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S.C. SUPREME COURT

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. 2025-000346

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 BRIEF

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STATEMENT OF ISSUES ON APPEAL

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.

STATEMENT OF THE CASE

This appeal concerns whether a non-signatory (here, Plaintiff Samuel H. Owens, Jr.) seeking to benefit from a contract containing an arbitration clause can use artful pleading to avoid being bound by that clause.

A. Plaintiff Owens alleges various claims seeking to benefit from alleged terms in a contract between Defendant Mary Black and Owens's insurer, Cigna.

Petitioner-Defendant Mary Black Health System, LLC ("Mary Black") is a community hospital. Petitioner-Defendants CHSPSC, LLC, and Professional Account Services, Inc. allegedly provide services to Mary Black and other hospital entities.[1] Owens and his co-Plaintiffs Jo Ann Blackwell and Michelene Brooks each allege that Mary Black provided them with emergency care following motor vehicle accidents.

This case was originally filed by Plaintiff Blackwell on January 20, 2017. (Appx. 225–237). Several years later, on April 24, 2020, the complaint was amended to include Owens and Brooks as additional named plaintiffs. (Appx. 243). This appeal mainly concerns Plaintiff Owens and Mary Black's assertion that Owens is bound to arbitrate his claims. He alleges that, on October 9, 2015, he was admitted to Mary Black following an automobile accident and "received medical treatment for injuries associated with the accident." (Appx. 273, ¶ 14).

At the time, he alleges, his health insurer was Cigna. (Appx. 273, ¶ 48). Mary Black's relationship with Cigna is governed by a Hospital Services Agreement ("Cigna Agreement"), which sets forth various aspects of the relationship between Mary Black and Cigna, including

[1] Plaintiffs allege (incorrectly) that CHSPSC, LLC, is an entity responsible for patient billing, and they allege that Professional Account Services, Inc. ("PASI") is an entity that performed billing and collection services for Mary Black. Aside from a conclusory allegation that CHSPSC and PASI exercise control over policies used by Mary Black, Plaintiffs do not allege any specific wrongful conduct by either entity.

billing practices or procedures and the negotiated rates that Cigna will pay on behalf of its insureds for covered services. (Appx. 469).

Owens alleges that Mary Black did not bill Cigna for the services provided after the accident, but sought payment by asserting a lien against his claims against the at-fault driver in the collision. (Appx. 273). He and his co-Plaintiffs allege, however, that Mary Black's contracts with "health insurance carriers" (like the Cigna Agreement) "required" Defendants to submit Plaintiffs' medical bills "directly to the carriers" (like Cigna). (Appx. 270, ¶ 28). And Plaintiffs also allege Defendants violated those contracts' terms by failing to do so, which, in turn, allegedly deprived Owens and his co-Plaintiffs of the purportedly discounted rates in those contracts. (Appx. 270–271, ¶¶ 26–32).

Owens and his co-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 with their insurers in the form of their insurance policies; (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 the relationships under the insurance policies. Although the claim is superficially focused on Plaintiffs' insurance policies, the benefit Plaintiffs seek—according to Plaintiffs' own allegations—is "the discounted amount [Defendants] agreed to accept from patients' health insurance" in *Defendants*' alleged contracts with Plaintiffs' insurers. (Appx. 271, ¶ 32; *see also id.* 270, ¶ 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—unjust enrichment and injunctive relief—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." (Appx. 278, ¶ 73). Thus, Plaintiffs allege, Defendants were unjustly enriched by seeking and receiving payment from Plaintiffs. (Appx. 278, ¶¶ 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. (Appx. 279, ¶¶ 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. (Appx. 274–275, ¶ 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 a single common issue alleged by Plaintiffs concerns *Plaintiffs'* alleged policies with their insurers.

B. Because the contract between Cigna and Defendants requires all disputes to be arbitrated, Defendants move to compel Owens to arbitration under the doctrine of direct benefits estoppel.

Plaintiff Owens's problem, however, is that the Cigna Agreement provides that all claims arising out of the agreement are subject to individual arbitration. (Appx. 481–482). Specifically, Section 6 of the Cigna Agreement contains the following arbitration clause:

> 6.2.2 Arbitration. . . . **Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement**. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator. The parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision shall not be consolidated with an arbitration involving other hospitals or third parties, and that the arbitrator shall be without power to conduct an arbitration on a class basis. Judgment upon the award rendered by

> the arbitrator may be entered in any court of competent jurisdiction. The Agreement will remain in full force and effect during any such period of arbitration unless otherwise terminated under the terms of this Agreement.

(Appx. 481–482) (emphasis added).

Defendants thus asked the circuit court to compel Owens to arbitrate his claims. As Defendants explained, although Owens is not a signatory to the Cigna Agreement, he seeks to directly benefit from it, by claiming that he was entitled to the agreement's allegedly discounted rates and that Defendants were allegedly obligated to bill Cigna at those rates for medical services Owens received. Put differently, 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 is the *sine qua non* of all Owens's claims. He alleges these facts give rise to his claim that Defendants tortiously interfered with his contract with Cigna because they deprived him of the alleged "benefit of" that relationship—namely, the right to receive the benefit of an alleged obligation under the Cigna Agreement for Mary Black to bill Cigna and at discounted rates, rather than seeking "additional monies to which Defendants were not entitled" by billing Owens. (Appx. 277, ¶ 66; *see also id.* 270–271, ¶¶ 27–29, 32). He further alleges that Defendants were unjustly enriched by billing Owens directly rather than billing Cigna directly at the Cigna Agreement's allegedly discounted rates. Additionally, he alleges that Defendants should be ordered to follow the terms of agreements like the Cigna Agreement.

Thus, Defendants explained, the doctrine of direct benefits estoppel (a type of equitable estoppel under which non-signatories are held to be bound by arbitration clauses in contracts they seek to enforce or derive a benefit from) precludes Owens—as a matter of fairness and equity—from seeking to benefit from some terms of the Cigna Agreement, while seeking to evade other terms that he does not like. Defendants also moved under Rule 12(b)(6) to dismiss all Plaintiffs' claims.

In a September 4, 2020 order, the circuit court denied the motions. Defendants moved for reconsideration, and that too was denied. On December 8, 2020, Defendants appealed.

C. Misapplying direct benefits estoppel, a split panel of the Court of Appeals affirms the circuit court's denial of Defendants' motion to compel arbitration.

On appeal, Defendants argued, among other things, that the circuit court erred in denying the motion to compel arbitration because direct benefits estoppel binds Owens to the CIGNA Agreement's arbitration provision.

The appeal remained pending for nearly four years, until, on September 18, 2024, a divided Court of Appeals affirmed the circuit court. The majority agreed that the arbitration provision in the Cigna Agreement is binding and enforceable. (Appx. 9). Yet the majority held that Owens was not estopped from avoiding the application of that provision.

To reach this decision, the majority ignored that Owens was seeking to enforce and exploit the Cigna Agreement to his benefit. Instead, the majority held—contrary to binding precedent—that direct benefits estoppel did not apply because Owens "never *alleged* in the complaint that he *received* a direct benefit from the CIGNA Agreement." (Appx. 10) (emphasis added). The majority also ignored that Owens had expressly alleged the existence of the Cigna Agreement in the Amended Complaint and instead stated, inaccurately, that Owens "did not know about the agreement prior to this litigation." (Appx. 10).

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." (Appx. 10). 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." (Appx. 10). The majority does not explain, however, how any purported duty for Mary Black could arise without the alleged requirements in the Cigna Agreement. For example,

the opinion identifies no basis in tort law to impose a duty on Mary Black and fails to recognize that prior decisions have established that there is no general duty for a healthcare provider to submit bills to a patient's health insurance carrier.[2]

Likewise, the majority held, without explanation, 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." (Appx. 11). But the majority provides no basis or justification for this conclusion. Indeed, Owens's insurance policy with Cigna is not even in the record.

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." (Appx. 11–12). The majority identifies no authority—from South Carolina or otherwise—that authorizes a court to force a party to litigate an arbitrable claim on the mere basis that other claims are (supposedly) not subject to arbitration.

As an alternative ground for Owens to avoid arbitration, the majority interpreted a class arbitration waiver in the Cigna Agreement to work exactly backwards. That is, rather than reading it to preclude, as intended, Owens from pursuing his claims on a class or collective basis, the Court of Appeals interpreted it as precluding Defendants from compelling Owens to arbitration because he had already joined a class action. (Appx. 12).[3]

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[2] *See 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).

[3] The majority also 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* Appx. 12–13). Although Defendants also sought review of that flawed decision, this Court did not certify the issue for review.

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." (Appx. 13–14). Thus, "equity prevents" Owens "from avoiding the arbitration clause that was part of [his insurer's] agreement." (Appx. 13) (internal quotation marks omitted). To hold otherwise "would both disregard equity and contravene the purposes underlying enactment of the Federal Arbitration Act." (Appx. 14) (internal quotation marks and brackets omitted).

D. The same Court of Appeals panel issues a unanimous decision in *Bennett* compelling arbitration under the principle of direct benefits estoppel that cannot be reconciled with the decision here.

The *same* day it issued its decision here, the *same* Court of Appeals panel issued a unanimous decision, authored by Judge Geathers, in *Bennett v. ACS Primary Care Physicians- Se. P.C.*, 444 S.C. 458, 908 S.E.2d 110 (Ct. App. 2024). The two cases are functionally indistinguishable, with striking similarities between the core allegations in each:

***Blackwell* Amended Complaint (Appx. 265 *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	¶ 4: "Defendant would bill Insureds directly at a rate higher than the negotiated BCBS rate, resulting in an increase to healthcare costs to Insureds."

Blackwell* Amended Complaint** (Appx. **265 *et seq.)	***Bennett* Complaint** (**Case No. 2021-001342, R. 37 *et seq.***)
and being entitled to have their medical bills submitted to their health insurance for payment."	
¶ 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 and allegedly charged higher rates for the medical services than those provided in the contract between the hospital and the patient's insurer. Like 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 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.

Unlike this case, however, the panel unanimously held that equitable estoppel required the *Bennett* plaintiffs to arbitrate their claims under 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).[4] 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* (Appx. 10) (holding that estoppel did *not* apply because Owens "never alleged in the complaint that he received a direct benefit from the CIGNA Agreement").

No party sought review of the Court of Appeals' decision in *Bennett*, and the time for any such review passed long ago. Here, on the other hand, Defendants timely petitioned for rehearing and rehearing en banc, both of which were denied on January 27, 2025. But Judge Geathers once again dissented, stating that, for the reasons stated in his original dissent, he would have granted rehearing. On June 25, 2025, the Court issued an order granting Petitioners' Petition for a Writ of Certiorari.

STANDARD OF REVIEW

Unless the parties "provide otherwise," "[t]he question of the arbitrability of a claim is an issue for judicial determination." *Zabinski v. Bright Acres Assocs.,* 346 S.C. 580, 596, 553 S.E.2d 110, 118 (2001). Thus, "[w]hether an arbitration agreement may be enforced against a nonsignatory to the agreement is a matter subject to de novo review by an appellate court." *Wilson v. Willis*, 426 S.C. 326, 335, 827 S.E.2d 167, 172 (2019).

[4] Although not in the record because it occurred in the circuit court while this appeal was pending, Plaintiffs here *also* 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.

When reviewing a motion to compel arbitration "[i]t is the policy of this state and federal law to favor arbitration[,] and 'any doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration.'" *Landers v. Fed. Deposit Ins. Co.*, 402 S.C. 100, 109, 739 S.E.2d 209, 213 (2013) (quoting *Am. Recovery Corp. v. Computerized Thermal Imaging, Inc.*, 96 F.3d 88, 92 (4th Cir. 1996)). "[T]he party resisting arbitration bears the burden of proving that the claims at issue are unsuitable for arbitration." *Dean v. Heritage Healthcare of Ridgeway, LLC*, 408 S.C. 371, 379, 759 S.E.2d 727, 731 (2014).

INTRODUCTION TO ARGUMENTS

The doctrine of direct benefits estoppel provides that—as a matter of equity and fairness—a nonsignatory to a contract containing an arbitration clause may not seek to obtain a direct benefit from the contract's terms while refusing to comply with the contract's arbitration clause. Here, Owens seeks to benefit from his insurer Cigna's agreement with Mary Black because his claims are all based on the theory that the agreement required Defendants to bill Cigna, not him, for the medical services he received and to do so at the discounted rates agreed to under that agreement. Accordingly, direct benefit estoppel applies, and Owens must arbitrate his claims.

Plaintiffs, however, sought to avoid that result by pleading one (out of three) claims in tort, and not contract. But, as courts across the country have held, a plaintiff may not use such artful pleading to avoid the application of direct benefits estoppel. Instead, courts look past labels to determine whether, at bottom and in substance, a non-signatory is seeking to secure a benefit under the contract it issue. If so, direct benefit estoppel applies, regardless of labels and artfully pleaded allegations. And, no matter the label, each one of Owens's claims seek to secure a benefit for him under the Cigna Agreement. He is bound, therefore, to arbitrate them. To hold otherwise would elevate form over substance, encourage gamesmanship, and reward improper efforts to forestall arbitration.

In affirming the circuit court's order denying Petitioner's motion to compel, however, the Court of Appeals majority not only erred—it extended an invitation to exactly those problems. Moreover, its decision cannot be reconciled with the same panel's decision in *Bennett*, issued the same day. In *Bennett*, the panel unanimously held, under functionally indistinguishable facts, that direct benefits estoppel did apply and arbitration must be compelled. As Judge Geathers (the authoring judge in *Bennett*) explained in dissent in this case, Owens's claims seek to enforce, and cannot be determined without reference to, the terms of a contract containing an arbitration provision. And, given the irreconcilable conflicts between the majority's decision in this case and the unanimous decision in *Bennett*, affirming the majority here will only further invite confusion and gamesmanship in the trial courts.

Defendants, therefore, urge this Court to reverse the Court of Appeals and order that direct benefits estoppel requires Owens, like the plaintiffs in *Bennett*, to arbitrate his claims, thus ensuring consistency and harmony in South Carolina law.

ARGUMENTS

I. The Court of Appeals majority erred in holding that the doctrine of direct benefits estoppel does not require Owens to arbitrate his claims.

When a nonsignatory plaintiff sues and seeks to obtain relief based on a contract containing an arbitration provision, South Carolina courts apply direct benefits estoppel to bar that plaintiff from avoiding the application of the contract's arbitration provision. *See 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 be compelled to arbitrate where the nonsignatory knowingly exploits the benefits of an agreement containing an arbitration clause." *Wilson*, 426 S.C. at 340–41, 827 S.E.2d at175 (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 *Pearson*, 400 S.C. at 290, 733 S.E.2d at 601 (quoting *Int'l Paper Co. v. Schwabedissen Maschinen & Anlagen GMBH*, 206 F.3d 411, 418 (4th Cir. 2000))). In other words, it is not necessary that the plaintiff has already received the benefit in order for direct benefits estoppel to apply. What matters is that the plaintiff seeks to obtain the benefit provided through the agreement.

And it applies here. No matter how Owens styles his claims for relief, his theory of liability is that he was harmed, and is entitled to recover, because Defendants did not allow him the benefit of the terms in the Cigna Agreement, including the benefit that Defendants bill his insurance carrier directly and do so at the discounted rates Defendants allegedly agreed to accept in its agreement with the insurance carrier. (Appx. 270–271, ¶¶ 27–29, 32). Viewed properly, therefore, Owens's claims "arise solely" from the agreement between Mary Black and the insurance carrier, 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 Court of Appeals majority misapplied the doctrine of benefits estoppel, in multiple ways.

A. Direct benefits estoppel applies because Owens seeks to receive a benefit under a contract with an arbitration clause and he was aware of the contract when his suit commenced.

The majority's analysis begins by asserting that direct benefits estoppel does not apply because Owens (1) "did not benefit from the CIGNA Agreement" and (2) "did not know about the agreement prior to this litigation." (Appx. 10). The first point is wrong on the law; the second wrong on the facts.

On the first point, the majority says that "Owens never alleged in the complaint that *he received* a direct benefit from the CIGNA Agreement." (Appx. 10). But this restrictive view of

the scope of direct benefits estoppel conflicts with South Carolina precedent, including *Bennett*. Specifically, 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 (emphasis added) (quoting *Pearson*, 400 S.C. at 290, 733 S.E.2d at 601 (quoting *Int'l* Paper, 206 F.3d at 418)); *see also Wilson*, 426 S.C. at 340, 827 S.E.2d at 175 (same); *Am. Bankers Ins. Grp. v. Long*, 453 F.3d 623 (4th Cir. 2006) (explaining that "a non-signatory will be estopped when his underlying claims *seek* a 'direct benefit' from the contract containing the arbitration clause") (emphasis added).

And this makes sense. If the plaintiff had already obtained the benefit, he would have no reason to sue. It is the attempt to use the contract to obtain the benefit that triggers direct benefits estoppel.

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 a contract between his insurer and his provider. 444 S.C. at 474, 908 S.E.2d at 118. Owens and his fellow Plaintiffs here mention those benefits throughout the Amended Complaint. (Appx. 270, ¶ 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* (Appx. 271, ¶ 32; Appx. 279 ¶¶ 77, 78, 80). Those same discounts cannot be considered direct benefit in *Bennett* and not a direct benefit in this case.

As for the second point, the majority is simply incorrect that Owens "did not know" of the Cigna Agreement "prior to litigation." (Appx. 10). On the contrary, Owens alleges that "[a]t the time of his medical treatment, Plaintiff Owens had valid health insurance coverage through

Cigna"; that Defendants "refused to submit" the bills for his treatment "to Plaintiff Owens's health insurance for payment"; and that these bills "would have been paid had they been submitted to his health insurance for payment." (Appx. 273, ¶¶ 49–51). Plaintiffs also repeatedly allege the existence of agreements between Defendants and Plaintiffs' insurers throughout the Amended Complaint. (Appx. 263–282, ¶¶ 9, 28, 29, 31, 57(b)–(e), 73, 77–78). In addition, as the same panel unanimously (and correctly) held in *Bennett*, any 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.

As support for its mistaken conclusions, the majority cites this Court's decision in *Wilson*. (Appx. 10 (citing *Wilson*)). But that case actually provides a helpful contrast with the circumstances in this case. *Wilson* involved fourteen lawsuits brought by various plaintiffs. *See Wilson*, 426 S.C. at 331–32, 827 S.E.2d at 170. Some plaintiffs were insureds who alleged that their insurance agent defrauded them; other plaintiffs were insurance agents who alleged that the same insurance agent engaged in illegal business practices. *See id.* The plaintiffs also named as defendants the agent's insurance agency and six insurance companies for which the agency sold policies, alleging, among other things, that all defendants engaged in unfair trade practices and failed to adequately investigate, train, and supervise the agent. *See id.*

Long after answering (and failing to mention arbitration in their answers), three of the defendant insurers moved to compel arbitration. *Id.*, 426 S.C. at 332–33, 827 S.E.2d at 170–71. They argued that their agreements with the defendant insurance agency contained an arbitration clause, and, thus, direct benefits estoppel bound plaintiffs to arbitrate. *Id*.

This Court disagreed. As the Court explained, the plaintiffs were not even aware of the existence of the agreements until "nearly a year into the litigation," when the insurers moved to compel arbitration. *Id.*, 426 S.C. at 342, 827 S.E.2d at 176. Moreover, the plaintiffs were not

seeking to secure any direct benefit from those agreements but, instead, were a group of "attenuated individuals" whose claims were independent of any formal business relationship between the insurers and the agency. *Id.*, 426 S.C. at 344–45, 827 S.E.2d at 177.

Here, in stark contrast, Owens's claims are premised on the existence of the CIGNA Agreement and contracts like it. Owens expressly seeks to receive the direct benefit of Cigna's contractual relationship with Mary Black—namely, the alleged contractual right to have Mary Black bill Cigna directly and do so at allegedly discounted rates. Direct benefits estoppel requires him to arbitrate those claims, and nothing in *Wilson* holds, or supports a conclusion, otherwise.

B. Owens may not avoid direct benefits estoppel through artful pleading.

The majority also held that Owens's tortious interference with contract claim is shielded from direct benefits estoppel 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." (Appx. 10–11). Implicit in the majority's analysis is the suggestion that, by styling a claim in tort and not contract, and by otherwise obscuring the nature of the claims, a plaintiff can avoid arbitration.

But courts across the country have refused to condone such gamesmanship. For example, the Texas Supreme Court held in similar circumstances that a plaintiff may not "recast" a contract claim as a "tortious interference claim" to avoid arbitration, because it is a tactic that "could be used to forestall arbitration" in violation of the FAA's requirement that arbitration agreements be placed "'on equal footing with other contracts.'" *In re Vesta Ins. Grp., Inc.*, 49 Tex. Sup. Ct. J. 445, 192 S.W.3d 759, 762 (2006) (quoting *E.E.O.C. v. Waffle House, Inc.*, 534 U.S. 279, 293 (2002)); *see also Grigson v. Creative Artists Agency LLC*, 210 F.3d 524, 526 (5th Cir. 2000) (explaining that parties may not "avoid" arbitration agreements "by casting their claims in tort, rather than contract").

On this point, the Fourth Circuit's decision in *Long* is particularly instructive. *See* 453 F.3d 623 (4th Cir. 2006). There, in resolving an appeal from the U.S. District Court for the District of South Carolina, the Fourth Circuit explained the application of principles of equitable estoppel, including the principle of direct benefits estoppel,[5] in the context of binding a signatory or nonsignatory to the arbitration provision in a contract. Indeed, the court in *Long* confronted the very question raised here: whether a plaintiff may thwart the application of equitable or direct benefits estoppel by purportedly basing claims on theories of liability other than breach of the agreement containing the arbitration provision. And the Fourth Circuit emphatically answered that a party "may not use artful pleading to avoid arbitration" in that way. *Id.* at 628 (internal quotation marks and brackets omitted).

The court explained that "the legal principle underlying the theory of equitable estoppel rests on a simple proposition: it is unfair for a party to rely on a contract when it works to its advantage, and repudiate it when it works to its disadvantage." *Id.* at 627 (cleaned up). The court in *Long* thus instructed courts to look at the substance of the underlying claims to determine whether the claims are based on the alleged breach of the obligations and duties created by a contract containing the arbitration provision, "regardless of the legal label assigned to the claim." *Id*. at 627-628 (citing *J.J. Ryan & Sons, Inc. v. Rhone Poulenc Textile, S.A.*, 863 F.2d 315, 319 (4th Cir. 1988)).

Applying these principles, the Fourth Circuit held that estoppel applied because the "claims clearly arose" out of the agreement containing the arbitration clause because, if that agreement did

[5] Although *Long* technically involved the "rely on" test that applies when a signatory is trying to avoid a contract's arbitration clause in a suit against a nonsignatory, rather than the "direct benefits" test that applies here, the Fourth Circuit explained that "any difference in the two tests is more semantic than substantive." *Long*, 453 F.3d at 629. "Both tests examine 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," so "the inquiry is ultimately the same." *Id.*

not exist, the plaintiff "would have no basis for recovery." *Id.* at 630. "Each of the Longs' individual claims," including their "interference with contract" claim, is "dependent upon their allegation that [the nonsignatory defendant] breached a duty created solely by [the contract], for without the alleged breach of the [contract], the Longs would have no cause to complain." *Id.*

So too here. As in *Long*, direct benefits estoppel requires Owens to arbitrate his claims under the CIGNA Agreement's arbitration provision because, if that agreement did not exist, Owens would have no basis for recovery and no cause to complain. Owens could not base a claim that he was injured by Defendants' failure to honor a duty to bill his insurer instead of him, or a failure to bill at rates set forth only in the agreement between Defendants and the insurer, on anything other than the agreement between Defendants and the insurer. This Court has held that there is no general duty for healthcare providers to submit bills to insurance providers under South Carolina law. *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. And Owens does not allege any duty to bill Cigna, or to bill or accept discounted rates, arising from *his* insurance policy with Cigna (much less any breach of any such duty, which a tortious interference claim requires). Indeed, Owens's insurance policy is not even in the record.

Instead, Owens and his co-Plaintiffs specifically allege that the hospital's duty to bill the insurer directly, and at discounted rates, arises directly from the agreement between the hospital and the insurer. (Appx. 270–276; 278–280). Thus, there is no duty, legal or contractual, for Defendants to submit bills to, and seek reimbursement from, a health insurer like Cigna *other than* the alleged terms in Defendants' agreements with those insurers.

Nor does the majority successfully avoid this result by asserting that, because Plaintiffs have phrased the claim in tort, their claims rely on an independent duty not to interfere with contracts rather than a contractual duty. (Appx. 11–12 (citing *Wilson*, 426 S.C. at 343, 827 S.E.2d

at 176)).[6] In the words of the Fourth Circuit, it does not matter that the intentional interference claim is "phrased in tort" because, "at root," Owens's claims "attempt to hold" Defendants "to the terms of" the CIGNAAgreement. *Long*, 453 F.3d at 630 (internal quotation marks and brackets omitted); *see also Zabinski*, 346 S.C. at, 597, 553 S.E.2d at 118–19 (explaining 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"). This follows from the long-established South Carolina principle that 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 instead "shown by the allegations of the complaint." *Id.*

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" (Appx. 267, ¶ 9; *see also* (Appx. 270, ¶ 31); (Appx. 274, ¶ 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." (Appx. 270, ¶¶ 28–29; *see also id.* ¶¶ 32, 57(b)–(c) (emphasis added)). This billing procedure and the contractual discount *is* the benefit Plaintiffs seek in the litigation. (Appx. 271, ¶ 32; 275, ¶ 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

[6] As already explained, *Wilson* is distinguishable, as the plaintiffs' claims there were truly independent of, and did not refer to, any obligations or rights in the defendant insurance agency's agreements with the defendant insurers.

relationship between Plaintiffs and their insurers does not appear until Plaintiffs set forth the elements of their obscurely pleaded tort claim. (Appx. 277, ¶ 64).

Still more, the majority's form-over-substance approach invites gamesmanship. Future plaintiffs would be able avoid arbitration by obscuring the true nature of their claims through artful pleading and strategic omissions, frustrating the FAA in the process. *See In re Vesta*, 192 S.W.3d at 762. That is exactly why courts look not to how a claim is styled, but instead ask "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." *Long*, 453 F.3d 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—[including] intentional interference with contractual relations[ ] and intentional interference with prospective contractual relations—are '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, 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). Owens, therefore, is subject to CIGNA Agreement's 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.

C. Direct benefits estoppel applies to Owens's unjust enrichment claim because it is based on an alleged duty arising solely from the CIGNA Agreement.

Turning to Owens's unjust enrichment claim, the Court of Appeals majority concedes that "Owens's unjust enrichment claim *refers to* the CIGNA Agreement." (Appx. 11) (emphasis added). But it nevertheless states that "the claim does not rely upon or have to be determined by reference to the CIGNA Agreement." (Appx. 11). This is not only incorrect—it directly conflicts with the decision in *Bennett*.

Indeed, 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* Appx. 278, ¶¶ 69–74, *with* Case No. 2021-001342, R. 46–47, ¶¶ 69–75) (see chart above). For example, Plaintiffs here alleged—just like the plaintiffs in *Bennett*—that it would be unjust for Defendants to retain certain unidentified funds "because payment for the services provided should have come from the health insurance carriers of Plaintiffs and the Class Members, with the amount to be paid for services provided determined *by the contracts between Defendants and patients' health insurance carriers*." (Appx. 278, ¶ 73 (emphasis added); *see also* Case No. 2021-001342, R. 46, ¶ 73 (Bennett complaint alleging that '[h]ad Defendant followed the terms of the [agreement with plaintiffs' health insurance carriers], it would have received less money for these services")).

From these allegations, the panel unanimously 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). Yet in this case, two panel members concluded that Owens's indistinguishable claim "does not

rely on the [the provider-insurer agreement]." (Appx. 11). These conflicting conclusions cannot both be correct.

The majority's threadbare attempt to justify its reasoning in this case 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." (Appx. 11).

As the majority conceded, however, Owens's 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." (Appx. 11 (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 (the supposed "should have" identified by the majority) 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. (Appx. 11).

This is no small matter. 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, uncertainty, and confusion. Courts below will struggle to determine whether future unjust enrichment claims are arbitrable under *Bennett* or non-arbitrable under majority's decision here. This Court should resolve that conflict, conform the

outcome of this case with *Bennett*, and hold that Owens's unjust enrichment claim must be arbitrated.

D. 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." (Appx. 11–12). In other words, the majority suggests that a plaintiff can avoid arbitration if an arbitrable claim is joined with 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.").

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 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.[7] The majority does not even consider this concern.

The majority erred for this reason as well, and its decision should be reversed.

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.

The majority attempts to buttress its flawed result by holding that a common class-arbitration waiver somehow permits Owens to participate in class litigation. (Appx. 12) (holding, with no further explanation, that the "natural and ordinary" reading of the CIGNA Agreement's class arbitration waiver "prevents Owens from arbitrating his claims"). In so holding, the majority misconstrues the CIGNA Agreement's plain language and 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." (Appx. 480-481). Putting these provisions together, they provide (1) Owens must arbitrate *all* disputes arising under the CIGNA Agreement, and (2) he must do so on an individual basis and not on behalf of, or as part of, any class.

As reflected in multiple decisions by the United States Supreme Court, the purpose of this second step (which is frequently found in arbitration agreements) is to make clear that the parties agree to resolve their disputes through *individual* arbitration and not through class arbitration. That

[7] The majority cites *Wilson* to support its claim-counting theory. (Appx. 11–12 (citing *Wilson*, 426 S.C. at 342, 827 S.E.2d at 176)). But the majority (once again) misreads *Wilson*. There, this Court found that *none* of the claims asserted implicated direct benefits estoppel. *See Wilson*, 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). This Court said nothing in *Wilson* to support the claim-counting rule invented by the majority below.

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 and to instead close 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." (Appx. 12).

To begin with, that is not a plausible interpretation of the provision's text. Indeed, it 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 frustrates one of the fundamental reasons parties agree to arbitrate in the first place. *See Epic Sys.*, 584 U.S. at 508–09. 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).

For these reasons, federal courts have rejected similar interpretations of class arbitration waivers. Take, for example, the Eastern District of California's decision in *Bouskous v. J.P.*

Morgan Chase Bank, N.A., 2020 WL 8483909, at *4–5 (E.D. Cal. Dec. 21, 2020). There, mirroring the majority's flawed reasoning here, the plaintiff argued that "because the language of the [class arbitration waiver] states that class claims cannot proceed in arbitration," it "functions as an exception to the arbitration requirement" and "enable[es] his class claims to proceed before this court because the parties did not agree to arbitrate class claims." *Id.* at *4.

The court flatly rejected this interpretation, stating that it "does not find plaintiff's interpretation of the provision to be plausible." *Id.* Instead, the court explained that, exactly like the waiver in the CIGNA Agreement, the class arbitration waiver in *Bouskous* "does not exclude plaintiff's claims from the *arbitration requirement*, it simply prohibits one from bringing [an arbitrable claim] on behalf of a class *in arbitration.*" *Id.* In other words, a class arbitration waiver "waives the right to bring claims on a class basis against defendant," and "the Supreme Court has held that such class action waivers are enforceable." *Id.* at *5. The majority provides no reasoned basis to interpret the CIGNA Agreement's class arbitration waiver any differently, and, indeed, no such basis exists.

Because the majority's reading diverges from decisions of the United States Supreme Court on class arbitration and the FAA, the CIGNA Agreement's class arbitration waiver provides no basis for Owens to avoid arbitration here.

CONCLUSION

For these reasons, Defendants respectfully request that the Court reverse the Court of Appeals and hold that, under the doctrine of direct benefits estoppel, Owens must arbitrate his claims.

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