaintiff does not contend that Progressive wrongfully reduced her med-pay reimbursement based on the "reasonable" or "necessary" terms of the Policy, resolving her claim would not resolve the claims of these class members. Instead, to resolve these class members' claims, the factfinder would have to determine, on an individual basis, whether Progressive properly concluded that the amount a given class member was billed was unreasonable, that the

services the class member received were unnecessary, or both.⁵ Courts around the country repeatedly have held that class certification is improper under such circumstances. *E.g.*, *Great Lakes Anesthesia, PLLC v. State Farm Mut. Auto. Ins. Co.*, No. 11-10658, 2011 WL 4507417, at *1 (E.D. Mich. Sept. 29, 2011) (noting that determinations regarding what is reasonable and necessary were individual questions); *Johnson v. GEICO Cas. Co.*, 673 F. Supp. 2d 255, 273 (D. Del. 2009) (explaining that “individualized inquiries would be required to determine whether each class member’s individual claim was actually medically necessary and their expenses reasonable”); *Ostrof v. State Farm Mut. Auto. Ins. Co.*, 200 F.R.D. 521, 528-529 (D. Md. 2001) (denying class certification because individualized factors involved in determining whether insurer paid “reasonable and necessary” expenses precluded commonality finding); *Ross-Randolph v. Allstate Ins. Co.*, No. DKC 99-3344, 2001 WL 36042162, at *7 (D. Md. May 11, 2001) (collecting cases reaching the same conclusion).

This Court will not depart from this established precedent. Instead, the Court holds that this issue alone is sufficient to destroy commonality, rendering class treatment inappropriate and requiring the Court to vacate its Order.

2. Resolving Plaintiff’s Claim Would Not Resolve A Number Of Other Determinative Issues Under The Policy.

In addition to the individualized “reasonable” and “necessary” inquiries implicated by Plaintiff’s proposed class, the factfinder also would have to resolve a number of other individualized issues to dispose of each class member’s claims because the Policy language makes clear that Progressive may have paid the class members less than the full amounts they

⁵ Similarly, resolving Plaintiff’s claim that Progressive violated Code § 38-77-144, which provides that med-pay coverage “is not subject to a set-off,” would not resolve the individual claims of class members whose expenses Progressive deemed “unreasonable” or whose services Progressive deemed “unnecessary.”

were billed for still other reasons. With its memorandum in support of its Motion, Progressive identified 39 Policy provisions under which Progressive could reduce the amount it reimburses an insured below the amount the insured's medical provider billed.

Plaintiff does not dispute that these 39 provisions are in the Policy; that Progressive applied any of those provisions in connection with her claim; or that the application of any of these provisions would be an individual issue that the Court could not resolve collectively. Instead, Plaintiff contends that these Policy provisions are irrelevant to the Court's decision because they relate only to "threshold coverage issues."⁶ See Pl.'s Supp. Br. at 1. According to Plaintiff, "Progressive's Standard Operating Procedures require that these issues be filtered prior to making any determination of whether medical bills should be processed." *Id.* Assuming that Plaintiff is correct that all 39 of the provisions are "threshold coverage issues," Plaintiff still does not explain why this renders these Policy provisions irrelevant. Regardless of when Progressive determines whether a claim meets the criteria in the Policy, it nevertheless makes that determination when adjusting a med-pay claim. In doing so, Progressive may either reduce a claim or reject it. In any event, each of these Policy provisions provides a basis for Progressive to reimburse an insured for a med-pay claim in an amount less than the amount the insured's medical provider billed.

Like reductions based on the "reasonableness" of each insured's medical expenses, reductions based on these 39 Policy provisions are inherently individualized. To resolve each class member's claims, the factfinder would have to delve into each class member's unique circumstances. And because Plaintiff does not contend that Progressive reduced her med-pay reimbursement based on any of these 39 provisions, the Court could not answer any of the

⁶ Unlike with respect to the "reasonableness" inquiry discussed above, Plaintiff does not contend that Progressive ignores these Policy provisions in practice.

questions posed by other class members by adjudicating Plaintiff's claims – which is precisely the objective of a class action. See *Gardner*, 353 S.C. at 22, 577 S.E.2d at 201 (“Requiring such individualized examination negates the benefits of a class action suit. . . .”). Accordingly, the Court holds that there is no commonality.

3. Authority Relied Upon By Plaintiff Does Not Apply

In arguing that she met her burden of demonstrating commonality, Plaintiff relies on the decision in *Littlefield v. South Carolina Forestry Commission*, 337 S.C. 348, 523 S.E.2d 781 (1999). Upon further review, however, the Court finds the *Littlefield* decision does not apply in this case. In *Littlefield*, the court held the class certification was appropriate because the only issue in the case was whether state agencies' interpretation of a statute governing the method of calculation of unused annual leave violated equal protection. 337 S.C. at 350, 523 S.E.2d at 782. Accordingly, in that case – unlike this one – there was, in fact, “one main issue of law which [was] identical for all plaintiffs,” all injuries resulted from the same conduct, and calculation of damages would not be difficult. See *id.* at 337 S.C. at 355, 523 S.E.2d at 784.

For the reasons described above, that is not the situation here. To the contrary, this is a case in which “the varying claims presented by the proposed class will require . . . intensive, individual fact-finding.” See *Martin v. State Farm Mut. Auto. Ins. Co.*, 809 F. Supp. 2d 496, 510 (S.D. W. Va. 2011) (denying motion for class certification because claims that insurer did not make uninsured motorist coverage available to purported class at “commercially reasonable rates” implicated multitude of individual issues that precluded finding of commonality under *Wal-Mart*). Rather than demonstrating that the purported class members “suffered the same injury,” the evidence shows that “because of the varying factual scenarios between putative class members, there are a wide variety of possible injuries – including no injury at all – caused by”

Progressive's alleged conduct. See *Martin v. JTH Tax, Inc.*, No. 9:10-cv-03016-DCN, 2013 WL 442425, at *6 (D.S.C. Feb. 5, 2013).

Consequently, "[t]his is not a typical class action where minor factual differences exist among the individualized cases of class members." See *Gardner*, 353 S.C. at 22, 577 S.E.2d at 201. To the contrary, the "factual differences" in this case "are the crux of a predominant legal issue" — i.e., whether Progressive breached the Policy or violated South Carolina law by paying the purported class members amounts less than they were billed. *Id.* On that basis, this Court adopts the reasoning of the South Carolina Supreme Court in *Gardner*, the facts of which are analogous to the facts here, and reaches the same conclusion: class certification is inappropriate.

B. Plaintiff's Unjust Enrichment Claim Does Not Implicate Common Issues.

The Court also holds that class certification is inappropriate because of the overwhelming individual issues implicated by Plaintiff's unjust enrichment claim. Plaintiff alleges, on behalf of herself and the purported class, that Progressive was unjustly enriched by "the reduced payments to the Plaintiff and class members under the medical payments portion of their insurance policies with [Progressive]." Second Am. Compl. ¶ 59. In other words, Plaintiff contends that Progressive was unjustly enriched as a result of its payments to the class members resulting from the myriad unique circumstances surrounding each class member's claims to Progressive.

Unjust enrichment is an equitable doctrine, which permits recovery of the amount that the defendant has been unjustly enriched at the expense of the plaintiff. *Dema v. Tenet Physician Servs. Hilton Head, Inc.*, 383 S.C. 115, 123, 678 S.E.2d 430, 434 (2009); *Ellis v. Smith Grading & Paving, Inc.*, 294 S.C. 470, 474, 366 S.E.2d 12, 15 (Ct. App. 1988). To recover for unjust enrichment on a classwide basis, Plaintiff must prove — for each class member — that (i) the class member conferred a benefit on Progressive; (ii) Progressive realized that benefit; and (iii) Progressive retained the benefit under circumstances that make it "inequitable" for Progressive to

do so "without paying ... its value." *Sauner v. Public Serv. Auth.*, 354 S.C. 397, 409, 581 S.E.2d 161, 167 (2003).

By its very nature, an unjust enrichment claim is unsuitable for resolution on a classwide basis because adjudicating it would require the factfinder to investigate the individualized circumstances surrounding each class member's claims. In particular, the factfinder would have to determine – based on each class member's unique circumstances – whether, by paying each class member an amount less than the full amount the class member was billed (as opposed to the amount the class member or her health insurer actually paid) "it would be inequitable" for Progressive to retain the class member's premium payments. Making such a determination would require the factfinder to consider, among other things:

- Whether Progressive paid the class member an amount less than what she was billed (as opposed to what she or her health insurer paid) because that was the amount her healthcare provider contracted to receive from her third-party payor;
- Whether Progressive paid the class member an amount less than what she was billed (as opposed to what she or her health insurer paid) because it rightly determined that her medical expenses were unreasonable;
- Whether Progressive paid the class member an amount less than what she was billed (as opposed to what she or her health insurer paid) because it rightly determined that her medical treatment was unnecessary in one or more respects;
- Whether Progressive paid the class member an amount less than what she was billed (as opposed to what she or her health insurer paid) because the class member otherwise was not entitled to coverage under the Policy.

- Whether the class member had to pay any money out-of-pocket as a result of Progressive paying her less than the amount she was billed;
- Whether the class member reaped a windfall as a result of Progressive paying her any amount of money in connection with her claim because she paid no money (or less money than Progressive paid her) for the medical services she received; and
- Whether the class member derived any benefits from paying premiums to Progressive, other than Progressive paying the expenses she actually incurred from receiving medical services in connection with her claim.

Put succinctly, there is no single question the factfinder can answer in addressing Plaintiff's individual claims that also will answer all of these questions with respect to each and every class member. Accordingly, Plaintiff's unjust enrichment claim renders class certification inappropriate. *See Mellon ex rel. Dutton v. Carolina Power & Light Co.*, 283 F.R.D. 280, 290 n.7 (D.S.C. 2012) (concluding that because unjust enrichment and other claims required the factfinder to make numerous "individualized determinations").

C. Plaintiff's Bad Faith And Tortious Interference Claims Do Not Implicate Common Issues.

For similar reasons, the Court holds that Plaintiff's bad faith claim is not amenable to class treatment. To state a claim for bad faith, Plaintiff must prove -- with respect to herself and the purported class -- that Progressive refused to pay each class member the benefits owed the class member under the Policy as a result of Progressive's "bad faith or unreasonable action in breach of an implied covenant of good faith and fair dealing." *See Temple v. Mut. of Omaha Ins. Co.*, No. 4:11-cv-00128-RBH, 2013 WL 314750, at *4 (D.S.C. Jan. 28, 2013) (construing South Carolina law). As a result, to resolve the class members' claims, the factfinder would be required

to determine, with respect to each class member, whether Progressive acted in "bad faith" or "unreasonably." Given the myriad differing situations in which the class members find themselves, as described above, the factfinder could not possibly make such a determination simply by resolving Plaintiff's claim. *See Gardner*, 353 S.C. at 22-23, 577 S.E.2d at 201 (denying class certification because factfinder would have to determine individually whether class members were "prejudiced" by defendant's alleged conduct).

Plaintiff's tortious interference claim precludes class certification for similar reasons as her bad faith claim. Namely, it would require the factfinder to determine whether Progressive intentionally procured the breach of its own contracts with the class members (assuming, for the sake of argument, that a party to a contract can state a claim for tortious interference with her own contract). *See Self v. Norfolk So. Corp.*, Nos. 1:06-cv-1730-MBS and 1:06-cv-2101-MBS, 2007 WL 540373, at *4 (D.S.C. Feb. 15, 2007). Accordingly, Plaintiff has not shown that commonality exists with respect to her bad faith or tortious interference claims.

III. Plaintiff Did Not Satisfy Her Burden Of Demonstrating That Her Claims Are Typical of the Class Members' Claims.

To meet the typicality threshold, Plaintiff must prove that her "interest in prosecuting [her] own case . . . simultaneously tend[s] to advance the interests of the absent class members." *See Dieter v. Microsoft Corp.*, 436 F.3d 461, 466 (4th Cir. 2006) (holding that named plaintiffs in antitrust class action were not typical of some purported class members because proving absent class members' claims would require "new and different proof" than evidence required to prove named plaintiffs' claims). Plaintiff thus must prove that she "possess[es] the same interest" and "suffer[ed] the same or similar injury" as the class members. *See Burton*, 2012 WL 7153877, at *3 (citing *McClain*, 105 F.3d at 903). When "variation" between a named plaintiff's claims and those of the purported class members "strikes at the heart of the respective causes of

actions,” courts “have readily denied class certification. See *Dieter*, 436 F.3d at 467 (citing cases).

For the same reasons Plaintiff is an inadequate class representative and there is no commonality, Plaintiff’s claims are atypical. Even if Plaintiff could prove her own claim (and she cannot), doing so would not resolve the claims of class members who are situated differently than Plaintiff. Plaintiff, therefore, has not – and cannot – establish typicality. See *Burton*, 2012 WL 7153877, at *5 (denying class certification because court found “it would be forced to sort through individualized questions . . . to determine whether each class member has a cognizable” claim), *Biggerstaff v. Voice Power Telecomm. Inc.*, No. 2002-GP-10-1351, 2003 WL 25564250, slip op. at 5 (9th Jud. Cir. Oct. 13, 2003) (denying class certification on lack of typicality grounds because “each specific fact of each member of the putative class will have to be examined to determine” liability).

IV. Plaintiff’s Proposed Class Definition Is Not Adequate.

In addition to the explicit requirements set forth in SCRCP 23(a), the Court also must consider whether Plaintiff’s proposed class definition is adequate. See *Cuming v. South Carolina Lottery Comm’n*, No. 3:05-cv-03608-MBS, 2008 WL 906705, at *1 (D.S.C. Mar. 31, 2008). Crafting an adequate class definition is not merely a ministerial act; it is essential to ensuring that the class action device accomplishes its goal of efficiently resolving a large number of claims in a single proceeding. If the Court must conduct individual inquiries for each potential class member merely to determine whether he or she is a member of the class, then the class definition is not “sufficiently definite so that it is administratively feasible for the [C]ourt to determine whether a particular individual is a member.” See *id.* (citing 7A Charles Alan Wright, *et al.*, *Federal Practice & Procedure* § 1760 (2d ed. 1986 & Supp. 2007)); see also *Flanagan* § 23.B.1

("Many of the problems about the 'class' aspect of the representative suit are traceable to vague and ambiguous pleadings that make the class too expansive and difficult to determine its membership.") Unless the flaws in the class definition are remediable, class certification under those circumstances is improper. *See Cuming*, 2008 WL 906705, at *1.

In this case, the class definition Plaintiff proposed in her Supplemental Reply – like the class certified in the Order – is overly broad. The proposed class would include insureds of three different insurers – Progressive Casualty, Progressive Direct, and Progressive Max (the only insurer with whom Plaintiff had a relationship) – who received payments from Progressive in amounts less than they were billed for medical services for any reason. As discussed above, Plaintiff failed to demonstrate that the proposed class implicates a common question that the Court can resolve simply by adjudicating Plaintiff's claim. To the contrary, simply to determine whether a particular individual is a member of a class Plaintiff theoretically could represent – that is, a class limited to individuals whom Progressive reimbursed in amounts matching what third-party payors paid the individuals' medical providers – the Court would have to conduct "extensive factual inquir[ies]." As a result, the class definition is inadequate. *See id.*

Plaintiff takes two different approaches to addressing the problems with the class definition. First, Plaintiff argues that this flaw in the class definition is not dispositive because "[t]he reasons for any write-downs to a medical bill are coded and explained in the Explanation of Benefits [EOB] to the insured." Pl.'s Supp. Br. at 2. This argument, however, merely underscores the inadequacy of the class definition. There is no evidence that EOBs contain detailed information about the reasons for payment reductions. In other words, Plaintiff has introduced no evidence indicating that the EOB differentiates between a reduction based on a third-party payor contract with the medical provider (as in Plaintiff's case) and a reduction based

on Progressive's determination that the insured's medical expenses were unreasonable. Moreover, even if the EOBs provided such detail, the evidence shows that the only way to identify class members based on EOBs would be to conduct a manual, file-by-file review of all of the EOBs. See Dep. Tr. of M. Silver at 27:19-28:6 (testifying that Progressive cannot ascertain "the number of persons who submitted claims and . . . didn't receive the maximum policy limits . . . and they received a payment that was less than one or more of their medical bills.").

Second, after the Court heard oral argument on Progressive's Rule 59(e) motion, Plaintiff proposed a new class definition, presumably in an effort to address Progressive's arguments regarding overbreadth. Specifically, Plaintiff proposed adding a fifth condition of class membership: to be a class member, the insured's file must contain documentation or reference to health insurance. Pl.'s Supp. Reply at 4. According to Plaintiff, this additional condition of class membership will "cull out claimants without health insurance who had a reduction." *Id.* At best, this proposal is a half-measure. As an initial matter, there is no way to determine which insureds' files contain documentation relating to health insurance without reviewing each of the files. Moreover, Plaintiff presents no evidence regarding how many potential class members might not have health insurance and thus would be excluded based on this condition. Dep. Tr. of M. Silver at 19:8-23. Put differently, there is no evidence indicating that after reviewing all of the potential class members' files for evidence of health insurance, a significant number of potential class members would be eliminated.

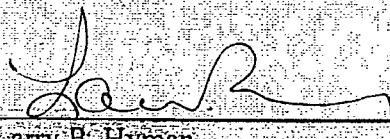
Ultimately, Plaintiff does not dispute that the only way to identify the class members in this case would be to conduct a manual file review. Instead, Plaintiff argues that the necessity of such a review is no bar to class certification reviewing "several hundred files . . . is not a large task for sophisticated insurance companies." Pl.'s Supp. Reply at 4. Plaintiff's assertion is based

on two misunderstandings of the law. First, the duty to review the files and identify the class members does not fall on Progressive; it falls on Plaintiff. See *Oppenheimer Fund, Inc. v. Sanders*, 437 U.S. 340, 358 (1978) (stating "general rule" that "representative plaintiff should perform the tasks" required to identify and notify class members, "for it is he who seeks to maintain the suit as a class action and to represent other members of his class"). More to the point here, however, the relative burden associated with conducting a manual file review is not the pertinent issue; a class definition that requires individualized factfinding to ascertain the proposed class members precludes class certification. See, e.g., *Burton*, 2012 WL 7153877, at *2 (denying class certification because, among other reasons, because based on proposed class definition, "it would be difficult to analyze . . . records . . . to determine whether a particular individual is a class member"); *Solo*, 2009 WL 4287706, at *6 (denying class certification because "[i]n order to ascertain who falls within the class, the court would have to make thousands of fact-intensive inquiries"); *Cuming*, 2008 WL 906705, at *1 (same). Accordingly, the Court holds that the class definition in the Order and the alternate class definition proposed in Plaintiff's Supplemental Reply are inadequate and that class certification thus is inappropriate.

CONCLUSION

For these reasons, the Court GRANTS Defendants' Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification, VACATES its February 14, 2013 Order, and DENIES Plaintiff's Motion for Class Certification.

This 20 day of Aug, 2013.



Larry B. Hyman
Presiding Judge, Fifteenth Judicial Circuit

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