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THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

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

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

v.

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

APPENDIX

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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., Appellants.

Appellate Case No. 2020-001613

Appeal From Spartanburg County
J. Mark Hayes, II, Circuit Court Judge

Opinion No. 6088
Heard March 4, 2024 – Filed September 18, 2024

AFFIRMED

James Lynn Werner and Katon Edwards Dawson, Jr., both of Parker Poe Adams & Bernstein, LLP, of Columbia, for Appellants.

Rachel Gottlieb Peavy, of Simmons Law Firm, LLC, of Columbia, for Respondents Michelene Brooks and Samuel H. Owens, Jr.

John S. Simmons and Rachel Gottlieb Peavy, of Simmons Law Firm, LLC, of Columbia; John Belton White, Jr., Griffin Littlejohn Lynch, and Marghretta Hagood Shisko, all of John B. White, Jr., P.A., of

Spartanburg; and Wes A. Kissinger, Thomas A. Killoren, Jr., and Ryan Frederick McCarty, of Spartanburg, all for Respondent Jo Ann Blackwell.

VINSON, J.: Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital (Mary Black); CHSPSC, LLC; and Professional Account Services, Inc. (PASI) (collectively, Providers) appeal the circuit court's denial of their motions to dismiss the amended complaint of Jo Ann Blackwell, Michelene Brooks, and Samuel Owens, Jr. (collectively, Insureds). Providers argue the circuit court erred by denying their motions to dismiss when Owens's claims were barred by the statute of limitations; Blackwell failed to state a claim for unjust enrichment and could not enforce the agreement between MedCost, Blackwell's insurance carrier, and Mary Black as a third-party beneficiary; Brooks's claims fell under the Medicare Act, which required them to initially seek payment from applicable auto or liability policy coverage; Brooks's and Owens's claims were barred by the voluntary payment doctrine; and the complaint failed to state sufficient facts to constitute a tortious interference with a contract claim or any viable cause of action against PASI or CHSPSC. Providers also appeal the circuit court's denial of their motion to stay the case and compel arbitration against Owens, arguing Owens's claims must be resolved through arbitration because he was attempting to enforce the agreement between Mary Black and CIGNA, Owens's insurance carrier. We affirm.

FACTS AND PROCUDURAL HISTORY

In this case, Insureds received medical treatment at Mary Black for injuries they sustained in automobile accidents. Insureds allege Providers sought payment for their services by submitting medical bills to Insureds and asserting liens against their third-party automobile accident claims instead of submitting medical bills to Insureds' health insurance carriers.

Blackwell originally filed the complaint as a class action against Providers on January 20, 2017. After obtaining leave from the circuit court, Blackwell amended the complaint in April 2020 to add Owens and Brooks as plaintiffs.

Blackwell, who stated she had valid health insurance through MedCost at the time of her accident, received treatment at Mary Black that resulted in $33,093.65 in medical bills. She alleged Providers refused to submit the medical bills to MedCost and instead sought collection by asserting liens against her potential

third-party automobile accident claim. Brooks alleged she had valid health insurance through Medicare at the time that she received treatment at Mary Black, and her treatment resulted in $9,982.44 in medical bills. Brooks further alleged Providers asserted liens against her third-party automobile claim instead of turning the medical bills over to Medicare for payment. Brooks stated Providers agreed to settle Brooks's account if she paid fifty percent of the medical bills, or $4,991.22. Brooks alleged Providers agreed to accept only the reduced payment after asserting a lien against her third-party recovery in her personal injury case and reviewing the settlement offer in that case. Similarly, Owens alleged he had valid health insurance coverage through CIGNA when he received medical treatment at Mary Black that resulted in a bill for $9,086.76. He alleged Providers refused to submit his medical bills to CIGNA and agreed to settle for fifty percent of the original bill after asserting a lien against his third-party recovery in his personal injury case and reviewing the settlement offer in that case. All Insureds alleged their health insurance carriers would have paid their medical bills had Providers submitted those bills to their respective carriers.

Insureds' amended complaint included claims for tortious interference with a contractual relationship, unjust enrichment, and injunctive relief. In their tortious interference with a contractual relationship claim, Insureds alleged they had "a valid business expectancy and/or contractual relationship" with their health insurance carriers that Providers knew or should have known about. They alleged Providers "intentionally and improperly inferred [sic] with and caused a disruption of the business expectancies and/or contractual relationships" between Insureds and their health insurance carriers. Insureds alleged Providers acted without justification and caused damages to Insureds, who paid premiums for health insurance but received no benefit. In their unjust enrichment cause of action, Insureds alleged Providers were unjustly enriched when they received "the benefits of proceeds to which they were not entitled" after billing Insureds for their medical expenses instead of their health insurance carriers. They alleged payment should have been made by the health insurance carriers and the amount paid should have been determined by the contracts between the carriers and Providers.

Insureds' cause of action for injunctive relief alleged Providers were required to send medical bills directly to the Insureds' health insurance carriers and to honor the carriers' contractual discounts for Mary Black's services. They allege Providers failed to honor the contractual discounts or its commitment to send Insureds' bills to the health insurance carriers. Insureds stated Providers attempted to increase their profit by seeking payment from Insureds directly despite the fact that they were "precluded from seeking payment for covered services from [sources other

than Insureds' health insurance carriers]." Insureds requested the circuit court find Providers violated the terms of Providers' agreements with the health insurance carriers, declare the practice invalid and void as a matter of law, and enter a permanent injunction enjoining Providers from continuing the practice.

In June 2020, Providers moved to dismiss the amended complaint or, in the alternative, to stay the case and compel arbitration. Providers argued the amended complaint failed to allege sufficient facts to constitute a tortious interference with contractual relationship claim; Brooks's claims fell under the Medicare Act, which required them to initially seek payment from any applicable auto or liability policy coverage; Blackwell failed to state a claim for unjust enrichment and was barred from enforcing the agreement between MedCost and Mary Black (the MedCost Agreement) as a third-party beneficiary; Owens's claims were barred by the statute of limitations; and Brooks's and Owens's claims were barred by the voluntary payment doctrine.

In addition, Providers argued Owens's claims against CHSPSC must be resolved through arbitration because he was attempting to enforce the agreement between Mary Black and CIGNA (the CIGNA Agreement), which included an arbitration clause. Section 6.2.1 of the CIGNA Agreement stated, in part,

> Any disputes between the parties arising with respect to the performance or interpretation of the Agreement shall first be resolved in accordance with the dispute resolution process outlined in the Administrative Guidelines. In the event the dispute is not resolved through that process, either party may request in writing that the parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the parties who have authority to settle the dispute. If the matter is not resolved within 60 days of a party's written request for negotiation, either party may initiate arbitration by providing written notice to the other party.

Section 6.2.2 of the CIGNA Agreement went on to state, in part, "Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement." Providers argued that if the circuit court found CHSPSC was a party to the CIGNA Agreement, then Owens must arbitrate his claims pursuant to the terms of the CIGNA Agreement because he intended to enforce the terms of the agreement. Insureds filed a response in opposition to Providers' motions to dismiss, and the circuit court heard the motions.

In September 2020, the circuit court issued an order denying Providers' Rule 12(b)(6) motions and their motion to compel arbitration against Owens. The circuit court held the terms of the CIGNA Agreement did not obligate Owens to participate in arbitration because he was not a party to the CIGNA Agreement. The circuit court found the arbitration provision stated it did not apply to third parties or "class" matters and, therefore, Owens was not required to arbitrate his claims. The circuit court also noted the agreement was for three years but contained a year-to-year renewal and found no decision could be made as to whether the agreement was in effect based on the information provided.

As to Providers' Rule 12(b)(6), SCRCP, motions to dismiss, the circuit court found the allegations included in the amended complaint were sufficient to state causes of action against CHSPSC and PASI and there was no prohibition against referring to Providers collectively. The circuit court found Insureds stated sufficient facts to assert a claim for tortious interference with a contractual relationship in the amended complaint because Insureds' allegations could reasonably be construed to mean Providers' conduct resulted in a breach of the contract between Insureds and their health insurance carriers. It also found Brooks's claims did not fail under the Medicare Act. The circuit court stated it would have to go outside the amended complaint to determine if Providers were required to seek payment from any applicable liability coverage before seeking payment from Medicare and presume facts not alleged in the amended complaint to find the at-fault driver in the automobile accident had a valid insurance policy from which Providers could collect. The circuit court also stated it could not accept the voluntary payment doctrine as a defense at this stage of litigation when it was bound to accept Insureds' theories of liability as fact in ruling on a Rule 12(b)(6) motion and Insureds alleged Owens and Brooks were extorted to make the payments involuntarily. The circuit court also found it could not dismiss Blackwell's claim for unjust enrichment because a reasonable inference could be made that it would be inequitable to allow Providers to be unjustly enriched by retaining "the benefits of their wrongful billing practices while attempting to collect a higher amount from [Insureds]."

Providers filed a motion to alter or amend the circuit court's ruling on the Rule 12(b)(6) motions and the motion to compel arbitration, which the circuit court denied. This appeal followed.

STANDARD OF REVIEW

"The determination of whether a claim is subject to arbitration is subject to *de novo* review." *Aiken v. World Fin. Corp. of S.C.*, 373 S.C. 144, 148, 644 S.E.2d 705, 707

(2007). "Nevertheless, a circuit court's factual findings will not be reversed on appeal if any evidence reasonably supports the findings." *Id.*

"Denials of Rule 12(b)(6) motions are not immediately appealable." *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 234, 847 S.E.2d 268, 274 (Ct. App. 2020).

LAW AND ANALYSIS

I. Arbitration

Providers argue the circuit court erred in failing to find Owens's claims were subject to the arbitration provision in the CIGNA Agreement. They contend Owens's claims must be arbitrated because they all involve his effort to enforce terms of the CIGNA Agreement and to derive direct benefits from the agreement. Providers further assert the circuit court erred in finding the language of the CIGNA Agreement stating "either party may initiate arbitration by providing written notice to the other party" renders the arbitration provision unenforceable because arbitration does not have to be the exclusive remedy to be binding and enforceable. They also argue the disclaimer of class arbitration and the bar to consolidating arbitrations with third parties found in the CIGNA Agreement did not render the arbitration provision unenforceable. We disagree.

"[T]he presumption in favor of arbitration applies to the scope of an arbitration agreement; it does not apply to the existence of such an agreement *or to the identity of the parties who may be bound* to such an agreement." *Wilson v. Willis*, 426 S.C. 326, 337, 827 S.E.2d 167, 173 (2019) (alteration in original) (quoting *Carr v. Main Carr Dev., LLC*, 337 S.W.3d 489, 496 (Tex. App. 2011)). "Moreover, because arbitration, while favored, exists solely by agreement of the parties, a presumption *against* arbitration arises where the party resisting arbitration is a nonsignatory to the written agreement to arbitrate." *Id.* at 337-38, 827 S.E.2d at 173. "[W]hen considered in the proper context, our statements that the law 'favors' arbitration mean simply that courts must respect and enforce a contractual provision to arbitrate as it respects and enforces all contractual provisions. There is, however, no public policy—federal or state—'favoring' arbitration." *Palmetto Constr. Grp., LLC v. Restoration Specialists, LLC*, 432 S.C. 633, 639, 856 S.E.2d 150, 153 (2021).

"South Carolina has recognized several theories that could bind nonsignatories to arbitration agreements under general principles of contract and agency law, including (1) incorporation by reference, (2) assumption, (3) agency, (4) veil

piercing/alter ego, and (5) estoppel." *Wilson*, 426 S.C. at 338, 827 S.E.2d at 174. Equitable estoppel "estops a nonsigner from refusing to comply with an arbitration provision of a contract if (1) the nonsigner's claim arises from the contractual relationship, (2) the nonsigner has 'exploited' other parts of the contract by reaping its benefits, and (3) the claim relies solely on the contract terms to impose liability." *Weaver*, 431 S.C. at 230, 847 S.E.2d at 272.

> In the arbitration context, the doctrine recognizes that a party may be estopped from asserting that the lack of his signature on a written contract precludes enforcement of the contract's arbitration clause *when he has consistently maintained that other provisions of the same contract should be enforced to benefit him*.

Pearson v. Hilton Head Hosp., 400 S.C. 281, 290, 733 S.E.2d 597, 601 (Ct. App. 2012) (quoting *Int'l Paper Co. v. Schwabedissen Maschinen & Anlagen GMBH*, 206 F.3d 411, 418 (4th Cir. 2000)).

"[U]nder the [theory of equitable estoppel], a nonsignatory may be compelled to arbitrate where the nonsignatory 'knowingly exploits' the benefits of an agreement containing an arbitration clause, and receives benefits flowing directly from the agreement." *Wilson*, 426 S.C. at 340-41, 827 S.E.2d at 175 (quoting *Belzberg v. Verus Invs. Holdings Inc.*, 999 N.E.2d 1130, 1134 (N.Y. 2013)). "A benefit is direct if it flows directly from the agreement." *Id.* at 343, 827 S.E.2d at 176. "In contrast, any benefit derived from an agreement is indirect where the nonsignatory exploits the contractual relationship of the parties, but does not exploit (and thereby assume) the agreement itself." *Id.* "Generally, these cases involve non-signatories who, during the life of the contract, have embraced the contract despite their non-signatory status but then, during litigation, attempt to repudiate the arbitration clause in the contract." *Pearson*, 400 S.C. at 291, 733 S.E.2d at 602 (quoting *E.I. DuPont de Nemours & Co. v. Rhone Poulenc Fiber & Resin Intermediates, S.A.S.*, 269 F.3d 187, 200 (3d Cir. 2001)).

Initially, we hold the arbitration clause of the CIGNA Agreement is binding and enforceable despite including language stating "either party may initiate arbitration" because Providers enforced the clause when they filed a motion to compel arbitration. *See MailSource, LLC v. M.A. Bailey & Assocs., Inc.*, 356 S.C. 370, 377, 588 S.E.2d 639, 643 (Ct. App. 2003) (finding an arbitration clause was elective and that "[e]ither party may demand arbitration of a dispute but neither is required to do so").

However, we hold the circuit court did not err in denying Providers' motion to compel arbitration against Owens under the theory of equitable estoppel. *See Wilson*, 426 S.C. at 340-41, 827 S.E.2d at 175 ("[U]nder the [theory of equitable estoppel], a nonsignatory may be compelled to arbitrate where the nonsignatory 'knowingly exploits' the benefits of an agreement containing an arbitration clause, and receives benefits flowing directly from the agreement." (quoting *Belzberg Holdings Inc.*, 999 N.E.2d at 1134)); *id.* at 345, 827 S.E.2d at 177 ("Equitable estoppel is, ultimately, a theory designed to prevent injustice, and it should be used sparingly."); *id.* (stating "equitable estoppel should be used sparingly to compel arbitration and noting it 'is more properly viewed as a shield to prevent injustice rather than a sword to compel arbitration'" (quoting *Hirsch v. Amper Fin. Servs.*, LLC, 71 A.3d 849, 852 (2013))). Unlike the third party in *Pearson*, Owens did not benefit from the CIGNA Agreement and did not know about the agreement prior to this litigation. *See Pearson*, 400 S.C. at 296-97, 733 S.E.2d at 605 (finding an anesthesiologist was equitably estopped from asserting he was not bound by an arbitration clause contained in a contract between a hospital and a medical professional placement company when he was able to work at the hospital and received payment for his work because of the contract and he knowingly accepted the benefits of the contract); *see also Wilson*, 426 S.C. at 342, 827 S.E.2d at 176 (finding nonsignatories were not bound by an arbitration clause in a contract under the theory of equitable estoppel when they were not aware of the contract before bringing their actions). Owens never alleged in the complaint that he received a direct benefit from the CIGNA Agreement, and his claims for tortious interference with a contract and unjust enrichment are not pled as arising from the CIGNA Agreement. *See Weaver*, 431 S.C. at 230, 847 S.E.2d at 272 ("[E]quitable estoppel . . . . estops a nonsigner from refusing to comply with an arbitration provision of a contract if (1) the nonsigner's claim arises from the contractual relationship, (2) the nonsigner has 'exploited' other parts of the contract by reaping its benefits, and (3) the claim relies solely on the contract terms to impose liability.").

Owens pled his tortious interference with a contract claim as arising out of *his* agreement with CIGNA, which he argues Providers interfered with, not the agreement between Mary Black and CIGNA. He alleges Providers "proximately caused" the Insureds' damages because Providers' "actions resulted in [Insureds] having paid premiums but receiving no or little benefit." Owens's tortious interference with a contract claim does not arise solely from or have to be determined in reference to the CIGNA Agreement; 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. *See Wilson*, 426 S.C. at 343, 827 S.E.2d at 176 ("When a

claim depends on the contract's existence and cannot stand independently—that is, the alleged liability 'arises solely from the contract or must be determined by reference to it'—equity prevents a person from avoiding the arbitration clause that was part of that agreement." (quoting *Jody James Farms, JV v. Altman Grp., Inc.*, 547 S.W.3d 624, 637 (Tex. 2018))); *id.* ("'[W]hen the substance of the claim arises from general obligations imposed by state law, including statutes, torts and other common law duties, or federal law,' direct-benefits estoppel is not implicated even if the claim refers to or relates to the contract *or would not have arisen 'but for' the contract's existence*." (quoting *Jody James Farms, JV*, 547 S.W.3d at 637)).

Owens's unjust enrichment claim, (again, as pled) also does not rely on the CIGNA Agreement. The amended complaint instead alleges Providers were unjustly enriched because "they received and retained the benefits of proceeds to which they were not entitled" and "[s]aid benefits were conferred on [Providers] by [Insureds] and were unlawfully obtained to the detriment of [Insureds]." The amended complaint further alleges "it would be unjust for [Providers] to retain these funds because payment of the services provided should have come from the health insurance of [Insureds], with the amount to be paid for services provided determined by the [CIGNA Agreement]." Owens alleges it was unjust for Providers to bill him for their medical services instead of CIGNA, his insurer. Owens's unjust enrichment claim refers to the CIGNA Agreement, but the claim does not rely upon or have to be determined by reference to the CIGNA Agreement. *See id.* ("When a claim depends on the contract's existence and cannot stand independently—that is, the alleged liability 'arises solely from the contract or must be determined by reference to it'—equity prevents a person from avoiding the arbitration clause that was part of that agreement." (quoting *Jody James Farms, JV*, 547 S.W.3d at 637)). The substance of Owens's unjust enrichment claim arises from the common law, and the claim could be determined in reference to Owens's insurance contract with CIGNA. *See id.* ("'[W]hen the substance of the claim arises from general obligations imposed by state law, including statutes, torts and other common law duties, or federal law,' direct-benefits estoppel is not implicated even if the claim refers to or relates to the contract or would not have arisen 'but for' the contract's existence." (quoting *Jody James Farms, JV*, 547 S.W.3d at 637)).

Although Owens's claim for injunctive relief does rely on the CIGNA Agreement in that he requested that the circuit court find Providers violated the agreement by billing him instead of CIGNA, the claim requests that the court enjoin Providers from engaging in unlawful billing practices in the future, not any benefit for Owens. We find the arbitration clause in the CIGNA Agreement should not apply to Owens when two of the three claims alleged do not arise from the CIGNA

Agreement. *Wilson*, 426 S.C. at 342, 827 S.E.2d at 176 (finding a third party was not bound by an arbitration clause in a contract when South Carolina law formed the basis for most of their claims).

Additionally, even if Owens's claims arose from the CIGNA Agreement, we find he would not be forced to arbitrate his claims because the agreement specifically states the arbitration provision does not apply to class actions. *See Park Regency, LLC v. R & D Dev. of the Carolinas, LLC*, 402 S.C. 401, 412-13, 741 S.E.2d 528, 534 (Ct. App. 2012) ("Where an agreement is clear and capable of legal interpretation, the court's only function is to interpret its lawful meaning, discover the intention of the parties as found within the agreement, and give effect to it."); *Heins v. Heins*, 344 S.C. 146, 158, 543 S.E.2d 224, 230 (Ct. App. 2001) (stating "the court must interpret contractual language in its natural and ordinary sense"). Section 6.2.2 of the CIGNA Agreement states "the arbitrator shall be without power to conduct an arbitration on a class basis." Owens is a member of a putative class, which could include other CIGNA insureds. Thus, we hold the language of the arbitration provision, interpreted in its natural and ordinary sense, prevents Owens from arbitrating his claims.

Based on the foregoing, we hold Owens is not bringing his claims as a third-party beneficiary of the CIGNA Agreement but as a participant in the CIGNA insurance plan seeking to receive the benefits of his contract with CIGNA.[1] Accordingly, we hold the circuit court did not err in denying Providers' motion to compel arbitration as to Owens, and we affirm the circuit court as to this issue.

II. Interlocutory Rulings

Even though such rulings are usually unpreserved, Providers argue this court should review the circuit court's denial of their Rule 12(b)(6) motion because it is reviewing the circuit court's denial of their motion to compel arbitration against Owens, which was immediately appealable. We disagree.

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[1] We note that the CIGNA Agreement stated any dispute should be resolved according to the Administrative Guidelines—which were not included in the record—and through a process of negotiation before the parties could request arbitration. The record does not include any indication Mary Black required Owens to resolve the dispute under the Administrative Guidelines or through negotiation before arguing he must arbitrate his claims pursuant to the CIGNA Agreement.

We decline to review the denial of Providers' Rule 12(b)(6) motions because the denials were interlocutory and are not immediately appealable. *See Weaver*, 431 S.C. at 234, 847 S.E.2d at 274 ("Denials of Rule 12(b)(6) motions are not immediately appealable."). Although this court has reviewed interlocutory orders when a motion to compel arbitration was before it, this court has also declined to review the denial of Rule 12(b)(6) motions under such circumstances. *See id.* (declining to address the denial of appellant's Rule 12(b)(6) motions when affirming the circuit court's denial of a motion to compel arbitration and opining the issues addressed in the Rule 12(b)(6) motions would benefit from further factual development); *cf. Cox v. Woodmen of World Ins. Co.*, 347 S.C. 460, 469-70, 556 S.E.2d 397, 402 (Ct. App. 2001) (considering the denial of a Rule 12(b)(8), SCRCP, motion to dismiss when the denial of a motion to compel arbitration was already before the court). Here, the only immediately appealable issue is the denial of Providers' motion to compel arbitration against Owens. Further, we believe the issues raised by Providers' Rule 12(b)(6) motions would benefit from further factual development. *See Doe v. Marion*, 373 S.C. 390, 395, 645 S.E.2d 245, 247 (2007) ("If the facts alleged and inferences reasonably deducible therefrom, viewed in the light most favorable to the plaintiff, would entitle the plaintiff to relief on any theory, then dismissal under Rule 12(b)(6) is improper."). Accordingly, we decline to address the denial of Providers' Rule 12(b)(6) motions under these circumstances.

CONCLUSION

Based on the foregoing, the circuit court's denial of Providers' motion to compel arbitration is

AFFIRMED.

HEWITT, J., concurs.

GEATHERS, J.: I respectfully depart from the decision reached by the majority. I interpret the causes of action in the Amended Complaint to invoke the Providers' contractual duties to the insurance carriers with which Insureds also had contracts. "When a claim depends on the contract's existence and cannot stand independently—that is, the alleged liability 'arises solely from the contract or must be determined by reference to it'—equity prevents a person from avoiding the arbitration clause that was part of that agreement." *Wilson v. Willis*, 426 S.C. 326, 343, 827 S.E.2d 167, 176 (2019) (quoting *Jody James Farms, JV v. Altman Grp., Inc.*, 547 S.W.3d 624, 637 (Tex. 2018)). In other words,

> [e]quitable estoppel precludes a party from asserting rights "he otherwise would have had against another" when his own conduct renders assertion of those rights contrary to equity. In the arbitration context, the doctrine recognizes that a party may be estopped from asserting that the lack of his signature on a written contract precludes enforcement of the contract's arbitration clause when he has consistently maintained that other provisions of the same contract should be enforced to benefit him. "To allow [a plaintiff] to claim the benefit of the contract and simultaneously avoid its burdens would both disregard equity and contravene the purposes underlying enactment of the [Federal] Arbitration Act."

Int'l Paper Co. v. Schwabedissen Maschinen & Anlagen GMBH, 206 F.3d 411, 417–18 (4th Cir. 2000) (citations omitted) (first alteration in original) (first quoting *First Union Commercial Corp. v. Nelson, Mullins, Riley & Scarborough* (*In re Varat Enters., Inc.*), 81 F.3d 1310, 1317 (4th Cir. 1996); then quoting *Avila Group, Inc. v. Norma J. of California*, 426 F. Supp. 537, 542 (S.D.N.Y. 1977)). Therefore, I would reverse the circuit court's denial of Providers' respective motions to compel arbitration.

The South Carolina Court of Appeals

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., Appellants.

Appellate Case No. 2020-001613

ORDER

After careful consideration of the petition for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petition for rehearing is denied.

_____ J.

_____ J.

For the reasons stated in the dissenting opinion, I would grant the petition for rehearing.

_____ J.

Columbia, South Carolina

FILED
Jan 27 2025

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The Honorable J. Mark Hayes, II

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THE STATE OF SOUTH CAROLINA
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APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

Case No. 2017-CP-42-00219
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Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly situated,

Respondents,

v.

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

Appellants,

APPELLANTS' BRIEF

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STATEMENT OF ISSUES ON APPEAL

I. **WHETHER THE CIRCUIT COURT ERRED IN DENYING DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, TO COMPEL PLAINTIFF OWENS TO ARBITRATE HIS CLAIMS AGAINST DEFENDANTS PURSUANT TO THE CIGNA AGREEMENT'S ARBITRATION PROVISION.**

II. **WHETHER THE CIRCUIT COURT ERRED IN FAILING TO DISMISS OWENS' CLAIMS ON THE GROUNDS HIS CLAIMS DO NOT RELATE BACK TO BLACKWELL'S FILING OF THE ORIGINAL COMPLAINT AND, THEREFORE, ARE BARRED BY THE APPLICABLE STATUTES OF LIMITATION.**

III. **WHETHER THE CIRCUIT COURT ERRED IN FAILING TO FIND THAT BLACKWELL IS NOT AN INTENDED THIRD-PARTY BENEFICIARY UNDER THE MEDCOST AGREEMENT AND, THEREFORE, LACKS STANDING TO PURSUE CLAIMS TO ENFORCE ITS TERMS.**

IV. **WHETHER THE CIRCUIT COURT ERRED IN FAILING TO DISMISS BLACKWELL'S CLAIM FOR UNJUST ENRICHMENT, BECAUSE BLACKWELL DID NOT ALLEGE SHE CONFERRED ANY BENEFIT TO DEFENDANTS.**

V. **WHETHER THE CIRCUIT COURT ERRED IN FAILING TO DISMISS BROOKS' CLAIMS BECAUSE HER CLAIMS ARE GOVERNED BY THE MEDICARE ACT AND UNDER THAT ACT AS A MATTER OF LAW DEFENDANTS WERE FIRST OBLIGATED TO PURSUE PAYMENT FROM ANY AVAILABLE AUTOMOBILE OR LIABILITY INSURANCE PRIOR TO BILLING MEDICARE.**

VI. **WHETHER THE CIRCUIT COURT ERRED IN FAILING TO DISMISS THE CLAIMS ASSERTED BY BROOKS AND OWENS BECAUSE THOSE CLAIMS ARE BARRED BY APPLICATION OF THE VOLUNTARY PAYMENT DOCTRINE.**

VII. **WHETHER THE CIRCUIT COURT ERRED IN FAILING TO DISMISS PLAINTIFFS' CLAIMS FOR TORTIOUS INTERFERENCE WITH A CONTRACT ON THE GROUNDS THAT THE AMENDED COMPLAINT DOES NOT ALLEGE ANOTHER RELEVANT CONTRACT WAS BREACHED.**

VIII. **WHETHER THE CIRCUIT COURT ERRED IN FINDING THAT THE AMENDED COMPLAINT STATES FACTS SUFFICIENT TO CONSTITUTE ANY VIABLE CAUSE OF ACTION AGAINST PASI OR CHSPSC.**

STATEMENT OF THE CASE

This case is premised entirely on allegations that Defendants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital ("Mary Black"); CHSPSC, LLC ("CHSPSC"); and Professional Account Services, Inc. ("PASI") (collectively, "Defendants") failed to submit bills to the applicable health insurance coverage for Plaintiffs Jo Ann Blackwell, Samuel Owens, and Michelene Brooks (collectively, "Plaintiffs") for emergency room care rendered to Plaintiffs at Mary Black following their involvement in motor vehicle collisions and, instead, submitted the bills to the Plaintiffs or asserted liens against their potential third-party automobile accident claims. The case began as a suit by only Plaintiff Jo Ann Blackwell. (R. 21). Eight (8) days after her automobile accident, which occurred on December 19, 2013, Blackwell was admitted as a patient at Mary Black. (R. 23). According to Blackwell, she had health insurance coverage through a health insurance provider (MedCost) at the time she was admitted to Mary Black. She contends that Mary Black did not submit a bill to MedCost for the medical services rendered to her and, instead, asserted a lien against her potential third-party automobile accident claim. (R. 27). Importantly, Blackwell never alleges that she actually paid the bill, or made any payment to Mary Black for the medical treatment she received. (R. 23-39; 63-80).

Based on these allegations, on January 20, 2017, Blackwell filed her initial Complaint, alleging claims collectively against Defendants for (1) tortious interference with contractual relationship (her health insurance), (2) unjust enrichment, and (3) injunctive relief (to enforce the terms of the contract between Mary Black and MedCost). (R. 23-35). In her Complaint, Blackwell also asserted she was an appropriate representative for a class of similarly situated persons. Defendants each timely filed answers to the Complaint.

More than two years later[1], on June 28, 2019, Blackwell—without consent of Defendants or leave from the circuit court—filed a purported Amended Complaint. (R. 41). This so-called Amended Complaint attempted to add (for the first time) Michelene Brooks and Samuel H. Owens, Jr. as additional named plaintiffs with new individual claims. (R. 41). However, each of them alleged they had health insurance coverage through other insurers—not MedCost. (R. 41-60).

In the purported Amended Complaint Owens alleged (1) he was injured in an automobile accident on October 9, 2015, and presented for medical treatment at Mary Black; (2) at that time he was covered by valid health insurance through CIGNA HealthCare of South Carolina, Inc. ("Cigna"); (3) Defendants did not submit a bill to Cigna and, instead, asserted a lien against his third-party automobile accident claim; and (4) Owens negotiated an agreement to settle his account with Mary Black and paid Mary Black a discounted amount for the services rendered. (R. 71-72).

In the purported Amended Complaint Brooks alleged (1) she was injured in an automobile accident on February 26, 2016, and presented for medical treatment at Mary Black; (2) at that time she was covered for health care through Medicare; (3) Defendants did not submit a bill to Medicare and, instead, asserted a lien against her third-party automobile accident claim; and (4) Brooks negotiated an agreement to settle her account with Mary Black and paid a discounted amount to Mary Black for the services rendered. (R. 70-72).

Based on these additional allegations in the purported Amended Complaint, Plaintiffs asserted claims for (1) unjust enrichment, (2) tortious interference with a contract, and (3) injunctive relief. (R. 75-78).

[1] On October 6, 2017, Blackwell and Defendants filed a Joint Motion for Complex Case Designation. In February 2019, the case was designated as complex and assigned to the Honorable J. Mark Hayes, II.

On August 19, 2019, Defendants filed a Motion to Strike or Dismiss the Amended Complaint. (R. 117). The Motion was based on the fact that, at that time, the Amended Complaint could not be filed as a matter of right under Rule 15 and it had been filed without motion, consent, or leave of the circuit court. (R. 117-120).

On October 18, 2019, prior to hearing or decision on the Motion to Strike, Blackwell filed a Motion to Amend her Complaint and again attempted to add Brooks and Owens as new and additional named plaintiffs in this case. (R. 121).

On October 24, 2019, Defendants filed a Memorandum of Law in Opposition to Blackwell's Motion to Amend the Complaint, arguing: (1) Rule 15 of the South Carolina Rules of Civil Procedure does not permit Blackwell to amend the complaint nearly three years after the litigation was initiated to add new plaintiffs and claims, and any claims by new Plaintiffs would not relate back to the date of filing of the original complaint; (2) Owens' claims for tortious interference with contract and unjust enrichment are futile because those claims are barred by the applicable statutes of limitation; (3) Brooks' claims are clearly futile, and fail as a matter of law, because her claims are expressly based on purported Medicare coverage and the Medicare Act requires a hospital to attempt to collect payment from any applicable auto or liability policy prior to seeking or obtaining payment from Medicare, plus she did not exhaust her administrative remedies prior to filing suit; (4) Blackwell's claim for unjust enrichment is clearly futile, and fails as a matter of law, because the Amended Complaint did not even allege that she had provided any of the Defendants with an unjust benefit; and (5) Blackwell cannot be a representative for the purported class because her express allegations reflect plainly that she does not even qualify as a member of the Amended Complaint's newly defined and proposed class. (R. 143-151).

The circuit court held a hearing on Blackwell's Motion to Amend the Complaint and on April 23, 2020, the circuit court issued an order granting Blackwell's Motion to Amend the Complaint. (R. 15). On April 24, 2020, Blackwell filed her Amended Complaint and Brooks and Owens were added to the case as named plaintiffs. (R. 61).

On June 8, 2020, Defendants each filed a Motion to Dismiss the Amended Complaint pursuant to Rule 12(b)(6) or, in the alternative, to Stay the Case and Compel Arbitration (collectively, the "Motion"), asserting the following arguments:

1. Owens must be compelled to arbitrate his claims against the Defendants because he is suing to enforce the terms of an agreement that contains a valid and enforceable agreement to arbitrate claims related to that agreement;

2. Plaintiffs' Amended Complaint utterly fails to state facts sufficient to constitute any viable cause of action against CHSPSC or PASI;

3. Plaintiffs' Amended Complaint utterly fails to allege facts sufficient to constitute a cause of action for tortious interference against any Defendant;

4. Brooks fails to state facts sufficient to constitute a claim against any Defendant because Brooks' claims are governed by the Medicare Act and the law under the Act does not support the claims alleged;

5. Brooks' and Owens' claims are barred as a matter of law under the voluntary payment doctrine;

6. Owens' claims are barred as a matter of law by the applicable limitations period;

7. Blackwell's Amended Complaint fails to state facts sufficient to constitute a claim against any Defendant for unjust enrichment because she does not allege she made any payment to, or conferred any actual benefit upon any Defendant; and

8. Blackwell is not, and cannot be, an intended third-party beneficiary under the agreement between Mary Black and her insurer.

(R. 152-166).

On July 29, 2020, the circuit court held a hearing on the Motion. (R. 81). On September 4, 2020, the circuit court issued a Form 4 Order denying the Motion. (R. 10).

On September 14, 2020, Defendants jointly filed a Motion to Alter or Amend. (R. 204). On November 4, 2020, the circuit court issued a Form 4 Order denying the Motion to Alter or Amend and on December 8, 2020, the Court issued an additional formal order denying the Motion to Alter or Amend. (R. 7).

Defendants timely filed their Notice of Appeal on December 8, 2020.

This appeal first concerns the fundamental question of whether Owens, who seeks to enforce the terms of a contract between the hospital and his insurance carrier as a non-signatory, third-party beneficiary of that contract, is required to arbitrate his claims. The contract he seeks to enforce, and from which he seeks to derive direct benefit, contains an arbitration provision—which requires all disputes arising from the contract to be submitted to binding arbitration. Secondly, this appeal seeks review regarding the errors by the circuit court in refusing to grant the Motion and to dismiss the claims of each of the Plaintiffs. Defendants assert that those matters should be addressed now, in this appeal, because judicial economy requires the Court to dispose of facially defective claims which utterly fail as a matter of law.

The appealability of the denial of the arbitration issues in the Motion is clear. The resolution of the remaining issues in the Motion addressing claims that are facially inadequate, and fail as a matter of law, is also appropriate and necessary at this time. It is imprudent, and would be a waste of judicial resources, to delay consideration of the other issues addressed by the Motion when the merit of those issues are evident from the face of the Amended Complaint. Such a conclusion is all the more compelling when Plaintiffs attempt to pursue class claims in the case on

allegations by named plaintiffs that are facially defective. This Court has latitude to consider those other issues as part of this appeal, and it should exercise that discretion.

FACTUAL BACKGROUND

This matter involves claims asserted by three separate and distinct plaintiffs. Each of the named Plaintiffs alleges that he/she was involved in a motor vehicle collision, received medical care at Mary Black, had health insurance coverage at the time of treatment, and received either a bill from Mary Black or notice that Mary Black asserted an interest in their recovery from the at-fault driver (instead of Mary Black submitting the claim for the medical services directly to their health insurer). Each Plaintiff further alleges that Defendants are parties to contracts with their health insurance providers which specify the manner in which Defendants are to bill for services rendered to insureds and the contractual, discounted rates that are to apply to the bill for such services. (R. 76-77). The relevant facts for each Plaintiff will be addressed in turn.

I. Jo Ann Blackwell

Blackwell was allegedly injured in an automobile accident on or about December 19, 2013. (R. 69). She was admitted as a patient at Mary Black on or about December 27, 2013. (R. 69). Blackwell was released from the hospital, following her treatment there, on January 3, 2014. (R. 69). Blackwell alleges that she had health insurance coverage through MedCost at the time she was admitted to Mary Black. (R. 69). She further alleges that Mary Black had a contract with MedCost which required that bills for medical services provided to her be sent directly to MedCost, not her, and that the contract provided for discounted rates for the services. (R. 67-70). She alleges Defendants did not submit a bill for her treatment to her health insurance provider (MedCost) and, instead, asserted a lien against her third-party automobile accident claim. (R.70). Blackwell does not allege she is a direct party to the Mary Black contract with MedCost. The Amended Complaint

contains no allegation that Blackwell made any payment, or gave any other benefit to Mary Black for the medical treatment rendered to her.

A. Hospital Services Agreement — MedCost

Mary Black is party to a Hospital Services Agreement with MedCost (the "MedCost Agreement"). (R. 250). That MedCost Agreement defines the terms of the relationship between Mary Black and MedCost, and includes the billing procedures and negotiated rates that MedCost will pay on behalf of its insureds for covered services. The MedCost Agreement also contains a plain and unambiguous express provision directly stating Mary Black's and MedCost's intent to bar third parties from enforcing the MedCost Agreement. (R. 258). This intent is unequivocally expressed in Section 10.9 of the MedCost Agreement, which states:

> This Agreement is entered into by and between the parties hereto for their benefit. **There is no intent by either party to create or establish a third party beneficiary status** or rights in a Covered Person, Employer, subcontractor, or other third party to this Agreement, except as such rights are expressly created and as set forth herein, and **no such third party shall have any rights to enforce any right to enjoy any benefit created or established under this Agreement**.

(R. 258) (emphasis added).

II. Samuel H. Owens, Jr.

On October 9, 2015, Owens was admitted to Mary Black following an automobile accident. (R. 71). Owens alleges that at the time of his medical treatment he had valid health insurance coverage through Cigna. (R. 71). Owens alleges that Mary Black had a contract with Cigna which required that bills for medical services provided to him be sent directly to Cigna, not him, and that the contract provided for discounted rates for the services. (R. 71). Owens alleges that Defendants did not submit the bill for his services to Cigna, but rather sought payment by asserting a lien against his claims against the at-fault driver in the collision. (R. 71). Owens admits that on or

about October 14, 2016, he negotiated an agreement to settle his account with Mary Black for a discounted payment of $4,543.38. (R. 71-72). More than three years after the date Owens alleges he paid Mary Black and settled his account, on October 18, 2019, Blackwell filed the Motion to Amend the Complaint and to add Owens and his separate claims to this case. (R. 121).

A. Hospital Services Agreement — Cigna Agreement

Mary Black is party to a Hospital Services Agreement with Cigna (the "Cigna Agreement"). (R. 263). That Cigna Agreement defines the terms which control various aspects of the relationship between Mary Black and Cigna, including billing practices and the negotiated rates that Cigna will pay on behalf of its insured for covered services. Owens' claims against Defendants arise out of the Cigna Agreement, because his claims are based upon his purported ability to enforce the negotiated rates that Cigna will pay on behalf of its insured for covered services. He has specifically asserted a claim for injunctive relief to enforce the terms of the Cigna Agreement. (R. 77-78). Therefore, Owens—a non-signatory to the Cigna Agreement—is suing to enforce the Cigna Agreement as a third-party beneficiary.

Section 6 of the Cigna Agreement contains the following dispute resolution provision:

> 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.

(R. 275-276) (emphasis added).

III. Michelene Brooks

On February 26, 2016, Brooks was admitted to Mary Black following an automobile accident. (R. 70). Brooks alleges that at the time of her medical treatment she was covered for health care services through Medicare. (R. 70). Brooks alleges that Defendants did not submit the bills for her health care services to Medicare, but instead sought collection of the amounts due by asserting a lien against her recovery from the at-fault driver in the accident. (R. 70). Brooks further admits that on or about September 26, 2017, she negotiated an agreement to settle her account by Mary Black accepting a discounted payment of $4,991.22. (R. 71).

STANDARD OF REVIEW

A. Motion to Compel Arbitration

The Court reviews the denial of a motion to compel arbitration *de novo*. *New Hope Missionary Baptist Church v. Paragon Builders*, 379 S.C. 620, 625, 667 S.E.2d 1, 3 (Ct. App. 2008). 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." *Hall v. Green Tree Servicing, LLC*, 413 S.C. 267, 271, 776 S.E.2d 91, 94 (Ct. App. 2015) (alteration in original) (quoting *Dean v. Heritage Healthcare of Ridgeway, LLC*, 408 S.C. 371, 379, 759 S.E.2d 727, 731 (2014)). A non-signatory who is suing to enforce an agreement is bound by the other terms of that agreement—including an agreement to arbitrate disputes arising from the agreement. *Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 288, 733 S.E.2d 597, 600 (Ct. App. 2012) (quoting *Int'l Paper Co. v. Schwabedissen Maschinen & Anlagen GMBH*, 206 F.3d 411, 416 (4th Cir. 2000)).

B. Motion to Dismiss[2]

A motion to dismiss must be granted if the facts alleged in the complaint, and inferences reasonably deducible therefrom, do not entitle the plaintiff to the relief sought. *Chewning v. Ford Motor Co.*, 346 S.C. 28, 32-33, 550 S.E.2d 584, 586 (Ct. App. 2001). In addition to review of the allegations in the complaint, when deciding the motion to dismiss a court may also consider documents incorporated into the complaint by reference, documents attached to the complaint itself, matters of which the court may take judicial notice, and documents submitted by the party moving to dismiss the complaint so long as the documents are integral to the complaint. *See Carolina First Corp. v. Whittle*, 343 S.C. 176, 190 n.7, 539 S.E.2d 402, 410 n.7 (Ct. App. 2000); *Brazell v. Windsor*, 384 S.C. 512, 516, 682 S.E.2d 824, 826 (2009); *HHHunt Corp. v. Town of Lexington*, 389 S.C. 623, 629-30, 699 S.E.2d 699, 701-02 (Ct. App. 2010); *see also Patterson v. Witter*, 425 S.C. 213, 235, 821 S.E.2d 677, 689 (2018) (acknowledging that the court may consider documents that are integral to the complaint when reviewing a motion to dismiss); *Goines v. Valley Cmty. Servs. Bd.*, 822 F.3d 159, 164 (4th Cir. 2016) (same).

ARGUMENTS

The cornerstone of this appeal is the error by the circuit court in denying the Motion and refusing to compel the claims brought by Owens to arbitration. The denial of that Motion is immediately appealable, as provided in S.C. CODE ANN. § 15-48-200. The circuit court's decision to refuse to compel Owens to arbitrate his claims and deny the Motion must be reversed.

[2] The Court may exercise its discretion to review the other interlocutory issues raised in Defendants' Motion because issues raised in an interlocutory order that are not directly appealable can be considered by the Court when raised in tandem with an immediately appealable issue. *See Ferguson v. Charleston Lincoln Mercury, Inc.*, 349 S.C. 558, 565, 564 S.E.2d 94, 98 (2002); *Cox v. Woodmen of World Ins. Co.*, 347 S.C. 460,469, 556 S.E.2d 397, 402 (Ct. App. 2001).

At the same time, the decision by the circuit court in denying other parts of the Motion should be addressed by the Court now, as part of this appeal, because reversal of the other erroneous decisions by the circuit court is in the interest of justice and judicial economy.

I. The circuit court erred in failing to compel Owens to arbitrate his claims against Defendants.

A. Owens is equitably estopped from avoiding the arbitration provision in the Cigna Agreement because he is seeking to take a direct benefit from that Agreement.

The circuit court erred in failing to find that Owens' claims are subject to the arbitration provision in the Cigna Agreement. Owens is bound to arbitrate his claims and is equitably estopped from avoiding the obligation to arbitrate his claims pursuant to the arbitration provision in the Cigna Agreement, because his claims all involve his effort to enforce terms of that Agreement and to derive direct benefit therefrom.

Owens undeniably bases his claims on the proposition that he is entitled to the direct benefits of the billing terms and procedures, and the discounted billing rates, created by and set forth in the Cigna Agreement. (R. 68; Amended Complaint ¶ 28). Owens' cause of action for so-called Injunctive Relief is nothing more than an unabashed, overt demand to enforce the Defendants' Agreement with his insurer (Cigna). Those payment terms do not exist or arise from any other source. Owens admitted as much to the circuit court when he said, "Plaintiffs' success on [their claim for injunctive relief] admittedly relies on the hospital services agreement." (R. 220; Plaintiffs' Memorandum in Opposition to Defendants' Motion to Alter of Amend p. 6). Furthermore, Owens specifically argued to the circuit court that he was "harmed by [Mary Black's] failure to act in accordance with the contract." (R. 216; Plaintiffs' Memorandum in Opposition to Defendants' Motion to Alter of Amend p. 2). Thus, it is undeniable that Owens' claims arise from the Cigna Agreement, and Owens seeks to enforce the terms of that Agreement and to recover

what damages he alleges to be caused by Defendants' failure to act in accordance with the Cigna Agreement.

In denying the Motion and refusing to compel Owens to arbitrate his claims against Defendants, the circuit court placed improper significance on its belief that Owens is not a party to the Cigna Agreement. However, the circuit court failed to conduct the required analysis under the principles of direct benefits estoppel and failed to apply those important principles to compel a non-signatory to arbitration. When Owens (a non-signatory to the Cigna Agreement) seeks to take direct benefits from the Cigna Agreement, and to enforce the terms contained therein, the doctrine of direct benefits estoppel binds him to all of the terms within the Cigna Agreement—including the arbitration provision. *See Pearson*, 400 S.C. at 288-90, 733 S.E.2d at 600-01. Under the direct benefits estoppel framework "[a] nonsignatory is estopped from refusing to comply with an arbitration clause 'when it receives a 'direct benefit' from a contract containing an arbitration clause.'" *Id.* at 290, 733 S.E.2d at 601 (quoting *Int'l Paper Co. v. Schwabedissen Maschinen & Anlagen GMBH*, 206 F.3d 411, 418 (4th Cir. 2000)). "'To allow [a plaintiff] to claim the benefit of the contract and simultaneously avoid its burdens would both disregard equity and contravene the purposes underlying enactment of the Arbitration Act.'" *Id.* (quoting *Int'l Paper*, 206 F.3d at 418).

In addition to his direct claim to enforce the Cigna Agreement, Owens' claim for unjust enrichment is clearly based on his alleged right to enforce the payment terms of that Agreement (including the payment rates negotiated between Mary Black and Cigna). Therefore, to hold other than that Owens is estopped from avoiding the obligation to arbitrate set forth in that Agreement would be to disregard the doctrine of direct benefits estoppel. Owens cannot enforce or derive benefit from some terms of the Cigna Agreement while simultaneously avoiding compliance with

the other terms—including the arbitration provision. *See Pearson*, 400 S.C. at 295, 733 S.E.2d at 604 ("[A] party may not rely on the contract when it works to its advantage, and repudiate it when it works to its disadvantage."). Thus, Owens is estopped from avoiding the application of the Cigna Agreement's arbitration provision.

The court in *Pearson*, 400 S.C. at 296-97, 733 S.E.2d at 605, applied the direct benefits estoppel framework to find a doctor (Pearson) was equitably estopped from asserting that, as a nonsignatory, he was not bound by the arbitration provision in a contract between a hospital and a medical professional placement company (Locum). The court found that although Pearson was a nonsignatory to the contract between the hospital and Locum, "he received a benefit due to the contract, in that he was able to work at the [h]ospital and receive payment for his work." *Id*. at 296, 733 S.E.2d at 605. The court stated that "[i]f not for that contract, then Dr. Pearson would have had to make separate arrangements with the [h]ospital in order to work there" and Pearson knowingly accepted the benefits of the contract between the hospital and Locum. *Id*. at 296-297, 733 S.E.2d at 605. The court found that in Pearson's complaint he was either seeking a benefit under the hospital's contract with Locum or he was attempting to hold the hospital accountable under his contract with Locum. *Id*. at 297, 733 S.E.2d at 605. Therefore, the *Pearson* court held that direct benefits estoppel applied in such circumstances and barred Pearson from avoiding the arbitration clause in the contract between the hospital and Locum. *Id*.

In a case with similar operative facts and issues, *Benton v. Vanderbilt University*, 137 S.W.3d 614, 619 (Tenn. 2004), the Tennessee Supreme Court addressed a non-signatory plaintiff's ("Benton") claim against a hospital ("Vanderbilt") based upon the hospital's alleged billing practices. The court specifically addressed the plaintiff's obligation to arbitrate under the agreement from which plaintiff sought to derive the claim rights. Benton was insured by Blue

Cross Blue Shield ("BCBS"), and Vanderbilt Hospital provided medical services to Benton after Benton suffered injuries in an automobile accident. *Id.* at 616. Vanderbilt and BCBS had a hospital services agreement between them like the Cigna Agreement. The agreement provided that Vanderbilt would bill BCBS for the medical services rendered to BCBS insureds (like Benton) at discounted rates. *Id*. Benton later filed a lawsuit against the at-fault driver for the personal injuries he suffered in the accident, but Vanderbilt then sought to collect the amount of the hospital expenses that had not been paid by BCBS and filed a statutory Notice of Hospital Lien against any monetary recovery that Benton might receive from the at-fault driver (a collection practice that is known as balance billing). *Id*. As a result of Vanderbilt's collection actions, Benton filed a complaint asserting claims against Vanderbilt for abuse of process, breach of contract, and violation of the Tennessee Consumer Protection Act on the grounds that Vanderbilt had agreed to accept payment in full from BCBS based on the hospital services agreement between Vanderbilt and BCBS. *Id.* In response to the Complaint, Vanderbilt moved to compel Benton to arbitrate his claims pursuant to the arbitration provision in the contract between Vanderbilt and BCBS. *Id.* On appeal, the Tennessee Supreme Court held that Benton was a third-party beneficiary attempting to enforce the contract between Vanderbilt and BCBS and Benton was bound by all of that agreement's terms—including the arbitration provision. *Id.* at 620. Accordingly, the Tennessee Supreme Court compelled Benton to arbitrate his claims against Vanderbilt pursuant to the hospital services agreement between BCBS and Vanderbilt. *Id*.

Significantly, in that case Benton argued (as does the circuit court in its decision here) that he was not subject to the arbitration provision because it only applied to the "parties to the agreement" and he was not a party to the agreement between Vanderbilt and BCBS. *Id*. at 619. The Tennessee Supreme Court rejected this argument and agreed with the courts of Alabama,

Pennsylvania, and Maryland, all of which relied on *Williston on Contracts* as well as the Restatement (Second) of Contracts, to find that a third-party beneficiary attempting to enforce the hospital services agreement is a "party" to that agreement for the purpose of enforcing the agreement's arbitration provision against him. *Id*.

The circuit court in this case did not provide any analysis of the direct benefits estoppel framework that was laid out and applied in *Pearson* and *Benton*. Similarly, the circuit court did not provide any basis for finding that Owens was not attempting to enforce the Cigna Agreement as a third-party beneficiary. Instead, the circuit court—without any discussion or explanation as to why *Pearson* and *Benton* were not directly on point (which they are)—found the facts and circumstances of this case were similar to the facts at issue in *Wilson v. Willis*, 426 S.C. 326, 340, 827 S.E.2d 167, 175 (2019) and *Weaver v. Brookdale Senior Living, Inc.*, 847 S.E.2d 268, 271 (S.C. Ct. App. 2020). (R. 3). However, those cases are not dispositive of the issues in this case. Those cases involve defendants who moved to compel the non-signatory plaintiffs to arbitrate claims pursuant to an agreement that the plaintiffs were not suing to enforce or from which to take direct benefit.

The court in *Wilson*, 426 S.C. at 340, 827 S.E.2d at 175, contrasted the proper application of direct benefits estoppel applied in *Pearson* with the different fact pattern present in the *Wilson* case. A fact pattern which the *Wilson* court found to only constitute indirect benefit. In analyzing the defendant insurers' motion to compel arbitration under the attending facts in that case, the court in *Wilson* distinguished between a party seeking to obtain direct benefits and a party seeking to obtain indirect benefits from a contract. *Id.* at 342-44, 827 S.E.2d at 176-77. Under the facts of the case in *Wilson*, the court found that the nonsignatory was not making a claim under or directly exploiting terms of the agreement which also contained the arbitration clause. Only the general

relationship of the parties arising from the agreement was relevant to the claims by the non-signatories in *Wilson*, not actual provisions of the agreement. In such circumstances, the *Wilson* court found that direct benefits estoppel did not apply. Those are not facts applicable to Owens' claims. Owens seeks to enforce specific provisions of the Cigna Agreement and to take benefits existing exclusively thereunder.

In *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 228, 847 S.E.2d 268, 271 (Ct. App. 2020), the court found a nursing home could not compel the plaintiff to arbitrate her claims related to the death of the plaintiff's grandmother in accordance with the arbitration provision in the residency agreement executed by the plaintiff's grandmother. Thus, the court affirmed the denial of the nursing home's motion to compel arbitration because (1) the plaintiff's claims relied on general tort duties and not any provision of the residency agreement; (2) the plaintiff had not "'exploited' or otherwise sought to enforce or benefit from the residency agreement;" and (3) the plaintiff was not attempting to procure any direct benefit specifically arising from the residency agreement while attempting to avoid its arbitration provision. *Weaver*, 431 S.C at 232-33, 847 S.E.2d at 273-74.

Like the plaintiffs in *Pearson* and *Benton*, Owens' claims are based upon the fundamental assertion that Defendants are obligated by the terms of the hospital services agreement to bill his health insurance provider (Cigna) at discounted rates, and Defendants may not seek to recover payment for the medical services rendered to Owens through his recovery from an at-fault driver's insurance carrier. Regardless of the merit or lack of merit in his claims, Owens' claims are absolutely and fundamentally dependent upon the specific alleged obligation that Defendants bill Cigna at discounted rates, and not attempt any billing to, or collection from Owens. That obligation—if it exists at all—is created by the Cigna Agreement. Unlike the plaintiffs in *Wilson*

and *Weaver*, Owens has admitted that his claims "admittedly rel[y] on the hospital services agreement." (R. 220; Plaintiffs' Memorandum in Opposition to Defendants' Motion to Alter of Amend p. 6). Owens has expressly argued that he was "harmed by [Mary Black's] failure to act in accordance with the contract." (R. 216; Plaintiffs' Memorandum in Opposition to Defendants' Motion to Alter of Amend p. 2). Those admissions alone negate the application of the holdings in *Wilson* and *Weaver*. Therefore, as an alleged third-party beneficiary seeking to enforce the Cigna Agreement, Owens is subject to all the terms and conditions of the Cigna Agreement (including the arbitration provision).

Accordingly, the Court must reverse the circuit court, stay the case, and compel Owens to arbitrate his claims against Defendants pursuant to the arbitration provision in the Cigna Agreement. Section 6.2.2 of the Cigna Agreement unequivocally provides that:

> Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement. . . .

(R. 275-276).

As discussed above, Owens' claims to enforce the billing and payment terms, and the discounted rates, set fourth only in the Cigna Agreement are unquestionably matters arising under the Cigna Agreement. Moreover, any doubt as to whether Owens' claims are within the scope of the Cigna Agreement's broad arbitration provision 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). Accordingly, Owens must individually arbitrate his claims against Defendants pursuant to the terms of the arbitration agreement contained within the Cigna Agreement.

B. The circuit court erred when it held the application of the arbitration provision was adversely affected by the arbitration provision being subject to either party's election to enforce the arbitration provision.

The circuit court erred in finding the arbitration agreement's language that "either party may initiate arbitration by providing written notice to the other party" renders the Cigna Agreement's arbitration provision unenforceable.

Contrary to the circuit court's erroneous conclusions, resolution of disputes in arbitration does not need to be identified as the exclusive remedy to be binding and enforceable. The arbitration provision is enforceable when any party demands it be enforced. In *MailSource, LLC v. M.A. Bailey & Associates Inc.*, 356 S.C. 370, 373, 588 S.E.2d 639, 640-41 (Ct. App. 2003), the court analyzed a similar elective arbitration provision and found the circuit court erred in failing to compel the plaintiff to arbitrate its claims against the defendant. In *MailSource*, the court stated that the principal agreement "required the parties to attempt in good faith to settle any disputes first through consultation and negotiation, and then by mediation. If those attempts failed, the agreement provided 'either party may demand that the dispute be arbitrated. . . .'" 356 S.C. 370, 373, 588 S.E.2d at 341. After the plaintiff filed an action against the defendant, the defendant moved the circuit court to compel arbitration. The court held that while the elective nature of the arbitration provision may be unique, nevertheless, the circuit court erred in refusing to compel the plaintiff to arbitrate its claims against the defendant. *Id*. at 377, 588 S.E.2d at 643.

Like the circuit court in *MailSource*, the circuit court in this case erred in denying the Motion and refusing to compel Owens to arbitrate his claims. The elective nature of the arbitration provision in the Cigna Agreement does not alter the proper analysis of the demand for arbitration pursuant to an enforceable agreement to arbitrate. The Cigna Agreement states that either party may demand arbitration and, like the defendant in *MailSource*, Defendants made a proper demand for arbitration in response to the Amended Complaint. Accordingly, the Court must reverse the

circuit court, stay the case, and compel Owens to arbitrate his claims against Defendants pursuant to the Cigna Agreement's arbitration provision.

C. The circuit court erred in finding the disclaimer of class arbitration and the bar to consolidating arbitrations with third-parties rendered the arbitration agreement unenforceable.

The Cigna Agreement's arbitration provision states:

> 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.

(R. 275-276).

The circuit court erred in finding that this language renders the Cigna Agreement's arbitration provision unenforceable against Owens—who is seeking to act as a party to the Agreement and enforce its terms to his direct benefit.

South Carolina courts have recognized the principle that the inclusion of express language stating that an arbitration will not include class claims is permissible and proper. *See York v. Dodgeland of Columbia, Inc.*, 406 S.C. 67, 94, 749 S.E.2d 139, 153 (Ct. App. 2013). Moreover, the arbitration provision's requirement that "arbitration conducted under this provision shall not be consolidated with an arbitration involving other hospitals or third parties" is simply an express statement that the arbitration will not be consolidated with other arbitration proceedings which is also valid and enforceable under the law. *See DIRECTV, Inc. v. Imburgia*, 577 U.S. 47, 50, 136 S. Ct. 463, 466, 193 L. Ed. 2d 365 (2015) (enforcing an anti-consolidation provision that stated "[n]either you nor we shall be entitled to join or consolidate claims in arbitration.").

Therefore, the circuit court erred in concluding the waiver of class arbitration and bar to consolidating arbitrations rendered the Cigna Agreement's arbitration provision unenforceable.

Accordingly, the Court must reverse the circuit court, stay the case, and compel Owens to arbitrate his claims against Defendants pursuant to the Cigna Agreement's arbitration provision.

II. The interlocutory issues raised in the Motion are subject to immediate review by the Court.

Given that the appeal in this case is unquestionably proper at this time and necessary to address the circuit court's denial of Defendants' motion to compel arbitration, *see* S.C. CODE ANN. § 15-48-200, this is a case where it is also proper and prudent for the Court to exercise its authority to review and address other erroneous rulings by the circuit court which, although not immediately appealable on their own, present the opportunity to avoid unnecessary and unwarrantedly protracted litigation. The Court has the authority to exercise its discretion to review the other interlocutory issues raised in the Defendants' Motion—and ruled upon in the circuit court's Order—because issues raised in an interlocutory order that are not directly appealable can be considered by the Court when raised in tandem with an immediately appealable issue. *See Cox v. Woodmen of World Ins. Co.*, 347 S.C. 460,469, 556 S.E.2d 397, 402 (Ct. App. 2001) (reviewing the appellants' Rule 12(b) arguments that were raised in tandem with a motion to compel arbitration); *Ferguson v. Charleston Lincoln Mercury, Inc.*, 349 S.C. 558, 565, 564 S.E.2d 94, 98 (2002) ("This Court reviews interlocutory orders when they contain other appealable issues."); *Hite v. Thomas & Howard Co.*, 305 S.C. 358, 360, 409 S.E.2d 340, 341 (1991) *overruled on other grounds by Huntley v. Young*, 319 S.C. 559, 462 S.E.2d 860 (1995) ("[A]n order that is not directly appealable will nonetheless be considered if there is an appealable issue before the Court and a ruling on appeal will avoid unnecessary litigation.").

In deciding when to exercise discretion to review an issue that would typically not be immediately appealable, courts consider whether immediate review will "avoid another appeal in the future and potentially narrow the issues for trial (i.e. judicial economy)." *Edge*

v. State Farm Mut. Auto. Ins. Co., 366 S.C. 511, 517, 623 S.E.2d 387, 390 (2005); *see also Roberts v. Recovery Bureau, Inc.*, 316 S.C. 492, 495 n.2, 450 S.E.2d 616, 618 n.2 (Ct. App. 1994) ("The appellate courts have discretion . . . to consider an unappealable order if an appealable issue is before the court and a ruling on appeal will avoid unnecessary litigation.").

Judicial economy favors immediate review of all of the issues raised in Defendants' Motion, because such review and consideration likely will eliminate the need for further proceedings (regardless of the forum) and may resolve important issues related to the scope of claims for further litigation. In this case those concerns and needs are heightened because Plaintiffs purport to base class claims on inherently flawed claims by the named Plaintiffs as purported class representatives.

For example, if the Court finds that Owens' claims are not subject to arbitration, then the Court may consider whether he even has a legally cognizable claim. As presented in the Motion, Owens' claims are, in fact, barred by the applicable statutes of limitation because Owens was added (improperly) to this matter—years after the filing of the original complaint and his claims cannot and do not, as a matter of law, relate back to Blackwell's filing of the original complaint. The time bar of Owens' claims is apparent on the face of his own allegations. Judicial economy favors the Court's immediate consideration of this legal issue, because immediate review and dismissal of Owens' claims allows Defendants and the circuit court to avoid wasting time and money on further litigation of those claims. Additionally, resolution of Owens' claims resolves a whole set of related and dependent class claims alleged.[3]

[3] A class representative can only represent those with the same claims against the same parties. *See Bailey v. Patterson*, 369 U.S. 31, 32-33, 82 S. Ct. 549, 550, (1962); *E. Tex. Motor Freight Sys., Inc. v. Rodriguez*, 431 U.S. 395, 403 (1977); *Edisto Fleets, Inc. v. S.C. Tax Comm'n*, 256 S.C. 350, 354, 182 S.E.2d 713, 714 (1971). Thus, since each named Plaintiff is covered by separate and different insurance, that named Plaintiff can only be a representative of a class with the same

As another example, judicial economy favors an immediate review of the claims asserted by Blackwell. Blackwell has asserted a claim for unjust enrichment against Defendants; however, for such a claim to exist, Blackwell must have adequately alleged, and must be able to prove, that she conferred an actual benefit on Defendants which they have unjustly retained and must return. But, Blackwell's Amended Complaint does not allege that she conferred any benefit upon any of the Defendants. Without conferring a benefit to Defendants, Defendants have not been unjustly enriched and there is no available remedy for Blackwell. Not only is a meritless claim by Blackwell dispensed without the costs and burdens of continuing litigation, as discussed above, her dismissal further reduces the scope of any purported class whose claims only she of the three named plaintiffs can represent. Judicial economy requires that the Court consider now the legal and factual defects in the claims and avoid wasting additional time and money in further litigation.

Based on the foregoing, judicial economy favors the immediate review of all of the issues raised in Motion which are set forth below.

III. The circuit court erred in failing to dismiss Owens' claims on the grounds that they are barred by the applicable statute of limitations because Owens' claims do not relate back to the filing of the original complaint.

The circuit court erred by denying the Motion and refusing to dismiss Owens' claims on the grounds they are barred by the applicable statutes of limitation. His claims, raised for the first time upon the filing of the Amended Complaint which added him as a new plaintiff, do not relate back to the date of Blackwell's filing of the original complaint. Therefore, Owens claims are facially time barred and must be dismissed.

Rule 15(c) of the South Carolina Rules of Civil Procedure governs the relation back of a pleading. *Jackson v. Doe*, 342 S.C. 552, 558, 537 S.E.2d 567, 570 (Ct. App. 2000). Rule 15(c)

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insurance. Dismissal of a named Plaintiff in this case eliminates putative class members with that same insurer.

and its relation back provision only apply, and may only validate a relation back argument, to a substitution or change in a party. *Id.* "[T]he addition of a party is not the same as a substitution or change of party." *Id.* The addition of a new party is not contemplated by Rule 15(c), and does not relate back. *Gause v. Smithers*, 384 S.C. 130, 133, 681 S.E.2d 607, 609 (Ct. App. 2009).

Claims asserted by new parties added to a case do not relate back to the original filing of the complaint. *See Jackson*, 342 S.C. at 558, 537 S.E.2d at 570; *Gause*, 384 S.C. at 133, 681 S.E.2d at 609. Because Owens' claims do not relate back to the filing of the original complaint, his claims for tortious interference with contract and unjust enrichment must be timely on their own. The new claims by Owens are not timely and are barred by the applicable statute of limitations. According to the Amended Complaint, Owens settled his bill with Mary Black on October 14, 2016. (R. 71-72; Amended Complaint ¶ 52), and any claims he might assert in this case certainly accrued no later than that date. *Holly Woods Ass'n of Residence Owners v. Hiller*, 392 S.C. 172, 183, 708 S.E.2d 787, 793 (Ct. App. 2011). Owens' claims are all based on the allegation that Defendants were not permitted to collect payment from him directly; therefore, when he made a direct payment to Mary Black on October 14, 2016, he knew or should have known that Mary Black was attempting to collect payment from him directly and not from his alleged health insurance provider.

Plaintiffs filed the Motion to Amend Complaint and add Owens on October 18, 2019. Therefore, more than three (3) years passed between the time Owens knew or should have known of his alleged claims (October 14 ,2016), and any action to commence his claims (October 18, 2019). *See Burgess v. Elliott*, No. 3:16-CV-3325-RBH, 2017 WL 1505421, at *3 (D.S.C. Apr. 27, 2017), *aff'd*, 696 F. App'x 125 (4th Cir. 2017) ("The applicable statute of limitations for civil actions of breach of contract, negligence, and tortious interference with contract is likewise three

years."); *Graham v. Welch, Roberts & Amburn, LLP*, 404 S.C. 235, 239, 743 S.E.2d 860, 862 (Ct. App. 2013) (holding a claim for unjust enrichment was barred by the three year statute of limitations).

It is clear from the face of the Amended Complaint that Owens did not commence his claim within the applicable three year limitation period. Therefore, Owens' claims are barred by the applicable statutes of limitation because his claims were not commenced within three (3) years of the date his complaint established that he knew or should have known he had the claims asserted, and his complaint does not relate back to Blackwell's filing of the original Complaint. Accordingly, the Court should reverse the circuit court and dismiss Owens' claims against Defendants on the grounds that his claims are barred by the applicable statutes of limitation.

IV. The circuit court erred in failing to dismiss Blackwell's claim for unjust enrichment, because Blackwell did not, and cannot allege she conferred any benefit to Defendants.

It is not disputed that South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: "(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its value." *Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994).

Blackwell's claim for unjust enrichment—according to the Amended Complaint and Plaintiffs' Response in Opposition to the Motion to Alter or Amend—is based upon the allegation that Defendants "assert[ed] liens against Plaintiff Blackwell's potential third party automobile accident claim." (R. 227; 70; Plaintiffs' Memorandum in Opposition to Defendants' Motion to Alter of Amend p. 13; Amended Complaint ¶ 40). Blackwell does not allege she paid any money or gave any value to Defendants.

A claim for unjust enrichment is a claim to have a defendant return a benefit that would be inequitable for the defendant to retain. *Columbia Wholesale*, 312 S.C. at 261, 440 S.E.2d at 130; *Campbell v. Robinson*, 398 S.C. 12, 24, 726 S.E.2d 221, 228 (Ct. App. 2012) (stating that restitution is the remedy for a claim for unjust enrichment). Blackwell cannot state a claim for unjust enrichment unless she can and does allege that she actually conferred a benefit to Defendants that can and must be returned. *Niggel Assocs., Inc. v. Polo's of N. Myrtle Beach, Inc.*, 296 S.C. 530, 532-33, 374 S.E.2d 507, 509 (Ct. App. 1988). She has utterly failed to make such an allegation. Indeed, she cannot make such an allegation because she never did confer any benefit upon Mary Black or the other Defendants. There is no factual allegation in either of Blackwell's Complaints that Defendants received or retain possession of anything of any value belonging to Blackwell. Thus, there is, and can be, no actionable unjust enrichment. *See also Harrison v. Christus St. Patrick Hosp.*, 430 F. Supp. 2d 591, 597 (W.D. La. 2006) (granting the hospital's motion to dismiss a patient's claim for unjust enrichment because "[n]one of the requirements of an unjust enrichment claim [were] satisfied" because, among other reasons, (i) the hospital received nothing from the patient and (ii) the patient paid nothing as a result of a contract with the hospital).

The only allegation by Blackwell is that Defendants asserted a lien against her potential third-party automobile accident claim. (R. 227; 70; Plaintiffs' Memorandum in Opposition to Defendants' Motion to Alter of Amend p. 13; Amended Complaint ¶ 40). However, a lien does not transfer a property interest. *See Horry Cty. v. Ray*, 382 S.C. 76, 83-84, 674 S.E.2d 519, 523-24 (Ct. App. 2009) ("An equitable lien is neither an estate or property in the thing itself, nor a right to recover the thing" (citation and internal quotation marks omitted)); *Matter of Hinson*, 20 B.R. 753, 758 (Bankr. D.S.C. 1982) (a judgment lien "does not operate to give a judgment creditor a

property interest in specific property" and "does not constitute a taking of property"). Thus, the mere assertion of a lien does not constitute the receipt or retention of a benefit.

Blackwell makes no allegations through which any court could award her restitution—the remedy for a claim of unjust enrichment. *Campbell*, 398 S.C. at 24, 726 S.E.2d at 228. Blackwell has conferred no payment, value or benefit to Defendants and Defendants do not owe and have nothing to return to Blackwell. Therefore, Blackwell's claim for unjust enrichment fails as a matter of law, and the Court should reverse the circuit court and dismiss Blackwell's claim for unjust enrichment.

V. The circuit court erred in failing to find that Blackwell lacks standing to pursue her claims because she is not an intended third-party beneficiary under the agreement between Mary Black and her health insurer (MedCost).

The circuit court erred in refusing to find that Blackwell's claims fail as a matter of law because she does not have the right to enforce the MedCost Agreement as a non-signatory third-party beneficiary due to the fact that the MedCost Agreement contains a plain and unambiguous disclaimer of third-party beneficiaries.[4]

Blackwell's claims are all premised upon her contention that she is a third-party beneficiary of the MedCost Agreement between Mary Black and her health insurer (MedCost). In fact, in the Response in Opposition to the Motions to Dismiss, Plaintiffs stated: "Plaintiffs contend they are third-party direct beneficiaries of the agreements between their insurance companies and Mary Black." (R. 175). Contrary to this assertion, Blackwell is not, and cannot be an intended third-party beneficiary who can sue to enforce that Agreement for her own benefit. Therefore, she cannot maintain any claim derived from or dependent upon the terms of that Agreement.

[4] The circuit court did not expressly rule on this issue despite Defendants raising the issue in the Motion and again requesting a ruling in the Motion to Alter or Amend.

In South Carolina, there is a presumption that a contract is not enforceable by a person who is not a party to the contract, and the expressed intent of the parties to the contract shall govern the interpretation of that contract. *See Windsor Green Owners Ass'n, Inc. v. Allied Signal, Inc.*, 362 S.C. 12, 17, 605 S.E.2d 750, 752 (Ct. App. 2004). It is well settled that the law presumes that parties contract exclusively for their own benefit. *See Ancrum v. Camden Water, Light & Ice Co.*, 82 S.C. 284, 295, 64 S.E. 151, 155 (1909). In order to overcome this presumption, a non-signatory third-party must show that the parties to a contract intended the third-party to be a direct beneficiary of the contract. *Touchberry v. City of Florence*, 295 S.C. 47, 48-49, 367 S.E.2d 149, 150 (1988). However, "[n]o third-party beneficiary status is created absent an intent by the parties to confer a substantial benefit on [a non-signatory third-party]." *Windsor Green Owners Ass'n, Inc.*, 362 S.C. at 19, 605 S.E.2d at 753 (emphasis added).

The line between a direct intended third-party beneficiary and a mere incidental or consequential third-party beneficiary is first drawn by examining the clear intent expressed by the actual parties to the contract. Absent an expression that the actual contracting parties clearly intended to directly benefit the third-party, that third-party is merely an incidental beneficiary with no right to enforce the contract. *See TC X, Inc. v. Commonwealth Land Title Ins. Co.*, 928 F. Supp. 618, 623 (D.S.C. 1995), *aff'd*, 86 F.3d 1152 (4th Cir. 1996). Therefore, the necessary first step in determining whether a party is an intended direct third-beneficiary of a contract is to ascertain and give legal effect to the language of the contract on the issue of intent. *Whitlock v. Stewart Title Guar. Co.*, 399 S.C. 610, 614, 732 S.E.2d 626, 628 (2012).

When the parties to a contract include an express third-party beneficiary disclaimer, as they did in the MedCost Agreement, a court is bound to find the parties did not intend to convey a direct benefit to third parties or to create a right for such third parties to enforce or sue upon the contract.

See Lightsey v. Toshiba Corp., No. 9:18-CV-190, 2019 WL 5872168, at *3 (D.S.C. Mar. 4, 2019) (applying New York law and finding that "[d]ismissal of a third-party-beneficiary claim is appropriate where the contract rules out any intent to benefit the claimant. . . .").

The MedCost Agreement plainly and directly expresses Mary Black's and MedCost's intent to bar third-parties from enforcing the MedCost Agreement. This intent is unequivocally stated in Section 10.9 of the MedCost Agreement, which expressly and definitively states Mary Black's and MedCost's intention that the contract was not to be construed to have any third-party beneficiaries:

> This Agreement is entered into by and between the parties hereto for their benefit. **There is no intent by either party to create or establish a third party beneficiary status** or rights in a Covered Person, Employer, subcontractor, or other third party to this Agreement, except as such rights are expressly created and as set forth herein, and **no such third party shall have any rights to enforce any right to enjoy any benefit created or established under this Agreement**.

(R. 258) (emphasis added).

Review of the plain and unambiguous language must result in a finding that Mary Black and MedCost did not express, and did not have, an intent to allow Blackwell to enforce the MedCost Agreement as a third-party beneficiary. In fact, they expressed the clear and unambiguous intent that neither she, nor others, were third-party beneficiaries with such rights. The circuit court did not find any facts allowing a conclusion to the contrary and identifies in its Orders no findings to justify a conclusion that Blackwell is an intended third-party beneficiary with rights to enforce or sue upon the terms of the Agreement. Since Blackwell is not a third-party beneficiary and lacks standing to enforce the MedCost Agreement as a third-party beneficiary, she cannot sue to enforce the terms of the MedCost Agreement or to pursue any of her alleged claims. Therefore, as a matter of law, Blackwell's claims must be dismissed and the circuit court erred in

refusing to dismiss her claims. Accordingly, the Court should reverse the circuit court and dismiss Blackwell's claims against Defendants.

VI. The circuit court erred in failing to dismiss Brooks' claims because her claims are governed by the Medicare Act and the law under that act does not support the claims alleged.

Like the other Plaintiffs, the *sine qua non*, of Brooks' claims is that Defendants were obligated to seek payment for her medical expenses from her health care coverage and not from her or another source. However, in her case the health care coverage is alleged to be through Medicare.

The circuit court erred in failing to dismiss Brooks' claims because under the controlling Medicare Act, 42 U.S.C.A. § 1395y(b)(2)(A)(ii), hospitals—like Mary Black—are required to seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare. Rather than recognizing the fatal flaw in Brooks' claims, the circuit court stated that it could not dismiss her claims based on the application of the Medicare Act because it was not specifically alleged in the Amended Complaint that the at-fault driver in the automobile accident had a valid insurance policy from which to collect.

The operative allegations by Brooks are simple:

1. On February 26, 2016, Brooks was injured in an automobile accident, and two days later, she presented to the emergency room at Mary Black for treatment. (R. 70; Amended Complaint ¶ 41);

2. Brooks had valid health insurance through Medicare. (R. 70; Amended Complaint ¶ 43);

3. Mary Black did not send a bill to Medicare and, instead, asserted a lien against her third-party automobile accident claim. (R. 70; Amended Complaint ¶ 44); and

4. Mary Black agreed to accept a reduced payment for the medical services provided to Brooks after reviewing the

> settlement offer in her personal injury case. (R. 71; Amended Complaint ¶ 46).

Brooks' claims against Defendants fail, as a matter of law, because of the controlling terms of the Medicare Act, 42 U.S.C.A. § 1395y(b)(2)(A)(ii). The Medicare Act requires hospitals—like Mary Black—to seek payment from any applicable automobile or liability policy prior to seeking or obtaining any payment from Medicare. 42 U.S.C.A. § 1395y(b)(2)(A)(ii). Specifically, the Medicare Act states:

> Payment under this subchapter may not be made . . . with respect to any item or service to the extent that . . . (ii) **payment has been made or can reasonably be expected to be made** under a workmen's compensation law or plan of the United States or a State **or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance**.

Id. (emphasis added).

All of Brooks' claims are based on the allegations that she had health coverage through Medicare, and Defendants are liable because they sought collections for her medical care costs by asserting a right to payment against the insurer for the at-fault driver in her automobile accident instead of immediately and directly submitting the claim for her medical care costs to Medicare. Thus, her claims against Defendants are baseless because of the controlling provisions of the Medicare Act.

Other jurisdictions that have been confronted with this issue have concluded that 42 U.S.C. § 1395y(b)(2)(A)(ii) explicitly prohibits medical service providers from collecting payment from Medicare when payment can reasonably be expected to be made under an automobile or liability insurance policy. *See Parkview Hosp., Inc. v. Roese*, 750 N.E.2d 384, 389 (Ind. Ct. App. 2001) ("[W]e find that Congress's intent is clearly expressed in 42 U.S.C. § 1395y(b)(2)(A)(ii). It explicitly prohibits medical service providers from collecting payment from Medicare when payment can reasonably be expected to be made promptly under an automobile or liability

insurance policy."); *Joiner v. Med. Ctr. E., Inc.*, 709 So. 2d 1209, 1221 (Ala. 1998) (holding that a hospital had a right under the Medicare Act to obtain full payment of its charges from the proceeds of the plaintiff patient's settlement with an automobile liability carrier, instead of filing a claim for reimbursement with Medicare).

The circuit court declined to dismiss Brooks' claims because it rationalized that it would be required to presume that the at-fault driver in her automobile accident had a valid insurance policy from which to collect. The circuit court failed to recognize that in South Carolina drivers are required under the law to have automobile insurance and "[i]n the absence of proof to the contrary, it is presumed that a person observed the law." *See* S.C. CODE ANN. §§ 56-10-10 to -40 and 56-10-210 to -280; S.C. CODE ANN. §§ 38-77-140, -150, and -160; *see also Croft v. Old Republic Ins. Co.,* 365 S.C. 402, 416-17, 618 S.E.2d 909, 916 (2005) (reciting insurance requirement principles); *Simmons v. Atl. Coast Line R. Co.*, 250 S.C. 199, 203, 157 S.E.2d 172, 175 (1967) (stating that it is presumed a person complied with the law). Thus, the circuit court's inference that the driver may not have had a valid automobile insurance policy is error and contrary to the established law that requires a presumption that the driver did in fact have a valid automobile insurance policy. Thus, it was appropriate and proper for Defendants reasonably to expect that payment could be made from an automobile or liability policy. And it was necessary then for Defendants to pursue that avenue of collection for Brooks' bills rather than submitting those bills to Medicare. In this light, the entire premise for Brooks' claims against Defendants is false and the claims must be dismissed.

In short, Defendants cannot be liable to Brooks in this case for doing exactly what Medicare requires of them. Brooks' entire premise for liability fails and her claims must be dismissed as a matter of law. Accordingly, the Court should reverse the circuit court and dismiss Brooks' claims.

VII. The circuit court erred in failing to dismiss the claims asserted by Brooks and Owens pursuant to the voluntary payment doctrine.

The circuit court erred in failing to apply the voluntary payment doctrine as a bar to the claims asserted by Brooks and Owens.

The relevant allegations in the Amended Complaints related to the payments made by Brooks and Owens are simple:

> 1. On or about September 26, 2017, **Defendants agreed to accept** a 50% reduction on Plaintiff Brooks's account and settle for $4,991.22. Defendants agreed to this reduction only after asserting a lien against Plaintiff Brooks's third-party recovery in her personal injury case and after reviewing the settlement offer for that case. (R. 71; Amended Complaint ¶ 46 (emphasis added)); and
>
> 2. On or about October 14, 2016, **Defendants agreed to accept** a 50% reduction on Plaintiff Owens's account and settle for $4,543.38. Defendants agreed to this reduction only after asserting a lien against Plaintiff Owens's third-party recovery in her personal injury case and after reviewing the settlement offer for that case. (R. 71-72; Amended Complaint ¶ 52 (emphasis added)).

These allegations result in one clear interpretation, Defendants accepted offers from Owens and Brooks to pay only fifty percent of the bills for the medical services rendered to them. Based on a plain reading of the Amended Complaint, these offers to settle were made by Owens and Brooks and accepted by Defendants. Yet, after making these offers, and making payments to Mary Black following the acceptance of those offers, Owens and Brooks sued Defendants. In effect, Owens and Brooks now sue Defendants for accepting settlement offers and payments which Plaintiffs offered.

The law of South Carolina does not allow such claims to proceed. It is a long standing and elementary principle of South Carolina law that no action will lie to recover money voluntarily paid. *Hardaway v. S. Ry. Co*., 90 S.C. 475, 488-89, 73 S.E. 1020, 1025 (1912); *Moody v. Stem*,

214 S.C. 45, 60, 51 S.E.2d 163, 169 (1948). The Amended Complaint does not contain any allegation that the payments were made under coercion or duress, or were in any way not voluntary.

Recently, in *Cross v. Ciox Health, LLC*, 438 F. Supp. 3d 572 (E.D.N.C. 2020), *appeal dismissed*, No. 20-1262, 2020 WL 5203205 (4th Cir. Aug. 31, 2020), the North Carolina District Court applied the voluntary payment doctrine to bar a plaintiff's class action claim based upon allegations that the Plaintiff was overcharged for medical records. In *Cross*, the plaintiff alleged that she requested medical records from the hospital that treated her, that she was overcharged for those records, and her attorney paid those charges on her behalf. *Cross* at 583. The District Court granted the defendant's Motion to Dismiss pursuant to Rule 12(b)(6) on the grounds that the plaintiff's claims were barred by the voluntary payment doctrine. *Id.* at 590. The District Court held:

> Here, where it is alleged that defendant provided an itemized bill showing charges for the medical records, and where it is alleged that plaintiffs' attorney proceeded to pay the bills as requested, payment thus was made by plaintiffs with full knowledge of all the facts pertinent to their instant claims. Accordingly, the voluntary payment doctrine bars their claims for unjust enrichment.

Id.

Moreover, the Court found that the plaintiff did not meet the standard for avoiding the application of the voluntary payment doctrine based on "coercion or duress" because "they have alleged their attorney both requested and paid for the medical records." *Id.*

In this case, Brooks and Owens make no allegations of fraud, duress or coercion in connection with the voluntary payments. Accordingly, the Court should reverse the circuit court and dismiss the claims asserted by Brooks and Owens on the grounds that their claims are barred by the voluntary payment doctrine.

VIII. The circuit court erred in failing to dismiss Plaintiffs' claim for tortious interference with a contract.

Plaintiffs' Amended Complaint utterly fails to allege facts sufficient to constitute a cause of action for tortious interference against any Defendant.

The circuit court found the Amended Complaint could be construed to state a theory of recovery for tortious interference with a contract on the grounds that the patients' contracts with their own insurers were breached because Plaintiffs paid their premiums and did not have their hospital bills paid by their insurers. The circuit court failed to recognized that the Amended Complaint does not actually allege facts sufficient to infer that those contracts were actually breached.

In this case, Plaintiffs acknowledge that the contracts in issue are those between themselves and their respective health insurers. Without a breach by the health insurers of their insurance contracts with Plaintiffs, there can be no recovery from Defendants under a cause of action for tortious interference with a contractual relationship. *First Union Mortgage Corp. v. Thomas*, 317 S.C. 63, 73, 451 S.E.2d 907, 913 (Ct. App. 1994); *see also Camp v. Springs Mortgage Corp.*, 310 S.C. 514, 517, 426 S.E.2d 304, 305-06 (1993) (stating the elements necessary for a claim for tortious interference with a contract).

Plaintiffs' Amended Complaint does not allege an actual breach by any of the health insurers of any of the relevant health insurance contracts (policies). The Amended Complaint contains only bald and unsupported allegations that Plaintiffs did not receive the benefit of their individual health insurance contracts. However, the failure to receive a benefit of a contract is not a breach of a contract. Plaintiffs do not even assert their individual contracts with their health insurance carriers were breached. *Eldeco, Inc. v. Charleston Cty. Sch. Dist.*, 372 S.C. 470, 482, 642 S.E.2d 726, 732 (2007) ("In the absence of a breach of a contract, [the plaintiff] cannot prove

the required elements of its cause of action for tortious interference with contractual relations."). Thus, Plaintiffs' conclusory and vague pleadings with not even an allegation that the third-party contract was breached, are insufficient to state a claim for tortious interference with a contractual relationship. Accordingly, the circuit court erred in refusing to dismiss Plaintiffs' claims for tortious interference with contract.

IX. The circuit court erred in concluding that the Amended Complaint states facts sufficient to constitute any viable cause of action against CHSPSC or PASI.

The circuit court erred in finding that the Amended Complaint's bare allegations against PASI and CHSPSC are sufficient to state any viable cause of action.

Plaintiffs' conclusory lumping together of "all Defendants" is insufficient to meet their pleading burden and state a claim against PASI or CHSPSC. The entirety of the specific and individual allegations against PASI and CHSPSC are encompassed in three paragraphs of the Amended Complaint:

> 16. Defendant CHSPSC, LLC, formerly known as Community Health Systems Professional Services Corporation, is a Delaware corporation with its principal place of business in Tennessee. On information and belief, CHSPSC regularly conducts business in the State of South Carolina and other states and has responsibility for the billing of patients and liens filed within the State of South Carolina.
>
> 17. Defendant Professional Account Services, Inc. ("PASI") is a Tennessee corporation with its principal place of business in Brentwood, Tennessee. PASI is a collection firm that regularly conducts business in the State of South Carolina and elsewhere.
>
> 18. On information and belief, CHSPSC and PASI exercise control over policies and procedures enacted by and implemented by Mary Black Health System, including policies relating to billing and liens, and all of these entities committed the acts and omission complained of herein jointly and in concert.

(R. 66-67).

The Amended Complaint contains no other specific or individual allegations about or against PASI or CHSPSC. Rather, the remainder of the Amended Complaint contains only non-specific generalized allegations referencing PASI, CHSPSC, and Mary Black collectively as "Defendants." There are no allegations sufficient to identify what PASI or CHSPSC did, or failed to do, which would support the assertion of each (or any) of the purported causes of action against them specifically. Furthermore, there are no factual allegations which could support or form the basis for any claim to pierce the corporate veil of PASI or CHSPSC, or to establish a basis for an amalgamation or conspiracy claim. *See Juntti v. Prudential-Bache Sec., Inc.*, 993 F.2d 228 (4th Cir. 1993) (affirming the dismissal of the plaintiff's complaint that contained an "impermissible aggregation of defendants without specifically alleging which defendant was responsible for which act."); *see also Magluta v. Samples*, 256 F.3d 1282, 1284 (11th Cir. 2001) ("The complaint is a quintessential 'shotgun' pleading of the kind we have condemned repeatedly, beginning at least as early as 1991. . . . The complaint is replete with allegations that 'the defendants' engaged in certain conduct, making no distinction among the fourteen defendants charged, though geographic and temporal realities make plain that all of the defendants could not have participated in every act complained of."); *Barmapov v. Amuial*, 986 F.3d 1321, 1324-25 (11th Cir. 2021) ("Besides violating the rules, shotgun pleadings also 'waste scarce judicial resources, inexorably broaden the scope of discovery, wreak havoc on appellate court dockets, and undermine the public's respect for the courts.'" (citation omitted)).

In *Scurmont LLC v. Firehouse Rest. Grp., Inc.*, No. 4:09-CV-00618-RBH, 2010 WL 11433199, at *16 (D.S.C. May 19, 2010), the Court found this type of group or "shotgun" pleading was insufficient to state a claim against individual defendants. In *Scurmont*, after filing the initial complaint, the plaintiff amended the complaint to assert claims not only against Firehouse

Restaurant Group, Inc., but also its alleged owners, Chris and Robin Sorensen. *Id*. The amended complaint contained only a single paragraph referencing the individual defendants and, thereafter, did not differentiate among the defendants or allege any facts establishing how the Sorensens specifically participated in, or directed any of the acts alleged. *Id.* Under those circumstances, this Court granted the Sorensens' Motion to Dismiss pursuant to Rule 12(b)(6) because the amended complaint failed to contain "any facts establishing how the Sorensens specifically participated in or directed any of the acts alleged against Firehouse." *Id.*

Similarly, in *Camel v. Cannon*, No. 6:06-3030-GRA-WMC, 2007 WL 465583 (D.S.C. Feb. 7, 2007), the court dismissed a prisoner's complaint against the individual prison guard defendants on the grounds that the complaint failed to identify facts as to how any of the individual defendants were involved in, or responsible for, the alleged misconduct. Applying even the liberal standard afforded to *pro se* litigants, the court held that the "lack of factual allegations of individual responsibility and/or vicarious liability of any of the named Defendants is fatal to his case at this stage of the litigation" and "[w]here there are no allegations of responsibility specifically naming any Defendant, there is nothing for this Court to liberally construe." *Id.* at *1 and *3.

Since, the Amended Complaint contains only group or collective conclusory allegations against PASI and CHSPSC, Plaintiffs have failed to plead ultimate facts sufficient to constitute any cause of action against PASI and CHSPSC. *See Jones v. Gilstrap*, 288 S.C. 525, 528, 343 S.E.2d 646, 648 (Ct. App. 1986) (providing that conclusory allegations in a complaint are insufficient to survive the defendant's motion to dismiss for failure to state a cause of action). Without alleging facts related to an act or omission by PASI or CHSPSC the Amended Complaint fails on its face and the claims against PASI and CHSPSC must be dismissed as a matter of law.

Accordingly, the circuit court erred in failing to dismiss the claims against PASI and CHSPSC based on the Plaintiffs' impermissible collective or "shotgun" pleadings that fail to state any facts sufficient to constitute a cause of action against CHSPSC or PASI.

CONCLUSION

Based on the foregoing, the Court must compel Owens to arbitration and stay the remaining claims, and should reverse the circuit court, and dismiss the claims asserted by each of the Plaintiffs.

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November 4, 2021
Columbia, South Carolina

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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

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

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Respondents,

v.

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

Appellants,

APPELLANTS' CERTIFICATE OF COUNSEL

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

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Counter-Statement of the Issues on Appeal

I. Did the lower court properly deny Mary Black's motion to compel arbitration against Samuel Owens, a CIGNA insured, where Mr. Owens was not a party to Mary Black's agreement with CIGNA, his claims do not fall within the terms or scope of the purported arbitration provision, and he never relied on the agreement or received any benefit therefrom?

II. Where the policy of South Carolina is to deny immediate review of interlocutory orders in order to avoid piecemeal litigation, should this Court decline to exercise its discretion to hear an appeal from the denial of various Rule 12(b)(6) motions, especially where there is no appealable order before the Court as to Respondents Blackwell and Brooks and the order denying dismissal lacks a sufficient nexus or companionship to the arbitration issue before the Court?

Counter-Statement of the Case

This is a class action lawsuit arising out of appellant Mary Black Memorial Hospital's refusal to submit bills for treatment rendered to its patients' health insurers. Apparently dissatisfied with its agreed-upon reimbursement rates with insurers, Mary Black (along with its related billing and collection entities, CHSPSC, LLC and Professional Account Services, Inc., all of which are appellants herein and collectively referred to as "Mary Black") instead sought to recover its charges from patients directly by asserting a lien against any potential third-party tort recovery or by seeking payment directly from the patient or from an auto insurer. By obtaining payment from a source other than the patient's health insurer, Mary Black presumably recovers more money for services rendered than it would otherwise receive if it submitted claims to the insurer under its hospital services agreements.

Respondent Jo Ann Blackwell, a MedCost insured, originally filed this case as a class action on January 20, 2017, asserting claims against Mary Black on behalf of herself and hundreds (or possibly thousands) of potential class members. Blackwell subsequently moved to amend the complaint on October 18, 2019, to assert identical claims by additional individuals who were harmed by Mary Black's practices. The lower court granted the motion and on April 24, 2020,

Respondents filed an Amended Class Action Complaint, which included two additional individuals, respondent Samuel H. Owens, Jr., a CIGNA insured, and respondent Michelene Brooks, a Medicare beneficiary, as named plaintiffs and putative class representatives.

Collectively, Respondents (hereinafter referred to as "Plaintiffs" or "Respondents") are asserting causes of action against Mary Black for tortious interference with contractual relationship, unjust enrichment, and injunctive relief individually and on behalf of the class members. The class, which has not yet been certified, is currently defined as:

> All individuals who, since January 20, 2014, received any type of healthcare treatment from any entity located in South Carolina that is owned or affiliated with Defendants, while being covered by valid health insurance, and whose medical bills resulting from that treatment were not submitted to their health insurance carrier for potential payment. (Am. Compl. ¶ 53.)

After Plaintiffs filed the amended complaint, Mary Black moved to compel arbitration against Samuel Owens, asserting that his claims should be compelled to arbitration pursuant to an arbitration provision contained in Mary Black's agreement with CIGNA under a "direct benefits estoppel" theory. Mr. Owens, a nonsignatory to the agreement, was the only plaintiff against whom Mary Black sought to compel arbitration. Mary Black also moved to dismiss the amended complaint in its entirety as to all plaintiffs pursuant to Rule 12(b)(6), SCRCP. By way of Form 4 order filed September 4, 2020, the lower court denied the motion to compel arbitration as against Mr. Owens and further denied the Rule 12(b)(6) motions as against all of the plaintiffs.[1] Mary

[1]Because no appealable order exists as to either Blackwell or Brooks under section 14-3-330 of the South Carolina Code, Plaintiffs contend that the appeal of the interlocutory order denying Mary Black's Rule 12 motions as to those plaintiffs should be dismissed pursuant to *McLendon v. S.C. Dep't of Highway,* 313 S.C. 525, 443 S.E.3d 539 (1994) (dismissing appeal of party without prejudice where sole issue raised on appeal was the denial of a Rule 12(b)(6) motion); *See also Huntley v. Young*, 319 S.C. 559, 560, 462 S.E.2d 860, 861 (1995) ("Since the order denying the Rule12(b)(6) motion does not finally decide any issue, it is not directly appealable.")

Black timely filed a motion to alter or amend, which was denied by way of Form 4 Order dated November 4, 2020, and formal order filed December 8, 2020. This appeal followed.

Factual Background

This case arises out of Mary Black's practice of seeking to recover its charges for treatment rendered from its patients directly, instead of from their respective health insurance plans, where a potential third party is identified by Mary Black as potentially liable for the patient's injuries. Plaintiffs' claims result from this policy and practice of Mary Black electing not to submit claims to health insurers for payment, and instead attempting to obtain payment for the patient's medical bills directly from the patient, from an auto insurer, and/or from the patient's third-party tort recovery. (Am. Compl. ¶¶ 4–8) (R. p. 64). Plaintiffs allege that Mary Black, as a standard business practice, routinely refused to submit patients' medical bills to their insurance providers if its screening identified a patient as one for whom third-party recovery might be available to pay for such treatment. (*Id.* ¶¶ 4–5.) (R. p.64). This was presumably done so that Mary Black could obtain a higher reimbursement than what might have been received from the patient's insurance. (*Id.* ¶ 6.) (R. p. 64). Plaintiffs further allege as follows: "[u]pon information and belief, Defendants are required by their contract with patients' health insurance carriers to submit insurance patients' medical bills directly to the carriers. Defendants were likewise required to submit the medical bills of Plaintiffs and the Class Members to their health insurance." (Am. Compl. ¶28.) (R. p. 68).[2] Regardless, the practical result is that upon receipt of such purported notice of lien, a patient's legal counsel cannot disburse settlement funds received up to the amount of the lien, thereby tying

[2] While the named Plaintiffs herein are insured by MedCost, Medicare, and CIGNA, respectively, it can be presumed that the putative class members could be insured by a variety of health insurance companies, as reflected in the class definition. (Am. Compl. ¶53.)

up funds due and owing to injured persons.[3] The patient is then forced to either meet the demand of Mary Black by way of some "compromise" payment (in order to access, at least in part, their rightful recovery) or refuse Mary Black's demand and allow their settlement funds to remain in trust indefinitely. Another name for this practice is extortion.[4]

A. The Blackwell-specific facts

While crossing the street in Spartanburg on December 19, 2013, Blackwell was injured when she was struck by a vehicle and transported to the trauma department of Spartanburg Regional Medical Center. She was subsequently transferred to Mary Black Hospital on December 27, 2013. Blackwell was discharged from Mary Black Hospital following treatment on January 3, 2014, but she continued to receive treatment through Mary Black thereafter. (*See* Am. Compl. ¶12) (R. p. 65). Blackwell had employer-based health insurance coverage through MedCost at the time she was admitted to Mary Black. She further alleges that Mary Black had a contract with MedCost, which required that bills for medical services provided to Ms. Blackwell

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[3] *See, e.g.*, Rule 1.15(e), RPC, Rule 407, SCACR ("When in the course of representation a lawyer is in possession of property in which two or more persons (one of whom may be the lawyer) claim interests, the property shall be kept separate by the lawyer until the dispute is resolved"); *see also* Comment 4 ("Paragraph (e) also recognizes that third parties may have lawful claims against specific funds or other property in a lawyer's custody, such as a client's creditor who has a lien on funds recovered in a personal injury accident. A lawyer may have a duty under applicable law to protect such third-party claims against wrongful interference by the client. In such cases, when the third- party claim is not frivolous under applicable law, the lawyer must refuse to surrender the property to the client until the claims are resolved. A lawyer should not unilaterally assume to arbitrate a dispute between the client and the third-party, but, when there are substantial grounds for dispute as to the person entitled to the funds, the lawyer may file an action to have a court resolve the dispute.").

[4] Mary Black appears to disregard the practical impact of this business practice, as reflected in its belief that "the *mere* assertion of a lien does not constitute the receipt or retention of a benefit" and that "it does not owe and has nothing to return to its patient." (App. Br. p. 27.) Its argument fails to recognize that a person's very health and well-being may depend on accessing the funds from their personal injury settlement—the same funds having been tied up in trust as a result of such "*mere assertion of lien.*" *See, e.g.*, Rule 1.15(e), SCRPC, Rule 407, SCACR.

be sent directly to MedCost, not her, and that the contract provided for discounted rates for the services. (Am. Compl. ¶¶9, 28–31, 36) (R. p. 65, 68, 69).[5] Instead, Mary Black asserted a lien against Blackwell's third-party automobile accident claim. She further alleges that her bills would have been paid if Mary Black had submitted them to MedCost for payment. (Am. Compl. ¶¶39–40) (R. p. 70). Mary Black contends that it is a party to a hospital services agreement with MedCost (the "MedCost Agreement"). (Mot. to Dismiss, June 8, 2020) (R. pp. 160-173).[6]

B. The Owens-specific facts

On October 9, 2015, Owens was admitted to Mary Black Hospital following an automobile accident in which he was rear-ended. Owens alleges that at the time of his medical treatment he had valid health insurance coverage through CIGNA. Owens alleges that Mary Black had a contract with CIGNA which required that bills for medical services provided to him be sent directly to CIGNA, not him, and that the contract provided for discounted rates for the services. Owens further alleges that his bills would have been paid had they been submitted to CIGNA for payment. (Am. Compl. ¶¶ 14, 28–31, 47–51) (R. p. 66, 68, 71). Owens alleges that Mary Black did not submit the bill for his services to CIGNA, but rather sought payment by asserting a lien

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[5] Blackwell does not allege she is a party to Mary Black's contract with MedCost.

[6] The MedCost agreement was not attached to the Amended Complaint or incorporated by reference into the pleading. Because this case was determined at the Rule 12(b)(6) stage – i.e. the four corners of the complaint – the lower court correctly declined to consider the MedCost Agreement in its review, despite Defendants' urging to the contrary. *See* Form 4 Order dated Sept. 4, 2020. (R. pp. 10-14). In Appellants' Designation of Matter to be included in the Record on Appeal and its Initial Brief of Appellants, Mary Black again urges this Court disregard the required standard of review at the Rule 12 stage, even going so far as to directly quote language from the MedCost agreement in its recitation of the factual background of the case. (App. Init. Br. p. 8.) (R. p. 243). Plaintiffs respectfully submit that this Court should decline to participate in this impermissible fact-finding mission and disregard any argument thereto. *See* Rule 210(c), SCACR; *See also* Rule 209(b), SCACR ("[T]he designation may only propose to include . . . other materials which may be properly included in the Record on Appeal [See Rule 210(c)]. A party shall not include any matter in his Designation which is not relevant to the appeal.")

against his claims against the at-fault driver in the collision. Owens admits that, under duress, he paid Mary Black a reduced amount in order to gain access to his settlement monies. (*See* Am. Compl. ¶¶51–52) (R. p. 71).

Mary Black contends that it is a party to a Hospital Services Agreement with CIGNA (the "CIGNA Agreement"). (Mot. to Dismiss p. 4.) (R. pp. 163-164). Section 6.2 of the CIGNA Agreement contains the following dispute resolution provisions:

> 6.2 Dispute Resolution.
>
> 6.2.1 CIGNA's Internal Dispute Resolution Process. Any disputes between the parties arising with respect to the performance or interpretation of the Agreement shall first be resolved in accordance with the dispute resolution process outlined in the Administrative Guidelines. In the event the dispute is not resolved through that process, either party may request in writing that the parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the parties who have authority to settle the dispute. If the matter is not resolved within 60 days of a party's written request for negotiation, either party may initiate arbitration by providing written notice to the other party. With respect to a payment or termination dispute, Hospital must submit
>
> 6.2.2 Arbitration. If a party initiates arbitration as provided above, the proceeding shall be held in the jurisdiction of Hospital's domicile. The parties will jointly appoint a mutually acceptable arbitrator. If the parties are unable to agree upon such an arbitrator within 30 days after a party has given the other party written notice of its desire to submit a dispute for arbitration, then the parties shall prepare a Request for a Dispute Resolution List and submit it to the American Health Lawyers Association Alternative Dispute Resolution Service ("AHLA ADR Service") along with the appropriate administration fee. In accordance with the Codes of Ethics and Rules of Procedure developed by the AHLA ADR Service, the parties will be sent a list of 10 arbitrators along with a background and experience description, references and fee schedule for each. The 10 will be chosen by the AHLA ADR Service on the basis of their experience in the area of the dispute, geographic location and other criteria as indicated on the request form. The parties to the dispute will review the qualifications of the 10 suggested arbitrators and rank them in order of preference from 1 to 9. Each party has the right to strike 1 of the names from the list. The person with the

> **lowest total will be appointed to resolve the case. Each party shall assume its own costs, but the compensation and expenses of the arbitrator and any administrative fees or costs shall be borne equally by the parties. 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.**

(Mot. to Dismiss Ex. B) (R. p. 243)

The CIGNA agreement does not mandate arbitration but instead provides that either party "*may initiate arbitration by providing written notice to the other party.*" It likewise does not define "party," and it provides that "the arbitrator shall be without power to conduct an arbitration on a class basis" and provides that "*an arbitration conducted under this provision shall not be consolidated with an arbitration involving other Mary Black or third parties . . . .*" *Id.*

C. The Brooks-specific facts

On February 28, 2016, Brooks was admitted to Mary Black Hospital following an automobile accident in which she was a passenger in a vehicle hit by another driver. Brooks alleges that, at the time of her medical treatment, she was covered for health care services through Medicare. (Am. Compl. ¶¶41–42) (R. p. 70). Brooks alleges that Mary Black did not submit the bills for her health care services to Medicare, but instead sought collection of the amounts due by asserting a lien against her recovery from the at-fault driver in the accident. Brooks admits that, under duress, she paid Mary Black a reduced amount in order to gain access to her settlement monies. (*See* Am. Compl. ¶¶44–46) (R. pp. 70-71).

Standard of Review

A. The Denial of Arbitration

"Arbitrability determinations are subject to *de novo* review." *Smith v. D.R. Horton, Inc.*, 417 S.C. 42, 47, 790 S.E.2d 1, 3 (2016). "However, a circuit court's factual findings will not be reversed on appeal if any evidence reasonably supports the findings." *Id.* at 48, 790 S.E.2d at 3. "[A] presumption *against* arbitration arises where the party resisting arbitration is a nonsignatory to the written agreement to arbitrate." *Wilson v Willis*, 426 S.C. 326, 337, 827 S.E.2d 167, 173 (2019) (quoting *Global Pac., LLC v. Kirkpatrick*, 88 N.E.3d 431, 435 (Ohio Ct. App. 2017)). An appellate court "will not disturb the trial court's underlying factual findings reasonably supported by the record." *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 228, 847 S.E.2d 268, 271 (Ct. App. 2020).

B. Review of Interlocutory Orders

It is well settled that an interlocutory order is not immediately appealable unless it involves the merits of the case or affects a substantial right. *Brown v. Cnty. of Berkeley*, 366 S.C. 354, 361, 622 S.E.2d 533, 537 (2005). "The basic policy behind denying immediate review of pretrial motions is avoidance of piecemeal litigation where the rights of the parties have not been substantially impacted." *Watson v. Underwood*, 407 S.C. 443, 458, 756 S.E.2d 155, 163 (Ct. App. 2014) (quoting *Breland v. Love Chevrolet Olds, Inc.*, 339 S.C. 89, 94, 529 S.E.2d 11, 13 (2000)). "The denial of a motion to dismiss does not establish the law of the case and the issue raised by the motion can be raised again at a later stage of the proceedings. Therefore, the denial of a motion to dismiss is not directly appealable." *Levi v. N. Anderson Cnty. EMS*, 409 S.C. 374, 382, 762 S.E.2d 44, 48 (Ct. App. 2014) (quoting *McLendon v. S.C. Dep't of Highways & Pub. Transp.*, 313 S.C. 525, 526 n.2, 443 S.E.2d 539, 540 n.2 (1994)). Issues in a Rule 12 order which "lack a sufficient nexus or companionship" to the issue on appeal fail "to justify [an appellate court's]

exercise of immediate appellate review." *See Brown v. Cnty. of Berkeley*, 366 S.C. 354, 362 n.5, 622 S.E.2d 533, 538 n.5 (2005) (declining to review the denial of motions to dismiss alongside the denial of a preliminary injunction); *See also S.C. Baptist Hosp. v. S.C. Dep't of Health & Env't Control*, 291 S.C. 267, 353 S.E.2d 277, 279 (1987) (declining to consider interlocutory appeal when the decision-maker has not yet had an opportunity to decide the merits of the case and consideration by appellate court would therefore be premature).

ARGUMENT

I. The Lower Court Correctly Held that Mr. Owens Could Not Be Compelled to Arbitration

"[A]rbitration is a matter of contract, and a party cannot be required to submit to arbitration any dispute which he has not agreed to submit." *Aiken v. World Fin. Corp.*, 373 S.C. 144, 149, 644 S.E.2d 705, 708 (2007) (citing *Zabinski v. Bright Acres Assoc.*, 346 S.C. 580, 596, 553 S.E.2d 110, 118 (2001)). Put another way, South Carolina law presumes contracts may only be enforced by their parties. *Touchberry v. City of Florence*, 295 S.C. 47, 367 S.E.2d 149 (1988). To compel Owens to arbitrate his claims, Mary Black "must demonstrate (1) there is a valid arbitration agreement, and (2) the claims fall within its scope." *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 228, 847 S.E.2d 268, 271 (Ct. App. 2020) (citing *Wilson v. Willis*, 426 S.C. 326, 827 S.E.2d 167 (2019)). Its quest fails on both fronts. Because there is at least *some* evidence – if not *substantial* evidence - in the record that reasonably supports the lower court's refusal to compel arbitration, this Court should affirm and allow the matter to proceed to discovery and trial.

"State law controls when an arbitration agreement may be enforced against someone who has not signed it." *Id.* at 230, 847 S.E.2d at 272. "[T]he presumption in favor of arbitration applies to the scope of the arbitration agreement; it does not apply to the existence of the arbitration agreement *or to the identity of the parties who may be bound to such an agreement*." *Id.* (emphasis

in original). "Moreover, because arbitration, while favored, exists solely by agreement of the parties, a presumption *against* arbitration arises when the party resisting arbitration is a nonsignatory to the written agreement to arbitrate." *Wilson,* 426 S.C. at 337-338, 827 S.E.2d at 173 (*citing Global Pac., LLC v. Kirkpatrick*, 88 N.E.3d 431, 435 (Ohio Ct. App. 2017).

Mary Black contends that Owens must arbitrate his claims due to an arbitration clause contained in a purported 2006 contract between Mary Black and CIGNA. (Def. Mot. to Dismiss.) Mary Black asserts that Owens, a non-signatory, is bound to arbitration under the theory of equitable estoppel, also known as "direct benefits estoppel," in the arbitration arena. App. Init. Br. at pp. 12-18. "This [direct benefits estoppel] theory . . . estops a nonsigner from refusing to comply with an arbitration provision in a contract if (1) the nonsigner's claim arises from the contractual relationship, (2) the nonsigner has "exploited" other parts of the contract by reaping its benefits, and (3) the claim relies solely on the contract terms to impose liability. . . [D]irect benefits estoppel is not implicated simply because a claim relates to or would not have arisen but for a contract's existence." *Weaver,* 431 S.C. at 230-231, 847 S.E.2d at 272 (quoting *Wilson*, 426 S.C. at 343, 827 S.E.2d at 176).

Mary Black contends the lower court erred when it "placed improper significance on its belief that Owens is not a party to the CIGNA agreement" and "failed to conduct the required analysis under the principles of direct benefits estoppel and failed to apply those important principles to compel a non-signatory to arbitration," arguing that "it is undeniable that Owens' claims arise from the Cigna agreement, and Owens seeks to enforce the terms of that Agreement and to recover what damages he alleges to be caused by Defendants' failure to act in accordance with the Cigna Agreement." (App. Init. Br. pp. 12-13.) Because Mary Black's argument fails on

all fronts, this Court should affirm the lower court for all the reasons contained herein or for any reason found in the record.

In urging this Court to reverse the well-reasoned orders of the lower court, Mary Black relies upon *Pearson v. Hilton Head Hospital,* 400 S.C. 281, 733 S.E.2d 597 (Ct. App. 2012), a case which is unpersuasive and easily distinguished from this action. In *Pearson,* a plaintiff physician, working at a hospital under a *locum tenens*- type arrangement, was a nonparty to a contract between the hospital and the *locum* that contained an arbitration clause. The Court compelled him to arbitration because it found that he "received a benefit due to the contract, in that he was able to work at the Hospital and receive payment for his work." *Id.* at 296, 733 S.E.2d at 605; *see also id.* at 296–97, 733 S.E.2d at 605 ("If not for that contract, then Dr. Pearson would have had to make separate arrangements with the Hospital in order to work there. He *knowingly accepted* benefits of the contract between the hospital and Locum. Accordingly, Dr. Pearson benefitted from that contract and should not be able to disclaim the arbitration agreement contained in it." (emphasis added)).

Here, Mr. Owens has not received or accepted any corresponding benefit from the hospital service agreement Mary Black entered into with CIGNA. In fact, it is because the exact opposite has taken place— he was harmed by Mary Black's failure to act in accordance with the contract— that he has been forced to bring this action. *See Pearson,* 400 *S.C.* at 291, 733 S.E.2d at 602 ("Generally, these cases involve non-signatories who, *during the life of the contract,* have embraced the contract despite their non-signatory status but then, during litigation, attempt to repudiate the arbitration clause in the contract." (emphasis added) (quoting *E.I. DuPont de Nemours & Co. v. Rhone Poulenc Fiber & Resin Intermediates, S.A.S.*, 269 F.3d 187, 200 (3d Cir. 2001))); *accord* 6 C.J.S. Arbitration § 18.

Our Supreme Court's recent decision in *Wilson v. Willis* - overturning the reversal of a trial court's order denying a motion to compel arbitration – is controlling of the case at bar. In *Wilson*, numerous insureds brought suit against their insurance agent, the broker who hired the agent, the agency, and the insurers whose policies the agency sold. *Wilson*, 426 S.C. 326, 827 S.E.2d 167 (2019). The plaintiff insureds alleged the agent, among other things, "forg[ed] insurance documents, [took] cash payments, and convert[ed] the payments to her own use, resulting in the Insureds having either no coverage or reduced coverage." *Id.* at 332, 827 S.E.2d at 170. Several insurers filed motions to compel arbitration based on arbitration clauses contained in contracts between the insurers and the agency. *Id.* at 332–33, 827 S.E.2d at 170-71. The insurers argued that "equitable estoppel should preclude [the plaintiffs'] assertion of their nonsignatory status because [their] claims were premised on duties that would not exist but for the Agency Agreement [the insurers] had with [the agency]." *Id.* at 333, 827 S.E.2d at 171.

In upholding the circuit court's denial of arbitration, the Supreme Court distinguished *Pearson*:

> We agree with [Plaintiffs] that the circumstances in *Pearson* are distinguishable. Unlike Dr. Pearson, [Plaintiffs] did not embrace the Agency Agreement during the life of the contract and then, during litigation, attempt to repudiate the arbitration clause in the contract. It is undisputed that [Plaintiffs] were never aware of the existence of the contract until they brought their tort actions against [the insurers].

Id. at 342, 827 S.E.2d at 176.

There is no evidence in the record that Mr. Owens "embraced" – or in fact was even aware of – CIGNA's agreement with Mary Black (or any arbitration provision contained therein) during the life of the contract; further, Owens' claims for unjust enrichment and tortious interference with contract are grounded in South Carolina common law and do not rely upon the Mary Black services agreement for recovery. Accordingly, any benefit conferred due to the existence of the agreements

would be indirect at best and provide no basis to compel arbitration. *See id.* at 343, 827 S.E.2d at 176 ("[D]irect benefits estoppel is not implicated simply because a claim relates to or would not have arisen 'but for' a contract's existence."); *id.* ("When a claim depends on the contract's existence and cannot stand independently—that is, the alleged liability 'arises solely from the contract or must be determined by reference to it'—equity prevents a person from avoiding the arbitration clause that was part of that agreement. But 'when the substance of the claim arises from general obligations imposed by state law, including statutes, torts and other common law duties, or federal law,' direct-benefits estoppel is not implicated even if the claim refers to or relates to the contract *or would not have arisen 'but for' the contract's existence*." (quoting *Jody James Farms, JV v. Altman Grp., Inc.*, 547 S.W.3d 624, 637 (Tex. 2018))); *see, e.g.*, *id.* at 342, 827 S.E.2d at 176 ("General principles of South Carolina law form the basis for most of [Plaintiffs'] claims. For example, [Plaintiffs'] allegation that [the insurers] possibly conspired with [the agent] and others to commit fraud is misconduct that does not arise from the contract.").

Owens' remaining claim for injunctive relief similarly does not warrant compelling arbitration. Although Owens' success on that claim admittedly relies on the hospital services agreements, the relief sought—enjoining Mary Black from engaging in unlawful billing practices in contravention of the agreements—will confer no direct benefit on him or the putative class members. Any benefit resulting from the successful litigation of this claim will inure only to future patients, as Mary Black would be forced to cease its practice going forward. Such an indirect and insubstantial benefit is insufficient to support Mary Black's attempt to compel arbitration. *See Equitable estoppel—Generally*, 1 Domke on Com. Arb. § 13:9 ("A nonsignatory who has received a direct benefit from a contract containing an arbitration clause may be estopped from refusing to comply with that arbitration clause. This approach does not apply if the claimed benefits are

insubstantial or indirect, nor does it apply if the claim merely relates to the contract." (footnote omitted)). Moreover, the fact that only one of Owens' claims relies on the health service agreements further weighs against enforcement of the arbitration clause. *See Wilson*, 426 S.C. at 342, 827 S.E.2d at 176 (denying arbitration and noting "[g]eneral principles of South Carolina law form the basis for *most* of Petitioners' claims" (emphasis added)).

Further, the lower court correctly found that Mary Black's argument fails because the CIGNA agreement's arbitration clause does not encompass Owens' claims.[7] The clause is limited to "disputes between the parties," and only CIGNA and Mary Black were parties to the agreement. The provisions of the arbitration clause also repeatedly refer to actions a "party," "the parties," or "Mary Black" may take, which indicates that it was not intended to encompass Owens' claims. The agreement does not define "party," so in interpreting the agreement, the ordinary definition of the term (which does not include Mr. Owens, a mere "participant") should be used. *See Plain meaning*, 11 Williston on Contracts § 32:3 (4th ed.) ("The plain, common, or normal meaning of

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[7] Despite Mary Black's assertion that the lower court erred in considering the elective nature of the arbitration clause, (App. Init. Br. pp. 19-20), the lower court did not rely on this fact in determining the arbitration clause was inapplicable to Mr. Owens. *See* Form 4 Order dated Sept. 4, 2020 at 3 (R. pp. 10-14) ("[T]he arbitration provision in the Cigna Agreement . . . does not apply to the Plaintiff as the Plaintiff is not a 'party' to the agreement. In accordance [with] the terms of the agreement, the Plaintiff is, at best, a 'participant' under the agreement's terms but not a 'party'. . . . As previously stated, the Plaintiff is not a 'party' to the agreement and its provisions are not enforceable as binding on the Plaintiff."). Accordingly, Mary Black's argument on this point is immaterial, as is its reliance upon *Mailsource v. M.A. Bailey*, 356 S.C. 370, 588 S.E.2d 639 (Ct. App. 2003). Appel. Init. Br. p. 19. In *Mailsource*, the parties to the litigation were the same parties to the asset purchase agreement which contained an "elective" arbitration agreement. When a dispute arose over an alleged breach of the non-compete clause contained in the purchase agreement, litigation ensued and the seller sought to compel arbitration. Since both the seller and the purchaser were parties to the contract containing the arbitration agreement, the Court of Appeals found the trial court had erred in failing to compel arbitration, as there was no evidence to support a finding of waiver. Here, the facts are entirely different: Mr. Owens was not a party to the hospital services agreement and whether the arbitration clause was elective or mandatory was immaterial to the trial court's analysis. Merely because the trial court considered the language contained in the arbitration provision as part of its overall analysis is not reversible error.

language will be given to the words of a contract unless the circumstances show that in a particular case a special meaning should be attached to them." (footnote omitted)); *Party*, BLACK'S LAW DICTIONARY (11th ed. 2019) ("Someone who takes part in a transaction <a party to the contract>."). Moreover, any ambiguity as to whether "party" encompasses Mr. Owens should be resolved against Mary Black. *See Contra proferentem: Ambiguities are interpreted against the drafter*, 11 Williston on Contracts § 32:12 (4th ed.) ("[I]t is a generally accepted principle that any ambiguity in that language will be interpreted against the drafter.").

The agreement does define "Participant" as "any individual . . . who is eligible and enrolled to receive Covered Services." (Mot. to Dismiss Ex. B) (R. p. 264). As this definition encompasses Mr. Owens, if CIGNA and Mary Black had intended to include a participant's claims within the scope of the arbitration clause, they could certainly have used that defined term. Instead, the clause explicitly excludes "arbitration on a class basis" and states "an arbitration conducted under this provision shall not be consolidated with an arbitration involving . . . third parties." (R. p. 276). Read as a whole, the arbitration clause demonstrates the contracting parties' intent not to include claims by "Participants," and any limited, specific language to the contrary should not override this interpretation. *See The contract is to be read as a whole; the "four corners" rule*, 11 Williston on Contracts § 32:5 (4th ed.) ("A contract will be read as a whole, and every part will be read with reference to the whole.").

Further support for affirming the decision of the lower court is found in this Court's recent opinion in *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 847 S.E.2d 268 (Ct. App. 2020), where it held that a nursing home's insistence that "direct benefits estoppel" required arbitration of a granddaughter's claims was wholly unsupported by the law. In *Weaver*, a granddaughter brought suit after her grandmother died on the grounds of a nursing home after wandering away.

The granddaughter discovered her maimed and dismembered body in a retention pond and, as a result, asserted claims for negligent and intentional infliction of emotional distress. The nursing home argued "direct benefits estoppel funnels the [granddaughter's] claims to arbitration because her ability to sue [the nursing home] stems from [her grandmother's] residency agreement, which includes the arbitration agreement." *Id.* at 272.

The Court disagreed, holding "this argument is easily scotched, for direct benefits estoppel is not implicated simply because a claim related to or would not have arisen but for a contract's existence." *Id.* The Court noted that the daughter "ha[d] not exploited or otherwise sought to enforce or benefit from the residency agreement, any more than a pedestrian run over by a truck has benefited from the contract for the purchase of the truck." *Id.* at 273. Declining to apply the doctrine of direct benefits equitable estoppel, the Court noted that "the heart of the theory 'is that the party entitled to invoke the principle was misled to his injury.'" *Id.* at 274 (quoting *Rodarte v. Univ. of S.C.*, 419 S.C. 592, 601, 799 S.E.2d 912, 916 (2017)). Finding no evidence of such conduct, the Court held there was no agreement to arbitrate between the parties and affirmed the denial of the motion to compel arbitration. Here, as in *Weaver*, Owens did not mislead Mary Black or cause it any injury. In fact, as reflected above, the opposite has taken place.

The lower court correctly found that Mr. Owens did not agree to arbitrate any claims with Mary Black because, *inter alia*, he never executed any arbitration agreement, is not a "party" to the CIGNA contract, and received no benefit therefrom. South Carolina law provides that the doctrine of equitable estoppel is inapplicable to the case at bar and, accordingly, the Court should affirm the lower court's order denying Mary Black's motion to compel arbitration for all the

reasons outlined herein, or, pursuant to Rule 220(c), SCACR, upon any additional ground appearing in the record.[8]

II. The Court Should Decline to Consider Interlocutory Orders

An order denying a Rule 12(b)(6) motion is interlocutory and not generally immediately appealable under South Carolina law. *See Levi v. N. Anderson Cnty. EMS*, 409 S.C. 374, 382, 762 S.E.2d 44, 48 (Ct. App. 2014) ("The denial of a motion to dismiss does not establish the law of the case and the issue raised by the motion can be raised again at a later stage of the proceedings."); *Brown v. Cnty. of Berkeley*, 366 S.C. 354, 362 n.5, 622 S.E.2d 533, 538 n.5 (2005) (declining to review the denial of defendants' individual motions to dismiss alongside the denial of a motion for preliminary injunction filed by the plaintiff where the Rule 12 orders "lack a sufficient nexus or companionship to justify [the] exercise of immediate appellate review", and observing "[c]ourts have made a practice of accepting appeals of denials of interlocutory orders not ordinarily immediately appealable when these appeals are companion to issues that are reviewable.")

Mary Black contends that that the Court of Appeals, in its discretion, should consider the trial court's interlocutory order denying a multitude of Rule 12 motions as against each of the plaintiffs as part of its appeal from the denial of their request to compel arbitration against Mr. Owens. In Mary Black's view, the lower court must be deprived of its discretion at the Rule 12

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[8] Mary Black urges this Court to adopt the reasoning of the Tennessee Supreme Court in *Benton v. Vanderbilt University*, 137 S.W.3d 614 (Tenn. 2004). *Benton* is inapposite, as the *Benton* plaintiff sued for breach of a hospital services contract which contained an arbitration provision. This is entirely different from the posture of the instant lawsuit, which asserts no claim for breach of the CIGNA contract. Further, South Carolina law mandates a presumption against arbitration where the party resisting arbitration is a nonsignatory – the *Benton* court announced no similar directive, and instead focused on the third-party beneficiary status of the plaintiff (acknowledging that it previously declined to enforce arbitration against nonsignatories asserting tort claims). *See Id.* at 620 (*citing Cocke Cnty. Bd. of Hwy. Comm'rs. v. Newport Utilities Bd.*, 690 S.W.2d 231 (Tenn. 1985) ("arbitration clauses are not binding on third parties who are not parties to the contract").

stage (and beyond) as to any litigant if an issue of arbitration as to a single litigant is before the trial court as well (and subsequently appealed).

Given that the sole appealable matter before this Court is the order denying a motion to compel arbitration against just one of the three plaintiffs, this Court should reject such an unwarranted intrusion into the traditional role of the trial court; decline to exercise its discretion to review the denial of any Rule 12(b)(6) motions; and affirm the lower court and remand the matter to the lower court for all the reasons contained herein or for any reason found in the record. *See* Rule 220(c), SCACR. Otherwise, the discretion afforded the trial court at the Rule 12 stage will be rendered meaningless if an appellant can divest the lower court of jurisdiction and leapfrog over the discovery process through an appeal of an arbitration order, allowing the Court of Appeals to essentially displace the trial court's essential role at the Rule 12 stage. Such a result is clearly disfavored under South Carolina law, which provides that "[i]n cases on appeal, the South Carolina Rules of Court provide for the trial court to retain jurisdiction over matters not affected by the appeal." *Cousar v. New London Eng'g Co.*, 306 S.C. 37, 40, 410 S.E.2d 243, 245 (1991) (observing retention of jurisdiction by trial court over discovery matters not an abuse of discretion).[9]

Mary Black cites to numerous cases in an attempt to circumvent the clear policy disfavoring review of interlocutory orders and urge this court to take up Rule 12 motions as matter of judicial economy; however, all of these cases are inapposite as they concern cases where the parties to the arbitration agreement were identical to the parties to the litigation. In *Cox v. Woodmen of the World*, 347 S.C. 460, 556 S.E.2d 397 (Ct. App. 2001), the Court of Appeals

[9] *See* Rule 241(a), SCACR and Rule 205, SCACR; *See also Tillman v. Oakes*, 398 S.C. 245, 728 S.E.2d 45 (Ct. App. 2012) (noting trial court retains jurisdiction over matters not affected by appeal).

considered the denial of a Rule 12(b)(8) motion along with the denial of a motion to compel arbitration where the class plaintiffs were all members of the same fraternal benefits society and subject to the same constitution (which contained the arbitration provision). The Court held that it could consider the order denying the motion to dismiss because there was an appealable issue before the court. *See id.* at 462–64, 556 S.E.2d at 398–99. Here, there exist no such commonalities, as Mary Black never sought to compel Plaintiffs Brooks and Blackwell to arbitration.[10] The other cases cited by Mary Black are similarly unpersuasive, as they deal with scenarios involving appeals by all plaintiffs. *See, e.g., Hite v. Thomas & Howard Co. of Florence*, 305 S.C. 358, 409 S.E.2d 340 (1991) (action by single minority shareholder against majority shareholder) (*overruled on other grounds by Huntley v. Young*, 319 S.C. 559, 462 S.E.2d 860 (1995); *Edge v. State Farm*, 366 S.C. 511, 623 S.E.2d 387 (2005) (agreeing to consider cross-appeal by defendant State Farm of interlocutory order denying motion to dismiss in case involving underlying appeal by Plaintiffs of dismissal of action against a co-defendant); *Roberts v. Recovery Bureau, Inc.*, 316 S.C. 492, 450 S.E.2d 616 (Ct. App. 1994) (allowing appeal by plaintiff of interlocutory order denying motion for summary judgment as against one defendant driver alongside appeal from the granting of summary judgment in favor of another defendant).

This lawsuit alleges serious malfeasance on the part of Mary Black – allegations which, if proven true, likely resulted in severe consequences for hundreds, if not thousands, of injured persons over the years. As such, the Court should reject Mary Black's proposed "short-circuit" approach which wholly divests the trial court of its discretionary role at the Rule 12 stage, renders meaningless the requirement that both the trial court and the appellate court presume all well-pled

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[10] *See, e.g., Wellman, Inc. v. Square D Co.*, 366 S.C. 61, 620 S.E.2d 86 (Ct. App. 2005) (finding error by trial court in forcing the resolution of all claims in one forum out of the interest of judicial economy).

facts in the complaint to be true, and allows Mary Black to circumvent discovery into the allegations contained in the pleading. [11]

A. As No Appealable Issues Exist as to Plaintiffs Michelene Brooks and Jo Ann Blackwell, the Court should Decline to Consider the Appeal

Mary Black has never sought to compel Ms. Brooks and Ms. Blackwell to arbitration and there exists no appealable issue as to these two plaintiffs or the putative class members they seek to represent. South Carolina law does not allow for the appeal of an interlocutory order where no appealable issue is before the court, *See, e.g., McLendon v. S.C. Dep't. of Highway*, 313 S.C. 525, 443 S.E.2d 539 (1994) (dismissing appeal of order denying motion to dismiss as not immediately appealable). Accordingly, this Court should decline to consider the majority of the "Issues on Appeal" listed in Appellant's Initial Brief, as excerpted below:

1. the denial of the motion to dismiss **Blackwell's** claim for unjust enrichment;
2. the denial of the motion to dismiss **Blackwell's** claims for lack of standing;
3. the denial of the motion to dismiss **Brooks'** claims under the Medicare Act;
4. the denial of the motion to dismiss **Brooks'** claims pursuant to the voluntary payment doctrine;
5. the denial of the motions to dismiss the claims of **Brooks** and **Blackwell** for tortious interference with their respective health insurance policies;
6. the denial of the motions to dismiss all claims asserted **by Brooks** and **Blackwell** against PASI and CHSPSC, LLC

(*See* App. Init. Br. p. 2, §§ III – VIII; pp. 25-39.)

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[11] *See Justice v. The Pantry*, 335 S.C. 572, 576, 518 S.E.2d 40, 42 (1999) (reiterating requirement that "[t]he trial court and this [C]ourt on appeal must presume all well pled facts to be true" and acknowledging "[t]he grant of a motion to dismiss for failure to state facts sufficient to constitute a cause of action cannot be upheld if facts alleged in the complaint and inferences reasonably deducible therefrom, if proven, would entitle the plaintiff to relief on any theory of the case." (quoting *Morrow Crane Co. v. T.R. Tucker Constr. Co.*, 293 S.C. 427, 429, 373 S.E.2d 701, 702 (Ct. App. 1988))).

B. If the Court Elects to Review Interlocutory Orders, It Should Affirm the Trial Court's Denial of the Motions to Dismiss.

"Rule 12(b)(6) permits the trial court to address the sufficiency of a pleading stating a claim; it is not a vehicle for addressing the underlying merits of the claim." *Skydive Myrtle Beach, Inc. v. Horry County*, 426 S.C. 175, 180, 826 S.E.2d 585, 587 (2019) (citing *Charleston Cnty. Sch. Dist. v. Harrell,* 393 S.C. 552, 557, 713 S.E.2d 604, 607 (2011) ("In considering a motion to dismiss pursuant to Rule 12(b)(6), SCRCP, the circuit court must base its ruling solely upon the allegations set forth on the face of the complaint."); *See also Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 556 (2007) ("[A] well-pleaded complaint may proceed even if it strikes a savvy judge that actual proof of those facts is improbable, and that a recovery is very remote and unlikely." (quoting *Scheuer v. Rhodes*, 416 U.S. 232, 236 (1974)). "At the Rule 12 stage, therefore, the first decision for the trial court is to decide only whether the pleading states a claim . . . . [A]ny plaintiff is . . . . entitled to litigate the validity of its original complaint without having to convince the trial court of the merits of its underlying complaint." *Skydive*, 426 S.C at 180, 826 S.E.2d at 588. [12]

In deciding a motion to dismiss under Rule 12(b)(6), "[t]he question for the court is whether in the light most favorable to the plaintiff, and with every doubt resolved in his behalf, the allegations set forth on the face of the complaint state any valid claim for relief." *Sloan Constr. Co. v. Southco Grassing, Inc.*, 377 S.C. 108, 112–13, 659 S.E.2d 158, 161 (2008) (citing *Plyler v. Burns*, 373 S.C. 637, 645, 647 S.E.2d 188, 192 (2007)). Where "the 'facts alleged and inferences

[12] Notably, under Rule 23(d), SCRCP, the trial court is also charged with protecting the interest of the unknown putative class members, including, but not limited to, the following: " In the conduct of actions to which this rule applies, the court may make appropriate orders: . . . (2) The court may at any time impose such terms as shall fairly and adequately protect the interest of the persons on whose behalf the action is brought or defended."

reasonably deducible therefrom would entitle the plaintiff to any relief on any theory of the case,' then dismissal under Rule 12(b)(6) is improper." *Id.* at 113, 659 S.E.2d at 161 (quoting *Stiles v. Onorato*, 318 S.C. 297, 300, 457 S.E.2d 601, 603 (1995)). A "complaint should not be dismissed merely because the court doubts the plaintiff will prevail in the action." *Doe v. Marion*, 373 S.C. 390, 395, 645 S.E.2d 245, 248 (2007) (citing *Toussaint v. Ham*, 292 S.C. 415, 416, 357 S.E.2d 8, 9 (1987)); *See also Kennedy v. Henderson*, 289 S.C. 393, 395, 346 S.E.2d 526, 527 (1986) ("[T]he complaint must be construed liberally in favor of the pleader and sustained if facts alleged, and inferences reasonably deducible therefrom, entitle the plaintiff to relief on any theory of the case." (citing *Blandon v. Coleman*, 285 S.C. 472, 475, 330 S.E.2d 298, 300 (1985))). A decision denying a motion to dismiss under Rule 12(b)(6) is reviewed for an abuse of discretion: "[a]n abuse of discretion may be found when the appellant shows that the conclusion reached by the [circuit] court was without reasonable factual support and resulted in prejudice to the rights of the appellant, thereby amounting to an error of law." *Karppi v. Greenville Terrazzo Co.*, 327 S.C. 538, 542, 489 S.E.2d 679, 681 (Ct. App. 1997).

1. The Lower Court Correctly Found Owens' Claims Not Time-Barred

The Court should affirm the denial of Mary Black's motion to dismiss Owens' claims on statute of limitations grounds. The trial court, taking the allegations in the amended complaint as true and drawing all inferences therefrom in plaintiff's favor, correctly determined that claims asserted by Mr. Owens "relate back" to the filing of the original complaint and such decision does not reflect an abuse of discretion.

Mary Black contends that "Owens' claims do not relate back to the filing of the original complaint . . ." and therefore "the new claims . . . are not timely and are barred by the applicable statute of limitations." (App. Init. Br. p. 24.) It further contends that "when he made a direct

payment to Mary Black on October 14, 2016, he knew or should have known that Mary Black was attempting to collect payment from him directly and not from his alleged health insurance provider." *Id.*

This Court should reject Mary Black's argument and affirm the lower court's finding that "any statute of limitations issue fails at this time" because Owens' claims relate back to the filing date of the original complaint in this matter, which was January 20, 2017. *See* Form 4 Order dated Sept. 4, 2020 at 4 (R. pp. 10-14). The trial court correctly found that Owens' claims arose out of the same conduct set forth in the original class action complaint—Mary Black's wrongful billing practices. *See* Rule 15(c), SCRCP ("Whenever the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleadings, the amendment relates back to the date of the original pleading."). Thus, *even if* the applicable statute of limitations started running on October 14, 2016, when "Defendants agreed to accept a 50% reduction on Plaintiff Owens's account and settle for $4,543.38," (Am. Compl. ¶ 52) (R. p. 71), his claims as set forth in the Amended Complaint relate back to the original date of filing and are nonetheless timely.[13]

Rule 15(c), SCRCP, governs the amendment of pleadings and the relation back of such amendments:

> **(c) Relation Back of Amendments.** Whenever the claim or defense asserted in the amended pleading arose out of the conduct, transaction or occurrence set forth or attempted to be set forth in the original pleadings, the amendment relates back to the date of the original pleading.

Accordingly, Rule 15(c) does not prohibit the addition of plaintiffs in an amended complaint. Here, the claims of Mr. Owens are materially unchanged from those in the original Complaint and

[13] Owens does not concede that the "trigger" date for statute of limitations purposes in this action is October 14, 2016.

certainly "arose out of the conduct, transaction or occurrence set forth or attempted to be set forth in the original pleadings." *Id.* In fact, Rule 15(c) explicitly allows the relation back of claims when the party against whom the claim is asserted is changed. *See id.* ("An amendment changing the party against whom a claim is asserted relates back if the foregoing provision is satisfied and" the party has notice or knowledge of the action.). Accordingly, Defendants' reliance on Rule 15(c) is misplaced.

Recent case law also stands in stark opposition to Mary Black's position. In *Patton v. Miller*, the plaintiff initially filed an action in her capacity as "next friend" to her daughter, and later moved to amend her complaint to change her capacity from "next friend" to her individual capacity. 420 S.C. 471, 477, 479, 804 S.E.2d 252, 255–56 (2017). On appeal from the denial of the motion, the Supreme Court found her claim was not time-barred:

> [Plaintiff's] individual claim . . . satisfies Rule 15(c) because it is the exact claim she made in the representative capacity. In fact, there is no difference between the old claim and the new claim except the capacity of the person bringing it. Therefore, [the] amended claims . . . relate back to the [initial date of] filing and comply with the statute of limitations.

Id. at 494, 804 S.E.2d at 264.

The *Patton* court further explained the purpose behind the rule:

> Rule 15(c) is based on the concept that once litigation involving particular conduct or a given transaction or occurrence has been instituted, the parties are not entitled to the protection of the statute of limitations against the later assertion by amendment of defenses or claims **that arise out of the same conduct, transaction, or occurrence as set forth in the original pleading.**

Patton, 420 S.C. at 496–97, 804 S.E.2d at 265 (emphasis added) (*citing Thomas v. Grayson*, 318 S.C. 82, 88, 456 S.E.2d 377, 380 (1995) ("The purpose of Rule 15(c) is to salvage causes of action otherwise barred by the statute of limitations.")

The *Patton* court also took the opportunity to address and distinguish *Valentine v. Davis*, 319 S.C. 169, 460 S.E.2d 218 (Ct. App. 1995), a case repeatedly cited by Mary Black in the lower court in support of its statute of limitations defense.[14] In *Patton*, the Supreme Court clarified that the *Valentine* opinion "stands only for the proposition that Rule 15 does not contemplate adding a new plaintiff *to assert a new claim*." *Id.* at 495, 804 S.E.2d at 264 (emphasis added). Given that no new claims were asserted by Mr. Owens and, in fact, his claims are identical to those of the other plaintiffs, *Valentine* remains wholly unpersuasive to the case at bar.

The amended complaint asserts the same causes of action as those contained in the original complaint. (*See* Amend. Compl.; Compl.) (R. pp. 63-80; R. pp. 23-40). By merely adding additional putative class representatives as plaintiffs, Mary Black suffers no prejudice: it defends the same claims asserted on behalf of the putative class, but now represented by two additional named class representatives. There are no new claims; instead, Plaintiffs merely "amend[ed their] complaint to assert the same claim in a new capacity." *Id.* at 496, 804 S.E.2d at 265; *see also Twelfth RMA Partners, L.P. v. Nat'l Safe Corp.*, 335 S.C. 635, 641, 518 S.E.2d 44, 47 (Ct. App. 1999) ("[Defendants] rely on *Valentine* ... for the proposition that a plaintiff may not add a new plaintiff to a case to assert a claim against the defendant. In this case, however, no new claims are being added. The court is only changing the name of the plaintiff. The subject of the claim . . . is still the same.").

Mary Black's reliance on *Gause v. Smithers* and *Jackson v. Doe* is misplaced, as both cases involved the addition of an entirely new defendant.[15] Here, the defendants have remained the same

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[14] *See, e.g.*, Def. Mem. In Supp. Of Mot. to Dism. pp. 7-8 (filed Jul. 24, 2020) (R. pp. 196-197); Def. Mot. to Alter or Amend p. 5 (filed Sept. 14, 2020) (R. pp. 204-214). However, Mary Black has not relied upon the *Valentine* case in its initial brief to this Court.

[15] *Gause*, 384 S.C. 130, 681 S.E.2d 607 (Ct. App. 2009); *Jackson*, 342 S.C. 552, 537 S.E.2d 567 (Ct. App. 2000).

and the claims asserted by Mr. Owens, individually and on behalf of the putative class members, are identical to those asserted by the original plaintiff (albeit with CIGNA insurance at issue). As such, there is no abuse of discretion and the Court should affirm the ruling of the trial court for all the reasons contained herein, or for any reason found in the record.

2. The Denial of the Motion to Dismiss Blackwell's Unjust Enrichment Claim was Not an Abuse of Discretion

"Restitution is a remedy designed to prevent unjust enrichment. Unjust enrichment is an equitable doctrine, akin to restitution, which permits the recovery of that amount the defendant has been unjustly enriched at the expense of the plaintiff." *Ellis v. Smith Grading & Paving, Inc.*, 294 S.C. 470, 474, 366 S.E.2d 12, 14 (Ct. App. 1988) (citation omitted) (quoting *Stanley Smith & Sons v. Limestone College*, 283 S.C. 430, 434, 322 S.E.2d 474, 478 (Ct. App. 1984)). "A party may be unjustly enriched when it has and retains benefits or money which in justice and equity belong to another." *Dema v. Tenet Physician Servs.-Hilton Head, Inc.*, 383 S.C. 115, 123, 678 S.E.2d 430, 434 (2009); *See also Williams Carpet Contractors, Inc. v. Skelly*, 400 S.C. 320, 327, 734 S.E.2d 177 (Ct. App. 2012) ("Failure to pursue a mechanic's lien, however, will not bar an action for quantum meruit recovery as a matter of law if a plaintiff can otherwise prove circumstances establishing unjust enrichment"); *Id.* (citing with approval *Costanzo v. Stewart*, 9 Ariz. App. 430, 432 (Ariz. Ct. App. 1969) for the proposition that the failure to file mechanic's lien did not bar recovery for unjust enrichment when owner paid no one, as Arizona court found that "recipient is liable for the reasonable value of the services irrespective of their value to him").

Mary Black argues that Plaintiff Blackwell's unjust enrichment claim fails because there are no allegations "that Plaintiff Blackwell, or anyone on her behalf or for her benefit, made any payment or provided any value to [Defendants] for the medical care she received." (Mary Black Mot. to Dismiss p. 3; PASI Mot. to Dismiss p. 5; CHSPSC Mot. to Dismiss p. 5.) (R. p. 162; R. p.

170; R. p. 156). In Mary Black's view, "Blackwell cannot state a claim for unjust enrichment unless she can and does allege that she actually conferred a benefit to Defendants that that can and must be returned." (App. Init. Br. p. 26)

Instead of acknowledging the seriousness of its practice of asserting liens against settlement funds – i.e., potentially tying up a patient's rightful monies for bodily injuries, lost wages, and the like as their attorney holds funds in trust as required under South Carolina law – Mary Black asserts that "the *only* allegation" asserted by Ms. Blackwell is that "Mary Black asserted a lien against her potential third-party automobile accident claim" and that "the *mere* assertion of a lien does not constitute the receipt or retention of a benefit." (App. Init. Br. pp. 26-27) (emphasis added). Such a casual dismissal of the claims asserted in this lawsuit reflects a fundamental misunderstanding of the very real consequences of its "business practices."

Viewing the amended complaint in the light most favorable to Blackwell, the trial court correctly found that Plaintiff Blackwell adequately stated a claim for unjust enrichment because "a reasonable factual conclusion . . . can be that the Defendants were unjustly enriched and it would be inequitable to allow them to retain the benefits of their wrongful billing practices while attempting to collect a higher amount from Plaintiffs." Form 4 Order dated Sept. 4, 2020 Order p. 4 (R. p. 13). Thus, the allegation that Mary Black "assert[ed] liens against Plaintiff Blackwell's potential third party automobile accident claim," (Am. Compl. ¶ 40) (R. p. 70), was sufficient for purposes of the pleading stage, where all well pled facts are presumed true, and all reasonable doubts are resolved in favor of the plaintiff. *Cf. Beverly v. Grand Strand Reg'l Med. Ctr., LLC*, 429 S.C. 502, 516, 839 S.E.2d 468, 475 (Ct. App. 2020) (noting that Plaintiff's complaint "alleges affirmative inequitable conduct seeking to deprive her of the benefit of her funds"), *cert granted* Nov. 25, 2020. In sum, the trial court correctly found that the facts alleged by Blackwell – and

the inferences reasonably deducible therefrom – were sufficient to entitle Blackwell to relief when viewed in the light most favorable to the plaintiff. This Court should affirm the sound rulings of the lower court and affirm for all the reasons stated herein or for any reason contained in the record.

3. The Trial Court Correctly Denied Dismissal of the Blackwell Claims on Standing Grounds

Mary Black contends that Ms. Blackwell may not "enforce the negotiated rates for medical services in the Participating Mary Black Agreement between her insurance provider (MedCost) and Mary Black" because language in "that Agreement expressly denies non-signatory third-parties (like Plaintiff Blackwell) the right to sue to enforce its terms." (App. Init. Br. pp. 27-30); (Mary Black Mot. to Dismiss. p. 4; PASI Mot. to Dismiss p. 5; CHSPSC Mot. to Dismiss p. 5.) (R. p. 163; R. p. 170; R. p. 156).

Pursuant to Rule 12(b)(6), the trial court must consider only materials within the four corners of the pleadings. *See Charleston Cnty Sch. Dist. v. Harrell*, 393 S.C. 552, 559, 713 S.E.2d 604, 608 (2011) ("[I]t is a well-settled principle that in resolving a Rule 12(b)(6) motion to dismiss, the court is limited to a consideration of the allegations contained within the four corners of the complaint.") As Mary Black's standing argument relies solely on a provision in a purported contract which is wholly outside the operative pleading, it should be rejected on that basis alone. *See generally O'Laughlin v. Windham*, 330 S.C. 379, 382, 498 S.E.2d 689, 691 (Ct. App. 1998) ("A ruling on a 12(b)(6) motion to dismiss must be based *solely* upon allegations set forth on the face of the complaint."). Rule 12(b)(6) expressly provides that when the court considers matters outside of the pleadings, the motion must be converted to one for summary judgment. The Court should reject Mary Black's continued attempts to ignore the scope of review for dismissal and improperly inject unpled facts into its analysis of the court below.

Besides relying on facts and allegations that do not appear in the Amended Complaint and are taken from a contract that has not been proven to be in force at times relevant to this action, Mary Black's argument that "the circuit court did not expressly rule on this issue despite Defendants raising the issue in the Motion [to dismiss] and again requesting a ruling in the Motion to Alter or Amend" is wholly unsupported by the record. (App. Init. Br. p. 27, n. 2.) In fact, the lower court expressly ruled on this issue when it stated that its review of the Mary Black service agreements "was limited to the arbitration issue. Any other consideration of the agreements goes beyond a SCRCP Rule 12(b)(6) analysis." Form 4 Order dated Sept. 4, 2020 at 3 (R. p. 12).

This is an unequivocal ruling by the lower court that correctly found Mary Black's argument premature and inappropriate at the Rule 12 stage.[16] As such, the trial court properly adhered to the longstanding principal that, at the Rule 12 stage, the court may look only within the four corners of the complaint to determine the sufficiency of the allegations therein. It is undisputed that no documents were incorporated into the amended complaint by reference or attached to the complaint itself, nor were there "matters of which the court may take judicial notice" (i.e. publicly available records such as deeds). Mary Black's sole basis for its argument that the lower court can consider documents outside the pleadings appears to be its belief that the trial court can rely upon documents submitted by a party moving to dismiss the complaint "*so long as the documents are integral to the complaint.*" (App. Init. Br. at p. 11) (citing *Carolina First Corp. v. Whittle,* 343 S.C. 176, 539 S.E.2d 402 (Ct. App. 2000); *Brazell v. Windsor*, 384 S.C. 512, 682 S.E.2d 824 (2009); *HHHunt Corp. v. Town of Lexington*, 389 S.C. 623, 699 S.E.2d 699 (Ct.

[16]This lends further support to Plaintiffs' contention that Mary Black wishes to place this Court in the shoes of the trial court, despite the fact that only limited written discovery has been exchanged, no depositions have been taken, and the trial court has never had an opportunity to address the merits of the claim.

App. 2010); and *Patterson v. Witter*, 425 S.C. 213, 821 S.E.2d 677 (2018). However, none of these cases are persuasive or replace the standard of review at the Rule 12 stage.

For instance, in *Patterson v. Witter*, the parties consented to consideration of documents outside the four corners of the complaint when they submitted affidavits and other documents for the Court's consideration. Here, the Plaintiffs have continuously objected to Mary Black's attempt to introduce contracts and other evidence outside the four corners of the complaint. *See, e.g.*, Pl. Resp. In Opp. To Mot. to Dismiss (R. pp. 174-189); Pl. Resp. in Opp. To Mot. to Alter or Amend (R. pp. 215-230). *Carolina First v. Whittle* is likewise inapposite, as there the Court of Appeals found no error and affirmed the trial court's refusal to consider documents outside the complaint, because any reference contained within the pleading was insufficient to comply with Rule 23 requirements for a shareholder derivative suit. Finally, *Brazell v. Windsor* presents a set of facts wholly distinct from those in the instant litigation. In *Brazell*, the trial court allowed consideration of an exhibit in a motion to dismiss based on the fact that the complaint expressly referred to the exhibit and purported to "attach and incorporate by reference" the specific exhibit. 384 S.C. at 516, 682 S.E.2d at 826. No such "incorporation by reference" or "express reference" is present in the Plaintiffs' amended complaint and the trial court correctly denied Mary Black's motion to dismiss Blackwell's claims for lack of standing.[17]

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[17] Regardless, the law is well-established in South Carolina that a nonparty may enforce contractual terms that intend to provide direct benefits to such person. *See, e.g., Kingman v. Nationwide Mut. Ins. Co.*, 243 S.C. 405, 412, 134 S.E.2d 217, 221 (1964) ("We have held in numerous cases that a contract between two persons, for the benefit of a third, even though such third party be not named therein, can be enforced by such third party."); *Jennings v. First of Ga. Underwriters Co.*, 283 S.C. 455, 457, 322 S.E.2d 694, 695 (Ct. App. 1984) (explaining contracts between two persons for the benefit of a third can be enforced by the third person even though she is not named therein). "The presumption that [a] contract is not enforceable by [a nonparty] may be overcome by showing he was intended to be the direct beneficiary of the contract." *Touchberry v. City of Florence*, 295 S.C. 47, 48-49, 367 S.E.2d 149, 150 (1988); *See also Beverly v. Grand Strand*, 429 S.C. at 511-512, 839 S.E.2d at 472-473 (holding that where a contract between Blue Cross Blue Shield and the

Here, the amended pleading set forth sufficient allegations that Ms. Blackwell was the intended third-party beneficiary of an agreement between MedCost (her insurance provider) and Mary Black, and that Mary Black agreed to accept a reduced amount from MedCost as payment for services rendered to its insureds. Blackwell further alleges that Mary Black failed to submit its bills to MedCost, thereby harming Ms. Blackwell. Taken together, Blackwell has alleged facts sufficient at the Rule 12 stage to support a claim of standing as a third-party beneficiary and this Court should affirm the order of the lower court for these reasons, or for any reason contained in the record.

4. Plaintiff Brooks' claims do not fail under the Medicare Act.

Mary Black argues that Brooks' claims fail as a matter of law because, pursuant to 42 U.S.C.A. § 1395y(b)(2)(A)(ii), they "were required to seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare." (Mary Black Mot. 2; PASI Mot. 3–4; CHSPSC Mot. 3–4.) (R. p. 161; R. pp. 168-169; R. pp. 154-155). Again, this argument is improper at this stage of the action because it presumes facts not alleged in the Amended Complaint. *See Charleston Cnty. Sch. Dist. v. Harrell*, 393 S.C. 552, 559, 713 S.E.2d 604, 608 (2011) ("It is a well-settled principle that in resolving a Rule 12(b)(6) motion to dismiss, the court is limited to a consideration of the allegations contained within the four corners of the complaint.")

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hospital contained language expressly stating, "*This Agreement is not intended to, and shall not be construed to make any person or entity a third party beneficiary,*" it was error for the trial court to dismiss the patient's breach of contract claim because the agreement as a whole must be examined to determine whether the contract intended to benefit members in the insurance plan.)

Mary Black's argument fails as a matter of law because it presumes that the at-fault driver in Brooks's automobile accident had a valid insurance policy from which to collect, even though this fact is not alleged anywhere in the Amended Complaint. Instead, the Amended Complaint merely alleges that Brooks was involved in an automobile accident and had valid health insurance coverage through Medicare, which would have paid her medical bills had they been submitted for payment. (Am. Compl. ¶¶ 41–44) (R. p. 70). Thus, Mary Black's argument not only relies on a fact outside of the amended pleading, but it would also require the Court to disregard the allegation in the Amended Complaint that "Plaintiff Brooks's medical bills would have been paid had they been submitted to her health insurance for payment." (Am. Compl. ¶ 44) (R. p. 70). Because this is wholly contrary to the Court's scope of review in deciding a Rule 12(b)(6), SCRCP, motion for dismissal, the Court should reject this argument and affirm the decision of the lower court. *See Harrell*, 393 S.C. at 559, 713 S.E.2d at 608; *Sloan Constr. Co.*, 377 S.C. at 112–13, 659 S.E.2d at 161.

5. **The voluntary payment doctrine fails to bar the claims of either Owens or Brooks**

As alleged in their complaint, Brooks and Owens only settled with Mary Black after it asserted unlawful liens against the plaintiffs' recoveries for their personal injuries. (*See* Am. Compl. ¶¶ 26, 46, 52) (R. pp. 68, 71). In addition, Plaintiffs alleged Mary Black "[sought] payment for medical bills by demanding cash payment directly from the patients, placing unlawful liens on patients' third-party tort claims, seeking medical payment benefits from patients' automobile insurers, turning patients over to collection agencies, and/or reporting patients to credit bureaus (thereby impairing patients' credit scores)." (*Id.* ¶ 26) (R. p. 68).

Mary Black asserts that that the voluntary payment doctrine bars the claims of both Plaintiff Brooks and Plaintiff Owens. (*See* Mary Black Mot. to Dismiss pp. 3, 5–6; PASI Mot. to Dismiss

pp. 4–5, 7; CHSPSC Mot. to Dismiss pp. 4–5, 7.) (R. pp. 162-165; R. pp. 169-172; R. pp. 155-158). Their arguments rely on two South Carolina cases, *Hardaway v. S. Railway Co.*, 90 S.C. 475, 73 S.E. 1020 (1912), and *Moody v. Stem*, 214 S.C. 45, 51 S.E.2d 163 (1948), and a North Carolina federal district court case, *Cross v. Ciox Health, LLC*, 38 F. Supp. 3d 572 (E.D.N.C. 2020). None of these authorities require dismissal of these Plaintiffs' claims, and the trial court correctly found that the Plaintiffs' allegations, along with the inferences reasonably drawn from those allegations, were sufficient to defeat dismissal with respect to the voluntary payment doctrine. In relevant part, the lower court ruled:

> Under a 12(b)(6) analysis, [the] decision [not to dismiss due to the voluntary payment doctrine] is reasonable given the assertion that payments made by the Plaintiffs were not voluntary, as the Plaintiffs only settled with Mary Black after the Mary Black asserted unlawful liens against them. Plaintiffs strongly assert that payments made as a result of extortion are not considered voluntary.
>
> Form 4 Order dated Sept. 4, 2020, at 4 (R. p. 13).

Viewed in the light most favorable to the plaintiffs, the trial court correctly found that any payments Brooks and Owens made to Mary Black were not voluntary. *See Hardaway*, 73 S.E. at 1025 ("[A] party cannot by direct action, or by way of set-off or counterclaim, recover money *voluntarily* paid with a full knowledge of all the facts, *and without any fraud, duress, or extortion*, although no obligation to make such payment existed." (emphasis added)). The allegations in the pleading reflect a pattern and practice on the part of Mary Black of coercing and extorting its patients into making payments for services that the hospital should have billed to the patients' insurers. No payments made under these circumstances can be considered voluntary. *See Cross*, 438 F. Supp. 3d at 590 (stating a payment is involuntary when there is "some actual or threatened exercise of power possessed, or believed to be possessed, by the party exacting or receiving the payment over the person or property of another, for which the latter has no other means of

immediate relief than by making the payment" (quoting *Big Bear of N. Carolina, Inc. v. City of High Point*, 240 S.E.2d 422, 424 (N.C. 1978))); 70 C.J.S. *Payment* § 103 ("Recovery may be allowed where the payment of an unlawful demand has been obtained by taking undue advantage of the payor's situation, where it has been made to prevent an injury to property rights, or where it was made to release a person or property from detention or to prevent an immediate seizure of person or property." (footnotes omitted)); *id.* ("Where a person is compelled, through the necessity of protecting his or her business interests, or under a business necessity to free or protect property from some duress or lien, to pay an unlawful demand, the payment is compulsory and may be recovered." (footnotes omitted)).

Additionally, Owens and Brooks did not make the payments to Mary Black with the requisite "full knowledge of all the facts." *Hardaway*, 73 S.E. at 1025. Specifically, these plaintiffs acted without knowledge of the contractual obligations Mary Black had in relation to the plaintiffs' insurers, except the commonly held belief that Defendants were required to submit patients' bills to their respective health insurers. (*See* Am. Compl. ¶28) (R. p. 68). In extracting payments from Owens and Brooks, Mary Black failed to inform its patients of its duties and obligations. Consequently, the voluntary payment doctrine is further inapplicable. *See Moody*, 214 S.C. at 53, 51 S.E.2d at 165 ("That cannot be said with propriety to be voluntarily done, where a formal assent thereto is induced by *mistake*, or procured by fraud or deception, as to facts material to control the operation of the will therein, any more than where such formal assent is extorted by the application of a *force* which fetters and obstructs its free working."); 70 C.J.S. *Payment* § 103 ("A payment is not voluntary if the payor reasonably and in good faith believes in his or her obligation or personal interest in making the payment."); *see, e.g.*, *Freeman v. J.L.H. Investments, LP*, 414 S.C. 362, 383, 778 S.E.2d 902, 913 (2015) ("Freeman paid the closing fee without full knowledge of what

comprised the fee. . . . Accordingly, we find that Hendrick's reliance on the voluntary payment doctrine is misplaced.").[18]

For all the reasons stated herein, or for any reason found in the record, the Court should affirm. The facts and inferences drawn from the facts alleged in the complaint, viewed in the light most favorable to the plaintiff, entitle the Plaintiffs to relief; accordingly, dismissal is unwarranted.

6. The Amended Complaint States a Claim for Tortious Interference with Contract

"[A]n action for tortious interference protects the property rights of the parties to a contract against unlawful interference by third parties." *Dutch Fork Dev. Group II, LLC v. SEL Props., LLC*, 406 S.C. 596, 604, 753 S.E.2d 840, 844 (2012) (quoting *Threlkeld v. Christoph*, 280 S.C. 225, 227, 312 S.E.2d 14, 15 (Ct. App. 1984)). The elements of a claim for tortious interference with contractual relations are: "(1) existence of a valid contract; (2) the wrongdoer's knowledge thereof; (3) his intentional procurement of its breach; (4) the absence of justification; and (5) resulting damages." *Id.* (quoting *Camp v. Springs Mortg. Corp.*, 310 S.C. 514, 517, 426 S.E.2d 304, 305 (1993)).

Here, Plaintiffs allege a claim for tortious interference with a contractual relationship based on Mary Black's knowledge of their contractual relationship with their health insurance providers and its willful refusal to submit Plaintiffs' and Class Members' Mary Black bills for payment by their insurance. (*See* Am. Compl. ¶¶ 63–68) (R. pp. 75-76). As a result of Mary Black's wrongful conduct, Plaintiffs and Class Members did not "receiv[e] the benefit of their relationships with

[18] While Mary Black argues that the claims of Brooks and Owens are barred because they made payments to Mary Black, they argue elsewhere that Blackwell's claims are barred for precisely the opposite reason—because she *did not* make any payments to Mary Black. In doing so, Mary Black advances a seemingly Kafkaesque scenario where claims arising out of these billing practices are barred both when payments are made and when they are not made. The practical result is to foreclose all relief arising from its conduct no matter the circumstances.

their respective health insurance carriers" and Plaintiffs and the Class Members "paid premiums but receiv[ed] no or little benefit." (*Id.* ¶¶ 66, 67) (R. pp. 75-76). Construed in the light most favorable to the Plaintiffs, the trial court correctly found that the allegations are sufficient to state a claim for tortious interference with contractual relations.

Defendants argue this cause of action should be dismissed because "[w]ithout a breach by the health insurers of their insurance contracts with Plaintiffs, there can be no recovery from Defendants under a cause of action for tortious interference with a contractual relationship." App. Init. Br. p. 35. (R. pp. 160-161). However, Mary Black again fails to construe the allegations in the light most favorable to Plaintiffs and reads Plaintiffs' allegations too narrowly, all the while seeking to have this Court impermissibly consider the merits of the claim, rather than the claim "as it is alleged." The trial court correctly determined that the allegations in the Amended Complaint can be reasonably construed to mean that Mary Black's conduct resulted in a breach of patients' contracts with their insurers since Plaintiffs alleged they paid premiums but did not have their Mary Black bills paid by their insurers. Accordingly, Mary Black's argument that Plaintiffs failed to allege facts sufficient to constitute a cause of action for tortious interference should be rejected and the decision of the lower court affirmed.

7. The Trial Court Correctly Found the Amended Complaint States Facts Sufficient to Support a Cause of Action Against Appellants PASI and CHSPSC

Mary Black, CHSPSC, and PASI are related entities that engaged in the wrongful billing and collection practices alleged in the Amended Complaint. CHSPSC and PASI are billing and collection entities related to Mary Black (Am Compl. ¶¶ 16–17) (R. p. 4). In their amended pleading, Plaintiffs assert facts and allegations against all defendants, and often refer to the defendants collectively. (*See, e.g.*, Am. Compl. ¶¶22–34) (R. pp.67-69) (alleging all defendants engaged in wrongful conduct). In addition, Plaintiffs allege that "CHSPSC and PASI exercise

control over policies and procedures enacted and implemented by Mary Black Health System, including policies relating to billing and liens, and all of these entities committed the acts and omissions complained of herein, jointly and in concert." (Am. Compl ¶ 18) (R. p. 66-67). Because these allegations as to both PASI and CHSPSC meet the pleading requirements, there exists no error in the denial of the motion to dismiss and this Court should affirm the decision of the lower court.

In seeking dismissal, both PASI and CHSPSC urge the Court to revert to past days of code pleading by arguing that the Amended Complaint lacks "specific or individual allegations" against them. (*See* App. Init. Br. pp. 36-39) (PASI Mot. to Dismiss pp. 1–3; CHSPSC Mot. to Dismiss pp. 1–3.) (R. pp. 166-168; pp. 152-154). However, this argument contravenes the well-established rules governing pleading in our state, as the Rules of Civil Procedure merely require a plaintiff to set forth "a short and plain statement of the facts showing that the pleader is entitled to relief." Rule 8(a)(2), SCRCP. Additionally, the purpose of the South Carolina Rules of Civil Procedure is "to secure justice, and . . . reduce formalities and technicalities." *Patton* 420 S.C. at 492, 804 S.E.2d at 263 (2017) (quoting James F. Flanagan, *South Carolina Civil Procedure* 3 (2d ed. 1996)). They are "designed to discourage battles over mere form and to sweep away needless procedural controversies that either delay a trial on the merits or deny a party his day in court because of technical deficiencies." *Id.* at 493, 804 S.E.2d at 263 (quoting 4 Charles Alan Wright et al., *Federal Practice and Procedure* § 1029 (4th ed. 2015)). Put simply, the governing South Carolina pleading requirements are no longer "technical confines of code pleading" but instead are "far more flexible notice pleading provisions of the Rules of Civil Procedure." *Patton*, 420 S.C. at 492.

Under South Carolina law, there exists no prohibition against pleading facts in the manner contained in the amended complaint at issue here. *See* Rule 8(e)(1), SCRCP ("Each averment of a

pleading shall be simple, concise, and direct. No technical forms of pleading or motions are required."); *Patton*, 420 S.C. at 493, 804 S.E.2d at 263 (observing that it is "entirely contrary to the spirit of the . . . Rules of Civil Procedure for decisions on the merits to be avoided on the basis of . . . mere technicalities" (quoting *Foman v. Davis*, 371 U.S. 178, 181 (1962))). Because the Amended Complaint provides sufficient notice to all Defendants of the allegations being made against them, the Court should reject the arguments of PASI and CHSPSC that the allegations against them are factually insufficient.

Mary Black further suggests Plaintiffs' pleadings improperly attempt to attach liability to each defendant; however, Plaintiffs have not alleged any defendant is vicariously liable for the actions of another, nor have Plaintiffs attempted to pierce the corporate veil of any defendant. Instead, Plaintiffs alleged in their pleading that all of the defendants acted in concert with one another, and each defendant's liability is the result of its own conduct (although such conduct may mirror that of the other defendants). Accordingly, Mary Black's cited authority from various federal courts of appeal is unpersuasive.

Mary Black's alternative suggestion that collective pleading is somehow prohibited or improper in South Carolina is equally incorrect. Abandoning their previous reliance on cases relied upon in the lower court, Mary Black cannot point to any case law, statute, or rule of civil procedure prohibiting collective pleading or requiring a plaintiff to repeat allegations against individual defendants when the defendants acted in concert. In fact, the opposite holds true. *See, e.g.*, *Connor v. Honeywell Int'l Inc.*, No. CIV.A. 2:12-1421-CWH, 2012 WL 6135193 (D.S.C. Nov. 13, 2012) (finding collective pleading to be proper where plaintiff believed defendants acted in concert). Defendants' cited authority offers no support to their position. *See Scurmont LLC v. Firehouse Rest. Grp., Inc.*, No. 4:09-CV-00618-RBH, 2010 WL 11433199, at *15 (D.S.C. May 19, 2010)

(finding a lack of specific personal jurisdiction over an individual defendant because the plaintiff failed to plead facts demonstrating the defendant committed wrongful acts within South Carolina).[19]

Accordingly, for all the reasons contained herein, or for any reason found in the record, the Court should affirm the lower's court refusal to dismiss the claims against PASI and CHSPC.

CONCLUSION

The lower court correctly denied the motion to compel Mr. Owens to arbitration and the multiple motions to dismiss as against all Plaintiffs. The orders of the lower court should be affirmed for all of the reasons stated herein, or for any other reason found in the record pursuant to Rule 220(c), SCACR, and the matter remanded to the lower court for trial.

Signature Page to Follow

[19] Mary Black's reliance on *Jones v. Gilstrap*, 288 S.C. 525, 343 S.E.2d 646 (Ct. App. 1986) is similarly misplaced. In *Jones*, the Court of Appeals sustained a *demurrer* to a complaint alleging breach of contract by a county employee where the plaintiff failed to set out the pertinent provisions of the handbook or personnel policies upon which she based her complaint, and there were no such contracts incorporated by referenced into the pleading. Here, Plaintiffs have not alleged a breach of contract and there were no "missing" documents necessary to support their claims.

Respectfully submitted,

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Dated: November 4, 2021

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

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

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

Respondents,

v.

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

Appellants,

APPELLANTS' REPLY BRIEF

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INTRODUCTION

Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital ("Mary Black"); CHSPSC, LLC ("CHSPSC"); and Professional Account Services, Inc. ("PASI") (collectively, "Defendants") hereby reply to the arguments presented by Respondents Jo Ann Blackwell, Samuel Owens, and Michelene Brooks (collectively, "Plaintiffs") in this matter. Plaintiffs' arguments are misplaced and incorrect. For the reasons set forth in Defendants' Appellants' Brief, and reiterated here, the Court should issue an order reversing the circuit court, compelling Owens to arbitrate his claims against Defendants, and dismissing the claims asserted by each of the Plaintiffs.

ARGUMENTS IN REPLY

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

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

When Owens (a non-signatory to the CIGNA Agreement) seeks to take direct benefits from the CIGNA Agreement, and to enforce the terms contained therein, the doctrine of direct benefits estoppel binds him to all of the terms within the CIGNA Agreement—including the arbitration provision. *See Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 288, 733 S.E.2d 597, 600 (Ct. App. 2012). Whether the circuit court erred in failing to compel Owens to arbitrate his claims against Defendants is controlled by the determination of whether Owens's claims seek to take a direct benefit from the CIGNA Agreement. If the Court finds that Owens is seeking to take benefit and

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

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

> Paragraph 28: Upon information and belief, **Defendants are required by their contracts with patients' health insurance carriers** to submit insurance patients' medical bills directly to the carriers. . . .
>
> Paragraph 29: **Defendants are required to honor a contractual discount with their patients' health insurance carriers** and accept discounted payments from those health insurance carriers in full satisfaction of the patients' debts.
>
> Paragraph 31: Patients are unable to submit their medical bills directly to their health insurance. Defendants are the entities responsible for such submissions and are the only entities in possession of the information required to make such submissions. Further, **Defendants have contracts with health insurance providers and health plans for reduced compensation for treating patients who have health insurance**.
>
> Paragraph 32: Through Defendants' bill collection practices, they attempt to maximize the amount they receive for services rendered by attempting to recover amounts billed from patients **rather than accepting the discounted amount they agreed to accept from patients' health insurance**.

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

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

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

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

> a. **Whether Defendants entered into express and/or implied agreements with various health insurance carriers** providing, among other things, that health insurance claims should be promptly submitted to the carriers for payment;
>
> b. **Whether Defendants violated their contracts with various health insurance carriers** by not submitting medical bills to the carrier;
>
> c. **Whether Defendants violated their contracts with various health insurance carriers** by pursuing recovery for services rendered by placing liens upon patients' property (such as third-party tort claims), pursuing medical payment benefits from auto insurers, pursuing payment directly from patients, and/or turning patients' accounts over to collections;
>
> d. **Whether Defendants violated their contracts with various health insurance carriers** by not offering a contractually agreed discount to patients covered by said policies

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

In support of his alleged cause of action for unjust enrichment Owens alleges, "[i]t would be unjust for Defendants to retain these funds because payment for the services provided should have come from the health insurance carriers of Plaintiffs and the Class Members, with the amount to be paid for services provided **determined by the contracts between Defendants and patients' health insurance carriers**." (R. 76) (emphasis added).

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

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

> Paragraph 78: Nevertheless, on information and belief, Defendants failed to honor **contractually agreed-upon discounts** regarding Plaintiffs' medical bills and those of the proposed Class Members. Defendants likewise failed to **honor their contractual commitment** to submit the medical bills of insured patients to those patients' insurance
>
> Paragraph 80: Through Defendants' bill collection practices, they attempt to optimize the amount received for services rendered by seeking from patients the full amount billed (or more than they are entitled to for the covered treatment), rather than **accepting the discounted amount they have agreed to accept from the patient's health insurance carrier**.

(R. 77).

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

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

All of Owens's allegations and admissions establish undeniably that that he is attempting to enforce and take a direct benefit from the CIGNA Agreement. That agreement contains a valid and enforceable arbitration provision. When Owens bases his claims on a purported entitlement to the benefits of those billing terms and discounted rates arising from the CIGNA Agreement, the doctrine of direct benefits estoppel binds him to all of the terms of the CIGNA Agreement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rule 15(c), SCRCP, governs the relation back of a pleading. *Jackson v. Doe*, 342 S.C. 552, 558, 537 S.E.2d 567, 570 (Ct. App. 2000). Rule 15(c) does not apply to the addition of a new party. *See id.*; *Gause v. Smithers*, 384 S.C. 130, 133, 681 S.E.2d 607, 609 (Ct. App. 2009). Thus, the claims of a newly added plaintiff—such as Owens and Brooks—do not relate back to the date of filing of the original plaintiff's initial complaint.

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

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

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

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

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

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

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

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

Id.

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

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

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

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

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

South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: "(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its value." *Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994). It is a quintessential element to a claim for unjust enrichment that the plaintiff must have conferred a benefit on the defendant. Indeed, the remedy for a claim for unjust enrichment is restitution. *Inglese v. Beal*, 403 S.C. 290, 297, 742 S.E.2d 687, 690-91 (Ct. App. 2013). And restitution merely permits a plaintiff to recover the value of the benefit that the plaintiff had previously conferred to the defendant. *JASDIP Properties SC, LLC v. Est. of Richardson*, 395 S.C. 633, 640, 720 S.E.2d 485, 488 (Ct. App. 2011). Thus, if nothing was given to the defendant, then there is nothing to return and there is no available remedy. Without a remedy, the claim fails.

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

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

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

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

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

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

In reviewing a motion to dismiss pursuant to Rule 12(b)(6), the Court may consider a document that is incorporated into the complaint, attached to the complaint, or integral to the complaint. *See Carolina First Corp. v. Whittle*, 343 S.C. 176, 190 n.7, 539 S.E.2d 402, 410 n.7 (Ct. App. 2000) (incorporated by reference); *HHHunt Corp. v. Town of Lexington*, 389 S.C. 623, 629-30, 699 S.E.2d 699, 701-02 (Ct. App. 2010) (attached to the complaint); *Patterson v. Witter*, 425 S.C. 213, 235, 821 S.E.2d 677, 689 (2018) (integral to the complaint); *Leichling v. Honeywell Int'l, Inc.*, 842 F.3d 848, 850-51 (4th Cir. 2016) (integral to the complaint); *Goines v. Valley Cmty. Servs. Bd.*, 822 F.3d 159, 166 (4th Cir. 2016) (same); *Kensington Volunteer Fire Dep't, Inc. v. Montgomery Cty., Md.*, 684 F.3d 462, 467 (4th Cir. 2012) (same); *Philips v. Pitt Cty. Mem'l Hosp.*, 572 F.3d 176, 180 (4th Cir. 2009) (same); *Am. Chiropractic Ass'n v. Trigon Healthcare, Inc.*, 367

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

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

> Paragraph 28: Upon information and belief, Defendants **are required by their contracts** with patients' health insurance carriers to submit insurance patients' medical bills directly to the carriers. . . .
>
> Paragraph 29: Defendants are **required to honor a contractual discount with their patients' health insurance carriers** and accept discounted payments from those health insurance carriers in full satisfaction of the patients' debts.
>
> Paragraph 31: Patients are unable to submit their medical bills directly to their health insurance. Defendants are the entities responsible for such submissions and are the only entities in possession of the information required to make such submissions. Further, **Defendants have contracts with health insurance providers and health plans for reduced compensation for treating patients who have health insurance**.

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

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

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

Blackwell alleges she has the right to enforce the terms of the MedCost Agreement for her own goals and benefit. She argues that she is an intended third-party beneficiary of the agreement. However, Blackwell is clearly not a party to the MedCost Agreement and she is not an intended third-party beneficiary who can sue to enforce that Agreement for her own benefit. The MedCost Agreement plainly and directly expresses the intent of Mary Black and MedCost to bar third parties from enforcing the MedCost Agreement. This intent is unequivocally stated in Section 10.9 of the MedCost Agreement, which expressly and definitively states Mary Black's and MedCost's intention that the contract not be construed to have any third-party beneficiaries:

> This Agreement is entered into by and between the parties hereto for their benefit. **There is no intent by either party to create or establish a third party beneficiary status** or rights in a Covered Person, Employer, subcontractor, or other third party to this Agreement, except as such rights are expressly created and as set forth herein, and **no such third party shall have any rights to enforce any right to enjoy any benefit created or established under this Agreement**.

(R. 258) (emphasis added).

For a court to construe and interpret the MedCost Agreement, the determinative action, is to review and give effect to the Agreement's plain and unambiguous language. *See Whitlock v. Stewart Title Guar. Co.*, 399 S.C. 610, 614, 732 S.E.2d 626, 628 (2012). The plain and unambiguous language of the MedCost Agreement compels the finding that Mary Black and MedCost did not express, and did not have, an intent to allow Blackwell to enforce the MedCost Agreement as a third-party beneficiary. *See Windsor Green Owners Ass'n, Inc. v. Allied Signal, Inc.*, 362 S.C. 12, 19, 605 S.E.2d 750, 753 (Ct. App. 2004). Since Blackwell lacks standing to

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

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

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

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

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

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

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

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

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

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

The allegations against PASI and CHSPSC are limited and specious. The entirety of the specific and individual allegations against PASI and CHSPSC are encompassed in three paragraphs of the Amended Complaint:

> 16. Defendant CHSPSC, LLC, formerly known as Community Health Systems Professional Services Corporation, is a Delaware corporation with its principal place of business in Tennessee. On information and belief, CHSPSC regularly conducts business in the State of South Carolina and other states and has responsibility for the billing of patients and liens filed within the State of South Carolina.
>
> 17. Defendant Professional Account Services, Inc. ("PASI") is a Tennessee corporation with its principal place of business in Brentwood, Tennessee.

> PASI is a collection firm that regularly conducts business in the State of South Carolina and elsewhere.
>
> 18. On information and belief, CHSPSC and PASI exercise control over policies and procedures enacted by and implemented by Mary Black Health System, including policies relating to billing and liens, and all of these entities committed the acts and omission complained of herein jointly and in concert.

(R. 66-67).

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

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

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

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

CONCLUSION

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

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November 4, 2021
Columbia, South Carolina

RECEIVED
Nov 04 2021
SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

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

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

Respondents,

v.

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

Appellants,

APPELLANTS' CERTIFICATE OF COUNSEL

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

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APPELLANTS' PETITION FOR REHEARING AND SUGGESTION FOR REHEARING EN BANC

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STATEMENT OF POINTS OVERLOOKED OR MISAPPREHENDED

Pursuant to Rules 219(b) and 221(a), SCACR, and for the reasons below, Defendants-Appellants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital ("Mary Black"); CHSPSC, LLC; and Professional Account Services, Inc. (collectively, "Defendants") petition the Court for rehearing and rehearing *en banc* of the September 18, 2024 panel Opinion No. 6088 (the "Panel Opinion"). Defendants request rehearing because:

I. The Panel Opinion directly conflicts with this Court's decision (by the same Panel of Judges) in *Bennett v. ACS Primary Care Physicians-Southeast P.C.*, Case No. 2021-001342, Opinion No. 6089, which concerns virtually identical allegations and legal questions. Because these two decisions are inconsistent and cannot be reconciled, Defendants request rehearing. If left unaddressed, the conflict will lead to inequitable results, sow confusion in the law of equitable estoppel and arbitration and encourage or promote gamesmanship and artful pleading.

II. The Panel Opinion misapprehends and misinterprets the applicable contract provisions reflecting the common contractual terms addressing the scope of the arbitration agreement and the class arbitration waiver. In so doing, the Panel Opinion is inconsistent with decisions by the United States Supreme Court, potentially violates the Federal Arbitration Act, and invites further gamesmanship in pleadings.

III. The Panel Opinion overlooks that, by failing to exercise its legitimate discretion in a proper case and failing to review orders denying Defendants' motions to dismiss, it failed to fully consider the nature of the claims that Defendants seek to arbitrate, contributing to the foregoing errors in the Panel Opinion.

BACKGROUND

A. Plaintiffs' Allegations.

Plaintiffs allege that Defendant Mary Black (a hospital) provided them with emergency care following motor vehicle accidents. Plaintiffs allege that Mary Black and its Co-Defendant affiliates' "contracts with patients' health insurance carriers" "required" Defendants to submit Plaintiffs' medical bills for this care "directly to the carriers." (R. 68, ¶ 28). But, according to Plaintiffs, Defendants billed them instead.

By doing so, Plaintiffs allege, Defendants tortiously interfered with certain contractual relationships and were unjustly enriched. Specifically, Plaintiffs' tortious interference theory is that (1) Plaintiffs allegedly had contractual relationships with their insurers; (2) Defendants allegedly knew or should have known of those relationships; and (3) Defendants allegedly interfered with and disrupted those relationships by preventing them from receiving the benefit of those relationships, in that Plaintiffs paid premiums but, due to Defendants' alleged billing practices, received "little to no benefit." (R. 75-76, ¶¶ 64–67). It is unclear—and Plaintiffs do not say—how any of this caused either Plaintiffs or their insurance carriers to breach any terms of the alleged contractual relationships between them. As for unjust enrichment, Plaintiffs allege that "payment for the services provided *should have come from the [Plaintiffs'] health insurance carriers*," with the amount to be paid "*determined by the contracts between Defendants and patients' health insurance carriers.*" (R. 76, ¶ 73 (emphasis added)). Thus, Plaintiffs allege, Defendants were unjustly enriched by receiving different amounts. (R. 76, ¶¶ 71–72). Plaintiffs also seek injunctive relief, alleging that Defendants "were required" to submit Plaintiffs' medical bills "directly to their health insurers for payment" and "to honor" certain "contractually agreed-upon discounts" arising from the contracts between Defendants and the Plaintiffs health insurance carriers. (R. 77, ¶¶ 76–78).

Plaintiffs style their case as a class action. In alleging the "principal common issues," however, Plaintiffs identify no common issues involving any alleged contractual agreement between themselves and their insurers. Instead, they primarily list purported violations of the specifically alleged contracts between *Defendants* and patients' insurers. (R. 72 - 73, ¶ 57(a) ("Whether Defendants entered into express and/or implied agreements with various health

insurance carriers…."); ¶ 57(b)–(e) (listing several questions about whether "Defendants violated" those alleged contracts)).

B. The Panel Opinion.

Plaintiff Samuel H. Owens, Jr. alleges that his health insurance carrier is CIGNA. (R. 71, ¶ 48). An agreement between CIGNA and Mary Black (the "CIGNA Agreement") requires any disputes arising with respect to its interpretation or performance to be resolved through individual arbitration. (R. 275–76). Based on the CIGNA Agreement, Defendants moved to compel Plaintiff Owens to the arbitration, and also moved under Rule 12(b)(6) to dismiss all claims for failure to state a claim. The circuit court denied the motions, and Defendants appealed.

On appeal, Defendants argued that the CIGNA Agreement's arbitration provision binds Plaintiff Owens, by application of the well-established principle of equitable estoppel, because he premised his suit on the theory that he should have received benefits under the CIGNA Agreement in the form of the lower health care charges that CIGNA negotiated with Defendants. Under the doctrine of equitable estoppel, Defendants explained, Owens may not claim a contractual benefit (contractually-mandated lower fees) on the one hand, while disclaiming a contractual obligation (arbitration) on the other. Relatedly, as analyzing the estoppel issue requires the Court to interrogate the nature of the claims, Defendants asked the Court to review the circuit court's denial of Defendants' motion to dismiss. Nevertheless, in the Panel Opinion, the Court affirmed the denial of Defendants' motions to compel arbitration and declined to review the motions to dismiss.

In addressing arbitration, the Panel Opinion correctly holds that the arbitration provision in the CIGNA Agreement is binding and enforceable. (Panel Op. at 9). It correctly notes that under equitable estoppel, "a nonsignatory may be compelled to arbitrate where the nonsignatory 'knowingly exploits' the benefits of an agreement containing an arbitration clause, and receives

benefits flowing directly from the agreement." (*Id*. at 9 (quoting *Wilson v. Willis*, 426 S.C. 326, 340–41, 827 S.E.2d 167, 175 (2019)). And, the Panel correctly explains that estoppel applies where "(1) the nonsigner's claim arises from the contractual relationship, (2) the nonsigner has 'exploited' other parts of the contract by reaping its benefits, and (3) the claim relies solely on the contract terms to impose liability." (*Id.* at 10 (quoting *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 230, 847 S.E.2d 268, 272 (Ct. App. 2020)).

Nevertheless—and contrary to Plaintiffs' own allegations—the Panel held that Owens was not estopped because he "never alleged in the complaint that he received a direct benefit from the CIGNA Agreement[] and his claims for tortious interference with a contract and unjust enrichment are not pled as arising from the CIGNA Agreement." (*Id.* at 10). The Panel Opinion states that Owens' tortious interference claim "does not arise solely from or have to be determined in reference to the CIGNA Agreement" because "it arises out of tort law and does not refer or relate to the CIGNA Agreement even if it would not have arisen but for the agreement." (*Id.*). Likewise, the Panel Opinion holds that the unjust enrichment claim "does not rely on the CIGNA Agreement" because, even though it "refers to the CIGNA Agreement," "the claim does not rely upon or have to be determined by refence to the CIGNA Agreement." (*Id.* at 11). Thus, the Panel Opinion states, "the claim could be determined in reference to Owen's insurance contract with CIGNA." (*Id.*).

Additionally, while the Panel Opinion recognizes that "Owens's claim for injunctive relief does rely on the CIGNA Agreement," the Panel Opinion concludes that Owens need not arbitrate this claim because his other two claims "do not arise from the CIGNA Agreement." (*Id.* at 11–12). In addition, as an alternative ground for refusing to compel arbitration, the Panel Opinion interprets a class arbitration waiver to hold that Defendants cannot to compel a plaintiff to

arbitration if the plaintiff already joined a class action. (*Id.* at 12). Finally, the Panel Opinion declines to review any part of the denial of Defendants' Rule 12(b)(6) motions, stating that "the issues raised by [the] Rule 12(b)(6) motions would benefit from further factual development." (*See id.* at 12–13).

This Panel Opinion was not unanimous. Agreeing with Defendants, Judge Geathers wrote in dissent that Owens is equitably estopped from disclaiming the agreement to arbitrate because "the causes of action in the Amended Complaint ... invoke [Defendants'] contractual duties to the insurance carriers with which the [Plaintiffs] also had contracts." (*Id.* at 13–14).

C. The *Bennett* Opinion.

On the very same day that the Panel Opinion issued, this Court (in fact, the same Panel of Judges) also decided *Bennett v. ACS Primary Care Physicians-Southeast P.C.*, No. 2021-001342, 2024 WL 4234720 (S.C. Ct. App. Sept. 18, 2024). This case and *Bennett* are virtually identical. As here, the *Bennett* plaintiffs brought a putative class action alleging that a defendant healthcare provider improperly sent bills to patients rather than their insurers. As here, the *Bennett* plaintiffs brought unjust enrichment and injunctive claims. As here, the *Bennett* defendants moved to compel arbitration because plaintiffs were bound by an agreement to arbitrate between defendants and plaintiffs' insurers and were equitably estopped from contending otherwise. As here, the circuit court denied the motion to compel arbitration and the defendants appealed.

Unlike here, however, this Court held in *Bennett* that equitable estoppel did apply and the plaintiffs in *Bennett* were subject to the arbitration clause in their defendants' agreements with their insurance carriers. *Bennett*, 2024 WL 4234720, at *3–4. Based on the irreconcilable differences in reasoning and outcome between this case and *Bennett,* and on other critical issues

that the Court appears to have either overlooked or misapprehended, Defendants respectfully petition for rehearing and rehearing *en banc*.

ARGUMENTS

I. The Panel Opinion Risks Confusion and Encourages Gamesmanship and Artful Pleading in Future Cases.

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

The rule of *stare decisis* is one of consistency. *Roof v. Charlotte, C. & A.R. Co.*, 4 S.C. 61, 62–63 (1872). "[W]here the same points come again in litigation, as well to keep the scale of justice even and steady," courts are "not delegated to pronounce a new law." (quoting Herbert Broom, *A Selection of Legal Maxims*)). Accordingly, where there is a "state of conflict" between decisions, "it is up to the court to 'choose ye this day whom he will serve" and "determine which doctrine best appeals to its sense of law, justice, and right." *Antley v. New York Life Ins. Co.*, 139 S.C. 23, 137 S.E. 199, 201 (1927).

The similarities between the core allegations in this case and those in *Bennett* are striking, as the following chart highlights:

***Blackwell* Amended Complaint (R. 63 *et seq.*)**	***Bennett* Complaint (Case No. 2021-001342, R. 37 *et seq.*)**
¶ 15: "[Mary Black] provided healthcare services for Plaintiffs and the general public"	¶ 8: "Defendant … provide[s] emergency medicine services."
¶ 28: "Defendants are required by their contracts with patients' health insurance carriers to submit insurance patients' medical bills directly to the carriers."	¶ 2: "Defendant … contract[ed] with [BCBS] … ([the] 'Provider Agreement'). Under the Provider Agreement, Defendant agreed to bill BCBS directly for services rendered to patients insured through BCBS ('Insureds')."
¶ 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."
¶ 57(c): "Defendants … pursue[ed] payment directly from patients[.]"	¶ 4: "Defendant would bill Insureds directly at a rate higher than the negotiated BCBS

	rate, resulting in an increase to healthcare costs 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."

Yet, in applying the doctrine of equitable estoppel to these indistinguishable allegations, the Court comes to divergent results, creating an immediate conflict in the law of equitable estoppel.

This conflict is most stark when one compares the respective treatment of the plaintiffs' unjust enrichment claims. The unjust enrichment allegations in *Bennett* are virtually identical to those here. (*Compare* R. 76 ¶¶ 69–74, *with* Case No. 2021-001342, R. 46–47 ¶¶ 69–75) (see chart above). That is, in both cases, the plaintiffs allege that the defendants were unjustly enriched because the defendants directly billed patients at a rate higher than what the defendant was contractually obligated to bill the patients' insurers. This Court nevertheless concludes in *Bennett* that the claim is "based on an alleged duty arising *solely* from the terms of the Provider Agreement" (2024 WL 4234720, at *3; *id.* at *12 (same) (Vinson J., concurring)), while simultaneously concluding here that the exact same claim "does not rely on the [the provider-insurer agreement]." (Panel Op. at 11). These divergent conclusions cannot both be correct.

When an appellate court issues conflicting decisions on the same day regarding the same fact pattern, the law becomes uncertain. Indeed such conflicting and irreconcilable decisions invite confusion and inconsistent results. Defendants urge the Court to quell the conflict and uncertainty

by rehearing this case and conforming the Panel Opinion here to the unanimous conflicting decision in *Bennett*.

B. The Panel Opinion Risks Rewarding Artful Pleading and Gamesmanship.

A primary consequence of the conflict between the Panel Opinion and the decision in *Bennett* is that it invites artful pleading and gamesmanship by instructing lower courts to elevate the form of a plaintiff's claims over substance. Indeed, it appears that artful pleading by Plaintiffs here led this Court to misapprehend the true nature of Plaintiffs' allegations, as follows.

1. The Panel Opinion risks encouraging plaintiffs to obscure the true nature of their claims and selectively omit factual allegations.

Here, the Panel Opinion holds that, by grounding his claim in tort and not contract, Owens can avoid equity. (Panel Op. at 10–11). This formalistic approach, however, overlooks the substance of Owens's claims and incites future litigants to use artful pleading to avoid arbitration.

As courts have long held, "the essential character of the cause of action, and the remedy or relief it seeks," are "shown by the allegations of the complaint," and, thus, the true nature of a claim 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). Thus, in the context of estoppel, while a plaintiff may assert a claim "phrased in tort," that plaintiff "may not use artful pleading to avoid arbitration" if "at root, those claims attempt to hold [the defendant] to the terms of [a contract with an arbitration provision]." *Am. Bankers Ins. Grp., Inc. v. Long*, 453 F.3d 623, 630 (4th Cir. 2006). The central question—regardless of how a plaintiff styles a claim—is "whether the plaintiff has asserted claims in the underlying suit that, either literally or obliquely, assert a breach of a duty created by the contract containing the arbitration clause." *Id.* at 629; *see also OSRX Inc. v. Anderson*, No. 22-CV-1737, 2023 WL 2472417, at *7 (D.S.C. Feb. 7, 2023) ("Although Plaintiffs' remaining claims—misappropriation of trade secrets …, intentional interference with contractual

relations, and intentional interference with prospective contractual relations—are '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)).

Here, Owens's claims did not depend solely on a general tort obligation. Instead, as the dissent recognized, Plaintiffs "invoke[d] the [Defendants'] contractual duties to the insurance carriers with which [Plaintiffs] also had contracts." (Panel Op. at 13 (Geathers, J., dissenting)). That is because—whether they sound in tort, contract, or equity—the essential character of Plaintiffs' claims is, at root, that Defendants should be held to the terms of their contracts with Plaintiffs' health insurance carriers, including the CIGNA Agreement.

This essential character of their claims sounds throughout the allegations of the Amended Complaint. Plaintiffs allege, multiple times, that Defendants "contracted with patients' health insurance providers for a reduced compensation for treating patients with health insurance" (R. 65 ¶ 9; *see also id.* ¶ 31, 57(a)). They allege, multiple times, that Defendants are "required by their contracts with patients' health insurance carriers to submit insurance patients' medical bills directly to the carriers" and "required to honor a contractual discount with their patients' health insurance carriers." (R. 68, ¶¶ 28–29; *see also id.* ¶ 57(b)–(c)). This contractual discount *is* the benefit Plaintiffs seek in the litigation. (R. 73 at 57(d)). The first mention, on the other hand, of any alleged contractual relationship between Plaintiffs and their insurers does not appear until Plaintiffs set forth the elements of their artfully pleaded tort claim. (R. 75, ¶ 64).

And it makes sense that Plaintiffs would focus on Defendants' agreements with their insurers. They must. Under South Carolina law, a healthcare provider has no general duty to submit bills to insurance providers. *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).

Instead, any affirmative duty to bill in a particular way must arise from a contract. Here, based on Plaintiffs' own allegations, the *only* contract giving rise to such a duty is an agreement like the CIGNA Agreement.[1]

Nor should a plaintiff be able to evade estoppel by simply failing to expressly allege a benefit under the operative agreement or knowledge of that agreement. (Panel Op. at 10 (holding that Owens is not estopped because he "did not benefit from the CIGNA Agreement and did not know about the agreement prior to this litigation")). As this Court held in *Bennett*, "the discounts and other provisions negotiated between [an insurer] and [a provider]" are a sufficient benefit to subject a patient to an arbitration clause in the insurer-provider contract by estoppel. 2024 WL 4234720, at *4. The Court in *Bennett* also agreed with the defendants that 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." *Id.*, at *2. Thus, if the Panel Opinion stands, future litigants seeking to avoid equitable estoppel will be encouraged to strategically omit undeniable allegations from their complaints.

In short, regardless of how he styles his claim, Owens literally and explicitly asserts a breach of the CIGNA Agreement as the basis for liability and seeks the benefit of *that* contractual relationship. *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

[1] To be sure, as the Panel Opinion acknowledges, estoppel "is not implicated simply because a claim relates to or would not have arisen 'but for' a contract's existence." *Wilson*, 426 S.C. at 343, 827 S.E.2d at 176; (Panel Op. at 10–11). However, *Wilson* does not authorize ignoring contracts whenever they are a but-for cause of a claim. Rather, the point is that it is not sufficient that a contract was a but-for cause of a plaintiff's injury. *See* 426 S.C. at 343, 827 S.E.2d at 176. Ultimately, it is "the substance of the claim" that matters. *Id.* (quoting *Jody James Farms, JV v. Altman Grp., Inc.*, 547 S.W.3d 624, 637 (Tex. 2018).

alleged liability "must be determined by reference to" the contract with the arbitration clause). Thus, because Owens premises his claims on the alleged terms of the CIGNA Agreement, he is subject to its arbitration provision and estopped from contending otherwise (just as the Court concluded in its unanimous decision in *Bennett*). Allowing him to avoid this result by obscuring the true nature of his claims works inequity and invites gamesmanship.

2. The Panel Opinion risks encouraging plaintiffs to attempt to avoid arbitration by alleging meritless non-arbitrable claims.

The Panel Opinion also risks encouraging future litigants to allege a host of non-arbitrable claims in a gambit to avoid arbitration. Specifically, the Panel Opinion 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 Panel Opinion nevertheless concludes that Owens does not have to arbitrate that claim, or any other, because "two of the three claims alleged do not arise from the CIGNA Agreement." (Panel Op. at 11–12). In other words, the Panel Opinion suggests that a plaintiff can avoid arbitration if an arbitrable claim is joined by some greater number of non-arbitrable claims. That is not the law.[2]

Moreover, deciding arbitrability of a claim based on the overall proportion of arbitrable and non-arbitrable claims is acutely vulnerable to gamesmanship. To promote judicial efficiency and reduce the risk of waiver, Defendants typically are forced to seek to compel arbitration early in a case, often with, or even before, a motion to dismiss, and thus typically must take the complaint

[2] Although the Panel Opinion cites *Wilson*, 426 S.C. at 342, 827 S.E.2d at 176, for this proposition, *Wilson* does not support this approach. In *Wilson*, the Supreme Court found that *none* of the claims asserted implicated direct benefits estoppel. *See id.* (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 actually arise from or need to be determined by reference to the contract). Accordingly, *Wilson* had no occasion to address what a court should do if one claim relies on a contract with an arbitration clause (and would be subject to estoppel and arbitration if brought alone), but additional claims do not.

as-pled. Under the Panel Opinion, future plaintiffs seeking to avoid arbitration may be encouraged to allege multiple non-arbitrable claims, even if those extra non-arbitrable claims lack merit. Because the Panel Opinion appears to have overlooked this concern, it warrants reconsideration.

II. The Panel Opinion Misconstrues the Plain and Unambiguous Language of the CIGNA Agreement and Is in Conflict with U.S. Supreme Court Precedent.

In holding that Owens cannot be compelled to arbitrate his individual claim because he filed a class action, the Panel Opinion misconstrues the CIGNA Agreement's plain language.

Specifically, the relevant portion of the CIGNA Agreement's arbitration clause states, "Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement." This unequivocal arbitration provision is not altered by any other language in the CIGNA Agreement. The CIGNA Agreement further clarifies, however, "that the arbitrator shall be without power to conduct an arbitration on a class basis." (R. 275–76).

As reflected in multiple decisions by the U.S. Supreme Court, this term—common to arbitration clauses—is there to make clear that the parties agree to resolve their disputes through *individual* arbitration and not through class arbitration. That is, the clause reflects 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, misapprehending the significance, purpose and meaning of this common language, the Panel Opinion seeks to read the clause to work the opposite of its intended effect; namely, to

close the door to arbitration when one party elects to allege, or even join, an alleged class action. That is, the Panel Opinion holds that this language, "interpreted in its natural and ordinary sense, prevents Owens from arbitrating his claims" because it "specifically states the arbitration provision does not apply to class actions." (Panel Op. at 12).

To begin with, in no way is that a legitimate interpretation of what the provision says. It says that (1) the parties agree that "[a]rbitration shall be the exclusive remedy for the resolution of disputes arising under the [CIGNA] Agreement" and (2) the parties agree that the arbitrator lacks "power to conduct" any such arbitration "on a class basis." (R. 275–76). To say, as the Panel Opinion does, that the arbitration provision "does not apply to class actions," therefore, gets it exactly backwards. The provision *precludes* class actions, by first requiring *all* disputes (whether styled as an individual or class action) to be arbitrated and by then making clear that those arbitrations cannot proceed on a class basis. The reading advanced by the Panel Opinion, on the other hand, defeats the purpose of the clause and, indeed, one of the fundamental reasons parties agree to arbitrate in the first place. *See Epic Sys.*, 584 U.S. at 508–09. In fact, the United States Supreme Court has gone as far as to hold that similar limitations on arbitration run afoul of the Federal Arbitration Act. *See, generally*, *AT&T Mobility LLC v. Concepcion*, 563 U.S. 333 (2011).

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

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

Defendants urge the Court to look more closely at the pleadings and consider the Rule 12(b)(6) arguments because, among other things they shed light on the ways in which the Panel

Opinion misapprehends the arbitration issue. *See Brown v. Cnty. of Berkeley*, 366 S.C. 354, 362 n.5, 622 S.E.2d 533, 538 n.5 (2005) (allowing review of interlocutory orders when they "are companion to issues that are [immediately] reviewable" by the appellate court). By way of example, a close analysis of whether Plaintiffs in fact stated a claim for tortious interference with a contract would aid the Court's estoppel analysis. "The elements of a cause of action for tortious interference with [a] contract" include, among other things, the wrongdoer's "intentional procurement of [the relevant contract's] breach." *Camp v. Springs Mortg. Corp.*, 310 S.C. 514, 517, 426 S.E.2d 304, 305 (1993). Plaintiffs, however, do not even allege any breach of an alleged contract between themselves and their insurers, much less that Defendants intentionally procured any such breach. Indeed, the only alleged breaches to be found in the Amended Complaint concern the alleged agreements between Defendants and Plaintiffs' insurers, and those breaches are bound to arbitration by virtue of direct benefits estoppel. *See Long*, 453 F.3d at 630. As this example shows, there are legal issues in common between the immediately appealable order on arbitration and the interlocutory order on the motions to dismiss. It thus would serve judicial economy, and aid this Court's understanding of this case, if this Court reheard the Rule 12(b)(6) issues.

Furthermore, addressing the manifest insufficiency of the Plaintiffs' causes of action is necessary in this case to prevent injustice and to provide for judicial economy and efficiency. *Edge v. State Farm Mut. Auto. Ins. Co.*, 366 S.C. 511, 517, 623 S.E.2d 387, 390 (2005) (allowing review of interlocutory orders when "such review would avoid another appeal in the future and potentially narrow the issues for trial (i.e. judicial economy)").[3] Judicial economy and the interests of justice

[3] Defendants moved to compel arbitration as to Plaintiff Owens *and* dismiss the other Plaintiffs' failed claims. When the circuit court denied the arbitration motion, Defendants immediately appealed. Although the case was filed as a unified putative class action, the circuit court refused to stay the case as to the other Plaintiffs. Instead, it pushed the case forward, issuing orders (over Defendants' strenuous objections) certifying a class and even striking Defendants' answers. Thus,

favor the Court's immediate review of the following issues and arguments raised by Defendants regarding the circuit court's error in denying the motions to dismiss: (1) Owens' claims are barred by the statute of limitations because they do not relate back to the filing of the original complaint; (2) Blackwell's claim for unjust enrichment fails because she does not allege that she conferred any benefit to Defendants; (3) Blackwell lacks standing to pursue her claims because she is not an intended third-party beneficiary under the agreement between Mary Black and her health insurer (MedCost); (4) Brooks's claims are governed by the Medicare Act and the law under that Act does not support the claims alleged; (5) Brooks and Owens' claims fail pursuant to the voluntary payment doctrine; and (6) the Amended Complaint does not state facts sufficient to constitute any viable cause of action against CHSPSC or PASI. Defendants incorporate by reference the arguments raised to the Court in support of those arguments in their Briefs and request the Court exercise its discretion to consider the merits of each of those arguments on rehearing.

Failure of this Court to exercise its clear authority to address now the errors in the circuit court's denial of the motions to dismiss is not in the interest of justice or judicial economy and efficiency. Moreover, addressing now the motions to dismiss would aid the Court in the understanding and resolution of the direct benefits estoppel issue material to the analysis of the arbitration issue.

CONCLUSION

For the foregoing reasons, Defendants respectfully request that this Court rehear this matter by panel or *en banc*.

s/James Lynn Werner
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Defendants are effectively prevented from addressing the merits of these defenses with, in Panel Opinion's words, the "benefit of further factual development." (Panel Op. at 12).

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October 18, 2024
Columbia, South Carolina

RECEIVED
Oct 18 2024
SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

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

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

Respondents,

v.

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

Appellants,

PROOF OF SERVICE

The undersigned hereby certifies that on October 18, 2024, a copy of Appellants' Petition for Rehearing and Suggestions for Rehearing En Banc was served on all counsel of record via email containing the above referenced document to counsels' individual AIS email addresses as follows:

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INTRODUCTION

Incorporating all arguments and statements contained within their Final Brief, Respondents Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr. (collectively, "Insureds") hereby submit this Return pursuant to the Court's request. Because Appellants Mary Black Health System, LLC d/b/a Mary Black Memorial Hospital, CHSPSC, LLC, and Professional Account Services, Inc. (collectively, "Providers") have failed to identify anything the Court overlooked or misapprehended in its opinion, *Blackwell v. Mary Black Health Sys., LLC*, Op. No. 6088 (S.C. Ct. App. filed Sept. 18, 2024) ("*Blackwell* opinion"), the Petition for Rehearing and Suggestion for Rehearing *en banc* should be denied.

At heart, Providers ask this Court to ignore the allegations of the operative complaint in order to reach a different conclusion and compel Mr. Owens to arbitration, mixing proverbial "apples and oranges" in a strained attempt to marry the decision in *this* case with the same panel's decision in an entirely different case.[1] But Providers' arguments are without merit and are legally incorrect. The opinion in this case and the *Bennett* opinion are neither inconsistent nor irreconcilable, and the record does not support Providers' argument that the complaints at issue concern "virtually identical allegations."

In the *Blackwell* opinion, a majority of the panel properly affirmed the lower court's denial of the motion to compel arbitration against Mr. Owens, a CIGNA insured. Mr. Owens was not a party to Mary Black's hospital services contract with CIGNA ("the CIGNA Agreement"), his claims do not fall within the terms or scope of the agreement's arbitration provision, and there was no evidence in the record that he ever relied on the CIGNA Agreement or received any benefit

[1] *Bennett v. ACS Primary Care Physicians-Se. P.C.*, Op. No. 6089 (S.C. Ct. App. filed Sept. 18, 2024) (*remittitur*) (hereafter "the *Bennett* opinion").

therefrom.[2] Indeed, despite Providers' argument to the contrary, the facts are the facts and the pleadings are the pleadings—the allegations in the Amended Complaint ("Complaint") do not assert that Mr. Owens's claims arise solely from the CIGNA Agreement, nor does the Complaint contain a breach of contract claim alleging that Mary Black breached its contract with CIGNA.[3]

For these reasons, the Petition for Rehearing should be denied, and the Court should similarly decline the suggestion for rehearing *en banc*. Consideration by the full court is not necessary "to secure or maintain uniformity of its decisions," and these proceedings do not involve questions of "exceptional importance." Rule 219(a), SCACR. Instead, the *Blackwell* opinion (and the *Bennett opinion*, for that matter) both address a scenario regularly reviewed by South Carolina appellate courts: a non-signatory to an arbitration agreement brings a lawsuit that relates, however tangentially, to a contract containing an arbitration agreement and a motion to compel the non-signatory to arbitration is filed; following the denial of the motion to compel, along with the denial of various Rule 12 motions to dismiss, an appeal follows from both the denial of the motion to compel and the admittedly interlocutory orders denying the Rule 12 motions. Since the Court thoughtfully and thoroughly considered and rejected the issues presented by Providers in their appeal, the Petition for Rehearing should be denied.

ARGUMENT

The appellate courts grant petitions for rehearing to correct points that the court "overlooked or misapprehended." Rule 221(a), SCRCP. But the purpose of a rehearing petition is not to address

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[2] In fact, the evidence is that Mr. Owens did not even know of the CIGNA Agreement's existence.

[3] As the panel explained in the *Bennett* opinion, the operative complaints at issue in *Bennett* contained such a cause of action and alleged that plaintiffs were third-party beneficiaries of the hospital's participating provider agreements with the insurance companies, in addition to asserting that those plaintiffs received direct benefits from the provider agreements. (*See Bennett* Op. at 3, 5–6, 8.)

"points the lawyers of losing parties overlooked themselves" or to permit "the case [to be] tried in the Court of Appeals a second time." *Checker Yellow Cab Co. v. Checker Cab & Parcel Serv., Inc.*, 287 S.C. 608, 612, 340 S.E.2d 549, 552 (Ct. App. 1986); *see also Kennedy v. S.C. Ret. Sys.*, 349 S.C. 531, 532, 564 S.E.2d 322, 322 (2001) (same). Additionally, hearing an appeal *en banc* is disfavored, and the Court of Appeals ordinarily does not exercise its discretion to accept rehearing *en banc* unless "consideration by the full court is necessary to secure or maintain uniformity of its decisions" or the appeal "involves a question of exceptional importance." Rule 219(a), SCRCP; *see Williamston v. Middleton*, 383 S.C. 490, 494, 681 S.E.2d 867, 869 (2009). The Court did not make a mistake in the *Blackwell* opinion by affirming the trial court's denial of Providers' motion to compel arbitration and declining to review the denial of their Rule 12 motions. The *Blackwell* opinion likewise can be reconciled with the Court's decision in the *Bennett* case, and this appeal does not present a "question of exceptional importance" that would require rehearing *en banc*. The Court should deny Appellants' Petition for Rehearing and Suggestion for Rehearing *En Banc*.

I. The *Blackwell* Opinion did not overlook or disregard any material fact or legal principle in affirming the denial of Providers' motions.

Providers seek rehearing in an effort to overturn the *Blackwell* opinion and the majority's reasoning therein, in effect urging the evisceration of a long line of cases addressing the equitable estoppel doctrine in the arbitration context. *See Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 733 S.E.2d 597 (Ct. App. 2012); *Wilson v. Willis*, 426 S.C. 337, 827 S.E.2d 167 (2019); *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 847 S.E.2d 268 (Ct. App. 2020). The Court should reject such an attempt and deny the Petition.

As an initial matter, these arguments were previously raised by Providers and rejected by

a majority of the *Blackwell* panel and therefore do not constitute a valid basis for rehearing.[4] (*See Blackwell* Op. at 8–10). Here, the Complaint asserts three causes of action against Providers: tortious interference with contract (specifically, Plaintiffs' individual health insurance policies); unjust enrichment; and injunctive relief. "The character of an action is primarily determined by the allegations contained in the complaint." *Stoneledge at Lake Keowee Owners' Ass'n v. Clear View Constr., LLC*, 413 S.C. 615, 620, 776 S.E.2d 426, 429 (Ct. App. 2015) (internal quotation marks omitted). Providers urge this Court to adopt the dissent's reasoning to hold that because Mr. Owens's claims relate to or arguably would not have arisen "but for" the CIGNA Agreement's existence, direct benefits estoppel requires arbitration of his claims. In so doing, Providers effectively seek the Court's reversal of *Weaver v. Brookdale Senior Living* (and the cases cited therein) and ask the Court to recharacterize Owens's claims as breach of contract claims and write in third-party beneficiary allegations where none exist.

Providers insist that "Plaintiffs' claims [are], at root, that Defendants should be held to the terms of their contracts Plaintiffs' health insurance carriers" and that the contractual discounts

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[4] In the Final Brief of Appellants, Providers asserted (wrongly) that Mr. Owens "seeks to enforce the terms of a contract between the hospital and his insurance carrier as a non-signatory, third-party beneficiary of that contract," and that "his claims all involve his effort to enforce terms of [the CIGNA agreement] and to derive direct benefit therefrom." (App. Br. 6, 12). While the panel found that the claim for injunctive relief—i.e., Mr. Owens's attempt to stop Providers from continuing its "refusal to bill" policy and extorting money from patients other than himself—did rely upon the CIGNA agreement, the panel also found that his other claims arose from his own health insurance policy with CIGNA. (*Blackwell* Op. at 9). Mr. Owens and the other plaintiffs allege that they had a valid business expectancy and/or contractual relationship with their own health insurance providers, which Providers intentionally and improperly interfered with by preventing them from receiving the benefit of those relationships. (*See* R. pp. 75–76 (Am. Compl. at ¶¶ 64–74)). Put another way, Insureds allege that they paid premiums for health insurance policies but received no benefits therefrom because Providers intentionally interfered with the policies in an effort to obtain greater compensation for services rendered from the insureds directly—a practice referred to as Providers' "refusal to bill" policy. As noted at oral argument, this practice did in fact result in Providers making more money than they would have obtained from submitting Insureds' medical bills to their health insurance carriers.

contained in the providers' agreements with various insurance carriers "*is* the benefit Plaintiffs seek in the litigation." (Pet. at 9). In fact, such assertions are untrue, misleading, and invite the Court to disregard the allegations in the Complaint. What the Insureds want are the benefits accorded to them under their own health insurance policies, for which they have paid premiums and received promises in return.[5] The Complaint clearly sets out these allegations, and the majority of the panel properly relied on them in reaching its decision. (*See* R. pp. 64, 73, 75–76 (Am. Compl. at ¶¶ 5–8, 57(e)–(g), 63–74)). The Court thus correctly affirmed the lower court, noting that Mr. Owens received no benefit from the CIGNA Agreement and never availed himself of the Agreement.

Having affirmed the order denying Providers' motion to compel Mr. Owens to arbitration, the panel properly declined to address the denial of their Rule 12(b)(6) motions. Providers' argument, at its core, seeks to do away with the traditional role of the trial court and overturn long-standing precedent by asking this Court not only to ignore the operative complaint when considering motions to compel arbitration, but also when considering Rule 12 motions. In essence, Providers seek to displace the role of by the trial court by "leapfrogging" over the trial court to obtain appellate review of an unappealable, interlocutory order. The panel correctly declined to endorse such an approach. (*See Blackwell* Op. at 11 (declining to address the denial of Providers' Rule 12(b)(6) motions)). *Cf. S.C. Baptist Hosp. v. S.C. Dep't of Health & Env't Control*, 291 S.C.

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[5] Providers focus on the discounted rates for services rendered, as established by their contracts with health insurance carriers, but they utterly neglect to acknowledge that Insureds are seeking and allege that they are entitled to have their hospital bills submitted to their health insurance carrier *regardless of the outcome*. This myopic focus on the purported discounts contained in the CIGNA Agreement, instead of on the "refusal to bill" policy which Insureds contend represents a practice better known as extortion, reflects Providers' continued attempts to distract from the business practice at issue, which they contend represents the "mere assertion of a lien," App. Br. 27, and fail to recognize the practical implications of the practice. *See e.g.*, Rule 1.15(e), RPC, Rule 407 SCACR.

267, 353 S.E.2d 277 (1987) (declining to consider interlocutory appeal when the decision-maker has not yet had an opportunity to decide the merits of the case and consideration by the appellate court would be premature); *Berkeley Cnty. Sch. Dist. v. Hub Int'l Ltd.*, 944 F.3d 225, 233 (4th Cir. 2019) (in reviewing denial of motion to compel arbitration, court must accept as true the allegations of the operative complaint that relate to the "underlying dispute between the parties"); *Justice v. The Pantry*, 335 S.C. 572, 576, 518 S.E.2d 40, 42 (1999) (reiterating requirement that "[t]he trial court and this [C]ourt on appeal must presume all well pled facts to be true" and acknowledging "[t]he grant of a motion to dismiss for failure to state facts sufficient to constitute a cause of action cannot be upheld if facts alleged in the complaint and inferences reasonably deducible therefore, if proven, would entitle the plaintiff to relief on any theory of the case" (quoting *Morrow Crane Co. v. T.R. Tucker Constr. Co.*, 293 S.C. 427, 429, 373 S.E.2d 701, 702 (Ct. App. 1988))).

II. The *Blackwell* Opinion does not conflict with the decision in the *Bennett* case.

The Court's decision in the *Bennett* case held that the plaintiff-insureds were equitably estopped from avoiding arbitration provisions in provider agreements between their health insurance and healthcare providers, but that decision and the *Blackwell* opinion can be reconciled. (*See Bennett* Op. at 9.) The opinion in *Bennett* held that equitable estoppel applied because the plaintiffs' allegations established that their claims for relief all arose solely from the provider agreements. (*See, e.g., id.* at 6 ("Bennett pled all of her claims as being based on an alleged duty arising *solely* from the terms of the Provider Agreement."); *id.* at 7 ("[A]ll of Gasser's claims were pled as being based on an alleged duty arising *solely* from the Provider Agreement.")). Additionally, the Court concluded that the plaintiffs were equitably estopped because of "admissions in their respective complaints that they received direct benefits from the Provider Agreements preclude them from avoiding the arbitration provisions in these agreements." (*Id.* at 9). Thus, just like the *Blackwell* opinion, the Court reached its decision in

the *Bennett* case after thoroughly analyzing the allegations in the plaintiffs' complaints. (*See id.* at 2, 6–7, 9).

That the decision in *Bennett* reached a different conclusion about the application of the equitable estoppel doctrine than the *Blackwell* opinion under similar facts does not mean that the decisions conflict or cannot be reconciled. The different outcomes result from differences in how the plaintiffs framed their cases in the pleadings, and it is well established that plaintiffs are the "architects of their own complaint." *Morrow v. Fundamental Long-Term Care Holdings, LLC*, 412 S.C. 534, 773 S.E.2d 144, 146 (2015); *see also Damico v. Lennar Carolinas, LLC*, 437 S.C. 596, 615, 879 S.E.2d 746, 757 (2022) ("[T]he plaintiff is the master of his own complaint . . . ."). Further, equitable estoppel is an equitable doctrine "designed to prevent injustice," and its application depends on the circumstances and equitable considerations, even in the arbitration context. *Wilson v. Willis*, 426 S.C. 326, 345, 827 S.E.2d 167, 177 (2019). Because of this, courts that have addressed the doctrine in reviewing arbitration orders unsurprisingly have reached different conclusions about its application based on the facts and the claims set forth in the pleadings. *See id.* at 342–45, 827 S.E.2d at 176–77; *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 230–32, 847 S.E.2d 268, 272–73 (Ct. App. 2020); *Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 296–97, 733 S.E.2d 597, 605 (Ct. App. 2012).

Although Providers argue that *Blackwell* and *Bennett* have the same "core allegations," they cherry pick allegations from the complaints and ignore that here (unlike in *Bennett*) Mr. Owens did not allege he benefited from the CIGNA Agreement, and his claims do not arise *solely* from that contract. (*Blackwell* Op. at 8; *see Bennett* Op. at 7.) Instead, the Complaint alleges that Providers' challenged business practice deprived the plaintiffs of the benefit of

their own insurance contracts and alleges claims arising out of South Carolina tort law. (*See Blackwell* Op. at 8–9; R. p. 75–76). That Providers disagree with the conclusion reached in this case does not mean the decisions are "conflicting and irreconcilable" or that they have created "an immediate conflict in the law of equitable estoppel." Courts addressing the doctrine in future cases are well-equipped to conduct the circumstance-specific analysis that was performed in both *Blackwell* and *Bennett*. This Court should decline Providers' hyperbolic attempt to create a conflict where none in fact exists.

III. This appeal does not present any exceptional or significant issues that the Court should address *en banc*.

A. Unfounded concerns of Artful Pleading and Gamesmanship Do Not Support Rehearing.

Providers' assertions that the *Blackwell* opinion will sow confusion and represent an endorsement of "artful pleading" and "gamesmanship" to avoid arbitration are entirely overblown. The idea that "artful pleading"—i.e., a well-pleaded complaint drafted by able counsel—is a detriment to the practice of law contravenes the long-acknowledged truth that writing well is one of the lawyer's most critical skills. In fact, our courts have long recognized the critical importance of artful pleading, disparaged here by Providers. *Cf. Layne v. Int'l Brotherhood of Elec. Workers*, 271 S.C. 346, 349, 247 S.E.2d 346, 351 (1978) (holding that while the Plaintiff's complaint "*suffers from a lack of artful pleading*," such deficiency would not be viewed as fatal to Plaintiff's claims (emphasis added)); *Dunlap v. Lindau Chems.*, C.A. No. 3:17-cv-0504-CMC-TER (D.S.C. Apr. 26, 2017) (holding that although plaintiff's allegations, originally filed in the Richland County Court of Common Pleas, were "*perhaps not the most artfully pleaded*," they were still sufficient to state a claim for violation of the ADA (emphasis added)).

The allegation that the *Blackwell* opinion will encourage or promote gamesmanship by encouraging future litigants seeking to avoid equitable estoppel "to strategically omit undeniable

allegations from their complaints" and "allege multiple non-arbitrable claims, even if those extra non-arbitrable claims lack merit," (Pet. at 10–12), similarly does not warrant rehearing. The trial courts, not the appellate courts, are best positioned to address gamesmanship in pleadings (and other litigation misconduct), and parties seeking to enforce arbitration provisions have the right to immediately appeal the denial of an arbitration motion.[6]

B. The *Blackwell* Opinion Does Not Misconstrue the Plain Language of the CIGNA Agreement or Conflict with the United States Supreme Court.

In addition to concluding that Mr. Owens's claims did not arise from the CIGNA Agreement, the *Blackwell* Opinion concluded that, "*even if*" they did, the Agreement's plain language prevented Mr. Owens from arbitrating his claims against Providers because it expressly prohibits class-wide arbitration. (*Blackwell* Op. at 10 (emphasis added)). The CIGNA Agreement supports this interpretation.

The CIGNA Agreement's dispute resolution provisions apply to "disputes between the parties arising with respect to the performance or interpretation of the Agreement," and the parties to the Agreement were CIGNA insurance and Mary Black Hospital. (R. p. 275; *see id.* at 263–64). Mr. Owens and other CIGNA insureds who received medical treatment at Mary Black Hospital, however, were not parties to the Agreement. Instead, these individuals fall within the Agreement's definition of "Participant"—"any individual . . . who is eligible and enrolled to receive Covered Services." (R. p. 264.) While the Agreement does not define "party" or "parties," the usual, ordinary meaning is "[o]ne who takes part in a transaction." *Party*, *Black's Law Dictionary* (11th ed. 2019); *see Arredondo v. SNH SE Ashley River Tenant, LLC*, 433 S.C. 69, 79, 81, 856 S.E.2d

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[6] In their Petition, Providers include matters outside the Record on Appeal. (*See* Pet. 14 n.3). To the extent the Court elects to consider these matters, Insureds respectfully submit that the trial court's orders that were entered after Providers filed this appeal provide a comprehensive history of this litigation.

550, 556, 557 (2021) (applying the "plain, ordinary, and popular meaning" to undefined terms in a contract). Further, the dispute resolution provisions repeatedly refer "a party" and "parties," while separately using the defined term "Participant" once. (*See* R. p. 275–76, §§ 6.2.1, 6.2.2). The language used in the Agreement thus indicates an intent not to apply to a non-party "Participant" such as Mr. Owens.

Although the Agreement states that arbitration is "the exclusive remedy for the resolution of disputes arising under this Agreement," it further provides that:

> 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.

(R. p. 276). Interpreting this language and the CIGNA Agreement as a whole, the panel correctly concluded that a non-signatory, non-party to the Agreement could not arbitrate his claims. *See generally Silver v. Aabstract Pools & Spas, Inc.*, 376 S.C. 585, 591, 658 S.E.2d 539, 542 (Ct. App. 2008) ("[T]he court must consider the contract as a whole, rather than deciding whether phrases in isolation could be interpreted in various ways . . . . [T]he intention of the parties and the meaning are gathered primarily from the contents of the writing itself, or, as otherwise stated, from the four corners of the instrument . . . .").

Further, the Panel's contractual interpretation of the language and provisions in the CIGNA Agreement does not conflict with the U.S. Supreme Court's opinion in *Epic Systems Corp. v. Lewis*, 584 U.S. 497 (2018). The *Epic* case is easily distinguishable because it involved claims brought by employees (individually and on behalf of others similarly situated), and the employees were signatories to agreements with their employers that contained arbitration provisions. *See id.* at 502–03. Here, in contrast, Mr. Owens did not sign or know about the CIGNA Agreement, and he did not have an employer/employee relationship with Providers. While parties to an agreement

can certainly agree to resolve their disputes through individual arbitration, Providers are incorrect that *Epic* required the Panel to conclude that a non-signatory, non-party had waived his right to bring claims on a class basis.

CONCLUSION

Providers' petition does not establish that the *Blackwell* opinion overlooked or misapprehended any important fact or legal principle, and the different conclusions reached in *Blackwell* and *Bennett* result from differences in how those cases were pled. The Court should neither rehear this matter nor accept Providers' suggestion for *en banc* review to address issues that should be handled by the trial courts.

Respectfully submitted,

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Dated: December 16, 2024

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Dec 16 2024
SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas
J. Mark Hayes, II, Circuit Court Judge

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

Appellate Case No. 2020-001613

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

v.

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

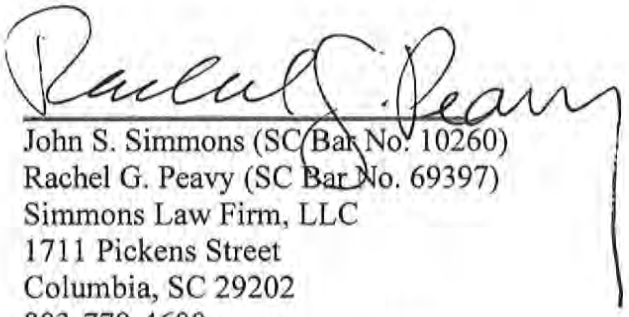
PROOF OF SERVICE

The undersigned hereby certifies that on December 16, 2024, Respondents' *Return to Petition for Rehearing* was served on all counsel of record via email containing the above referenced document to counsels' individual AIS email addresses as follows:

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December 16, 2024
Columbia, South Carolina

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Dec 23 2024
SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

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

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

Respondents,

v.

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

Appellants,

APPELLANTS' REPLY TO RETURN IN OPPOSITION TO THE PETITION FOR REHEARING

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Appellants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital ("Mary Black"); CHSPSC, LLC; and Professional Account Services, Inc. (collectively, "Defendants") submit this Reply to the Plaintiffs' Return to the Petition for Rehearing.

I. The Panel Opinion directly conflicts with, and cannot be reconciled with, *Bennett.*

Both *Bennett* and this case deal with materially similar issues, allegations, and facts about whether plaintiffs should be compelled to arbitration. *See Bennett v. ACS Primary Care Physicians-Se. P.C.*, 444 S.C. 458, 488, 908 S.E.2d 110, 126 (Ct. App. 2024). As explained in Defendants' Petition for Rehearing, these decisions cannot be reconciled and will lead to inequitable results, sow confusion in the law of equitable estoppel and arbitration, and encourage procedural gamesmanship.

In their Return, Plaintiffs concede that the two cases have "similar facts" and, indeed, appear to agree that the cases even have the same "'core allegations.'" [Return at 8]. But they continue to assert that the cases can be distinguished, as suggested by the majority in the Panel Opinion and in the concurrence in *Bennett*, on the basis that compelling arbitration in *Bennett* was required because (1) the plaintiffs in that case expressly asserted that they were third-party beneficiaries of the Provider Agreement at issue; and (2) the plaintiffs' breach of contract or breach of implied contract and unjust enrichment claims in that case arose solely from the Provider Agreement. *Id.* at 7–8. As explained in Defendants' Petition, however, these supposed distinctions fall apart when one reviews the operative allegations in the two cases.

Here, just like in *Bennett*, Plaintiffs sued their healthcare provider because the provider did not bill their health insurers directly and, relatedly, because the provider did not bill the discounted rates as agreed to between the insurers and provider. Thus, the core issues in this case and *Bennett* are the same:

1. From what source does any duty arise for the Defendants to bill the health insurer directly for the medical services rendered to the Plaintiffs?; and

2. From what source does the duty arise for those services to be billed at discounted rates as agreed to between the Defendants and those health insurers?

The answers to those questions are provided by Plaintiffs themselves in the Amended Complaint and in other overt representations made to the courts in this litigation.

A. Plaintiffs' Amended Complaint alleges that Defendants' duty to bill the health insurer directly arises from the Defendants' contracts.

In the Amended Complaint, each of the Plaintiffs allege that they are aggrieved, and are entitled to damages, because Defendants did not directly bill their health insurers for the services rendered by Mary Black Hospital, and thus Plaintiffs allegedly failed to receive the discounted rates agreed to between the Defendants and those insurers. (R. 65 ¶ 9; *see also id.* ¶ 31, 57(a)). In Paragraph 28 of their Amended Complaint, for example, each Plaintiff alleges:

> Defendants are required **by their contracts with patients' health insurance carriers** to submit insurance patients' medical bills directly to the carriers.

(R. 68) (emphasis added). In Paragraph 29 of their Amended Complaint each Plaintiff alleges:

> 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.

(R.68) (emphasis added). Further, in Paragraph 31 of their Amended Complaint each Plaintiff reiterates the allegation:

> Defendants **have contracts with health insurance providers and health plans for reduced compensation** for treating patients who have health insurance.

(R. 68) (emphasis added).

Aside from these allegations of a *contractual* duty running from Defendants to Plaintiffs' insurers, there are no allegations in the Amended Complaint that the duties to bill the health insurer directly, or to bill and accept discounted rates, arise from any source. There are no allegations that such duties arise from the patients' health insurance policies (between themselves and their respective insurer) or by operation of law.[1]

In short, as in *Bennett*, Plaintiffs' claims here arise solely from the terms of the Agreements between Mary Black Hospital and their health insurers (CIGNA for Owens). Their artful pleading to try to obfuscate the nature of their claims changes nothing.

B. Plaintiffs conceded that their case is premised on the allegation that they are third-party beneficiaries to their insurers' contracts with Defendants.

The concurring opinion in *Bennett* stressed that the plaintiffs there were "required to arbitrate" because they "expressly asserted that they were third-party beneficiaries" of their insurers' agreements with the defendant providers. Notably, Plaintiffs do not discuss this point in their Return. Nor could they, as Plaintiffs admitted—and in fact argued—to the circuit court that they were third-party beneficiaries of the agreements between their insurers and the provider.

As Plaintiffs proposed in their Return, reviews of prior proceedings in the case and prior orders issued by the Circuit Court reveal important truths about this case and the underlying basis and purpose of the Plaintiffs' claims. In fact, in the Plaintiffs' Motion to the Circuit Court to certify the alleged class, the Plaintiffs expressly represented to the Circuit Court:

> **The plaintiffs' contend that they are third-party beneficiaries of the agreements between their insurance companies and Mary Black** . . . .

[1] In fact, such duties do not arise by operation of law. *See Wogan v. Kunze,* 366 S.C. 583, 605, 623 S.E.2d 107, 119 (Ct. App. 2005), *affd as modified*, 379 S.C. 581, 666 S.E.2d 901 (2008); *Beverly v. Grand Strand Reg'l Med. Ctr., LLC*, 429 S.C. 502, 514, 839 S.E.2d 468, 474 (Ct. App. 2020), *aff'd,* 435 S.C. 594, 869 S.E.2d 812 (2022).

(emphasis added). When asked by the Circuit Court to submit a proposed order certifying the class, Plaintiffs submitted a proposed order with the exact same language set forth above. And, the Circuit Court entered the order certifying the class using the exact same language set forth above as proposed by the Plaintiffs.[2]

Thus, the allegations in the Amended Complaint in this case and in those other express representations by Plaintiffs to the Circuit Court, reflect that the distinction attempted in the concurring opinion in *Bennett* is inapplicable. In fact, the total Record reveals that the operative facts in this case and *Bennett* are not distinguishable—they are the same. Just as those facts required an order compelling arbitration in *Bennett*, so to do they require such an order in this case. Plaintiffs claim third-party beneficiary status under the Agreements between Mary Black Hospital and the health insurers, and they plainly sought to enforce provisions of those Agreements to their direct benefit. As such, Owens must be compelled to arbitrate his claims against Defendants.

II. The argument that Owens and the other Plaintiffs received no benefit from the Agreement between the Hospital and their insurers and, therefore, should not be bound to the terms of such Agreement is unavailing.

In their Return, Plaintiffs argue that they received no benefit from the Agreements between Mary Black and their health insurers, and that they did not avail themselves of those Agreements and, therefore, should not be bound by the terms of the Agreements between Mary Black and their health insurers. The question, however, is not whether Plaintiffs already received the benefits

[2] For the Court's convenience, Defendants provide the Circuit Court's order as an exhibit. The Circuit Court's November 1, 2022 order granting Plaintiffs' motion for class certification is one of the orders included in the Notice of Appeals filed by Defendants in Appellate Case No. 2024-001546. The Court can take judicial notice of its own records, files and proceedings for all proper purposes. *Freeman v. McBee*, 280 S.C. 490, 494, 313 S.E.2d 325, 327 (Ct. App. 1984); *see also Sloan v. Greenville Cnty.*, 380 S.C. 528, 537, 670 S.E.2d 663, 668 (Ct. App. 2009) (taking judicial notice of issues pending in related subsequent appeals between the same parties).

under the Agreements between Mary Black Hospital and their health insurers.[3] The relevant inquiry is whether they are suing to secure or obtain such benefits.

In this case, it is plain from their Amended Complaint that Plaintiffs filed this action to obtain benefits from, and to enforce the terms of, the Agreements between the Defendants and the health insurers. The essence of the lawsuit and Plaintiffs' claims is that they are suing to enforce rights or duties arising solely from the Hospital/Insurer Agreements, including the duties to submit the bills for the patients' care directly to the health insurers and to bill and collect for that care at the discounted rates. Therefore, as parties seeking to take benefits they allege not to have received from those agreements, the Plaintiffs (Owens in particular) are bound by all the terms of the Agreements they are attempting to enforce—including the arbitration provision in the CIGNA Agreement.

III. Owens's purported lack of knowledge of the CIGNA Agreement is inconsistent with the allegations of the Amended Complaint and does not change the fact that he brought an action to enforce its terms.

Plaintiffs argue, in Footnote 2 of their Return, that Plaintiff Owens "did not even know of the CIGNA Agreement's existence." This contention directly contradicts Paragraph 28 of his Amended Complaint, in which Owens alleges: "Defendants are required by their contracts with patients' [Owens's] health insurance carriers to submit insurance patients' [Owens's] medical bills directly to the carriers." (R. 68). If Owens did not know of the existence of the CIGNA Agreement, he could not have asserted the allegations, as he did, in Paragraph 28 of his Amended Complaint. Just as the Court recognized in *Bennett,* the insureds knew about the provider agreements when they filed their complaints seeking to enforce them. Plaintiffs' argument to the contrary should be disregarded.

[3] Parties ordinarily do not sue to obtain benefits they already received.

IV. The CIGNA Agreement's bar to class arbitration does not render Owens's claims against Defendants outside the scope of disputes that must be compelled to arbitration pursuant to that Agreement.

The CIGNA Agreement mandates in no uncertain terms that "Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement." The scope of the arbitration obligation is all disputes; an attempt to conclude otherwise would be to impermissibly rewrite the Agreement. Owens claimed a dispute about the duty to bill the insurer directly and to accept discounted charges in accordance with the Agreement and he must arbitrate his dispute.

In other cases where plaintiffs attempted Owens's argument (tried to convert a class action waiver into a limitation on the scope of the arbitration provision), courts have rejected it. Those courts recognized that the individual plaintiff was bound, and must be compelled, to arbitrate his/her claims and he simply could not pursue class claims in that dispute resolution. *See Bouskous v. J.P. Morgan Chase Bank, N.A.*, 2020 WL 8483909, at *5 (E.D. Cal. Dec. 21, 2020); *Holman v. Bath & Body Works, LLC*, 2021 WL 5826468, at *9 (E.D. Cal. Dec. 8, 2021), *report and recommendation adopted*, 2022 WL 463298 (E.D. Cal. Feb. 15, 2022). The courts in *Bouskous* and *Holman* reviewed and rejected the argument that an arbitration provision that bars an arbitrator from hearing class claims limits the scope of his duty to arbitrate and places even his individual claims outside the scope of an arbitration provision. In fact, the court in *Bouskous* concluded that the plaintiff's arguments that the class action wavier placed the plaintiff's claims outside the scope of the arbitration agreement was not plausible and noted that the class action / collective action waiver provision at issue simply prohibited one from bringing claims on behalf of a class in arbitration and, therefore, the plaintiff was required to arbitrate his claims individually. *Bouskous*, at *4.

Moreover, it is perfectly acceptable and enforceable for the Agreement to clarify that Owens may not consolidate his dispute with others and that the arbitration may not be conducted

as a class claim. *See AT&T Mobility LLC v. Concepcion*, 563 U.S. 333, 336 (2011). In fact, the United States Supreme Court holds that class arbitration is not permissible unless the arbitration agreement specifically and expressly states that the arbitration may be conducted on a class-wide basis. *Lamps Plus, Inc. v. Varela*, 587 U.S. 176, 187–88 (2019); *Stolt-Nielsen S.A. v. AnimalFeeds Int'l Corp.*, 559 U.S. 662, 684 (2010). The arbitration provisions in the CIGNA Agreement do not authorize class claim arbitration.

CONCLUSION

For the foregoing reasons, Defendants respectfully request that this Court rehear this matter by panel or *en banc*.

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December 23, 2024
Columbia, South Carolina

ELECTRONICALLY FILED - 2022 Nov 01 3:10 PM - SPARTANBURG - COMMON PLEAS - CASE#2017CP4200219

STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

IN THE COURT OF COMMON PLEAS
SEVENTH JUDICIAL CIRCUIT

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

Plaintiffs,

v.

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

Defendants.

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

ORDER

CERTIFYING CLASS

RECEIVED
Sep 16 2024
SC Court of Appeals

This matter came before the Court on motion of Plaintiffs Jo Ann Blackwell and Michelene Brooks, individually and on behalf of all others similarly-situated, to certify a class action pursuant to Rule 23, SCRCP. A hearing was held on September 12, 2022, at the Spartanburg County Courthouse. Present at the hearing were Marghretta H. Shisko and Rachel G. Peavy, appearing as counsel for the Plaintiffs, and attorneys James L. Werner and Katon Dawson appearing for the Defendants. After careful and thorough review of the briefing, argument, and applicable law, the Court hereby finds that this case is suitable for class action treatment and hereby certifies a class consistent with the definition set forth herein.

Factual Background

This lawsuit arises from allegations that the Defendants, a hospital and related billing/collection entities (at times collectively referred to as "the Hospital"), engaged in "unlawful, unfair, and predatory and billing practices." (Am. Compl. ¶ 1.) These practices involved the Defendants' routine refusal to submit medical bills to certain patients' insurance carriers if the Hospital's

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screening identified the patients as ones for whom third-party recovery might be available to pay for such treatment—usually, a patient who was treated following a motor vehicle collision. Plaintiffs allege that the Hospital engaged in this wrongful and predatory practice in order to collect more money than what they might have received from the patients' insurance. (*See id.* ¶¶ 4–8.) The plaintiffs, individually and on behalf of the class members, are asserting causes of action for tortious interference with contractual relationships, unjust enrichment, and injunctive relief.

The plaintiffs contend that they are third-party beneficiaries of the agreements between their insurance companies and Mary Black, and that the defendants interfered with the plaintiffs' own relationships with their insurance companies by attempting to collect payments from the plaintiffs at a higher amount than what the Hospital contracted for with the insurance companies. (*See id.* ¶ 57.) Each of the named plaintiffs—Jo Ann Blackwell, Micheline Brooks, and Samuel Owens—is an accident victim who received treatment at Mary Black Hospital, but the defendants impermissibly attempted to collect payment from the plaintiffs directly or from their third-party tort recoveries. (*See id.* ¶¶ 35–52.) These named plaintiffs are seeking to represent a class of patients whose medical bills were not submitted to their health insurance for payment. (*See id.* ¶¶ 21, 53.)

According to the Hospital, it collected an estimated $1,816,454.85 for treatment and services rendered to approximately 1,538 patients at Mary Black Hospital during the relevant period.[1] This amount is for medical bills that the Hospital did not submit to the patient's insurance carrier,

[1] This "approximate" number of 1,538 was provided by Mary Black in its supplemental responses to Plaintiffs' second set of interrogatories. Given the Hospital's ongoing discovery obligations in this case, to the extent that it identifies additional patients treated during the relevant time period at its facilities (i.e., locations in both Spartanburg, South Carolina and Gaffney, South Carolina), the Court directs the Hospital to supplement and amend its discovery responses in accordance with the South Carolina Rules of Civil Procedure and pursuant to the Court's prior orders and directives.

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which totaled approximately $7,199,837.54.[2] The amount that the Hospital estimated it would have received if it had properly billed those patients' insurance carriers was $990,349.66. Accordingly, the Hospital received nearly 100% in additional profits from the business practice challenged by the plaintiffs.

Procedural History

Plaintiff Jo Ann Blackwell originally filed this case as the only named plaintiff on January 20, 2017, suing the defendants individually and on behalf of all other individuals who were patients at Mary Black Hospital or any other facility in South Carolina "owned or affiliated with Defendant Community Health Systems" following a motor vehicle accident and who had health insurance at the time of treatment. (Original Compl. ¶ 41.) Plaintiff served discovery on the defendants on September 8, 2017. Later, additional named plaintiffs affected by Mary Black's policy sought to join the lawsuit, and the plaintiffs filed a motion to amend the complaint to add new named plaintiffs to represent the class on October 18, 2019. The Court entered an Order Granting Plaintiffs' Motion for Leave to Amend the Complaint on April 23, 2020, and the plaintiffs filed the amended complaint the following day.

On June 8, 2020, the defendants moved to dismiss the amended complaint or, in the alternative, to stay and compel arbitration as to Plaintiff Owens. The Court entered an order denying the defendants' motions on September 4, 2020, and thereafter denied the defendants' motions to alter or amend. The defendants then filed a Notice of Appeal on December 8, 2020, appealing the Court's order denying Defendants Motion to Dismiss or in the Alternative to Stay and Compel

[2] The Hospital has identified in discovery at least 14 insurance carriers (plus related affiliates and/or subsidiaries) with whom it had agreements to promptly submit claims for payment.

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Arbitration. During this time period, Plaintiffs also filed motions to compel responses to the discovery served in 2017.

After filing the notice of appeal, the defendants asserted that the entire case was stayed during the pendency of the appeal, and they opposed the plaintiffs' efforts to conduct discovery with respect to the class as a whole. The Court entered an Order, dated July 6, 2021, finding that "while the claims of Mr. Owens—both individually and on behalf of the putative class of CIGNA insureds—are stayed pending the appeal of the denial of Defendants' motion to compel arbitration against him, the claims of Ms. Brooks and Blackwell are not affected by such appeal and may proceed." (Order 4–5.) On November 23, 2021, the Court entered an Order on Plaintiffs' Motion to Compel, finding that the plaintiffs were entitled to conduct class-wide discovery in the case and that the discovery sought concerning the potential class of affected patients and the defendants' billing policy was not unreasonable, overly broad, or unduly burdensome, nor was it outside the bounds of relevance under South Carolina law. (Order, Nov. 23, 2021.)[3]

Legal Standard

The South Carolina Supreme Court "has expressed the viewpoint that class actions are favored in this state." *Grazia v. S.C. State Plastering, LLC*, 390 S.C. 562, 576, 703 S.E.2d 197, 204 (2010). This is because "[t]he class-action device saves the resources of both the courts and the parties by permitting an issue potentially affecting every [class member] to be litigated in an

[3] The Court believes that the history of discovery in this case—and issues related to the Hospital's conduct regarding same—has been fully addressed in both the November 23 order referenced herein, as well as the Court's recent order of August 2, 2022. As to the Hospital's argument that the certification of a class is somehow premature in light of the Hospital's decision not to pursue discovery pending its appeal of the denial of its motion to compel arbitration as against Mr. Owens, the Court disagrees. *See* July 6, 2021 Order.

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economical fashion under Rule 23." *Id.* (second alteration in original) (quoting *Califano v. Yamasaki*, 442 U.S. 682, 701(1979)).

Rule 23 of the South Carolina Rules of Civil Procedure sets forth the following requirements with respect to class actions in state court:

> One or more members of a class may sue or be sued as representative parties on behalf of all only if the court finds (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, (4) the representative parties will fairly and adequately protect the interests of the class, and (5) in cases in which the relief primarily sought is not injunctive or declaratory with respect to the class as a whole, the amount in controversy exceeds one hundred dollars for each member of the class.

Rule 23(a), SCRCP. "The first four criteria are often referred to as the requirements for numerosity, commonality, typicality and adequacy of representation." *Gardner v. S.C. Dep't of Revenue*, 353 S.C. 1, 21, 577 S.E.2d 190, 200 (2003). The proponents of maintaining a case as a class action "have the burden of proving these prerequisites of class certification have been met." *Waller v. Seabrook Island Prop. Owners Ass'n*, 300 S.C. 465, 467, 388 S.E.2d 799, 801 (1990) (citing *Windham v. Am. Brands, Inc.*, 565 F.2d 59 (4th Cir. 1977)). However, "Rule 23, SCRCP, endorses a more expansive view of class action availability than its federal counterpart." *Grazia*, 390 S.C. at 576, 703 S.E.2d at 204 (quoting *Littlefield v. S.C. Forestry Comm'n*, 337 S.C. 348, 354–55, 523 S.E.2d 781, 784 (1999)).

"It is within a trial court's discretion whether a class should be certified." *Pope v. Heritage Cmtys., Inc.*, 395 S.C. 404, 421, 717 S.E.2d 765, 774 (Ct. App. 2011) (citing *Tilley v. Pacessetter Corp.*, 333 S.C. 33, 42, 508 S.E.2d 16, 21 (1991)); *see also King v. Am. Gen. Fin., Inc.*, 386 S.C. 82, 88, 687 S.E.2d 321, 324 (2009) (same). However, in determining whether to certify a class, a court should "not look to the merits." *King*, 386 S.C. at 88, 508 S.E.2d at 324 (quoting *Tilley*, 333 S.C. at 43, 508 S.E.2d at 21); *see also Knowles v. Standard Sav. & Loan Ass'n*, 274 S.C. 58, 59,

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261 S.E.2d 49, 49 (1979) ("Neither does certification reach the 'merits' of the underlying cause of action . . . .").

Moreover, as this Court has recognized on numerous occasions, during hearings and in its written orders, Rule 23 imposes a special duty on the trial courts in this State to protect the interests of putative class members and provides the courts with authority to protect those interests. For example, "[t]he court may at any time impose such terms as shall fairly and adequately protect the interest of the persons on whose behalf the action is brought or defended." Rule 23(d)(2), SCRCP. Additionally, an order certifying a class "may be conditional, and may be altered or amended before the decision on the merits." Rule 23(d)(1), SCRCP; *see also McGann v. Mungo*, 287 S.C. 561, 570–71, 340 S.E.2d 154, 159 (Ct. App. 1986) ("[T]he circuit court can either require the plaintiffs to plead, redefine the alleged class itself, or designate subclasses.").

Legal Conclusions and Factual Findings

The Court is mindful of the South Carolina Supreme Court's mandate that, upon the filing of a motion for class certification, it is "**incumbent** on the circuit court to determine whether or not the action meets each of the five prerequisites proponents of class certification are required to prove." *Grazia*, 703 S.E.2d at 204 (2010) (emphasis added). "In determining whether the plaintiff has met the requirements of Rule 23, the court is limited to assessing the sufficiency of the allegations within the complaint." *Walbeck v. I'On Company, LLC*, 426 S.C. 494, 511, 827 S.E.2d 348, 357 (Ct. App. 2019), *cert. granted* Mar. 15, 2022.

When examining information presented by plaintiffs seeking to satisfy the requirements of Rule 23(a), the court must apply a "rigorous analysis" to determine whether each prerequisite is satisfied. *Gardner*, 353 S.C. at 21, 577 S.E.2d at 200 (*citing Waller*, 300 S.C. at 467, 388 S.E.2d at 801). The "rigorous analysis" standard cited in *Gardner* and *Waller* derives from a United States

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Supreme Court case, *General Telephone Co. of Southwest v. Falcon*, 457 U.S. 147 (1982). In that case, the Supreme Court noted that "sometimes the issues are plain enough from the pleadings to determine whether the interests of the absent parties are fairly encompassed within the named plaintiff's claim, and sometimes it may be necessary for the court to probe behind the pleadings before coming to rest on the certification question." *Id.* at 160. While *General Telephone* focused on a Title VII class action under federal law, the Court stated that "a Title VII class action, like any other class action, may only be certified if the trial court is satisfied, after a rigorous analysis, that the prerequisites of Rule 23(a) have been satisfied." *Id.* at 161.

Having conducted the requisite "rigorous analysis," the Court hereby concludes that this case meets all elements required for class certification under Rule 23, SCRCP, and thereby certifies the class as:

> All individuals who, since January 1, 2014, received any type of healthcare treatment from any entity located in South Carolina that is owned or affiliated with Defendants, while being covered by valid health insurance other than Cigna, and whose medical bills resulting from that treatment were not submitted to their health insurance carrier for potential payment.

As further explained in detail below, this class[4] satisfies each of the required elements of Rule 23(a), SCRCP, and proceeding with the class mechanism in this case will serve the Rule's goals of finality, efficiency, and economy.

[4] The class definition proposed by the Plaintiffs in their Motion differed slightly from that contained within their amended complaint and prior pleadings. However, the Court, in its discretion, may modify the class definition as required and necessary under the Rules. *See, e.g., McGann*, *supra*. In this case, given the pending appeal as to Mr. Owens (a CIGNA insured), the Court finds it appropriate to carve out the claims of Mr. Owens until such time as a final decision has been rendered by the appellate courts. If the appeal of Plaintiff Owens's claims ends while this case is still pending, the Court can revise the class definition in an amended class certification order consistent with Rule 23(d), SCRCP. The Court respectfully rejects the Defendants' argument that the class is a "moving target" simply because the definition may change over time.

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1. The proposed class satisfies the numerosity requirement.

Rule 23 permits class certification only if "the class is so numerous that joinder of all members is impracticable." Rule 23(a)(1), SCRCP; *see also Salmonsen v. CGD, Inc.*, 377 S.C. 442, 459, 661 S.E.2d 81, 91 (2008) ("Rule 20 joinder and Rule 23 class actions should not co-exist."). "[T]he rationale for allowing a class action is 'to manage litigation involving numerous class members *who would otherwise all have access to court via individual lawsuits*.'" *Farmer v. Monsanto Corp.*, 353 S.C. 553, 558, 579 S.E.2d 325, 328 (2003) (quoting *Worth v. City of Rogers*, 89 S.W.3d 875, 879 (Ark. 2002)); *cf. Arthur v. SunTrust Bank (in re LandAmerica § 1031 Exch. Servs. Inc. IRS § 1031 Tax Deferred Exch. Litig.)*, C.A. No.: 8:09-cv-00415, 2012 WL 13124593, 2012 U.S. Dist. LEXIS 97933, at *16 (D.S.C. July 12, 2012) ("The Court may find the numerosity factor satisfied if the Court concludes it would be difficult, inconvenient, and wasteful to attempt to join more than 400 plaintiffs into one case, using permissive joinder."). A proposed class with 30 members or more will usually satisfy the numerosity requirement. *See Williams v. Henderson*, 129 F. App'x 806, 811 (4th Cir. 2005).

The plaintiffs brought this action alleging, prior to discovery, that "[t]he Class consists of hundreds and perhaps thousands of individual members and is, therefore, so numerous that individual joinder of all members is impractical." (Am. Compl. ¶ 55.) Discovery in this case to date has borne out this allegation— according to the defendants, there are approximately 1,538 patients affected by the defendants' refusal to bill their insurance carriers. These patients are all members of the class who would have otherwise been able to file individual cases against the defendants. Permitting class treatment of these numerous claims is desirable because it permits the claims to be litigated together without burdening the courts and creating the possibility of inconsistent results. Because the proposed class is so numerous that it would be impracticable to join all the

members in a single lawsuit, the Court finds that class treatment here satisfies Rule 23(a)(1), SCRCP.

2. There are common questions of law and fact.

Rule 23 does not impose a stringent commonality requirement. "When the party opposing the class has engaged in some course of conduct that affects a group of persons and gives rise to a cause of action, one or more of the elements of that cause of action will be common to all parties affected." *Newberg on Class Actions* § 3:20 (5th ed.). The South Carolina Court of Appeals has explained that:

> The essence of a class action is common questions of law and fact and Rule 23(a)(2) reflects this. It is important to note that the subsection does not demand that all questions of law and fact be common, only that there be common issues among the class. In fact, a single common issue will suffice if it is important enough. It also follows that the mere existence of individual issues does not defeat class action status.
>
> There is no qualitative or quantitative test in the Rule. Ultimately, commonality is a judgment that the issues are sufficiently similar so that the class action will be a more efficient means of resolving the problem, even though some individual issues may be litigated in any event.

McCann, 287 S.C. at 568, 340 S.E.2d at 157–58. "Though our Rule 23 does not specifically require [that] the common issues 'predominate,' there must be a proper balance between common and individualized issues in order to achieve the efficiencies the class procedure was designed to promote." *Hensley v. S.C. Dep't of Soc. Servs.*, 429 S.C. 144, 152, 838 S.E.2d 510, 514 (2020).

In demonstrating commonality, a movant is not required to prove that "every issue in the case [is] common to all class members." *Gardner*, 353 S.C. at 21, 577 S.E.2d at 200 (quoting *O'Connor v. Boeing N. Am., Inc.*, 184 F.R.D. 311, 329 (C.D. Cal. 1998)). Instead, the proposed class meets the commonality requirement "where the class shares a determinative issue." *Id.* at 21, 577 S.E.2d at 200–01. The presence of "minor factual differences" among the individual class

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members' cases should not prevent class certification where the class members' claims turn on a common dispositive question. *Id.* at 23, 577 S.E.2d at 201; *see also* Newberg § 3.20 ("Because not all questions need be common, the fact that class members must individually demonstrate their right to recover, or that they may suffer varying degrees of injury, will not bar a finding of commonality.").

Here, the Court finds that the Defendants' policy and practice of refusing to bill health insurance impacted every member of the proposed class in a similar manner, such that the Plaintiffs' allegations arise from a common set of facts. The claims of the proposed class members all share significant, common issues, both legal and factual, which bind the proposed class together, and those issues are sufficiently similar in this Court's view such that the class action device is the most efficient means of resolving those claims. The Plaintiffs have alleged claims for tortious interference and unjust enrichment, and the facts needed to establish liability as among all class members will be the same. The Court finds that all of these claims turn on the hospital's knowledge or belief that these patients presented for treatment while covered by health insurance, thereby requiring the hospital to submit the patients' medical bills to insurance—and the Hospital's willful refusal to do so. (*See* Am. Compl. ¶¶ 64–66.)

Although the individual plaintiffs had different insurance and will have suffered different amounts of damages based on the treatment they received at the Hospital and their insurance coverage, the Court concludes that those are "minor factual differences" compared to the overarching, determinative issue of the Hospital's conduct in enacting and implementing this billing policy. Additionally, the Amended Complaint seeks injunctive and declaratory relief that is common to all putative class members. (*See* Am. Compl. ¶¶ 76–83.) Indeed, this Court has previously found that the "evidence to date reveals that the 'failure to bill' implicated multiple carriers and the types

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of damages sustained by patients were *consistent across the board*." (Order, Nov. 23, 2021, at 4 (emphasis added).) The Court thereby finds that the proposed class action satisfies the commonality requirement of Rule 23(a)(2).[5]

3. The claims of the named plaintiffs and the asserted defenses are typical of the class.

To establish typicality, the moving party must demonstrate that "the 'claims or defenses of the representative parties [are] typical of the claims or defenses of the class.'" *Pope*, 395 S.C. at 422, 717 S.E.2d at 774 (quoting Rule 23(a)(3), SCRCP). The requirement of typicality is similar to the commonality requirement. *See Gen. Tel. Co.*, 457 U.S. at 157 n.13 ("The commonality and typicality requirements of Rule 23(a) tend to merge."); *see also Broussard v. Meineke Disc. Muffler Shops*, 155 F.3d 331, 340 (4th Cir. 1998) ("The typicality and commonality requirements . . . ensure that only those plaintiffs or defendants who can advance the same factual and legal arguments may be grouped together as a class." (quoting *Mace v. Van Ru Credit Corp.*, 109 F.3d 338, 341 (7th Cir. 1997)). While commonality focuses on whether the case arises from a common set of facts, the typicality requirement looks at whether those facts present similar claims or defenses across the proposed class. *See Pope*, 395 S.C. at 422, 717 S.E.2d at 774–75.

Here, the Court finds that the claims of the proposed class members and the named plaintiffs all arise from the same practices of the defendants and are based on the same legal theories. The proposed class thus satisfies Rule 23(a)(3)'s typicality requirement. *See generally Gen. Tel.*

[5] The Defendants, in urging the Court to deny the motion for class certification, rely upon the cases of *Wal-Mart Stores, Inc. v. Dukes, et al.*, 564 U.S. 338 (2011), and *MCG Health, Inc. v. Perry, et al.*, 755 S.E.2d 341 (Ga. App. 2014). After careful review of these cases, the Court declines to adopt the Defendants' position. As noted herein, South Carolina's Rule 23 embraces a far more expansive view of the class action mechanism than that provided for under the federal rule applicable in *Wal-Mart*; furthermore, the Court finds the opinion of the Georgia court, applying Georgia law, to be unpersuasive and inapplicable to the instant case.

Co. v. EEOC, 446 U.S. 318, 330 (1980) ("The typicality requirement is said to limit the class claims to those fairly encompassed by the named plaintiff's claims.").

4. The named plaintiffs and class counsel will provide adequate representation.

The class action mechanism is intended to allow a large number of claims to be litigated through a representative party or parties. *See Salmonsen*, 377 S.C. at 458–59, 661 S.E.2d at 90–91; *see also O'Quinn v. Beach Assocs.*, 272 S.C. 95, 104, 249 S.E.2d 734, 738 (1978) ("The very purpose of a class action is to avoid the necessity of requiring each member of the class to prove the elements of the cause of action."). Accordingly, Rule 23 requires that the representative parties must "fairly and adequately protect the interests of the class." Rule 23(a)(4), SCRCP. In considering this requirement, the trial court should evaluate "(1) whether class counsel are qualified, experienced, and generally able to conduct the proposed litigation; and (2) whether Plaintiffs' claims are sufficiently interrelated with and not antagonistic to the class claims as to ensure fair and adequate representation." *Lott v. Westinghouse Savannah River Co.*, 200 F.R.D. 539, 561 (D.S.C. 2000). The adequacy of representation requirement "is a question of fact which depends upon the circumstances of each case." *Waller*, 300 S.C. at 468, 388 S.E.2d at 801 (citing *McGowan v. Faulkner Concrete Pipe Co.*, 659 F.2d 554 (5th Cir. 1981)).

Here, with respect to the adequacy of representation requirement, the Plaintiffs alleged in their pleading that:

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

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(Am. Compl. ¶ 59.) Although the Defendants have denied these allegations, the Court can identify no facts to support a finding that the named plaintiffs and their counsel are unable to provide adequate representation and protect the interests of all proposed class members. The Court further finds that Defendants' argument on the adequacy of class representation impermissibly goes to the merits of the claims in this case and therefore must respectfully be disregarded.

a. The class representatives will adequately represent the class members.

The South Carolina Supreme Court has explained that "the named plaintiff [must] at all times adequately represent the interests of the absent class members" to satisfy the Due Process Clause. *Hosp. Mgmt. Assocs. v. Shell Oil Co.*, 356 S.C. 644, 654, 591 S.E.2d 611, 616 (2004) (quoting *Phillips Petroleum Co. v. Shutts*, 472 U.S. 797, 812 (1985)). "In determining whether a particular named plaintiff will adequately represent a proposed class pursuant to Rule 23(a)(4) one factor [the trial court] must consider is whether the named plaintiff has interests that are antagonistic or adverse to those of the rest of the class." *Waller*, 300 S.C. at 468, 388 S.E.2d at 801 (citing *Runion v. U.S. Shelter*, 98 F.R.D. 313 (D.S.C. 1983)). "The kind of antagonism that will defeat the maintenance of a class action is the kind which relates to the subject matter in controversy, as when the named representative has a claim which conflicts with the economic interests of the class." *Id.* (citing *Sperry Rand Corp. v. Lawson*, 554 F.2d 868 (8th Cir. 1977)). "For a conflict of interest to prevent plaintiffs from meeting [the adequacy of representation requirement], that conflict 'must be fundamental. It must go to the heart of the litigation.'" *Gunnells v. Healthplan Servs.*, 348 F.3d 417, 430–31 (4th Cir. 2003) (quoting 6 Alba Conte & Herbert B. Newberg, *Newberg on Class Actions* § 18:14 (4th ed. 2002)). Additionally, this rule "does not require either that the proposed class representatives have legal knowledge or a complete understanding of the representative's role in the class litigation." *Thorpe v. D.C.*, 303 F.R.D. 120, 151 (D.D.C. 2014).

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After careful review, the Court finds that the proposed class members in this case share a common objective of establishing Defendants' liability, and the named plaintiffs do not have interests antagonistic to those of the other class members. The two named plaintiffs are indeed "part of the class and possess the same interests and [have] suffer[ed] the same injury as the class members." *Hosp. Mgmt. Assocs.*, 356 S.C. at 664, 591 S.E.2d at 622 (quoting *Amchem Prods. v. Windsor*, 521 U.S. 591, 625–26 (1997)). There is also no indication that either of the named plaintiffs has any conflict of interest that would render her unfit to serve as a class representative. While the Defendants have previously argued that Ms. Blackwell and Ms. Brooks should not be permitted to represent the proposed class, the Court finds that those arguments go to the merits and should not be considered at the certification stage. *See King*, 386 S.C. at 88, 508 S.E.2d at 324 (quoting *Tilley*, 333 S.C. at 43, 508 S.E.2d at 21); *Knowles*, 274 S.C. at 59, 261 S.E.2d at 49.

b. The plaintiffs' attorneys are qualified and competent to represent the entire class.

The adequacy of representation requirement also considers the qualifications, competency, and any conflicts of class counsel.[6] *See Hosp. Mgmt. Assocs.*, 356 S.C. at 665–66, 591 S.E.2d at 622. Class counsel should serve the interests of the entire class and "adequately represent that absent class plaintiffs at all times." *Hege*, 780 F. Supp. 2d at 432. "In the absence of proof to the contrary, courts presume that class counsel is competent and sufficiently experienced to vigorously prosecute the class action." *Morgan v. United Parcel Serv. of Am., Inc.*, 169 F.R.D. 349, 357 (E.D. Mo. 1996) (citing *Zapata v. IBP, Inc.*, 167 F.R.D. 147, 161 (D. Kan. 1996)).

[6] In the class action settlement context, courts have recognized that the prospect of an attorney's fee award may create a conflict of interest, but "the conflict of interest created by attorney['s] fees in a class action does not render the attorneys' representation inadequate *per se*." *Hege v. Aegon USA, LLC*, 780 F. Supp. 2d 416, 432 (D.S.C. 2011). Moreover, Rule 23 mitigates any potential conflict by requiring the trial court to approve any such settlements. *See* Rule 23(c), SCRCP.

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Throughout this litigation, the Court has repeatedly noted that all attorney involved are experienced and competent litigators whose briefing and argument are consistently of the highest quality. No conflicts of interest have been raised that would prevent Plaintiffs' counsel from adequately representing the interests of the class as a whole, and the firms of Simmons Law Firm, LLC and John B. White, Jr., P.A. employ able attorneys who have litigated numerous class actions and complex cases. For example, both firms are currently representing political subdivisions in the *In re: South Carolina Opioid Litigation* proceedings, and lawyers in both firms have represented the State of South Carolina as lead counsel in numerous cases against pharmaceutical companies and other large corporate defendants. *See, e.g.*, *State ex rel. Wilson v. Ortho-Mcneil-Janssen Pharms.*, 414 S.C. 33, 44–45, 777 S.E.2d 176, 181–82 (2015) (representing the Attorney General in suing Janssen Pharmaceuticals, Inc. for violations of the South Carolina Unfair Trade Practices Act). The Court accordingly finds that the adequacy of class counsel has been established.

5. The Plaintiffs are seeking class-wide declaratory and injunctive relief, and the amount in controversy exceeds $100 for each class member.

Rule 23 requires that the amount in controversy exceed $100 for each class member "in cases in which the relief primarily sought is not injunctive or declaratory with respect to the class as a whole." Rule 23(a)(5), SCRCP. The South Carolina Supreme Court has adopted the rule that, "unless the law gives a different rule, *the sum claimed by the plaintiff controls* if the claim is apparently made in good faith." *Gardner v. Newsome Chevrolet-Buick*, 304 S.C. 328, 331, 404 S.E.2d 200, 201 (1991). In cases where the primary relief sought is injunctive or declaratory in nature, the plaintiffs need not satisfy the $100 minimum for each class member, *see* Rule 23(a)(5), SCRCP, but here the Court finds that Rule 23(a)(5) is nonetheless satisfied because the plaintiffs are asserting claims for declaratory and injunctive relief, and the amount in controversy exceeds $100 for each of the class members.

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The Amended Complaint seeks "final injunctive relief or corresponding declaratory relief with respect to the Class as a whole," in addition to monetary damages. (Am. Compl. ¶¶ 60, 62.) The plaintiffs assert a separate claim for injunctive relief in Count III of the Amended Complaint, seeking a declaration that the defendants violated the plaintiffs' rights through their billing policy and an injunction prohibiting them from engaging in such conduct in the future. (*Id.* at ¶ 83.) The Amended Complaint's prayer for relief also confirms that the primary relief sought is injunctive and declaratory in nature. (*See id.* at ¶¶ 16–17.) Additionally, discovery has revealed that the Hospital attempted to collect an estimated $7,199,837.54 in medical bills from approximately 1,538 patients instead of seeking payment from the patients' insurers. Even in cases where the Hospital did not actually collect from a class member, the Court finds it reasonable to conclude that the class member will have suffered more than $100 in damages associated with time and efforts spent communicating with both the defendants and their own insurance plan about the medical bills. Thus, the Court finds that Rule 23(a)(5), SCRCP, has been satisfied.

Conclusion

Having conducted the required "rigorous review"—and charged with the duty of protecting the rights of absent putative class members—the Court concludes that this matter is appropriate for class action status. Accordingly, the Court certifies the following class:

> All individuals who, since January 1, 2014, received any type of healthcare treatment from any entity located in South Carolina that is owned or affiliated with Defendants, while being covered by valid health insurance other than Cigna, and whose medical bills resulting from that treatment were not submitted to their health insurance carrier for potential payment.

The Court appoints the following attorneys as class counsel: John B. White, Jr.; Marghretta H. Shisko; and Griffin L. Lynch of John B. White, Jr., P.A.; and John S. Simmons and Rachel G. Peavy of Simmons Law Firm, LLC. The Court directs class counsel to take all steps necessary to

publish and/or provide notice to the potential class members and to take such other and further action as they deem reasonable and necessary for the prosecution of this action. Further to this point, Defendants are hereby ordered to provide to class counsel within seven (7) days of the filing of this Order all contact information for those patients identified by the Hospital as having been affected by the aforementioned business practice, to include names, last known addresses, telephone numbers, and e-mail addresses for such individuals (or, in the event the Hospital is on notice that such patient is deceased, then such available contact information for the next of kin and/or personal representative as may be contained in the Hospital's records).[7]

AND IT IS SO ORDERED.

_____
J. Mark Hayes, II
Circuit Court Judge, 7th Judicial Circuit

Dated: _____

At: _____

[7] The parties in this case are subject to a Consent Protective Order, filed April 11, 2019, and, as such, the Court is confident that the provided information will be appropriately safeguarded by all involved. The Court specifically finds that, pursuant to Paragraph 5(b.)(v.) of such Order, Class Counsel may share this information with any entity engaged or retained by them for purposes of providing notice to class members.

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Spartanburg Common Pleas

Case Caption:	Jo Ann Blackwell , plaintiff, et al VS Mary Black Health System, Llc , defendant, et al
Case Number:	2017CP4200219
Type:	Order/Class Certification

IT IS SO ORDERED

s/ J. Mark Hayes, II #2132

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

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

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

Respondents,

v.

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

Appellants,

PROOF OF SERVICE

The undersigned hereby certifies that on December 23, 2024, a copy of **Appellants' Reply to Return in Opposition to the Petition for Rehearing** was served on all counsel of record via email containing the above referenced document to counsels' individual AIS email addresses as follows:

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December 23, 2024
Columbia, South Carolina

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

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Respondents,

v.

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

Appellants,

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STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

IN THE COURT OF COMMON PLEAS
SEVENTH JUDICIAL CIRCUIT

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

Plaintiffs,

v.

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

Defendants.

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

ORDER DENYING DEFENDANTS' MOTION TO ALTER OR AMEND

BACKGROUND

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

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

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

STANDARD OF REVIEW

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

ANALYSIS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

IT IS SO ORDERED.

Judge's electronic signature page follows.

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Spartanburg Common Pleas

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

Case Number: 2017CP4200219

Type: Order/Other

IT IS SO ORDERED

s/ J. Mark Hayes, II #2132

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

ELECTRONICALLY FILED - 2020 Nov 04 12:34 PM - SPARTANBURG - COMMON PLEAS - CASE#2017CP4200219

FORM 4

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

JUDGMENT IN A CIVIL CASE

CASE NO. 2017CP4200219

Jo Ann Blackwell et al
PLAINTIFF(S)

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

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT**. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☑ **DECISION BY THE COURT**. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other

☐ **STAYED DUE TO BANKRUPTCY**

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** *(CHECK APPLICABLE BOX)*: ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

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

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

Please see below.

ORDER INFORMATION

This order ☐ ends ☑ does not end the case. ☑ See Page 2 for additional information.

For Clerk of Court Office Use Only

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

John Doe

NAMES OF TRADITIONAL FILERS SERVED BY MAIL

Court Reporter:

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

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

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

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

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

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Spartanburg Common Pleas

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

Case Number: 2017CP4200219

Type: Order/Electronic Form 4

IT IS SO ORDERED

s/ J. Mark Hayes, II #2132

ELECTRONICALLY FILED - 2020 Sep 04 4:23 PM - SPARTANBURG - COMMON PLEAS - CASE#2017CP4200219

FORM 4

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

JUDGMENT IN A CIVIL CASE

CASE NO. 2017CP4200219

Jo Ann Blackwell, et al	**Mary Black Health System, LLC et al**
PLAINTIFF(S)	DEFENDANT(S)

Submitted by: The Honorable J. Mark Hayes II	**Attorney for :** ☐ Plaintiff ☐ Defendant or ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT**. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☒ **DECISION BY THE COURT**. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other

☐ **STAYED DUE TO BANKRUPTCY**

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** *(CHECK APPLICABLE BOX)*: ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

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

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

ORDER INFORMATION

This order ☐ ends ☒ does not end the case.

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

INFORMATION FOR THE JUDGMENT INDEX

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

Judgment in Favor of (List name(s) below)	**Judgment Against (List name(s) below)**	**Judgment Amount To be Enrolled (List amount(s) below)**
	N/A	N/A
		$
		$

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

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

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

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

ELECTRONICALLY FILED - 2020 Sep 04 4:23 PM - SPARTANBURG - COMMON PLEAS - CASE#2017CP4200219

Circuit Court Judge	Judge Code	Date

For Clerk of Court Office Use Only

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

Thomas A. Killoren Jr., Ryan Frederick McCarty,	Katon Edwards Dawson Jr., James Lynn Werner
Marghretta Hagood Shisko, John S. Simmons,	
John Belton White, Jr.	
ATTORNEY(S) FOR THE PLAINTIFF(S)	**ATTORNEY(S) FOR THE DEFENDANT(S)**
	CLERK OF COURT

Court Reporter:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you all for continued cooperation and attention.

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Spartanburg Common Pleas

Case Caption:	Jo Ann Blackwell , plaintiff, et al VS Mary Black Health System, Llc , defendant, et al
Case Number:	2017CP4200219
Type:	Order/Form 4

IT IS SO ORDERED

s/ J. Mark Hayes, II #2132

ELECTRONICALLY FILED - 2020 Apr 23 12:52 PM - SPARTANBURG - COMMON PLEAS - CASE#2017CP4200219

STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

IN THE COURT OF COMMON PLEAS
SEVENTH JUDICIAL CIRCUIT

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

Plaintiffs,

v.

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

Defendants.

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

ORDER GRANTING PLAINTIFFS' MOTION FOR LEAVE TO AMEND THE COMPLAINT

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

IT IS ORDERED that Plaintiffs' Motion for Leave to Amend the Complaint is GRANTED. Pursuant to Rule 15, SCRCP, leave to amend "shall be freely given when justice so requires and

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

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

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

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

Judge's Signature Page Follows

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Spartanburg Common Pleas

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

Case Number: 2017CP4200219

Type: Order/Other

IT IS SO ORDERED

s/ J. Mark Hayes, II #2132

FORM 4

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

JUDGMENT IN A CIVIL CASE

CASE NO. 2017CP4200219

Jo Ann Blackwell et al
PLAINTIFF(S)

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

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT**. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☑ **DECISION BY THE COURT**. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ **ACTION DISMISSED** (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other

☐ **ACTION STRICKEN** (*CHECK REASON*): ☐ Rule 40(j), SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other

☐ **STAYED DUE TO BANKRUPTCY**

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT** *(CHECK APPLICABLE BOX)*: ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

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

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

See below for additional order information

ORDER INFORMATION

This order ☐ ends ☑ does not end the case. ☑ See Page 2 for additional information.

For Clerk of Court Office Use Only

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

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

NAMES OF TRADITIONAL FILERS SERVED BY MAIL

ELECTRONICALLY FILED - 2020 Feb 11 9:43 AM - SPARTANBURG - COMMON PLEAS - CASE#2017CP4200219

Court Reporter:

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

Thank you all for the arguments and the briefings.

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

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

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ELECTRONICALLY FILED - 2020 Feb 11 9:43 AM - SPARTANBURG - COMMON PLEAS - CASE#2017CP4200219

Spartanburg Common Pleas

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

Case Number: 2017CP4200219

Type: Order/Electronic Form 4

IT IS SO ORDERED

s/ J. Mark Hayes, II #2132

ELECTRONICALLY FILED - 2017 Jan 20 11:59 AM - SPARTANBURG - COMMON PLEAS - CASE#2017CP4200219

STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

IN THE COURT OF COMMON PLEAS
SEVENTH JUDICIAL CIRCUIT

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

Plaintiff,

v.

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

Defendants.

C.A. No. 2016-CP-42-_____

SUMMONS

TO THE ABOVE NAMED DEFENDANTS:

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

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

s/John B. White, Jr._____
John B. White, Jr.
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January 20, 2017

ELECTRONICALLY FILED - 2017 Jan 20 11:59 AM - SPARTANBURG - COMMON PLEAS - CASE#2017CP4200219

STATE OF SOUTH CAROLINA COUNTY OF SPARTANBURG	IN THE COURT OF COMMON PLEAS SEVENTH JUDICIAL CIRCUIT
Jo Ann Blackwell, individually and on behalf of all others similarly-situated, Plaintiff, v. Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; Community Health Systems, Inc.; CHSPSC, LLC; Professional Account Services, Inc.; and John Doe, Defendants.	**C.A. No. 2016-CP-42-_____**

CLASS ACTION COMPLAINT

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

PARTIES, JURISDICTION, AND VENUE

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

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

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

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

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

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

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

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

a) All individual employees, agents, or contractors who were performing services of any kind for Mary Black Memorial Hospital during the events described herein who are or may be liable for damages to Plaintiff and the proposed Class Members;

b) All individuals or business entities other than Mary Black Memorial Hospital who hired, employed, or supervised any individual employees, agents, or contractors who were performing the duties of accounts receivable/payable services for Mary Black Memorial Hospital;

c) All individuals or business entities who own or control Mary Black Memorial Hospital; and

d) All insurers of Mary Black Memorial Hospital and/or any John Doe Defendant who raise the issue of non-profit or charitable status or immunity from suit.

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

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

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FACTUAL ALLEGATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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CLASS ACTION ALLEGATIONS

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

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

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

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

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

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

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

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

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

b) Whether Defendants violated their contracts with various health insurance carriers by not submitting medical bills to the carrier;

c) Whether Defendants violated their contracts with various health insurance carriers by pursuing recovery for services rendered by placing liens upon patients' property (such as third-party tort claims), pursuing medical payment benefits from auto insurers, pursuing payment directly from patients, and/or turning patients' accounts over to collections;

d) Whether Defendants violated their contracts with various health insurance carriers by not offering a contractually agreed discount to patients covered by said policies;

e) Whether Defendants have violated their contracts with Plaintiff and the Class Members by seeking payment for charges that were covered by valid commercial health insurance;

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f) Whether Defendants improperly refused to submit the Plaintiff's and the Class Members' medical bills to Plaintiff's and the Class Members' health insurance carriers for payment;

g) Whether Defendants profited by refusing to submit said medical bills to said health insurance carriers for payment;

h) Whether Defendants have been unjustly enriched at the expense of Plaintiff and the Class Members through their misconduct;

i) Whether Defendants breached their duty of good faith and fair dealing to the Plaintiff and the Class through the misconduct described herein;

j) Whether Defendants are liable to Plaintiff and the Class Members based on a claim on money they have received; and

k) Whether Defendants should be enjoined from continuing their improper and unlawful billing practices as described herein.

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

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

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

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

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

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

COUNT I
TORTIOUS INTERFERENCE WITH CONTRACTUAL RELATIONSHIP

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

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

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

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

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

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

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

COUNT II
UNJUST ENRICHMENT

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

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

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

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

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

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

COUNT III
INJUNCTIVE RELIEF

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

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

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

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

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

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

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

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

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

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

JURY DEMAND

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

PRAYER FOR RELIEF

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

(a) For an Order certifying that this action may be maintained as a class action and appointing Plaintiff and her counsel to represent the class;

(b) For a declaration that Defendants' actions violated Plaintiff's and the Class Members' rights under South Carolina law as pleaded in Counts I through IV;

(c) For all actual damages, statutory damages, punitive damages, penalties, and remedies available for the Defendants' violations of Plaintiff's and the Class Member's rights under South Carolina law;

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(d) For a declaration that Defendants, through their actions and misconduct as alleged above, have been unjustly enriched and for an order that Defendants disgorge any unlawfully gained proceeds;

(e) For pre-judgment interest as provided by law;

(f) For post-judgment interest as provided by law;

(g) For declaratory relief and a permanent injunction enjoining Defendants from engaging in the unlawful billing practices as detailed in this Complaint;

(h) For an award to Plaintiff and the Class Members of their reasonable attorneys' fees;

(i) For an award to Plaintiff and the Class Members of their costs and expenses of this action; and

(j) For such other and further relief as this Court may deem necessary and proper.

Respectfully submitted,

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

s/John B. White, Jr._____
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Spartanburg, South Carolina

January 20, 2017

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STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

IN THE COURT OF COMMON PLEAS
SEVENTH JUDICIAL CIRCUIT

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

Plaintiffs,

v.

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

Defendants.

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

AMENDED SUMMONS

TO THE ABOVE NAMED DEFENDANTS:

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

HARRISON WHITE, P.C.

*s/John B. White, Jr.*_____
John B. White, Jr. (S.C. Bar No. 5996)
Thomas A. Killoren, Jr. (S.C. Bar No. 69490)
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and

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Spartanburg, South Carolina

June 28, 2019

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STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

IN THE COURT OF COMMON PLEAS
SEVENTH JUDICIAL CIRCUIT

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

Plaintiffs,

v.

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

Defendants.

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

AMENDED CLASS ACTION COMPLAINT

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

INTRODUCTION AND BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

PARTIES, JURISDICTION, AND VENUE

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

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

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

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

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

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

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

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

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

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

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

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

FACTUAL ALLEGATIONS

1. Defendants' policies and practices

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Plaintiff Blackwell

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

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

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

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

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

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

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

3. Plaintiff Brooks

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

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

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

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

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

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

4. Plaintiff Owens

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

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

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

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

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

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

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

CLASS ACTION ALLEGATIONS

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

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

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

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

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

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

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

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b) Whether Defendants violated their contracts with various health insurance carriers by not submitting medical bills to the carrier;

c) Whether Defendants violated their contracts with various health insurance carriers by pursuing recovery for services rendered by placing liens upon patients' property (such as third-party tort claims), pursuing medical payment benefits from auto insurers, pursuing payment directly from patients, and/or turning patients' accounts over to collections;

d) Whether Defendants violated their contracts with various health insurance carriers by not offering a contractually agreed discount to patients covered by said policies;

e) Whether Defendants have violated their contracts with Plaintiff and the Class Members by seeking payment for charges that were covered by valid commercial health insurance;

f) Whether Defendants improperly refused to submit the Plaintiff's and the Class Members' medical bills to Plaintiff's and the Class Members' health insurance carriers for payment;

g) Whether Defendants profited by refusing to submit said medical bills to said health insurance carriers for payment;

h) Whether Defendants have been unjustly enriched at the expense of Plaintiff and the Class Members through their misconduct;

i) Whether Defendants breached their duty of good faith and fair dealing to the Plaintiff and the Class through the misconduct described herein;

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j) Whether Defendants are liable to Plaintiff and the Class Members based on a claim on money they have received; and

k) Whether Defendants should be enjoined from continuing their improper and unlawful billing practices as described herein.

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

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

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

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

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

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

COUNT I
TORTIOUS INTERFERENCE WITH CONTRACTUAL RELATIONSHIP

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

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

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

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

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

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

COUNT II
UNJUST ENRICHMENT

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

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

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

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

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

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

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COUNT III
INJUNCTIVE RELIEF

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

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

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

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

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

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

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

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

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

JURY DEMAND

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

PRAYER FOR RELIEF

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

(a) For an Order pursuant to S.C.R.C.P. 23 certifying that this action may be maintained as a class action and appointing Plaintiffs and their counsel to represent the class;

(b) For a declaration that Defendants' actions violated the rights of Plaintiffs and the Class Members under South Carolina law;

(c) For all actual damages, statutory damages, punitive damages, penalties, and remedies available for the Defendants' violations of the rights of Plaintiffs and the Class Members under South Carolina law;

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(d) For a declaration that Defendants, through their actions and misconduct as alleged above, have been unjustly enriched and for an order requiring Defendants to disgorge any unlawfully gained proceeds;

(e) For pre-judgment interest as provided by law;

(f) For post-judgment interest as provided by law;

(g) For declaratory relief and a permanent injunction enjoining Defendants from engaging in the unlawful billing practices as detailed in this Complaint;

(h) For an award to Plaintiffs and the Class Members of their reasonable attorneys' fees;

(i) For an award to Plaintiffs and the Class Members of their costs and expenses of this action; and

(j) For such other and further relief as this Court may deem necessary and proper.

Signature Page Follows

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Respectfully submitted,

*s/John B. White, Jr.*_____

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

and

John S. Simmons (S.C. Bar No. 10260)
Simmons Law Firm, LLC
1711 Pickens Street
Columbia, SC 29201
Tel: (803) 779-4600

Attorneys for Plaintiffs

Spartanburg, South Carolina

June 28, 2019

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ELECTRONICALLY FILED - 2020 Apr 24 11:00 AM - SPARTANBURG - COMMON PLEAS - CASE#2017CP4200219

STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

IN THE COURT OF COMMON PLEAS
SEVENTH JUDICIAL CIRCUIT

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

Plaintiffs,

v.

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

Defendants.

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

AMENDED SUMMONS

TO THE ABOVE-NAMED DEFENDANTS:

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

HARRISON WHITE, P.C.

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

and

John S. Simmons (S.C. Bar No. 10260)
Simmons Law Firm, LLC
1711 Pickens Street
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Attorneys for Plaintiffs

Spartanburg, South Carolina

April 24, 2020

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IN THE COURT OF COMMON PLEAS
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Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly-situated,

Plaintiffs,

v.

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

Defendants.

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

AMENDED CLASS ACTION COMPLAINT

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

INTRODUCTION AND BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

PARTIES, JURISDICTION, AND VENUE

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

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

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

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

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

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

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

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

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

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

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

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

FACTUAL ALLEGATIONS

1. Defendants' policies and practices

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Plaintiff Blackwell

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

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

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

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

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

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

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

3. Plaintiff Brooks

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

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

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

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

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

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

4. Plaintiff Owens

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

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

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

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

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

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

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

CLASS ACTION ALLEGATIONS

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

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

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

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

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

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

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

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b) Whether Defendants violated their contracts with various health insurance carriers by not submitting medical bills to the carrier;

c) Whether Defendants violated their contracts with various health insurance carriers by pursuing recovery for services rendered by placing liens upon patients' property (such as third-party tort claims), pursuing medical payment benefits from auto insurers, pursuing payment directly from patients, and/or turning patients' accounts over to collections;

d) Whether Defendants violated their contracts with various health insurance carriers by not offering a contractually agreed discount to patients covered by said policies;

e) Whether Defendants have violated their contracts with Plaintiff and the Class Members by seeking payment for charges that were covered by valid commercial health insurance;

f) Whether Defendants improperly refused to submit the Plaintiff's and the Class Members' medical bills to Plaintiff's and the Class Members' health insurance carriers for payment;

g) Whether Defendants profited by refusing to submit said medical bills to said health insurance carriers for payment;

h) Whether Defendants have been unjustly enriched at the expense of Plaintiff and the Class Members through their misconduct;

i) Whether Defendants breached their duty of good faith and fair dealing to the Plaintiff and the Class through the misconduct described herein;

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j) Whether Defendants are liable to Plaintiff and the Class Members based on a claim on money they have received; and

k) Whether Defendants should be enjoined from continuing their improper and unlawful billing practices as described herein.

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

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

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

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

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

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

COUNT I
TORTIOUS INTERFERENCE WITH CONTRACTUAL RELATIONSHIP

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

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

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

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

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

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

COUNT II
UNJUST ENRICHMENT

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

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

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

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

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

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

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COUNT III
INJUNCTIVE RELIEF

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

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

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

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

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

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

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

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

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

JURY DEMAND

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

PRAYER FOR RELIEF

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

(a) For an Order pursuant to S.C.R.C.P. 23 certifying that this action may be maintained as a class action and appointing Plaintiffs and their counsel to represent the class;

(b) For a declaration that Defendants' actions violated the rights of Plaintiffs and the Class Members under South Carolina law;

(c) For all actual damages, statutory damages, punitive damages, penalties, and remedies available for the Defendants' violations of the rights of Plaintiffs and the Class Members under South Carolina law;

(d) For a declaration that Defendants, through their actions and misconduct as alleged above, have been unjustly enriched and for an order requiring Defendants to disgorge any unlawfully gained proceeds;

(e) For pre-judgment interest as provided by law;

(f) For post-judgment interest as provided by law;

(g) For declaratory relief and a permanent injunction enjoining Defendants from engaging in the unlawful billing practices as detailed in this Complaint;

(h) For an award to Plaintiffs and the Class Members of their reasonable attorneys' fees;

(i) For an award to Plaintiffs and the Class Members of their costs and expenses of this action; and

(j) For such other and further relief as this Court may deem necessary and proper.

Signature Page Follows

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Respectfully submitted,

*s/John B. White, Jr.*_____

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Spartanburg, South Carolina

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

July 29, 2020
Spartanburg, South Carolina

B E F O R E:

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

Julie A. Cendroski,
Circuit Court Reporter
Seventh Judicial Circuit

A P P E A R A N C E S

MARGHRETTA HAGOOD SHISKO, ESQUIRE
For The Plaintiffs

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

KATON EDWARDS DAWSON, JR., ESQUIRE
For the Defendants

JAMES LYNN WERNER, ESQUIRE
For the Defendants.

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EXHIBITS

	MARKED	ENTERED

NO EXHIBITS PROFFERED

MOTION TO DISMISS

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

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

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

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

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

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

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

COURT REPORTER: I am, Judge.

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

MR. WERNER: Hello?

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

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

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

MR. WERNER: I did just hear that.

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

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

the time.

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

MR. WERNER: I will do it, Judge.

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

COURT REPORTER: Yes, sir.

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

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

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

the focus of this ---

COURT REPORTER: I lost him.

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

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

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

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

under those agreements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the bill directly to Medicare.

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

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

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

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

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

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

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

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

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

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

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

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

THE COURT: Is that it?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. WERNER: Can you all still hear me?

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

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

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

THE COURT: Okay. Yes, ma'am.

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

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

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

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

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

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

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

And, ultimately, the question is whether the

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

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

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

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

MS. SHISKO: Pardon?

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

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

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

MR. WERNER: Sorry.

THE COURT: Now you're unmuted. Okay.

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

THE COURT: Can you back up to that point?

MS. SHISKO: Sure.

THE COURT: Okay.

MS. SHISKO: Can you hear me now?

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

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

COURT REPORTER: (Indicating.)

THE COURT: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

But in any event, we have now amended the

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

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

I think that's all. I addressed that.

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

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

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

Honor determines that class can and should be certified.

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

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

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

You know, the whole Medicare argument is --

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

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

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

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

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

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

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

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

THE COURT: CIGNA, okay.

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

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

MR. WERNER: That's correct, Judge.

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. WERNER: Thank you, Judge.

MS. SHISKO: Thank you.

MR. WERNER: Stay safe everyone.

THE COURT: You all too.

MR. DAWSON: Thank you.

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

--- THIS ENDS REQUESTED TRANSCRIPT ---

COURT REPORTER CERTIFICATE

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

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

s/Julie A Cendroski
Julie A. Cendroski
Circuit Court Reporter
Seventh Judicial Circuit

ELECTRONICALLY FILED - 2019 Aug 19 4:07 PM - SPARTANBURG - COMMON PLEAS - CASE#2017CP4200219

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

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

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

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

2. The purported Amended Complaint is not proper because it purports to add two new named Plaintiffs which is not proper and is not allowed pursuant to Rule 15.

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

3. Neither of the two purported new named Plaintiffs sought or obtained an order allowing them to intervene in the case in accordance with Rule 24 and their joinder in the case is otherwise improper.

4. The claims of the purported new Plaintiff, Michelene Brooks, fail as a matter of law and must be dismissed pursuant to Rule 12(b)(6). According to the allegations on the face of the purported Amended Complaint, all of Ms. Brooks' claims are based on the allegations that she had health insurance coverage through Medicare and that Defendants are liable because they sought collections for her medical care costs by asserting a right to payment against the insurer for the at-fault driver in her auto accident instead of submitting the claim for her medical care costs to Medicare. However, in accordance with 42 U.S.C.A. § 1395y(b)(2)(A)(ii) (The Medicare Act), Defendants were required to seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare. Furthermore, Ms. Brooks does not allege that she exhausted her administrative remedies under the Medicare Act as she

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

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

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

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August 19, 2019
Columbia, South Carolina

ELECTRONICALLY FILED - 2019 Oct 18 2:06 PM - SPARTANBURG - COMMON PLEAS - CASE#2017CP4200219

STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

IN THE COURT OF COMMON PLEAS
SEVENTH JUDICIAL CIRCUIT

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

Plaintiffs,

v.

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

Defendants.

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

MOTION FOR LEAVE TO AMEND COMPLAINT

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

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

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

Here, the Rule 15 criteria are satisfied. Plaintiffs seek to amend the complaint to add additional named plaintiffs to pursue claims in a representative capacity, and the proposed amendment will not prejudice the defendants. *See Twelfth RMA Partners, L.P. v. Nat'l Safe Corp.*, 335 S.C. 635, 641, 518 S.E2d 44, 47 (Ct. App. 1999) (allowing the substitution of a plaintiff through an amended complaint, reasoning that "[t]he [defendants] rely on *Valentine v. Davis* for the proposition that a plaintiff may not add a new plaintiff to a case to assert a claim against the defendant. In this case, however, no new claims are being added. The court is only changing the name of the plaintiff. The subject of the claim . . . is still the same." (citation omitted)); *Patton*, 420 S.C. at 493, 804 S.E.2d at 263 (allowing the addition of a plaintiff in a new capacity). Additionally, Plaintiffs' amendment to add new named plaintiffs as class representatives is not asserting any new claims. Since this case is a class action, the class members' claims will be litigated regardless and the subject of the claim is still the same, thus the addition of the new named plaintiffs should be permitted under Rule 15.

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

Respectfully submitted,

s/John B. White, Jr.

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EXHIBIT A

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STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

IN THE COURT OF COMMON PLEAS
SEVENTH JUDICIAL CIRCUIT

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

Plaintiffs,

v.

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

Defendants.

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

AMENDED CLASS ACTION COMPLAINT

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

INTRODUCTION AND BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

PARTIES, JURISDICTION, AND VENUE

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

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

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

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

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

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

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

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

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

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

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

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

FACTUAL ALLEGATIONS

1. Defendants' policies and practices

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Plaintiff Blackwell

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

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

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

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

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

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

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

3. Plaintiff Brooks

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

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

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

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

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

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

4. Plaintiff Owens

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

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

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

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

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

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

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

CLASS ACTION ALLEGATIONS

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

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

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

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

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

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

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

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b) Whether Defendants violated their contracts with various health insurance carriers by not submitting medical bills to the carrier;

c) Whether Defendants violated their contracts with various health insurance carriers by pursuing recovery for services rendered by placing liens upon patients' property (such as third-party tort claims), pursuing medical payment benefits from auto insurers, pursuing payment directly from patients, and/or turning patients' accounts over to collections;

d) Whether Defendants violated their contracts with various health insurance carriers by not offering a contractually agreed discount to patients covered by said policies;

e) Whether Defendants have violated their contracts with Plaintiff and the Class Members by seeking payment for charges that were covered by valid commercial health insurance;

f) Whether Defendants improperly refused to submit the Plaintiff's and the Class Members' medical bills to Plaintiff's and the Class Members' health insurance carriers for payment;

g) Whether Defendants profited by refusing to submit said medical bills to said health insurance carriers for payment;

h) Whether Defendants have been unjustly enriched at the expense of Plaintiff and the Class Members through their misconduct;

i) Whether Defendants breached their duty of good faith and fair dealing to the Plaintiff and the Class through the misconduct described herein;

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j) Whether Defendants are liable to Plaintiff and the Class Members based on a claim on money they have received; and

k) Whether Defendants should be enjoined from continuing their improper and unlawful billing practices as described herein.

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

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

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

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

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

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

COUNT I
TORTIOUS INTERFERENCE WITH CONTRACTUAL RELATIONSHIP

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

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

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

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

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

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

COUNT II
UNJUST ENRICHMENT

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

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

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

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

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

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

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COUNT III
INJUNCTIVE RELIEF

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

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

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

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

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

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

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

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

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

JURY DEMAND

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

PRAYER FOR RELIEF

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

(a) For an Order pursuant to S.C.R.C.P. 23 certifying that this action may be maintained as a class action and appointing Plaintiffs and their counsel to represent the class;

(b) For a declaration that Defendants' actions violated the rights of Plaintiffs and the Class Members under South Carolina law;

(c) For all actual damages, statutory damages, punitive damages, penalties, and remedies available for the Defendants' violations of the rights of Plaintiffs and the Class Members under South Carolina law;

(d) For a declaration that Defendants, through their actions and misconduct as alleged above, have been unjustly enriched and for an order requiring Defendants to disgorge any unlawfully gained proceeds;

(e) For pre-judgment interest as provided by law;

(f) For post-judgment interest as provided by law;

(g) For declaratory relief and a permanent injunction enjoining Defendants from engaging in the unlawful billing practices as detailed in this Complaint;

(h) For an award to Plaintiffs and the Class Members of their reasonable attorneys' fees;

(i) For an award to Plaintiffs and the Class Members of their costs and expenses of this action; and

(j) For such other and further relief as this Court may deem necessary and proper.

Signature Page Follows

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Respectfully submitted,

*s/John B. White, Jr.*_____

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

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

FACTS AND PROCEDURAL HISTORY

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

1. On December 27, 2013, Plaintiff Blackwell was admitted to Mary Black Memorial Hospital (the "Hospital") following an automobile accident. [Amended Complaint ¶¶ 12, 35].

2. Plaintiff Blackwell received medical treatment and was released from the Hospital on January 3, 2014. [Amended Complaint ¶¶ 12, 35].

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3. Plaintiff Blackwell alleges that she had health insurance coverage at the time she was admitted to the Hospital. [Amended Complaint ¶ 36].

4. The Hospital did not submit a claim for payment of her bill to her health insurance carrier. [Amended Complaint ¶ 37].

5. Instead, the Hospital submitted the bill for her hospital care to the liability insurance carrier for the at fault driver in her accident (State Farm). [Amended Complaint ¶ 38].

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

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

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

[Complaint ¶ 41].

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

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

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

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

[Amended Complaint ¶ 53].

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

1. On October 9, 2015, Plaintiff Owens was admitted to the Hospital following an automobile accident. [Amended Complaint ¶ 14, 47].

2. Plaintiff Owens alleges that at the time of his medical treatment he had valid health insurance coverage through Cigna. [Amended Complaint ¶ 48].

3. On or about October 14, 2016, Plaintiff Owens—through counsel—negotiated an agreement to settle his account for a payment of $4,543.38. [Amended Complaint ¶ 52].

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

1. On February 26, 2016, Plaintiff Brooks was admitted to the Hospital following an automobile accident. [Amended Complaint ¶ 41].

2. Plaintiff Brooks alleges that at the time of her medical treatment she had valid health insurance coverage through Medicare. [Amended Complaint ¶ 42].

3. On or about September 26, 2017, Plaintiff Brooks—through counsel—negotiated an agreement to settle her account for a payment of $4,991.22. [Amended Complaint ¶ 46].

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

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

STANDARD OF REVIEW

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

ARGUMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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42 U.S.C.A. § 1395y(b)(2)(A)(ii).

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

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

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

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

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

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CONCLUSION

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

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October 24, 2019
Columbia, South Carolina

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

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

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

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

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

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

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

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

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

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

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

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

II. Plaintiff Brooks

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

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

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

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

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

[1] CHSPSC is a separate and distinct entity from Mary Black and PASI and is not responsible for Mary Black's billings, but the allegations of the Amended Complaint must be accepted as true *only* for the purposes of this motion under Rule 12 of the South Carolina Rules of Civil Procedure.

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

III. Plaintiff Blackwell

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

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

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

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

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

IV. Plaintiff Owens

A. Plaintiff Owens must arbitrate his claims against CHSPSC

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

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

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

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

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

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CONCLUSION

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

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

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June 8, 2020
Columbia, South Carolina

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

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STATE OF SOUTH CAROLINA COUNTY OF SPARTANBURG	IN THE COURT OF COMMON PLEAS SEVENTH JUDICIAL CIRCUIT
Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly situated, Plaintiffs, v. Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; and CHSPSC, LLC; Professional Account Services, Inc., Defendants.	C.A. No. 2017-CP-42-00219 **DEFENDANT MARY BLACK HEALTH SYSTEM, LLCS' MOTION DISMISS PURSUANT TO RULE 12(B)(6) OR, IN THE ALTERNATIVE, TO STAY THE CASE AND COMPEL ARBITRATION**

Defendant Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital ("Mary Black"'), hereby moves to dismiss the Amended Complaint of each Plaintiff, Jo Ann Blackwell, Michelene Brooks and Samuel H. Owens's (collectively, "Plaintiffs"), pursuant to Rule 12(b)(6) of the South Carolina Rules of Civil Procedure. Alternatively, Mary Black moves the Court to stay the case and compel Plaintiff Owens to arbitrate his claims against Mary Black.

I. The Amended Complaint of each Plaintiff fails to state facts sufficient to constitute a cause of action against Mary Black.

A. Failure to State a Claim for Tortious Interference with Contractual Relationship

The Court should dismiss Plaintiffs' claims for tortious interference with the contractual relationship between Plaintiffs and their health insurance carriers because the generic and conclusory allegations in the Amended Complaint fail to allege the essential elements of the claim that (1) Plaintiffs' contracts with their health insurance carriers were breached and (2) that Mary Black caused Plaintiffs' contracts with their health insurance carriers to be breached. *See Camp v. Springs Mortgage Corp.*, 310 S.C. 514, 517, 426 S.E.2d 304, 305-06 (1993) (stating that a claim for tortious interference with contract requires a plaintiff allege the following: (1) the existence of

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a valid contract, (2) the wrongdoer's knowledge thereof, (3) the intentional procurement of its breach, (4) the absence of justification, and (5) resulting damages). Without a breach of Plaintiffs' contracts with their health insurance carriers, there can be no recovery under a cause of action for tortious interference with a contractual relationship. *First Union Mortgage Corp. v. Thomas*, 317 S.C. 63, 73, 451 S.E.2d 907, 913 (Ct. App. 1994). Accordingly, Plaintiffs' claims for tortious interference with a contractual relationship must be dismissed as a matter of law.

II. Plaintiff Brooks

A. Plaintiff Brooks's claims fail under the Medicare Act.

All of Plaintiff Brooks's claims are based on the allegations that she had health insurance coverage through Medicare and that Mary Black is liable because it sought collections for her medical care costs by asserting a right to payment against the insurer for the at-fault driver in her automobile accident instead of immediately and directly submitting the claim for her medical care costs to Medicare. However, in accordance with 42 U.S.C.A. § 1395y(b)(2)(A)(ii) ("The Medicare Act"), Mary Black was required to seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare. *See Parkview Hosp., Inc. v. Roese*, 750 N.E.2d 384, 389 (Ind. Ct. App. 2001) ("[W]e find that Congress's intent is clearly expressed in 42 U.S.C. § 1395y(b)(2)(A)(ii). It explicitly prohibits medical service providers from collecting payment from Medicare when payment can reasonably be expected to be made promptly under an automobile or liability insurance policy."); *Joiner v. Med. Ctr. E., Inc.*, 709 So. 2d 1209, 1221 (Ala. 1998) (holding that an Alabama hospital had a right under the Medicare Act to obtain full payment of its charges from the proceeds of the plaintiff patient's settlement with an automobile liability carrier, instead of filing a claim for reimbursement with Medicare). Therefore, Mary Black may not be held liable for acting in compliance with the Medicare Act and all of Plaintiff Brooks's claims must be dismissed as a matter of law.

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B. Plaintiff Brooks's claims are barred by the voluntary payment doctrine.

Plaintiff Brooks's claims are barred by the voluntary payment doctrine. *Hardaway v. S. Ry. Co.*, 90 S.C. 475, 488-89, 73 S.E. 1020, 1025 (1912) (stating that it is an elementary principle of South Carolina law that no action will lie to recover money voluntarily paid); *Moody v. Stem*, 214 S.C. 45, 60, 51 S.E.2d 163, 169 (1948). Plaintiff Brooks alleges that "Defendants agreed to accept a 50% reduction on Plaintiff Brooks's account and settle for $4,991.22." [Amended Complaint ¶ 46]. Therefore, her claims to recover the funds she voluntarily paid are barred by the voluntary payment doctrine and must be dismissed as a matter of law. *See Cross v. Ciox Health, LLC*, No. 4:19-CV-7-FL, 2020 WL 534289, at *11 (E.D.N.C. Feb. 3, 2020) (applying similar North Carolina law and granting a motion to dismiss pursuant to Rule 12(b)(6) on the grounds that the voluntary payment doctrine barred the plaintiffs' purported class claims for unjust enrichment because the plaintiffs' attorneys voluntarily paid the requested amounts to a medical records provider).

III. Plaintiff Blackwell

A. Plaintiff Blackwell fails to state a claim for unjust enrichment

Plaintiff Blackwell's claim for unjust enrichment must be dismissed as a matter of law pursuant to Rule 12(b)(6). The Amended Complaint does not even allege that Plaintiff Blackwell, or anyone on her behalf or for her benefit, made any payment or provided any value to Mary Black for the medical care she received. *See Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994) (stating that South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: "(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its

value"). Accordingly, Plaintiff Blackwell's claim for unjust enrichment must be dismissed as a matter of law.

B. The MedCost Agreement bars enforcement by non-signatory third-parties.

Plaintiff Blackwell's claims must be dismissed as a matter of law because all of her claims are derived from her alleged ability to enforce the negotiated rates for medical services in the Participating Hospital Agreement between her insurance provider (MedCost) and Mary Black, (Amended Complaint ¶¶ 28-31). The express language of that Agreement expressly denies non-signatory third-parties (like Plaintiff Blackwell) the right to sue to enforce its terms. (A copy of the Participating Hospital Agreement will be filed as **Exhibit A** to this Motion after the Court has entered an appropriate order permitting Defendants to file confidential contracts with insurance carriers under seal). Since Plaintiff Blackwell lacks standing to enforce the Participating Hospital Agreement as a third-party beneficiary, she lacks standing to enforce the terms of the agreement and pursue any of her alleged claims. Therefore, as a matter of law, Plaintiff Blackwell's claims fail and must be dismissed.

IV. Plaintiff Owens

A. Plaintiff Owens must arbitrate his claims against Mary Black.

If the Court allows Plaintiff Owens's claims against Mary Black to continue in any way based on the allegations that Plaintiff Owens is entitled to enforce the billing and payment terms of the Hospital Services Agreement between his alleged insurance provider (CIGNA) and Mary Black, then Mary Black moves to compel arbitration of Plaintiff Owens's claims pursuant to the arbitration requirements of the Agreement and to stay further proceedings in this action. (A copy of the Hospital Services Agreement between CIGNA and Mary Black will be filed as **Exhibit B** to this Motion after the Court has entered an appropriate order permitting Defendants to file confidential contracts with insurance carriers under seal). Section 6.2.2 of the CIGNA Hospital

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Services Agreement states, "Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement." Plaintiff Owens is attempting to enforce the terms of agreement between Mary Black and CIGNA against Mary Black. If Plaintiff Owens is allowed to proceed on claims seeking to enforce terms of that Agreement against Mary Black, then Plaintiff Owens must individually arbitrate his claims against Mary Black pursuant to the terms of the arbitration agreement contained within the contract between Mary Black and CIGNA.

B. Plaintiff Owens's claims are barred by the applicable statutes of limitation.

If the Court finds that Plaintiff Owens's claims are not subject to the arbitration provision in the Hospital Services Agreement, then the Court should dismiss Plaintiff Owens's claims for tortious interference with contract and unjust enrichment on the grounds that those claims are barred by the applicable statutes of limitation. *See Graham v. Welch, Roberts & Amburn, LLP*, 404 S.C. 235, 239, 743 S.E.2d 860, 862 (Ct. App. 2013) (holding a claim for unjust enrichment was barred by the three-year statute of limitations); *Burgess v. Elliott*, No. 3:16-CV-3325-RBH, 2017 WL 1505421, at *3 (D.S.C. Apr. 27, 2017), *aff'd*, 696 F. App'x 125 (4th Cir. 2017) ("The applicable statute of limitations for civil actions of breach of contract, negligence, and tortious interference with contract is likewise three years."). In the Amended Complaint, Plaintiff Owens alleges he settled his bill with the Mary Black on October 14, 2016. [Amended Complaint ¶ 52]. Plaintiffs filed the Motion to Amend Complaint on October 18, 2019. Therefore, more than three (3) years have passed since Plaintiff Owens knew or should have known of his alleged claims. Accordingly, his claims are barred by the applicable statutes of limitation.

C. Plaintiff Owens's claims are barred by the voluntary payment doctrine.

If the Court finds that Plaintiff Owens's claims are not subject to the arbitration provision in the Hospital Services Agreement, then Plaintiff Owens's claims are barred by the voluntary payment doctrine. *See Hardaway v. S. Ry. Co.*, 90 S.C. 475, 488-89, 73 S.E. 1020, 1025 (1912)

(stating that it is an elementary principle of South Carolina law that no action will lie to recover money voluntarily paid); *Moody v. Stem*, 214 S.C. 45, 60, 51 S.E.2d 163, 169 (1948). Plaintiff Owens alleges that "Defendants agreed to accept a 50% reduction on Plaintiff Owens's account and settle for $4,543.38." [Amended Complaint ¶ 52]. Therefore, his claims to recover the funds he voluntarily paid are barred by the voluntary payment doctrine and must be dismissed as a matter of law. *See Cross*, 2020 WL 534289, at *11.

CONCLUSION

This Motion is based upon the allegations in the Amended Complaint, the controlling statutes and case law, and may be supported by such memoranda of law and arguments as are submitted to the Court and parties prior to a hearing hereon.

WHEREFORE, having shown the basis for the Motion to Dismiss or, in the alternative, compelling arbitration, Mary Black requests the Court dismiss Plaintiffs' Amended Complaint on the grounds that Plaintiffs have failed to allege facts sufficient to constitute a cause of action, or in the alternative, compel Plaintiff Owens to arbitrate his claims against Mary Black.

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June 8, 2020
Columbia, South Carolina

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STATE OF SOUTH CAROLINA COUNTY OF SPARTANBURG	IN THE COURT OF COMMON PLEAS SEVENTH JUDICIAL CIRCUIT
Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly situated, Plaintiffs, v. Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; and CHSPSC, LLC; Professional Account Services, Inc., Defendants.	C.A. No. 2017-CP-42-00219 **DEFENDANT PROFESSIONAL ACCOUNT SERVICES, INC.'S MOTION DISMISS PURSUANT TO RULE 12(B)(6) OR, IN THE ALTERNATIVE, TO STAY THE CASE AND COMPEL ARBITRATION**

Defendant Professional Account Services, Inc. ("PASI") hereby moves to dismiss the Amended Complaint of each Plaintiff, Jo Ann Blackwell, Michelene Brooks and Samuel H. Owens's (collectively, "Plaintiffs"), pursuant to Rule 12(b)(6) of the South Carolina Rules of Civil Procedure. Alternatively, PASI moves the Court to stay the case and compel Plaintiff Owens to arbitrate his claims against PASI.

I. The Amended Complaint of each Plaintiff fails to state facts sufficient to constitute a cause of action against PASI.

A. Plaintiffs' Amended Complaint fails to state a claim based on a lack of factual (specific) allegations

The entirety of the specific and individual allegations against PASI are encompassed in two paragraphs:

> 17. Defendant Professional Account Services, Inc. ("PASI") is a Tennessee corporation with its principal place of business in Brentwood, Tennessee. PASI is a collection firm that regularly conducts business in the State of South Carolina and elsewhere.
>
> 18. On information and belief, CHSPSC and PASI exercise control over policies and procedures enacted by and implemented by Mary Black Health System, including

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> policies relating to billing and liens, and all of these entities committed the acts and omission complained of herein jointly and in concert.

The Amended Complaint contains no other specific or individual allegations against PASI. Rather, the remainder of the Amended Complaint contains only non-specific generalized allegations referencing PASI, CHSPSC, LLC, and Mary Black Health System, LLC collectively as Defendants. There are no allegations sufficient to identify what PASI did, or failed to do, which would support the assertion of each (or any) of the purported causes of action. Furthermore, there are no factual allegations which could support or form the basis for any claim to pierce the corporate veil of PASI or to establish a basis for an amalgamation or conspiracy claim. *See Pro Slab, Inc. v. Argos USA Corp.*, No. CV 2:17-3185-BHH, 2018 WL 6985008, at *5 (D.S.C. June 28, 2018), *reconsideration granted on other grounds*, No. CV 2:17-3185-BHH, 2018 WL 6985010 (D.S.C. Dec. 3, 2018) (granting the defendants' motions to dismiss on the grounds that that the plaintiffs' amended complaint simply lumped together members of corporate families and impermissibly ascribed liability to groups rather than to individual entities); *see also Scurmont LLC v. Firehouse Rest. Grp., Inc.*, No. 4:09-CV-00618-RBH, 2010 WL 11433199, at *15 (D.S.C. May 19, 2010) (dismissing claims against an individual defendant because the complaint only contained general conclusory allegations against the defendants collectively and the plaintiffs failed to plead sufficient facts that an individual defendant committed any wrongful act within the State of South Carolina, let alone any wrongful act causally related to the plaintiff's alleged injuries).

Since, the Amended Complaint contains only conclusory allegations against PASI, Plaintiffs have, therefore, failed to plead ultimate facts sufficient to constitute any cause of action against PASI. *See Jones v. Gilstrap*, 288 S.C. 525, 528, 343 S.E.2d 646, 648 (Ct. App. 1986) (providing that conclusory allegations in a complaint are insufficient to survive the defendant's

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motion to dismiss for failure to state a cause of action). Without alleging facts related to an act or omission by PASI the Amended Complaint fails on its face and the claims against PASI must be dismissed as a matter of law.

B. Plaintiffs' Amended Complaint fails to allege facts sufficient to constitute a cause of action for tortious interference with contractual relationship

The Court should dismiss Plaintiffs' claims for tortious interference with the contractual relationship between Plaintiffs and their health insurance carriers because the generic and conclusory allegations in the Amended Complaint fail to allege the essential elements of the claim that (1) Plaintiffs' contracts with their health insurance carriers were breached and (2) that PASI caused Plaintiffs' contracts with their health insurance carriers to be breached. *See Camp v. Springs Mortgage Corp.*, 310 S.C. 514, 517, 426 S.E.2d 304, 305-06 (1993) (stating that a claim for tortious interference with contract requires a plaintiff allege the following: (1) the existence of a valid contract, (2) the wrongdoer's knowledge thereof, (3) the intentional procurement of its breach, (4) the absence of justification, and (5) resulting damages). Without a breach of Plaintiffs' contracts with their health insurance carriers, there can be no recovery under a cause of action for tortious interference with a contractual relationship. *First Union Mortgage Corp. v. Thomas*, 317 S.C. 63, 73, 451 S.E.2d 907, 913 (Ct. App. 1994). Accordingly, Plaintiffs' claims for tortious interference with a contractual relationship must be dismissed as a matter of law.

II. Plaintiff Brooks

A. Plaintiff Brooks's claims fail under the Medicare Act.

All of Plaintiff Brooks's claims are based on the allegations that she had health insurance coverage through Medicare and that PASI is liable because it sought collections for her medical care costs by asserting a right to payment against the insurer for the at-fault driver in her automobile accident instead of immediately and directly submitting the claim for her medical

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care costs to Medicare. However, in accordance with 42 U.S.C.A. § 1395y(b)(2)(A)(ii) ("The Medicare Act"), PASI was required to seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare. *See Parkview Hosp., Inc. v. Roese*, 750 N.E.2d 384, 389 (Ind. Ct. App. 2001) ("[W]e find that Congress's intent is clearly expressed in 42 U.S.C. § 1395y(b)(2)(A)(ii). It explicitly prohibits medical service providers from collecting payment from Medicare when payment can reasonably be expected to be made promptly under an automobile or liability insurance policy."); *Joiner v. Med. Ctr. E., Inc.*, 709 So. 2d 1209, 1221 (Ala. 1998) (holding that an Alabama hospital had a right under the Medicare Act to obtain full payment of its charges from the proceeds of the plaintiff patient's settlement with an automobile liability carrier, instead of filing a claim for reimbursement with Medicare). Therefore, PASI may not be held liable for acting in compliance with the Medicare Act and all of Plaintiff Brooks's claims must be dismissed as a matter of law.

B. Plaintiff Brooks's claims are barred by the voluntary payment doctrine.

Plaintiff Brooks's claims are barred by the voluntary payment doctrine. *Hardaway v. S. Ry. Co.*, 90 S.C. 475, 488-89, 73 S.E. 1020, 1025 (1912) (stating that it is an elementary principle of South Carolina law that no action will lie to recover money voluntarily paid); *Moody v. Stem*, 214 S.C. 45, 60, 51 S.E.2d 163, 169 (1948). Plaintiff Brooks alleges that "Defendants agreed to accept a 50% reduction on Plaintiff Brooks's account and settle for $4,991.22." [Amended Complaint ¶ 46]. Therefore, her claims to recover the funds she voluntarily paid are barred by the voluntary payment doctrine and must be dismissed as a matter of law. *See Cross v. Ciox Health, LLC*, No. 4:19-CV-7-FL, 2020 WL 534289, at *11 (E.D.N.C. Feb. 3, 2020) (applying similar North Carolina law and granting a motion to dismiss pursuant to Rule 12(b)(6) on the grounds that the voluntary payment doctrine barred the plaintiffs' purported class claims

for unjust enrichment because the plaintiffs' attorneys voluntarily paid the requested amounts to a medical records provider).

III. Plaintiff Blackwell

A. Plaintiff Blackwell fails to state a claim for unjust enrichment

Plaintiff Blackwell's claim for unjust enrichment must be dismissed as a matter of law pursuant to Rule 12(b)(6). The Amended Complaint does not even allege that Plaintiff Blackwell, or anyone on her behalf or for her benefit, made any payment or provided any value to PASI for the medical care she received. *See Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994) (stating that South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: "(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its value"). Accordingly, Plaintiff Blackwell's claim for unjust enrichment must be dismissed as a matter of law.

B. The MedCost Agreement bars enforcement by non-signatory third-parties (like Plaintiff Blackwell).

Plaintiff Blackwell's claims must be dismissed as a matter of law because all of her claims are derived from her alleged ability to enforce the negotiated rates for medical services in the Participating Hospital Agreement between her insurance provider (MedCost) and Mary Black, (Amended Complaint ¶¶ 28-31). The express language of that Agreement expressly denies non-signatory third-parties (like Plaintiff Blackwell) the right to sue to enforce its terms. (A copy of the Participating Hospital Agreement will be filed as **Exhibit A** to this Motion after the Court has entered an appropriate order permitting Defendants to file confidential contracts with insurance carriers under seal). Since Plaintiff Blackwell lacks standing to enforce the Participating Hospital Agreement as a third-party beneficiary, she lacks standing to enforce the

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terms of the agreement and pursue any of her alleged claims. Therefore, as a matter of law, Plaintiff Blackwell's claims fail and must be dismissed.

IV. Plaintiff Owens

A. Plaintiff Owens must arbitrate his claims against PASI

If the Court allows Plaintiff Owens's claims against PASI to continue in any way based on the allegations that Plaintiff Owens is entitled to enforce the billing and payment terms of the Hospital Services Agreement between his alleged insurance provider (CIGNA) and Mary Black, and that PASI is a party or subject to said Agreement then PASI moves to compel arbitration of Plaintiff Owens's claims pursuant to the arbitration requirements of the Agreement and to stay further proceedings in this action. (A copy of the Hospital Services Agreement between CIGNA and Mary Black will be filed as **Exhibit B** to this Motion after the Court has entered an appropriate order permitting Defendants to file confidential contracts with insurance carriers under seal). Section 6.2.2 of the CIGNA Hospital Services Agreement states, "Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement." Having alleged that PASI is liable for failure to comply with the terms of the agreement between Mary Black and CIGNA, Plaintiff Owens is attempting to enforce the terms of that Agreement against PASI. Although PASI expressly denies that it is a party to the contract between Mary Black and CIGNA, if Plaintiff Owens is allowed to proceed on claims seeking to enforce terms of that Agreement against PASI, then to the extent PASI is alleged to be bound by the contract between Mary Black and CIGNA, then Plaintiff Owens must individually arbitrate his claims against PASI pursuant to the terms of the arbitration agreement contained within the contract between Mary Black and CIGNA.

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B. Plaintiff Owens's claims are barred by the applicable statutes of limitation.

If the Court finds that Plaintiff Owens's claims are not subject to the arbitration provision in the Hospital Services Agreement, then the Court should dismiss Plaintiff Owens's claims for tortious interference with contract and unjust enrichment on the grounds that those claims are barred by the applicable statutes of limitation. *See Graham v. Welch, Roberts & Amburn, LLP*, 404 S.C. 235, 239, 743 S.E.2d 860, 862 (Ct. App. 2013) (holding a claim for unjust enrichment was barred by the three-year statute of limitations); *Burgess v. Elliott*, No. 3:16-CV-3325-RBH, 2017 WL 1505421, at *3 (D.S.C. Apr. 27, 2017), *aff'd*, 696 F. App'x 125 (4th Cir. 2017) ("The applicable statute of limitations for civil actions of breach of contract, negligence, and tortious interference with contract is likewise three years."). In the Amended Complaint, Plaintiff Owens alleges he settled his bill with the Mary Black on October 14, 2016. [Amended Complaint ¶ 52]. Plaintiffs filed the Motion to Amend Complaint on October 18, 2019. Therefore, more than three (3) years have passed since Plaintiff Owens knew or should have known of his alleged claims. Accordingly, his claims are barred by the applicable statutes of limitation.

C. Plaintiff Owens's claims are barred by the voluntary payment doctrine.

If the Court finds that Plaintiff Owens's claims are not subject to the arbitration provision in the Hospital Services Agreement, then Plaintiff Owens's claims are barred by the voluntary payment doctrine. *See Hardaway*, 90 S.C. at 488-89, 73 S.E. at 1025; *Moody*, 214 S.C. at 60, 51 S.E.2d at 169. Plaintiff Owens alleges that "Defendants agreed to accept a 50% reduction on Plaintiff Owens's account and settle for $4,543.38." [Amended Complaint ¶ 52]. Therefore, his claims to recover the funds he voluntarily paid are barred by the voluntary payment doctrine and must be dismissed as a matter of law. *See Cross*, 2020 WL 534289, at *11.

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CONCLUSION

This Motion is based upon the allegations in the Amended Complaint, the controlling statutes and case law, and may be supported by such memoranda of law and arguments as are submitted to the Court and parties prior to a hearing hereon.

WHEREFORE, having shown the basis for the Motion to Dismiss or, in the alternative, compelling arbitration, PASI requests the Court dismiss Plaintiffs' Amended Complaint on the grounds that Plaintiffs have failed to allege facts sufficient to constitute a cause of action, or in the alternative, compel Plaintiff Owens to arbitrate his claims against PASI. [1]

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[1] Alternatively, PASI moves the Court to enter an Order requiring Plaintiffs submit a more definite statement and allege the necessary facts to establish and identify the claims Plaintiffs are asserting against PASI, rather than the collective "Defendants." *See* Rule 12(e), SCRCP. Presently, PASI cannot reasonably be required to frame a response to Plaintiff's Amended Complaint without a more definite statement as to the facts and allegations that are being alleged against PASI.

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STATE OF SOUTH CAROLINA

COUNTY OF SPARTANBURG

IN THE COURT OF COMMON PLEAS

SEVENTH JUDICIAL CIRCUIT

Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly-situated,

Plaintiffs,

v.

Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; CHSPSC, LLC; and Professional Account Services, Inc.,

Defendants.

C.A. No. 2017-CP-42-00219

Hon. J. Mark Hayes, II

PLAINTIFFS' RESPONSE IN OPPOSITION TO DEFENDANTS' MOTIONS TO DISMISS

Plaintiffs Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly-situated, respectfully submit this Response in Opposition to three (3) motions to dismiss filed by the defendants in this matter. Defendants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital ("Mary Black"), CHSPSC, LLC ("CHSPSC"), and Professional Account Service, Inc. ("PASI") have filed separate motions to dismiss the Amended Complaint and/or to compel Plaintiff Owens to arbitrate his claims against them. Because Defendants' motions all raise similar (if not identical) arguments, Plaintiffs are submitting a single, consolidated response in opposition to the motions to dismiss to address all arguments. For the reasons set forth herein, Defendants' motions should all be denied and Plaintiffs should be permitted to proceed with discovery that will enable them to file a motion to certify a class of similarly-situated individuals under Rule 23(a), SCRCP.

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BACKGROUND

Plaintiff Jo Ann Blackwell originally filed this case as a class action on January 20, 2017, asserting claims against Defendants, a hospital and related entities, on behalf of herself and hundreds (or possibly thousands) of potential class members. On April 24, 2020, Plaintiffs filed an Amended Class Action Complaint, which included two additional individuals, Samul H. Owens, Jr., and Michelene Brooks, as named plaintiffs. Plaintiffs are asserting causes of action for tortious interference with contractual relationship, unjust enrichment, and injunctive relief individually and on behalf of the class members against all the defendants.

The claims of the named plaintiffs and the class members (collectively, "Plaintiffs") stem from Defendants' policy, in cases where a potential third party might be liable for a patient's injuries, of not submitting claims to health insurers for payment or refunding payments to health insurance carriers and then attempting to obtain payment for the patient's medical bills directly from the patient, from an auto insurer, and/or from the patient's third-party tort recovery. (*See* Am. Compl. ¶¶ 4–8.) Plaintiffs allege that Defendants, as a standard business practice, routinely refused to submit patients' medical bills to their insurance providers if Defendants' screening identified a patient as one for whom third-party recovery might be available to pay for such treatment. (*Id.* ¶¶ 4–5.) This was done so that Defendants could obtain a higher reimbursement than what might have been received from the patient's insurance. (*Id.* ¶ 6.)

Plaintiffs contend they are third-party direct beneficiaries of the agreements between their insurance companies and Mary Black, and that Defendants interfered with Plaintiffs' own relationships with their insurance companies by attempting to collect payments from Plaintiffs at a higher amount than what Mary Black contracted for with Plaintiffs' insurance companies. (*See id.* ¶ 57.) Each of the named plaintiffs is an accident victim who received treatment at Mary Black

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and, thereafter, Defendants refused to submit their bills to their health insurance companies for payment. (*See id.* ¶¶ 35–52.) Instead, Defendants engaged in impermissible attempts to collect directly from Plaintiffs or from Plaintiffs' third-party tort recovery. (*See id.* ¶¶ 40, 45, 51.) The named plaintiffs are seeking to represent a class of patients whose medical bills were not submitted to their health insurance carriers for payment. (*Id.* ¶¶ 21, 53.)

Defendants Mary Black, CHSPSC, and PASI are related entities that engaged in the wrongful billing and collection practices alleged in the Amended Complaint. Mary Black is the hospital where Plaintiffs received treatment (*see id.* ¶ 2), and CHSPSC and PASI are billing and collection entities related to Mary Black (*see id.* ¶¶ 16–17). In particular, Plaintiffs allege that "CHSPSC and PASI exercise control over policies and procedures enacted and implemented by Mary Black Health System, including policies relating to billing and liens, and all of these entities committed the acts and omissions complained of herein, jointly and in concert." (*Id.* ¶ 18.)

MOTION TO DISMISS STANDARD

The South Carolina Rules of Civil Procedure require a complaint to contain, among other things, "a short and plain statement of the facts showing that the pleader is entitled to relief." Rule 8(a)(2), SCRCP; *see Clark v. Clark*, 293 S.C. 415, 416, 361 S.E.2d 328, 328 (1987). "In considering a motion to dismiss a complaint based on a failure to state facts sufficient to constitute a cause of action, the trial court must base its ruling solely on allegations set forth in the complaint." *Doe v. Marion*, 373 S.C. 390, 395, 645 S.E.2d 245, 247 (2007) (citing *Spence v. Spence*, 368 S.C. 106, 116, 628 S.E.2d 869, 874 (2006)). In deciding a motion to dismiss under Rule 12(b)(6), "[t]he question for the court is whether in the light most favorable to the plaintiff, and with every doubt resolved in his behalf, the allegations set forth on the face of the complaint state any valid claim for relief." *Sloan Constr. Co. v. Southco Grassing, Inc.*, 377 S.C. 108, 112–13, 659 S.E.2d 158,

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161 (2008) (citing *Plyler v. Burns*, 373 S.C. 637, 645, 647 S.E.2d 188, 192 (2007)). Where "the 'facts alleged and inferences reasonably deducible therefrom would entitle the plaintiff to any relief on any theory of the case,' then dismissal under Rule 12(b)(6) is improper." *Id.* at 113, 659 S.E.21d at 161 (quoting *Stiles v. Onorato*, 318 S.C. 297, 300, 457 S.E.2d 601, 603 (1995)).

Additionally, a "complaint should not be dismissed merely because the court doubts the plaintiff will prevail in the action." *Doe*, 373 S.C. at 395, 645 S.E.2d at 248 (citing *Toussaint v. Ham*, 292 S.C. 415, 416, 357 S.E.2d 8, 9 (1987)); *see also Kennedy v. Henderson*, 289 S.C. 393, 395, 346 S.E.2d 526, 527 (1986) ("[T]he complaint must be construed liberally in favor of the pleader and sustained if facts alleged, and inferences reasonably deducible therefrom, entitle the plaintiff to relief on any theory of the case." (citing *Blandon v. Coleman*, 285 S.C. 472, 475, 330 S.E.2d 298, 300 (1985))). "At the Rule 12 stage, therefore, the first decision for the trial court is to decide only whether the pleading states a claim." *Skydive Myrtle Beach, Inc. v. Horry Cty.*, 426 S.C. 175, 180, 826 S.E.2d 585, 588 (2019). Plaintiffs are "entitled to litigate the validity of [their] pleading without having to convince the trial court of the merits of [their] underlying claim." *Id.* Additionally, when a case raises a novel question of law, dismissal under Rule 12(b)(6) is improper. *See Chestnut v. AVX Corp.*, 413 S.C. 224, 228, 776 S.E.2d 82, 84 (2015) (reversing dismissal of a negligence claim that raised the novel issue of "stigma damages").

ARGUMENT

Defendants are attempting to have this case dismissed prior to engaging in discovery on the merits of the class allegations (other than some limited, early discovery regarding Plaintiff Blackwell's claims) by attacking the claims of the named plaintiffs. Because the Amended Complaint adequately states claims on behalf of the individuals named plaintiffs and the class members,

the Court should deny Defendants' motions and permit Plaintiffs to litigate the validity of their claims on the merits.

1. Plaintiffs' Amended Complaint states sufficient factual allegations against both PASI and CHSPSC.

Both PASI and CHSPSC argue that the Amended Complaint lacks "specific or individual allegations" against them and should be dismissed on that basis. (*See* PASI Mot. 1–3; CHSPSC Mot. 1–3.) However, as set forth above, the South Carolina Rules of Civil Procedure merely require a plaintiff to set forth "a short and plain statement of the facts showing that the pleader is entitled to relief." Rule 8(a)(2), SCRCP. Additionally, the purpose of the South Carolina Rules of Civil Procedure is "to secure justice, and . . . reduce formalities and technicalities." *Patton v. Miller*, 420 S.C. 471, 492, 804 S.E.2d 252, 263 (2017) (quoting James F. Flanagan, *South Carolina Civil Procedure* 3 (2d ed. 1996)). They are "designed to discourage battles over mere form and to sweep away needless procedural controversies that either delay a trial on the merits or deny a party his day in court because of technical deficiencies." *Id.* at 493, 804 S.E.2d at 263 (quoting 4 Charles Alan Wright et al., *Federal Practice and Procedure* § 1029 (4th ed. 2015)).

Here, the allegations in the Amended Complaint as to both PASI and CHSPSC meet the pleading requirements. Plaintiffs have asserted facts and allegations against all Defendants, and often refer to the defendants collectively in the Amended Complaint. (*See* Am. Compl. 22–34 (alleging all defendants engaged in wrongful conduct).) There is no prohibition on pleading facts in this manner in South Carolina. *See* Rule 8(e)(1), SCRCP ("Each averment of a pleading shall be simple, concise, and direct. No technical forms of pleading or motions are required."); *Patton*, 420 S.C. 493, 804 S.E.2d at 263 (observing that it is "entirely contrary to the spirit of the . . . Rules of Civil Procedure for decisions on the merits to be avoided on the basis of . . . mere technicalities" (quoting *Foman v. Davis*, 371 U.S. 178, 181 (1962))). Additionally, Plaintiffs allege that PASI and

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CHSPSC exercised control over the wrongful policies and procedures regarding billing and liens and that the defendants acted "jointly and in concert." (Am. Compl. ¶ 18.) Because the Amended Complaint provides sufficient notice to all Defendants of the allegations being made against them, the Court should reject the arguments of PASI and CHSPSC that the allegations against them are factually insufficient.

2. Plaintiffs have alleged sufficient facts to state a claim for tortious interference with contractual relationship.

"[A]n action for tortious interference protects the property rights of the parties to a contract against unlawful interference by third parties." *Dutch Fork Dev. Group II, LLC v. SEL Props., LLC*, 406 S.C. 596, 604, 753 S.E.2d 840, 844 (2012) (quoting *Threlkeld v. Christoph*, 280 S.C. 225, 227, 312 S.E.2d 14, 15 (Ct. App. 1984)). The elements of a claim for tortious interference with contractual relations are: "(1) existence of a valid contract; (2) the wrongdoer's knowledge thereof; (3) his intentional procurement of its breach; (4) the absence of justification; and (5) resulting damages." *Id.* (quoting *Camp v. Springs Mortg. Corp.*, 310 S.C. 514, 517, 426 S.E.2d 304, 305 (1993)). Here, Plaintiffs allege a claim for tortious interference with a contractual relationship based on Defendants' knowledge of their contractual relationship with their health insurance providers and Defendants' willful refusal to submit Plaintiffs' and Class Members' hospital bills for payment by their insurance. (*See* Am. Compl. ¶¶ 63–68.) As a result of Defendants' wrongful conduct, Plaintiffs and Class Members did not "receiv[e] the benefit of their relationships with their respective health insurance carriers" and Plaintiffs and the Class Members "paid premiums but receiv[ed] no or little benefit." (*Id.* ¶¶ 66, 67.) Plaintiffs allegations are sufficient to state a claim for tortious interference with contractual relations.

Defendants argue this cause of action should be dismissed because "[w]ithout a breach of Plaintiffs' contracts with their health insurance carriers, there can be no recovery under a cause of

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action for tortious interference with a contractual relationship." (Mary Black Mot. 3.) However, Defendants fail to construe the allegations in the light most favorable to Plaintiffs, and they read Plaintiffs' allegations too narrowly. The allegations in the Amended Complaint can be reasonably construed to mean that Defendants' conduct resulted in a breach of patients' contracts with their insurers because Plaintiffs alleged they paid premiums and did not have their hospital bills paid by their insurers. Defendants' argument that Plaintiffs failed to allege facts sufficient to constitute a cause of action for tortious interference should be rejected.

3. Plaintiff Brooks's claims do not fail under the Medicare Act as a matter of law.

Defendants argue that Plaintiff Brooks's claims fail as a matter of law because, pursuant to 42 U.S.C.A. § 1395y(b)(2)(A)(ii), they "were required to seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare." (Mary Black Mot. 2; PASI Mot. 3–4; CHSPSC Mot. 3–4.) However, this argument is improper at this stage of the action because it presumes facts not alleged in the Amended Complaint. *See Charleston Cty. Sch. Dist. v. Harrell*, 393 S.C. 552, 559, 713 S.E.2d 604, 608 (2011) ("It is a well-settled principle that in resolving a Rule 12(b)(6) motion to dismiss, the court is limited to a consideration of the allegations contained within the four corners of the complaint."). Defendants' argument presumes that the at-fault driver in Brooks's automobile accident had a valid insurance policy from which to collect, but this is not alleged anywhere in the Amended Complaint. Instead, the Amended Complaint merely alleges that Brooks was involved in an automobile accident and had valid health insurance coverage through Medicare, which would have paid her medical bills had they been submitted for payment. (Am. Compl. ¶¶ 41–44.) Defendants' argument not only relies on a fact outside Plaintiffs' complaint, but it would also require the Court to disregard the allegation in the Amended Complaint that "Plaintiff Brooks's medical bills would have been paid had they been

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submitted to her health insurance for payment." (Am. Compl. ¶ 44.) Because this is contrary to the Court's scope of review in deciding a Rule 12(b)(6), SCRCP, motion for dismissal, Defendants' argument must be rejected. *See Harrell*, 393 S.C. at 559, 713 S.E.2d at 608; *Sloan Constr. Co.*, 377 S.C. at 112–13, 659 S.E.2d at 161.

4. The voluntary payment doctrine does not bar the claims of either Plaintiff Brooks of Plaintiff Owens.

Defendants also make the same arguments that the voluntary payment doctrine bars the claims of both Plaintiff Brooks and Plaintiff Owens. (*See* Mary Black Mot. 3, 5–6; PASI Mot. 4–5, 7; CHSPSC Mot. 4–5, 7.) Their arguments rely on two South Carolina cases, *Hardaway v. S. Railway Co.*, 90 S.C. 475, 73 S.E. 1020 (1912), and *Moody v. Stem*, 214 S.C. 45, 51 S.E.2d 163 (1948), and a North Carolina federal district court case, *Cross v. Ciox Health, LLC*, 38 F. Supp. 3d 572, 590 (E.D.N.C. 2020), which is currently on appeal to the Fourth Circuit Court of Appeals. None of these authorities require dismissal of Plaintiffs' claims, and the voluntary payment doctrine is inapplicable here for several reasons.

First, any payments Brooks and Owens made to Mary Black were not voluntary. *See Hardaway*, 73 S.E. at 1025 ("[A] party cannot by direct action, or by way of set-off or counterclaim, recover money *voluntarily* paid with a full knowledge of all the facts, *and without any fraud, duress, or extortion*, although no obligation to make such payment existed." (emphasis added)). As Plaintiffs alleged in their complaint, Brooks and Owens only settled with Mary Black after the hospital asserted unlawful liens against the plaintiffs' recoveries for their personal injuries. (*See* Am. Compl. ¶¶ 26, 46, 52.) In addition, Plaintiffs alleged Mary Black "[sought] payment for medical bills by demanding cash payment directly from the patients, placing unlawful liens on patients' third-party tort claims, seeking medical payment benefits from patients' automobile insurers,

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turning patients over to collection agencies, and/or reporting patients to credit bureaus (thereby impairing patients' credit scores)." (*Id.* ¶ 26.)

As is shown by these allegations, Mary Black coerced and extorted its patients into making payments the hospital should have billed to the patients' insurers. No payments made under these circumstances can be considered voluntary. *See Cross*, 438 F. Supp. 3d at 590 (stating a payment is involuntary when there is "some actual or threatened exercise of power possessed, or believed to be possessed, by the party exacting or receiving the payment over the person or property of another, for which the latter has no other means of immediate relief than by making the payment" (quoting *Big Bear of N. Carolina, Inc. v. City of High Point*, 294 N.C. 262, 266, 240 S.E.2d 422, 424 (1978))); 70 C.J.S. *Payment* § 103 ("Recovery may be allowed where the payment of an unlawful demand has been obtained by taking undue advantage of the payor's situation, where it has been made to prevent an injury to property rights, or where it was made to release a person or property from detention or to prevent an immediate seizure of person or property." (footnotes omitted)); *id.* ("Where a person is compelled, through the necessity of protecting his or her business interests, or under a business necessity to free or protect property from some duress or lien, to pay an unlawful demand, the payment is compulsory and may be recovered." (footnotes omitted)).

Additionally, Owens and Brooks did not make the payments to Mary Black "with full knowledge of all the facts." *Hardaway*, 73 S.E. at 1025. Specifically, the plaintiffs acted without knowledge of the contractual obligations Mary Black had in relation to the plaintiffs' insurers, including the requirement to seek compensation from the insurers for services rendered to patients, the prohibition on seeking compensation from patients (except for co-payments and other certain allowed fees), and the discounted compensation rates the hospital was obligated to accept from the

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insurers. In extracting the payments from Owens and Brooks, Mary Black also deceptively failed to inform them that, pursuant to its contracts with the insurers, they were under no obligation to compensate the hospital. Consequently, the voluntary payment doctrine is further inapplicable. *See Moody*, 214 S.C. at 53, 51 S.E.2d at 165 ("That cannot be said with propriety to be voluntarily done, where a formal assent thereto is induced by *mistake*, or procured by fraud or deception, as to facts material to control the operation of the will therein, any more than where such formal assent is extorted by the application of a *force* which fetters and obstructs its free working." (emphasis in original)); 70 C.J.S. *Payment* § 103 ("A payment is not voluntary if the payor reasonably and in good faith believes in his or her obligation or personal interest in making the payment."); *see, e.g.*, *Freeman v. J.L.H. Investments, LP*, 414 S.C. 362, 383, 778 S.E.2d 902, 913 (2015) ("Freeman paid the closing fee without full knowledge of what comprised the fee. . . . Accordingly, we find that Hendrick's reliance on the voluntary payment doctrine is misplaced.").[1]

5. The statute of limitations does not bar Plaintiff Owens's claims.

Defendants all make an identical argument that "the Court should dismiss Plaintiff Owens's claims for tortious interference with contract and unjust enrichment on the grounds that those claims are barred by the applicable statutes of limitations." (Mary Black Mot. 5; PASI Mot. 7; CHSPSC Mot. 7.) This Court should reject Defendants' argument because Plaintiff Owens's claims relate back to the filing date of the original complaint in this matter, which was January 20, 2017. His claims arise out of the same conduct set forth in the original class action complaint—

[1] While Defendants argue here that Brooks's and Owens's claims are barred because they made payments to Mary Black, they argue elsewhere in their Motions that Blackwell's claims are barred for precisely the opposite reason—because she *did not* make any payments to Mary Black. In doing so, Defendants advance the untenable position that claims arising out of their improper billing practices are barred when payments to the hospital are both made and not made, thereby attempting to foreclose all relief for their conduct.

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Defendants' wrongful billing practices. *See* Rule 15(c), SCRCP ("Whenever the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleadings, the amendment relates back to the date of the original pleading."). So, even if the applicable statute of limitations started running on October 14, 2016, when "Defendants agreed to accept a 50% reduction on Plaintiff Owens's account and settle for $4,543.38," (Am. Compl. ¶ 52), because his claims as set forth in the Amended Complaint relate back to the original date of filing, they are timely.

6. Plaintiff Owens should not be required to arbitrate his claims.

Defendants also argue Owens must arbitrate his claims against all Defendants due to an arbitration clause in a purported 2006 contract between Mary Black and CIGNA, Owens's insurer. As an initial matter, neither CHSPSC nor PASI are parties to the contract. Moreover, because the contract does not confer any direct benefits on CHSPSC or PASI, neither is an intended third-party beneficiary of the contract. *See Helms Realty, Inc. v. Gibson-Wall Co.*, 363 S.C. 334, 340, 611 S.E.2d 485, 488 (2005) ("A third-party beneficiary is a party that the contracting parties intend to directly benefit."); Restatement (Second) of Contracts § 302(1) (1981) (providing "a beneficiary of a promise is an intended beneficiary if recognition of a right to performance in the beneficiary is appropriate to effectuate the intention of the parties"); *Bob Hammond Const. Co. v. Banks Const. Co.*, 312 S.C. 422, 425, 440 S.E.2d 890, 892 (Ct. App. 1994) (finding "[t]he mere fact that [a party] might ultimately and indirectly benefit from [a] contract between [other parties] is not sufficient" to confer status as an intended beneficiary). At most, CHSPSC and PASI may be incidental beneficiaries to the contract, and as such, they lack standing to enforce any arbitration agreement contained therein. *See Trancik v. USAA Ins. Co.*, 354 S.C. 549, 553, 581 S.E.2d 858, 861 (Ct. App. 2003) ("South Carolina contract law carries a presumption that an individual who is not a party to

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a contract lacks privity to enforce it."); *cf. Bob Hammond Const. Co.*, 312 S.C. at 424, 440 S.E.2d at 891 ("[I]f a contract is made for the benefit of a third person, that person may enforce the contract if the contracting parties intended to create a direct, rather than an incidental or consequential, benefit to such third person.").

Additionally, the contract Defendants produced to Plaintiffs and filed with the Court was executed in July 2006 and had an initial term of only three years. Owens's claim against Defendants, however, did not accrue until at least October 2015, over nine years later. (*See* Am. Compl. ¶ 14.) Defendants have produced no proof, whether by affidavit or other documentary evidence, demonstrating that the 2006 contract was operative at the time Owens's claim accrued and, consequently, that he could possibly be bound by the contract's arbitration clause. *See Jackson Mills, Inc. v. BT Capital Corp.*, 312 S.C. 400, 404, 440 S.E.2d 877, 879 (1994) (stating a "valid ground[] upon which to challenge [an] arbitration clause" is that "the controversy arose out of events occurring subsequent to expiration of the arbitration agreement"). Accordingly, compelling arbitration at this stage in the litigation is unwarranted. If the Court declines to deny Defendants' motion to compel arbitration with prejudice, Plaintiffs respectfully ask the Court to either deny the motion without prejudice or hold the motion in abeyance pending the completion of discovery relevant to this issue. *See, e.g.*, *Towles v. United HealthCare Corp.*, 338 S.C. 29, 34, 524 S.E.2d 839, 842 (Ct. App. 1999) (noting "[t]he circuit court . . . denied United's motion to compel arbitration 'with leave to refile it after completing discovery in this action'"); *S.C. Pub. Serv. Auth. v. Great W. Coal (Kentucky), Inc.*, 312 S.C. 559, 561, 437 S.E.2d 22, 24 (1993) (noting the circuit court "held the motion for arbitration in abeyance pending discovery and denied the motion to dismiss").

7. Plaintiff Blackwell's claim for unjust enrichment should not be dismissed.

"'Restitution is a remedy designed to prevent unjust enrichment.' Unjust enrichment is an equitable doctrine, akin to restitution, which permits the recovery of that amount the defendant has

been unjustly enriched at the expense of the plaintiff." *Ellis v. Smith Grading & Paving, Inc.*, 294 S.C. 470, 474, 366 S.E.2d 12, 14 (Ct. App. 1988) (citation omitted) (quoting *Stanley Smith & Sons v. Limestone College*, 283 S.C. 430, 434, 322 S.E.2d 474, 478 (Ct. App. 1984)). "A party may be unjustly enriched when it has and retains benefits or money which in justice and equity belong to another." *Dema v. Tenet Physician Servs.-Hilton Head, Inc.*, 383 S.C. 115, 123, 678 S.E.2d 430, 434 (2009). Here, Defendants argue Plaintiff Blackwell's unjust enrichment claim fails because there are no allegations "that Plaintiff Blackwell, or anyone on her behalf or for her benefit, made any payment or provided any value to [Defendants] for the medical care she received." (Mary Black Mot. 3; PASI Mot. 5; CHSPSC Mot. 5.)

Viewing the Complaint as a whole, and in favor of the pleader, Plaintiff Blackwell has adequately pleaded a claim for unjust enrichment. Plaintiffs allege that all Defendants have been unjustly enriched because it would be inequitable to allow them to retain the benefits of their wrongful billing practices while attempting to collect from Plaintiffs a higher amount than they would have received if they had billed Plaintiffs' insurance companies. The fact that Plaintiffs allege Defendants "assert[ed] liens against Plaintiff Blackwell's potential third party automobile accident claim," (Am. Compl. ¶ 40), is sufficient for purposes of the pleading stage, and Plaintiff Blackwell's unjust enrichment claim should be allowed to proceed. *Cf. Beverly v. Grand Strand Reg'l Med. Ctr., LLC*, 429 S.C. 502, 516, 839 S.E.2d 468, 475 (Ct. App. 2020) (noting that Plaintiff's complaint "alleges affirmative inequitable conduct seeking to deprive her of the benefit of her funds").

8. Plaintiff Blackwell has standing as a third-party beneficiary.

Defendants also argue that Plaintiff Blackwell may not "enforce the negotiated rates for medical services in the Participating Hospital Agreement between her insurance provider

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(MedCost) and Mary Black" because, according to Defendants, language in "that Agreement expressly denies non-signatory third-parties (like Plaintiff Blackwell) the right to sue to enforce its terms." (Mary Black Mot. 4; PASI Mot. 5; CHSPSC Mot. 5.)

Defendants' argument relies on a provision in a contract which is outside the pleading and should be rejected on that basis alone. *See generally O'Laughlin v. Windham*, 330 S.C. 379, 498 S.E.2d 689, 691 (Ct. App. 1998) ("A ruling on a 12(b)(6) motion to dismiss must be based *solely* upon allegations set forth on the face of the complaint."). Additionally, even if it were proper for the Court to consider the Participating Hospital Agreement at this stage (which it is not), Defendants do not identify the precise language of the provision and have not established that the Agreement was in effect and applied at the time Plaintiff Blackwell's claims arose. Discovery on these (and other) issues is warranted, and the Court should reject Defendants' arguments that Plaintiff Blackwell lacks standing.

Even assuming, for the sake of argument, that any contract between a plaintiff's insurance company and Mary Black contains language purporting to exclude members as third-party beneficiaries or prohibiting members from suing to enforce its terms, that would not be dispositive. "Under South Carolina law, it is well settled that a nonparty may enforce contractual terms that intentionally provide her direct benefits." *Beverly*, 429 S.C. at 506, 839 S.E.2d at 470. And, in *Beverly*, a case that involved similar allegations by a patient against a hospital, the contract between the patient's insurance company, Blue Cross Blue Shield (BCBS), and the hospital contained language expressly stating, "This Agreement is not intended to, and shall not be construed to make any person or entity a third party beneficiary." *Id.* at 508, 839 S.E.2d at 471. Notwithstanding this language, the Court of Appeals concluded that the agreement as a whole should be

examined to determine whether the contract intended to benefit members in the insurance plan. *See id.* at 509–13, 839 S.E.2d at 472–73. The Court of Appeals explained:

> Beverly argues and we agree the PPO here is intended to benefit its participants. Grand Strand gained access to BCBS's expansive membership along with guaranteed reimbursements from BCBS in exchange for accepting both reduced payments as well as the responsibility of submitting Members' claims to BCBS. BCBS gained greater cost control in exchange for promising prompt payment for Grand Strand's services and touting Grand Strand's PPO provider status to Members. Beverly's allegations that Grand Strand's failure to submit Beverly's bill to BCBS and refusal to bill her at the reduced reimbursement rate state a claim that Grand Strand breached its contract in denying Beverly benefits arising from the Agreement. Therefore, the circuit court erred in dismissing Beverly's breach of contract claim.

Id. at 513, 839 S.E.2d at 473.

Here, Plaintiffs have set forth sufficient allegations that they were the intended third-party beneficiaries of agreements between their insurance providers and Mary Black, and under those agreements, Mary Black agreed to accept a reduced amount of payment for its hospital services. Plaintiffs also allege Defendants failed to submit their hospital bills to their insurance companies as required. Defendants' argument that Plaintiff Blackwell lacks standing as a third-party beneficiary should be rejected.

CONCLUSION

Based upon the foregoing, the Court should deny all of Defendants' Motions to Dismiss and further deny Defendants' motions to compel Plaintiff Owens to arbitrate his claims.

Signature Page Follows

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Respectfully submitted,

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July 24, 2020

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STATE OF SOUTH CAROLINA COUNTY OF SPARTANBURG	IN THE COURT OF COMMON PLEAS SEVENTH JUDICIAL CIRCUIT
Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly situated, Plaintiffs, v. Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; and CHSPSC, LLC; Professional Account Services, Inc., Defendants.	C.A. No. 2017-CP-42-00219 **DEFENDANTS' MEMORANDUM OF LAW IN SUPPORT OF THE MOTION TO DISMISS PURSUANT TO RULE 12(B)(6) OR, IN THE ALTERNATIVE, TO STAY THE CASE AND COMPEL ARBITRATION**

Defendants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital ("Mary Black"), CHSPSC, LLC ("CHSPSC"), Professional Account Services, Inc. ("PASI") (collectively, "Defendants") submit this Reply Memorandum in support of their respective Motions to Dismiss and to Compel Arbitration in the captioned matter, and to debunk the Plaintiffs' Response in Opposition to the Motions – which Response lacks merit and is utterly misplaced. For ease of reference, Defendants will address Plaintiffs' arguments in the order they were presented.

1. <u>Plaintiff's Amended Complaint utterly fails to state facts sufficient to constitute any viable cause of action against CHSPSC or PASI.</u>

Plaintiffs' conclusory lumping together of "all Defendants" is insufficient to meet their pleading burden and state a claim against PASI or CHSPSC. *See SD3, LLC v. Black & Decker (U.S.) Inc.*, 801 F.3d 412, 422-23 (4th Cir. 2015) ("[T]he complaint must forecast that factual showing, and if it fails to allege particular facts against a particular defendant, then the defendant must be dismissed.").

The entirety of the specific and individual allegations against PASI and CHSPSC are encompassed in three paragraphs of the Amended Complaint:

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16. Defendant CHSPSC, LLC, formerly known as Community Health Systems Professional Services Corporation, is a Delaware corporation with its principal place of business in Tennessee. On information and belief, CHSPSC regularly conducts business in the State of South Carolina and other states and has responsibility for the billing of patients and liens filed within the State of South Carolina.

17. Defendant Professional Account Services, Inc. ("PASI") is a Tennessee corporation with its principal place of business in Brentwood, Tennessee. PASI is a collection firm that regularly conducts business in the State of South Carolina and elsewhere.

18. On information and belief, CHSPSC and PASI exercise control over policies and procedures enacted by and implemented by Mary Black Health System, including policies relating to billing and liens, and all of these entities committed the acts and omission complained of herein jointly and in concert.

The Amended Complaint contains no other specific or individual allegations against PASI or CHSPSC. Rather, the remainder of the Amended Complaint contains only non-specific generalized allegations referencing PASI, CHSPSC, and Mary Black collectively as Defendants. There are no allegations sufficient to identify what PASI or CHSPSC did, or failed to do, which would support the assertion of each (or any) of the purported causes of action. Furthermore, there are no factual allegations which could support or form the basis for any claim to pierce the corporate veil of PASI or CHSPSC or to establish a basis for an amalgamation or conspiracy claim. *See Pro Slab, Inc. v. Argos USA Corp.*, No. CV 2:17-3185-BHH, 2018 WL 6985008, at *5 (D.S.C. June 28, 2018), *reconsideration granted on other grounds*, No. CV 2:17-3185-BHH, 2018 WL 6985010 (D.S.C. Dec. 3, 2018) (granting the defendants' motions to dismiss on the grounds that that the plaintiffs' amended complaint simply lumped together members of corporate families and impermissibly ascribed liability to groups rather than to individual entities); *see also Scurmont LLC v. Firehouse Rest. Grp., Inc.*, No. 4:09-CV-00618-RBH, 2010 WL 11433199, at *15 (D.S.C. May 19, 2010) (dismissing claims against an individual defendant because the complaint only

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contained general conclusory allegations against the defendants collectively and the plaintiffs failed to plead sufficient facts that an individual defendant committed any wrongful act within the State of South Carolina, let alone any wrongful act causally related to the plaintiff's alleged injuries).

Since, the Amended Complaint contains only conclusory allegations against PASI and CHSPSC, Plaintiffs have, therefore, failed to plead ultimate facts sufficient to constitute any cause of action against PASI and CHSPSC. *See Jones v. Gilstrap*, 288 S.C. 525, 528, 343 S.E.2d 646, 648 (Ct. App. 1986) (providing that conclusory allegations in a complaint are insufficient to survive the defendant's motion to dismiss for failure to state a cause of action). Without alleging facts related to an act or omission by PASI or CHSPSC the Amended Complaint fails on its face and the claims against PASI and CHSPSC must be dismissed as a matter of law.

2. Plaintiffs' Amended Complaint utterly fails to allege facts sufficient to constitute a cause of action for tortious interference against any Defendant.

A claim for tortious interference with contract requires the Plaintiffs allege (1) the existence of a valid contract, (2) Defendants' knowledge thereof, (3) Defendants' intentional procurement of a breach of the contract, (4) the absence of justification for the breach of the contract, and (5) resulting damages. *Camp v. Springs Mortgage Corp.*, 310 S.C. 514, 517, 426 S.E.2d 304, 305-06 (1993). In this case, the Plaintiffs acknowledge that the contracts in issue are those between themselves and their respective health insurers. Without a breach of Plaintiffs' contracts with their health insurance carriers, there can be no recovery under a cause of action for tortious interference with a contractual relationship against Defendants. *First Union Mortgage Corp. v. Thomas*, 317 S.C. 63, 73, 451 S.E.2d 907, 913 (Ct. App. 1994)

Plaintiffs' Amended Complaint does not allege an actual breach of any of the relevant contracts. The Amended Complaint contains only bald and unsupported allegations that Plaintiffs did not receive the benefit of their individual health insurance contracts. However, the failure to

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receive a benefit of a contract is not a breach of a contract. Plaintiffs do not even assert their individual contracts with their health insurance carriers were breached. *Eldeco, Inc. v. Charleston Cty. Sch. Dist.*, 372 S.C. 470, 482, 642 S.E.2d 726, 732 (2007) ("In the absence of a breach of a contract, [the plaintiff] cannot prove the required elements of its cause of action for tortious interference with contractual relations."). Thus, Plaintiffs' conclusory and vague pleadings with not even an allegation that the third-party contract was breached, are insufficient to state a claim for tortious interference with a contractual relationship. Accordingly, Plaintiffs' claims for tortious interference with a contractual relationship must be dismissed as a matter of law.

3. Plaintiff Brooks fails to state facts sufficient to constitute a claim against any Defendant because Brooks' claim is governed by the Medicare Act and the law under that Act does not support the claim alleged.

When the applicable law does not recognize or sanction the claim alleged, dismissal of that claim pursuant to Rule 12(b)(6) is appropriate. In this case, in their own words in the Response in Opposition to the Motions to Dismiss, Plaintiffs admit:

> The claims of the named plaintiffs and the class members (collectively, "Plaintiffs") stem from Defendants' policy, in cases where a potential third party might be liable for a patient's injuries, of not submitting claims to health insurers for payment or refunding payments to health insurance carriers and then attempting to obtain payment for the patient's medical bills directly from the patient, from an auto insurer, and/or from the patient's third-party tort recovery. (See Am. Compl. ¶¶ 4–8.) Plaintiffs allege that Defendants, as a standard business practice, routinely refused to submit patients' medical bills to their insurance providers if Defendants' screening identified a patient as one for whom third-party recovery might be available to pay for such treatment. (*Id.* ¶¶ 4–5.) This was done so that Defendants could obtain a higher reimbursement than what might have been received from the patient's insurance. (*Id.* ¶ 6.)
>
> Plaintiffs contend they are third-party direct beneficiaries of the agreements between their insurance companies and Mary Black, and that Defendants interfered with Plaintiffs' own relationships with their insurance companies by attempting to collect payments from Plaintiffs at a higher amount than what Mary Black contracted for with Plaintiffs' insurance companies. (*See id.* ¶ 57.) Each of the named plaintiffs is an accident victim who received treatment at

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> Mary Black and, thereafter, Defendants refused to submit their bills to their health insurance companies for payment. (*See id.* ¶¶ 35–52.) Instead, Defendants engaged in impermissible attempts to collect directly from Plaintiffs or from Plaintiffs' third-party tort recovery. (*See id.* ¶¶ 40, 45, 51.)

Plaintiff Brooks' claims against Defendants must be dismissed because all of her claims fail, as a matter of law, under the Medicare Act, 42 U.S.C.A. § 1395y(b)(2)(A)(ii). All of Plaintiff Brooks' claims are based on the allegations that she had health insurance coverage through Medicare and that Defendants are liable because they sought collections for her medical care costs by asserting a right to payment against the insurer for the at-fault driver in her automobile accident instead of immediately and directly submitting the claim for her medical care costs to Medicare.

The Medicare Act requires hospitals—like Mary Black—to seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare. 42 U.S.C.A. § 1395y(b)(2)(A)(ii). Specifically, the Medicare Act states:

> Payment under this subchapter may not be made . . . with respect to any item or service to the extent that . . . (ii) payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State **or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance**.

Id. (emphasis added).

Other jurisdictions that have been confronted with this issue have concluded that 42 U.S.C. § 1395y(b)(2)(A)(ii) explicitly prohibits medical service providers from collecting payment from Medicare when payment can reasonably be expected to be made under an automobile or liability insurance policy. *See Parkview Hosp., Inc. v. Roese*, 750 N.E.2d 384, 389 (Ind. Ct. App. 2001) ("[W]e find that Congress's intent is clearly expressed in 42 U.S.C. § 1395y(b)(2)(A)(ii). It explicitly prohibits medical service providers from collecting payment from Medicare when payment can reasonably be expected to be made promptly under an automobile or liability insurance policy."); *Joiner v. Med. Ctr. E., Inc.*, 709 So. 2d 1209, 1221 (Ala. 1998) (holding that

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a hospital had a right under the Medicare Act to obtain full payment of its charges from the proceeds of the plaintiff patient's settlement with an automobile liability carrier, instead of filing a claim for reimbursement with Medicare). In short, Defendants cannot be liable to Brooks in this case for doing exactly what Medicare requires of them. Brooks' entire premise for liability fails and her claims must be dismissed as a matter of law.

4. Plaintiffs Brooks' and Owens' claims are barred as a matter of law under the voluntary payment doctrine.

It is a long standing and elementary principle of South Carolina law that no action will lie to recover money voluntarily paid. *Hardaway v. S. Ry. Co*., 90 S.C. 475, 488-89, 73 S.E. 1020, 1025 (1912); *Moody v. Stem*, 214 S.C. 45, 60, 51 S.E.2d 163, 169 (1948).

Recently, in *Cross v. Ciox Health, LLC*, No. 4:19-CV-7-FL, 2020 WL 534289, at *11 (E.D.N.C. Feb. 3, 2020), the North Carolina District Court applied the voluntary payment doctrine to bar a plaintiff's class action claim based upon allegations that the Plaintiff was overcharged for medical records. In *Cross*, the plaintiff alleged that she requested medical records from the hospital that treated her, that she was overcharged for those records, and her attorney paid those charges on her behalf. *Cross*, 2020 WL 534289, at *3. The District Court granted the defendant's Motion to Dismiss pursuant to Rule 12(b)(6) on the grounds that the plaintiff's claims were barred by the voluntary payment doctrine. The District Court held:

> Here, where it is alleged that defendant provided an itemized bill showing charges for the medical records, and where it is alleged that plaintiffs' attorney proceeded to pay the bills as requested, payment thus was made by plaintiffs with full knowledge of all the facts pertinent to their instant claims. Accordingly, the voluntary payment doctrine bars their claims for unjust enrichment.

Moreover, the Court found that the plaintiff did not meet the standard for avoiding the application of the voluntary payment doctrine based on "coercion or duress" because "they have alleged their attorney both requested and paid for the medical records."

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In this case, Plaintiffs make no allegations of fraud, duress or coercion in connection with the voluntary payments. In fact, while Plaintiffs seek to hide the facts in their Complaint, the voluntary payments were negotiated and made by the same attorneys now representing Plaintiffs.

5. Plaintiff Owens' claims are barred as a matter of law by the applicable limitations period.

When the instant action was commenced on January 20, 2017, Owens was not a Plaintiff or party in the case, and there were no allegations about him or his situation. Plaintiff Blackwell moved to amend her 2017 Complaint on October 18, 2019, and in that Motion to Amend sought to add Owens as a new Plaintiff in the case for the first time.

However, Rule 15 does not permit the original Plaintiff to amend the complaint to add new plaintiffs asserting new claims. The Court in *Valentine v. Davis*, 319 S.C. 169, 172, 460 S.E.2d 218, 219 (Ct. App. 1995) summarized the application of Rule 15 as follows:

> Rule 15, SCRCP, does not allow an existing plaintiff to add a new plaintiff to the case to assert a claim against the defendant. Rule 15(a) only permits an existing plaintiff to add, modify, delete, or change claims against an existing defendant. Rule 15(b) addresses amendments to conform to the evidence presented at trial. Rule 15(c) deals with relation back of amendments. **None of these subsections addresses a motion to add a plaintiff as contemplated in this case.**

(emphasis added). Rule 15(c) only applies to allow relation back of an amendment in a substitution or change in a party, and "the addition of a party is not the same as a substitution or change of party." *Jackson v. Doe*, 342 S.C. 552, 558, 537 S.E.2d 567, 570 (Ct. App. 2000).

Plaintiffs' Motion to Amend the Complaint added two new parties (Brooks and Owens), to assert new claims based on new factual allegations. The authorities in South Carolina are clear, "Rule 15 does not contemplate adding a *new* plaintiff to assert a *new* claim. . . ." *Patton v. Miller*, 420 S.C. 471, 495, 804 S.E.2d 252, 264 (2017) (emphasis added).

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Rule 15(c), SCRCP, addresses whether an amendment to a complaint relates back to the filing of the original complaint. *Valentine*, 319 S.C. at 172, 460 S.E.2d at 219. Since the addition of a new plaintiff is not contemplated by Rule 15(c), *Gause v. Smithers*, 384 S.C. 130, 133, 681 S.E.2d 607, 609 (Ct. App. 2009), Rule 15(c) does not allow for Plaintiff Owens's claims to relate back to the filing of the original complaint, because he is a newly added party asserting claims based upon his own individual facts.

Because Plaintiff Owens' claims do not relate back to the filing of the original complaint, his claims for tortious interference with contract and unjust enrichment are barred by the applicable statute of limitations. According to the purported Amended Complaint, Plaintiff Owens settled his bill with the Hospital on October 14, 2016 [Amended Complaint ¶ 52], and his claims accrued. Plaintiffs filed the Motion to Amend Complaint on October 18, 2019. Therefore, more than three (3) years passed between the time Plaintiff Owens knew or should have known of his alleged claims, and any possible action to commence his claims. *See Burgess v. Elliott*, No. 3:16-CV-3325-RBH, 2017 WL 1505421, at *3 (D.S.C. Apr. 27, 2017), *aff'd*, 696 F. App'x 125 (4th Cir. 2017) ("The applicable statute of limitations for civil actions of breach of contract, negligence, and tortious interference with contract is likewise three years."); *Graham v. Welch, Roberts & Amburn, LLP*, 404 S.C. 235, 239, 743 S.E.2d 860, 862 (Ct. App. 2013) (holding a claim for unjust enrichment was barred by the three year statute of limitations). Because it is clear from the face of the Amended Complaint that Owens did not commence his claim within the three year limitation period, his complaint fails as a matter of law and must be dismissed.

6. <u>Plaintiff Owens must be compelled to arbitrate his claims.</u>

If the Court allows Plaintiff Owens's claims against Defendants to continue in any way based on the allegations that Plaintiff Owens is entitled to enforce the billing and payment terms of the Hospital Services Agreement between his alleged insurance provider (CIGNA) and Mary

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Black (the "CIGNA Agreement"), then Plaintiff Owens must be compelled to arbitrate his claims against Defendants pursuant to the arbitration requirements of the Agreement and to stay further proceedings in this action.[1]

"The question of the arbitrability of a claim is an issue for judicial determination." *Zabinski v. Bright Acres Assocs.*, 346 S.C. 580, 596, 553 S.E.2d 110, 118 (2001). The policy of the United States and the State of South Carolina is to favor the arbitration of disputes. *Zabinski*, 346 S.C. at 596, 553 S.E.2d at 118. A motion to compel arbitration, when there is an arbitration clause in the written contract, should be granted unless the arbitration clause in question is not susceptible to any interpretation which would apply to the asserted dispute. *Tritech Elec., Inc. v. Frank M. Hall & Co.*, 343 S.C. 396, 399, 540 S.E.2d 864, 865 (Ct. App. 2000). "To decide whether an arbitration agreement encompasses a dispute, a court must determine whether the factual allegations underlying the claim are within the scope of the broad arbitration clause, regardless of the label assigned to the claim." *Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 287, 733 S.E.2d 597, 600 (Ct. App. 2012) (quoting *Zabinski*, 346 S.C. at 597, 553 S.E.2d at 118). "Any doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration." *Id.* (quoting *Zabinski*, 346 S.C. at 597, 553 S.E.2d at 118).

Section 6.2.2 of the CIGNA Agreement states:

> Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement.

All of Plaintiff Owens's claims arise from the CIGNA Agreement and his efforts to derive benefit from that Agreement and to enforce it against each of the Defendants. All of Plaintiff Owens's claims relate to his alleged ability to enforce the terms of the CIGNA Agreement and receive the negotiated rates for the medical services Mary Black provided to him. Any doubt as

[1] A copy of the Hospital Services Agreement between CIGNA and Mary Black has been filed under seal as **Exhibit B** to this Motion.

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to whether Plaintiff Owens's claims are within the scope of the CIGNA Agreement's broad arbitration provision must be resolved in favor of arbitration. *Landers v. Fed. Deposit Ins. Co.*, 402 S.C. 100, 109, 739 S.E.2d 209, 213 (2013).

Although Plaintiff Owens is a non-signatory to the CIGNA Agreement, because he seeks to enforce the Agreement and to derive benefit from its terms, he is bound by its valid and enforceable arbitration clause. The doctrine of direct benefits estoppel prevents the non-signatory from claiming he is not bound by the arbitration agreement when he is attempting to receive a direct benefit from a contract containing an arbitration clause. *Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 295-96, 733 S.E.2d 597, 604 (Ct. App. 2012). Thus, for Plaintiff Owens to assert, or derive any benefit from the CIGNA Agreement, he must be bound by the provision therein requiring arbitration. Accordingly, if Plaintiff Owens is allowed to proceed on claims seeking to enforce terms of the CIGNA Agreement against Defendants, then Plaintiff Owens must individually arbitrate his claims against Defendants pursuant to the terms of the arbitration agreement contained within the CIGNA Agreement.

Plaintiffs argument that the Agreement containing the arbitration provision is not valid or applicable in this case is ridiculous. As Plaintiffs could no doubt read, the CIGNA Agreement expressly provided in Section 5.1:

> 5.1 Term. This agreement shall be for an initial term of 3 years . . . Thereafter, this Agreement shall continue from year to year unless terminated pursuant to the Termination provision.

Plaintiff Owens bases the claim on the existence and applicability of that Agreement. He alleges it to exist and apply and there is nothing indicating it was terminated. Owens is bound by the Arbitration Agreement since he seeks the benefit of the other terms of the Agreement.

7. Plaintiff Blackwell's Amended Complaint fails to state facts sufficient to constitute a counsel action against any Defendant for Unjust Enrichment.

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South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: "(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its value." Columbia Wholesale Co., Inc. v. Scudder May N.V., 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994). Blackwell does not, and cannot plead any payment made to any Defendant, or any actual benefit conferred upon any Defendant, Therefore, no claim for unjust enrichment can exist.

8. Plaintiff Blackwell is not an intended third-party beneficiary under the agreement between Mary Black and her health insurer.

Plaintiff Blackwell's claims are all premised upon her contention that she is a third-party beneficiary of the MedCost Agreement between Mary Black and her health insurer. She alleges she has the right to enforce the terms of that Agreement for her own goals and benefit. However, Blackwell is not a party to that MedCost Agreement and she is not an intended third-party beneficiary who can sue to enforce that Agreement for her own benefit.

In South Carolina, there is a presumption that a contract is not enforceable by a person who is not a party to the contract, and the expressed intent of the parties to the contract shall govern the interpretation of that contract. *See Windsor Green Owners Ass'n, Inc. v. Allied Signal, Inc.*, 362 S.C. 12, 17, 605 S.E.2d 750, 752 (Ct. App. 2004). It is well settled that the law presumes that parties contract exclusively for their own benefit. *See Ancrum v. Camden Water, Light & Ice Co.*, 82 S.C. 284, 295, 64 S .E. 151, 155 (1909). In order to overcome this presumption, a non-signatory third-party must show that the parties to a contract intended the third-party to be a direct beneficiary of the contract. *Touchberry v. City of Florence*, 295 S.C. 47, 48–49, 367 S.E.2d 149, 150 (1988). However, "[n]o third-party beneficiary status is created absent an intent by the parties to confer a substantial benefit on [a non-signatory third-party]." *Windsor Green Owners Ass'n, Inc.*, 362 S.C. at 19, 605 S.E.2d at 753 (emphasis added).

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The line between a direct intended third-party beneficiary of a contract and an incidental or consequential third-party beneficiary is first drawn by examining the clear intent expressed by the actual parties to the contract. Absent an expression that the actual contracting parties clearly intended to directly benefit the third-party, that third-party is merely an incidental beneficiary with no right to enforce the contract. *See TC X, Inc. v. Commonwealth Land Title Ins. Co.*, 928 F. Supp. 618, 623 (D.S.C. 1995), *aff'd*, 86 F.3d 1152 (4th Cir. 1996) (applying South Carolina law to a claim for breach of a title insurance policy). Therefore, the necessary first step in determining whether a party is an intended direct third-beneficiary of a contract is to ascertain and give legal effect to the language of the contract on the issue of intent. *Whitlock v. Stewart Title Guar. Co.*, 399 S.C. 610, 614, 732 S.E.2d 626, 628 (2012) ("The cardinal rule of contract interpretation is to ascertain and give legal effect to the parties' intentions as determined by the contract language." (citation omitted)).

When the parties to a contract include an express third-party beneficiary disclaimer, as they did in the MedCost Agreement, a court is bound to find the parties did not intend to convey a direct benefit to third parties or to create a right for such third parties to enforce or sue upon the contract. *See Lightsey v. Toshiba Corp.*, No. 9:18-CV-190, 2019 WL 5872168, at *3 (D.S.C. Mar. 4, 2019) (applying New York law and finding that "[d]ismissal of a third-party-beneficiary claim is appropriate where the contract rules out any intent to benefit the claimant. . . .").[2]

The MedCost Agreement plainly and directly expresses Mary Black and MedCost's intent to bar third-parties from enforcing the MedCost Agreement. This intent is unequivocally stated in

[2] While not binding precedent because it is an unpublished opinion, in *Atherton v. Tenet Healthcare Corp.*, No. 2005-UP-362, 2005 WL 7084013, at *4 (Ct. App. May 25, 2005) the Court of Appeals held the third-party disclaimer in the contract at issue in that case conveyed an unambiguous expression of the parties' intent to exclude third-parties from being able to enforce its terms and that such an expression of intent was controlling. The application and enforceability of third-party beneficiary disclaimers in hospital services agreements has not been directly addressed in a published opinion in South Carolina.

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Section 10.9 of the MedCost Agreement, which expressly and definitively states Mary Black and MedCost's intention that the contract was not to be construed to have any third-party beneficiaries:

> This Agreement is entered into by and between the parties hereto for their benefit. There is no intent by either party to create or establish a third party beneficiary status or rights in a Covered Person, Employer, subcontractor, or other third party to this Agreement, except as such rights are expressly created and as set forth herein, and no such third party shall have any rights to enforce any right to enjoy any benefit created or established under this Agreement.

Review of the plain and unambiguous language must result in a finding that Mary Black and MedCost did not express, and did not have, an intent to allow Plaintiff Blackwell to enforce the MedCost Agreement as a third-party beneficiary. In fact, they expressed the clear and unambiguous intent that neither she, nor others, were third-party beneficiaries with such rights. Since Plaintiff Blackwell lacks standing to enforce the MedCost Agreement as a third-party beneficiary, she lacks standing to enforce the terms of the agreement or to pursue any of her alleged claims. Therefore, as a matter of law, Plaintiff Blackwell's claims must be dismissed.

Blackwell's attempt to rely on the decision by a panel of the court of appeals in *Beverly v. Grand Strand Regional Medical Center*, 429 S.C. 502, 839 S.E. 2d 468 (Ct. App. 2020), is not applicable. First, the petition for writ of certiorari in that case is still pending. Second, in that case the panel asserted that there were certain specific provisions in the agreement in issue which created the third party rights asserted, notwithstanding the disclaimer of third party beneficiaries. In this case, there are no allegations of provisions creating or conveying third party rights.

CONCLUSION

Based on the foregoing, Defendants request the Court dismiss Plaintiffs' Amended Complaint on the grounds that Plaintiffs have failed to allege facts sufficient to constitute a cause

of action, or in the alternative, compel Plaintiff Owens to arbitrate his claims against Defendants.

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July 28, 2020
Columbia, South Carolina

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STATE OF SOUTH CAROLINA COUNTY OF SPARTANBURG	IN THE COURT OF COMMON PLEAS SEVENTH JUDICIAL CIRCUIT
Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly situated, Plaintiffs, v. Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; and CHSPSC, LLC; Professional Account Services, Inc., Defendants.	C.A. No. 2017-CP-42-00219 **DEFENDANTS' MOTION TO ALTER OR AMEND**

Defendants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital ("Mary Black"), CHSPSC, LLC ("CHSPSC"), and Professional Account Services, Inc. ("PASI") (collectively, "Defendants") by and through undersigned counsel, hereby move the Court pursuant to Rule 59(e) of the South Carolina Rules of Civil Procedure for an Order altering, amending, or vacating the order denying Defendants' Motion to Dismiss Pursuant to Rule 12(B)(6) or, in the Alternative, to Stay the Case and Compel Arbitration (the "Motion"). Defendants respectfully submit that the Order contains conclusions of law that the evidence in the record does not support and that overlook or misapprehend controlling law.

I. The Court erred in failing to compel Plaintiff Samuel Owens to arbitrate his claims against Defendants.

A. Plaintiff Samuel Owens is equitably estopped from avoiding the arbitration provision in the CIGNA Agreement because he is seeking to take a direct benefit from that Agreement.

The Court erroneously concluded that the terms of the CIGNA Agreement do not apply to Plaintiff Owens. South Carolina courts have repeatedly recognized that non-signatories who are attempting to enforce contracts to which they are not a party are bound by all of the terms of the

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contracts they are seeking to enforce—including the arbitration provisions. *See Pearson v. Hilton Head Hosp*., 400 S.C. 281, 290, 733 S.E.2d 597, 601 (Ct. App. 2012) (applying direct benefits estoppel to compel a nonsignatory doctor to arbitrate his claims against a hospital pursuant to the arbitration provision in the hospital's contract with another entity because the doctor sought to take direct benefits from that contract in his lawsuit). Plaintiff Owens' claims against Defendants are based upon the alleged contractual requirement that Mary Black submit his hospital bills to his alleged insurance provider (CIGNA). *See* Amended Complaint ¶ 28 ("Defendants are required by their contracts with patients' health insurance carriers to submit insurance patients' medical bills directly to the carriers."). Plaintiff Owens is not a signatory to the CIGNA Agreement. Thus, Plaintiff Owens is a non-signatory who is attempting to enforce and to derive benefit from the terms of an agreement to which he is not a party.

When Plaintiff Owens (a non-signatory to the CIGNA Agreement) seeks to take direct benefits from the CIGNA Agreement, and to enforce the terms contained therein, the doctrine of direct benefits estoppel binds him to all of the terms within the CIGNA Agreement—including the arbitration provision. *See Pearson*, 400 S.C. at 290, 733 S.E.2d at 601. Under the direct benefits estoppel framework "[a] nonsignatory is estopped from refusing to comply with an arbitration clause 'when it receives a 'direct benefit' from a contract containing an arbitration clause.'" *Id.* at 290, 733 S.E.2d at 601 (quoting *Int'l Paper Co. v. Schwabedissen Maschinen & Anlagen GMBH*, 206 F.3d 411, 418 (4th Cir. 2000)). "'To allow [a plaintiff] to claim the benefit of the contract and simultaneously avoid its burdens would both disregard equity and contravene the purposes underlying enactment of the Arbitration Act.'" *Id.* (quoting *Int'l Paper*, 206 F.3d at 418).

Direct benefits estoppel applies regardless of whether Plaintiff Owens is a signatory to the CIGNA Agreement. *See Thompson v. Pruitt Corp.*, 416 S.C. 43, 59, 784 S.E.2d 679, 688 (Ct. App. 2016) ("[A] party may be estopped from asserting that the lack of his signature on a written

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contract precludes enforcement of the contract's arbitration clause when he has consistently maintained that other provisions of the same contract should be enforced to benefit him." (citation omitted)). To hold otherwise would be to disregard the doctrine of direct benefits estoppel and permit Plaintiff Owens to enforce the terms of the CIGNA Agreement while simultaneously permitting him to avoid compliance with the other terms of the CIGNA Agreement—including the arbitration provision. *See Pearson*, 400 S.C. at 295, 733 S.E.2d at 604 ("[A] party may not rely on the contract when it works to its advantage, and repudiate it when it works to its disadvantage."). Thus, the Court's finding that the CIGNA Agreement "does not apply to the Plaintiff as Plaintiff is not a 'party'" to the Agreement is an error of law that must be corrected.

Moreover, any analysis as to whether Plaintiff Owens should be required to arbitrate his claims must be reviewed and decided in the context of the absolutely clear and unquestionable policy, of both South Carolina and the United States, favoring the arbitration of disputes and "any doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration." *Landers v. Fed. Deposit Ins. Corp.*, 402 S.C. 100, 108, 739 S.E.2d 209, 213 (2013); *see also Zabinski v. Bright Acres Assocs.*, 346 S.C. 580, 596, 553 S.E.2d 110, 118 (2001). The Court's analysis of the arbitration provision in the CIGNA Agreement appears to have ignored the policy favoring arbitration in South Carolina.

B. The fact that the arbitration may be elective does not permit the Court to deny Defendants' Motion to Compel Arbitration.

Contrary to the Court's statements, resolution of disputes in arbitration does not need to be identified as the exclusive remedy to be binding and enforceable upon a demand from a proper party.

In *MailSource, LLC v. M.A. Bailey & Associates Inc.*, 356 S.C. 370, 373, 588 S.E.2d 639, 640-41 (Ct. App. 2003), the Court of Appeals analyzed a similar elective arbitration provision and found the circuit court erred in failing to compel the plaintiff to arbitrate its claims against the

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defendant. In *MailSource*, the Court stated that the principal agreement "required the parties to attempt in good faith to settle any disputes first through consultation and negotiation, and then by mediation. If those attempts failed, the agreement provided 'either party may demand that the dispute be arbitrated. . . .'" 356 S.C. 370, 373, 588 S.E.2d at 341. After the plaintiff filed an action against the defendant, the defendant moved the circuit court to compel arbitration. The court held that while the elective nature of the arbitration provision may be unique, nevertheless, the circuit court erred in refusing to compel the plaintiff to arbitrate its claims against the defendant. *Id*. at 377, 588 S.E.2d at 643.

Like the circuit court in *MailSource*, this Court erred in denying Defendants' Motion to Compel Arbitration of Plaintiff Owens' claims. The elective nature of the arbitration provision in the CIGNA Agreement does not alter a proper analysis of a demand for arbitration pursuant to an enforceable agreement to arbitrate. The CIGNA Agreement states that either party may demand arbitration and, like the defendant in *MailSource*, Defendants made a proper demand for arbitration in response to the Amended Complaint. Accordingly, the Court should alter or amend its order and find Plaintiff Owens is required to arbitrate his claims against Defendants.[1]

C. The disclaimer of third-parties and class arbitration does not alter the necessary conclusion that Plaintiff Owens is obligated to arbitrate his claims against Defendants.

The CIGNA Agreement's express statement that an arbitration conducted pursuant to the Agreement will not include class claims or third-parties does not render the arbitration provision unenforceable against Plaintiff Owens. South Carolina Courts and the United States Supreme Court have recognized the principle that parties may not arbitrate class claims unless the agreement

[1] Defendants further note that the Court's reference to the elective language in the arbitration provision and its impact on the issues in this case was raised *sua sponte* for the first time by the Court in its order. This language or its impact on the Defendants' motion was not raised as an issue by the Plaintiffs.

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to arbitrate expressly states that the parties agreed to arbitrate such claims. *See Grant v. Chevrolet*, No. 2017-001897, 2020 WL 4661330, at *2 (S.C. Ct. App. Aug. 12, 2020) (applying the reasoning of the United States Supreme Court in *Lamps Plus, Inc. v. Varela*, 139 S. Ct. 1407, 1412, 203 L. Ed. 2d 636 (2019) and *Stolt-Nielsen S.A. v. AnimalFeeds Int'l Corp.*, 559 U.S. 662, 673, 130 S. Ct. 1758, 1768, 176 L. Ed. 2d 605 (2010) to find that an arbitration provision must expressly state that the parties agree to arbitrate class issues, otherwise a party will be required to arbitrate their claims alone and the class claims may not proceed). Thus, the inclusion of express language stating that an arbitration will not include class claims is permissible and proper, and such language does not render the arbitration provision unenforceable. To the contrary, such language is directly enforceable and expresses a clear intent that the arbitration of claims pursuant to the arbitration provision in the CIGNA Agreement will only involve Plaintiff Owens and the parties that he is attempting to enforce the agreement against—Defendants.

II. In the alternative, the Court erred in failing to dismiss Plaintiff Owens' claims on the grounds that they are barred by the applicable statute of limitations.

The Court erred in finding that Plaintiff Owens' claims should not be dismissed pursuant to the applicable statutes of limitations. As a matter of law, Plaintiff Owens' claims do not relate back to the filing of the original complaint and, therefore, his claims are barred by the applicable statutes of limitation. While the Court erred in allowing the amendment to add new plaintiffs in the first place, that does not change the law that the claims for the new plaintiffs do not relate back to the date of the filing of the original complaint.

Rule 15(c) of the South Carolina Rules of Civil Procedure addresses the relation back of amendments to a complaint for the purpose of applying the statute of limitations. Rule 15(c) does not permit the relation back of a new claim filed by a new plaintiff that was added to a case pursuant to an amended complaint. *See Valentine v. Davis*, 319 S.C. 169, 172, 460 S.E.2d 218, 219 (Ct. App. 1995). Rule 15(c) only applies, and may only validate a relation back argument, to a

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substitution or change in a party. "[T]he addition of a party is not the same as a substitution or change of party." *Jackson v. Doe*, 342 S.C. 552, 558, 537 S.E.2d 567, 570 (Ct. App. 2000). The addition of a new party is not contemplated by Rule 15(c), and does not relate back. *Gause v. Smithers*, 384 S.C. 130, 133, 681 S.E.2d 607, 609 (Ct. App. 2009).

Thus, Rule 15(c) does not allow for Plaintiff Owens's claims to relate back to the filing of the original complaint because he is a newly added plaintiff asserting claims based upon his own individual facts. Specifically, Plaintiff Owens' claims are new and different from Plaintiff Blackwell's original claims because his claims arise out of a different automobile accident, he is covered by a different insurance carrier (which results in his claims being affected by his contract with his insurance carrier and his insurance carrier's contract with Mary Black), and he actually paid to settle his debt to Mary Black. Therefore, the Court erred in finding that Plaintiff Owens' claims relate back to the filing of original complaint and are not barred by the applicable statutes of limitation. Accordingly, the Court should alter or amend its order and dismiss all of Plaintiff Owens's claims because his claims do not relate back to the filing of the original complaint and, as is evident on the face of the Amended Complaint, are barred by the applicable statutes of limitation.

III. The Court's analysis of the application of the voluntary payment doctrine contains improper and incendiary assertions based on facts not pled and arguments not presented to the Court.

As an initial matter, Defendants take great umbrage with the Court's statement (or at least implication) that the payments made on behalf of Plaintiff Owens and Plaintiff Brooks were "a result of extortion." It is improper and frankly alarming that the Court would make such an accusation against the Defendants when no such allegation has been made and none could ever be support by the facts.

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In reviewing a Motion to Dismiss pursuant to Rule 12(b)(6) the Court considers the facts alleged in a light most favorable to the non-moving party; however, the Court is not permitted to create facts and allegations to avoid the application of an affirmative defense. The Court's improper statement that the payments made on behalf of Plaintiff Owens and Plaintiff Brooks were the result of "extortion" is wholly improper. The parties to this case are undeniably aware that counsel for Plaintiff Owens and Plaintiff Brooks negotiated settlements with Mary Black and voluntarily paid the settlement amounts negotiated. If Plaintiffs Owens or Plaintiff Brooks—or their counsel—intended to dispute the billing practices of Defendants, then they should have raised their concerns before negotiating a settlement of the hospital bills that are now in dispute. Allowing these claims to proceed based on the Court's assumption of new facts, and an intentional failure by the Plaintiffs to include in their pleadings all the necessary facts, is improper and should not be permitted by courts in this state.

IV. The Court erred in failing to dismiss Plaintiff Blackwell's claim for unjust enrichment, because Plaintiff Blackwell does not allege she conferred any benefit to Defendants.

In ruling on a motion to dismiss the Court is to construe the facts in favor of the non-moving party; however, this standard does not permit the Court to ignore the absence of critical facts.

South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: "(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its value." *Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994).

The Amended Complaint contains **no factual allegation** that (a) Plaintiff Blackwell made a payment or conferred a benefit to Mary Black (or any of the Defendants), (b) Mary Black realized

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a benefit conferred upon it by Plaintiff Blackwell, or (c) the retention of a benefit by Mary Black would be unjust. Rather, review of the Amended Complaint's allegations reveals only that Mary Black conferred a benefit to Plaintiff Blackwell—it provided medical services to her between December 27, 2013 and January 3, 2014. Plaintiff Blackwell does not—and cannot—allege that she conferred a benefit to Mary Black—because she never paid for that medical treatment.

The Court's order does not identify any benefit conferred by Plaintiff Blackwell to the Defendants. The Court, in its Order, is guilty of the same error perpetuated by the Amended Complaint; namely, an unfounded and unsubstantiated, conclusory joinder of generic Plaintiffs and generic Defendants in its general conclusion. This is exactly why collective pleading is improper and results in erroneous analysis. The Amended Complaint does not contain any allegation that Plaintiff Blackwell conferred a benefit upon Defendants and, therefore, it is not possible for the Defendants to have unjustly retained any benefit. The Court's Order fails to identify any allegation that could be construed to permit any other finding, because no such allegation exists in the Amended Complaint. Therefore, the Court should alter or amend its order and find Plaintiff Blackwell failed to state a claim for unjust enrichment.

V. The Court failed to address the argument that Plaintiff Blackwell is barred from enforcing the terms of the MedCost Agreement pursuant to the Agreement's express disclaimer of third-party beneficiaries.

Plaintiff Blackwell's claims are all premised upon her contention that she is a third-party beneficiary of the MedCost Agreement between Mary Black and her health insurer. She alleges she has the right to enforce the terms of that Agreement for her own goals and benefit. However, Plaintiff Blackwell is not a party to the MedCost Agreement and she is not an intended third-party beneficiary who can sue to enforce that Agreement for her own benefit.

As raised in the Motion to Dismiss, the MedCost Agreement plainly and directly expresses Mary Black and MedCost's intent to bar third-parties from enforcing the MedCost Agreement.

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This intent is unequivocally stated in Section 10.9 of the MedCost Agreement, which expressly and definitively states Mary Black and MedCost's intention that the contract was not to be construed to have any third-party beneficiaries:

> This Agreement is entered into by and between the parties hereto for their benefit. There is no intent by either party to create or establish a third party beneficiary status or rights in a Covered Parson, Employer, subcontractor, or other third party to this Agreement, except as such rights are expressly created and as set forth herein, and no such third party shall have any rights to enforce any right to enjoy any benefit created or established under this Agreement.

The Court's Order does not address or decide this issue raised in the Motion, despite the law clearly establishing that the Court's determinative step in reviewing the MedCost Agreement is to review and give effect to its plain and unambiguous language. *See Whitlock v. Stewart Title Guar. Co.*, 399 S.C. 610, 614, 732 S.E.2d 626, 628 (2012) ("The cardinal rule of contract interpretation is to ascertain and give legal effect to the parties' intentions as determined by the contract language." (citation omitted)). The plain and unambiguous language of the MedCost Agreement compels the finding that Mary Black and MedCost did not express, and did not have, an intent to allow Plaintiff Blackwell to enforce the MedCost Agreement as a third-party beneficiary. *See Windsor Green Owners Ass'n, Inc. v. Allied Signal, Inc.*, 362 S.C. 12, 19, 605 S.E.2d 750, 753 (Ct. App. 2004) ("No third-party beneficiary status is created absent an intent by the parties to confer a substantial benefit on [a non-signatory third-party]."). Since Plaintiff Blackwell lacks standing to enforce the MedCost Agreement as a third-party beneficiary, she lacks standing to enforce the terms of the agreement and pursue any of her alleged claims. Therefore, as a matter of law, Plaintiff Blackwell's claims must be dismissed. Accordingly, the Court erred in failing to address this issue because it is determinative of the claims asserted by Plaintiff Blackwell.

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VI. The Court erred in permitting Plaintiffs to collectively plead claims against the Defendants.

The Court's refusal to find that such a style of collective pleading is improper is an error. The Court's decision ignores the well-established law in South Carolina that corporations are not liable for each other's obligations merely because of some type of centralized control or mutual purposes. *See Pertuis v. Front Roe Restaurants, Inc.*, 423 S.C. 640, 654, 817 S.E.2d 273, 280 (2018), *reh'g denied* (Aug. 16, 2018); *see also Pro Slab, Inc. v. Argos USA Corp.*, No. CV 2:17-3185-BHH, 2018 WL 6985008, at *5 (D.S.C. June 28, 2018), *reconsideration granted on other grounds*, No. CV 2:17-3185-BHH, 2018 WL 6985010 (D.S.C. Dec. 3, 2018) (granting the defendants' motions to dismiss on the grounds that that the plaintiffs' amended complaint simply lumped together members of corporate families and impermissibly ascribed liability to groups rather than to individual entities); *Scurmont LLC v. Firehouse Rest. Grp., Inc.*, No. 4:09-CV-00618-RBH, 2010 WL 11433199, at *15 (D.S.C. May 19, 2010) (dismissing claims against an individual defendant because the complaint only contained general conclusory allegations against the defendants collectively and the plaintiffs failed to plead sufficient facts that an individual defendant committed any wrongful act within the State of South Carolina, let alone any wrongful act causally related to the plaintiff's alleged injuries). Allowing Plaintiffs to collectively plead claims against the Defendants is the equivalent of allowing Plaintiffs to pierce the corporate veil without the need to plead facts to support piercing the corporate veil. Plaintiffs are not permitted to simply collectively accuse the Defendants of wrongdoing without pleading the facts necessary to permit Defendants to share such liability. Therefore, the Court erred in finding Plaintiffs adequately plead facts to state claims against CHSPSC and PASI.

CONCLUSION

Based on the foregoing, Defendants request the Court alter or amend its Order and dismiss Plaintiffs' Amended Complaint on the grounds that Plaintiffs have failed to allege facts sufficient

to constitute a cause of action, or in the alternative, compel Plaintiff Owens to arbitrate his claims against Defendants.

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September 14, 2020
Columbia, South Carolina

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STATE OF SOUTH CAROLINA COUNTY OF SPARTANBURG	IN THE COURT OF COMMON PLEAS SEVENTH JUDICIAL CIRCUIT
Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly-situated, Plaintiffs, v. Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; CHSPSC, LLC; and Professional Account Services, Inc., Defendants.	**C.A. No. 2017-CP-42-00219** Hon. J. Mark Hayes, II **PLAINTIFFS' RESPONSE IN OPPOSITION TO DEFENDANTS' MOTION TO ALTER OR AMEND**

Incorporating all arguments from their previously filed memorandum of law, Plaintiffs Jo Ann Blackwell; Michelene Brooks; and Samuel H. Owens, Jr.; individually and on behalf of all others similarly-situated, respectfully submit this Response in Opposition to Defendants' Motion to Alter or Amend this Court's September 4, 2020 Order denying Defendants' Motions to Dismiss. Because there is no evidence the Court has misunderstood or failed to fully consider or rule upon any issue raised by Defendants, the Court should deny the motion and allow the matter to proceed to discovery. Defendants merely reiterate the same arguments raised in their prior memorandum and at the hearing and provide no basis for reconsideration or amendment of the Court's Order. *See, e.g.*, *Collins Music Co. v. IGT*, 353 S.C. 559, 579 S.E.2d 524 (Ct. App. 2002) (where movant merely repeated the same arguments found in its memorandum and failed to identify any issue raised but not ruled upon, motion for reconsideration was properly denied).

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ARGUMENT

1. The Court correctly found that Owens should not be compelled to arbitrate his claims against Defendants.

In addition to the reasons advanced in Plaintiffs' Response in Opposition to Defendants' Motions to Dismiss, compelling Owens to arbitrate his claims against Defendants would be improper because equitable estoppel is inapplicable under these circumstances and the arbitration clause, by its own terms, does not encompass Plaintiffs' claims.

Defendants' reliance on equitable estoppel to enforce the arbitration clause as to Owens, a nonparty to the CIGNA agreement, is misplaced. Defendants cite *Pearson v. Hilton Head Hospital*, 400 S.C. 281, 733 S.E.2d 597 (Ct. App. 2012), to support their argument; however, *Pearson* is easily distinguished from this action. There, the plaintiff, while also a nonparty to the contract at issue containing an arbitration clause, "received a benefit due to the contract, in that he was able to work at the Hospital and receive payment for his work." *Id.* at 296, 733 S.E.2d at 605; *see also id.* at 296–97, 733 S.E.2d at 605 ("If not for that contract, then Dr. Pearson would have had to make separate arrangements with the Hospital in order to work there. He *knowingly accepted* benefits of the contract between the Hospital and Locum. Accordingly, Dr. Pearson benefitted from that contract and should not be able to disclaim the arbitration agreement contained in it." (emphasis added)).

Here, however, Plaintiffs have not received or accepted any corresponding benefit from the hospital service agreements Mary Black entered into. In fact, it is because the exact opposite has taken place—Plaintiffs were harmed by Defendants' failure to act in accordance with the contract—that Plaintiffs have been forced to bring this action against Defendants. *See id.* at 291, 733 S.E.2d at 602 ("Generally, these cases involve non-signatories who, *during the life of the contract*, have embraced the contract despite their non-signatory status but then, during litigation, attempt

to repudiate the arbitration clause in the contract." (emphasis added) (quoting *E.I. DuPont de Nemours & Co. v. Rhone Poulenc Fiber & Resin Intermediates, S.A.S.*, 269 F.3d 187, 200 (3d Cir. 2001))); *accord* 6 C.J.S. Arbitration § 18.

The South Carolina Court of Appeals recently addressed a similar scenario in *Weaver v. Brookdale Senior Living, Inc*., where it held that a nursing home's insistence that "direct benefits estoppel" required arbitration of a granddaughter's claims was unsupported by the law. 847 S.E.2d 268, 271 (S.C. Ct. App. 2020). In *Weaver*, a granddaughter brought suit after her grandmother died on the grounds of a nursing home after wandering away. *Id.* The granddaughter discovered her body, maimed and dismembered, in a retention pond, and as a result, asserted claims for negligent and intentional infliction of emotional distress. *Id.* The nursing home argued "direct benefits estoppel funnels the [granddaughter's] claims to arbitration because her ability to sue [the nursing home] stems from [her grandmother's] residency agreement, which includes the arbitration agreement." *Id.* at 272. The Court of Appeals disagreed, holding "this argument is easily scotched, for direct benefits estoppel is not implicated simply because a claim related to or would not have arisen but for a contract's existence." *Id.* The court noted that the daughter "ha[d] not exploited or otherwise sought to enforce or benefit from the residency agreement, any more than a pedestrian run over by a truck has benefited from the contract for the purchase of the truck." *Id.* at 273. Declining to apply the doctrine of direct benefits equitable estoppel, the Court noted that "the heart of the theory 'is that the party entitled to invoke the principle was misled to his injury.'" *Id.* at 274 (quoting *Rodarte v. Univ. of S.C.*, 419 S.C. 592, 601, 799 S.E.2d 912, 916 (2017)). Finding no evidence of such conduct, the Court held there was no agreement to arbitrate between the parties and affirmed the denial of the motion to compel arbitration. Here, as in *Weaver*, Plaintiffs did not mislead Defendants or cause them any injury. In fact, as stated above, the opposite has taken place.

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Similarly, in *Wilson v. Willis*, numerous insureds brought suit against their insurance agent, the insurance broker who hired the agent, the insurance agency, and the insurers whose policies the agency sold. 426 S.C. 326, 331, 827 S.E.2d 167, 170 (2019). The plaintiff insureds alleged the agent, among other things, "forg[ed] insurance documents, [took] cash payments, and convert[ed] the payments to her own use, resulting in the Insureds having either no coverage or reduced coverage." *Id.* at 332, 827 S.E.2d at 170. Several insurers filed motions to compel arbitration based on arbitration clauses contained in contracts between the insurers and the agency. *Id.* at 332–33, 827 S.E.2d at 170-71. The insurers argued that "equitable estoppel should preclude [the plaintiffs'] assertion of their nonsignatory status because [their] claims were premised on duties that would not exist but for the Agency Agreement [the insurers] had with [the agency]." *Id.* at 333, 827 S.E.2d at 171. In upholding the circuit court's denial of the insurers' motions, however, the Supreme Court distinguished *Pearson*:

> We agree with [Plaintiffs] that the circumstances in *Pearson* are distinguishable. Unlike Dr. Pearson, [Plaintiffs] did not embrace the Agency Agreement during the life of the contract and then, during litigation, attempt to repudiate the arbitration clause in the contract. It is undisputed that [Plaintiffs] were never aware of the existence of the contract until they brought their tort actions against [the insurers].

Id. at 342, 827 S.E.2d at 176. Rather than using *Pearson* as a guidepost, Plaintiffs respectfully submit that *Weaver* and *Wilson* are much more similar to the circumstances of this case and are controlling as to this issue.

In addition to the complete lack of prior benefits, any future benefit that may be conferred on Plaintiffs is insufficient to mandate arbitration. As Defendants acknowledged in their Motion, equitable estoppel is only available to enforce an arbitration clause when a nonsignatory receives a "direct benefit" from the contract containing the arbitration clause. *See* Defendants' Motion to Alter or Amend, at 2. However, Plaintiffs will not receive any direct benefit from the CIGNA

hospital service agreement even if they are ultimately successful in this litigation. "It is important to distinguish direct benefits from indirect benefits because when the benefits to a nonsignatory are merely indirect, arbitration cannot be compelled." *Wilson*, 426 S.C. at 343, 827 S.E.2d at 176. "A benefit is direct if it flows directly from the agreement." *Id.* "In contrast, any benefit derived from an agreement is indirect where the nonsignatory exploits the contractual relationship of the parties, but does not exploit (and thereby assume) the agreement itself." *Id.*

Here, Plaintiffs' claims for unjust enrichment and tortious interference with a contractual relationship are grounded on independent South Carolina law and do not rely on the hospital service agreements for recovery. Accordingly, any benefit conferred due to the existence of the agreements would be indirect at best, and those claims provide Defendants no support in their attempt to compel arbitration. *See id.* at 343, 827 S.E.2d at 176 ("[D]irect benefits estoppel is not implicated simply because a claim relates to or would not have arisen 'but for' a contract's existence."); *id.* ("When a claim depends on the contract's existence and cannot stand independently—that is, the alleged liability 'arises solely from the contract or must be determined by reference to it'—equity prevents a person from avoiding the arbitration clause that was part of that agreement. But 'when the substance of the claim arises from general obligations imposed by state law, including statutes, torts and other common law duties, or federal law,' direct-benefits estoppel is not implicated even if the claim refers to or relates to the contract *or would not have arisen 'but for' the contract's existence*." (quoting *Jody James Farms, JV v. Altman Grp., Inc.*, 547 S.W.3d 624, 637 (Tex. 2018))); *see, e.g.*, *id.* at 342, 827 S.E.2d at 176 ("General principles of South Carolina law form the basis for most of [Plaintiffs'] claims. For example, [Plaintiffs'] allegation that [the insurers] possibly conspired with [the agent] and others to commit fraud is misconduct that does not arise from the contract.").

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Plaintiffs' remaining claim for injunctive relief similarly does not warrant compelling arbitration. Although Plaintiffs' success on that claim admittedly relies on the hospital service agreements, the relief sought—enjoining Defendants from engaging in unlawful billing practices in contravention of the agreements—will confer no direct benefit on Plaintiffs. Any benefit resulting from the successful litigation of this claim will inure to future patients. Such an indirect and insubstantial benefit is insufficient to support Defendants' attempt to compel arbitration. *See Equitable estoppel—Generally*, 1 Domke on Com. Arb. § 13:9 ("A nonsignatory who has received a direct benefit from a contract containing an arbitration clause may be estopped from refusing to comply with that arbitration clause. This approach does not apply if the claimed benefits are insubstantial or indirect, nor does it apply if the claim merely relates to the contract." (footnote omitted)). Moreover, the fact that only one of Plaintiffs' claims relies on the health service agreements further weighs against enforcement of the arbitration clause. *See Wilson*, 426 S.C. at 342, 827 S.E.2d at 176 (denying arbitration and noting "[g]eneral principles of South Carolina law form the basis for *most* of Petitioners' claims" (emphasis added)).

Next, the Court correctly found in its Order denying dismissal that Defendants' argument fails because the CIGNA agreement's arbitration clause does not encompass Plaintiffs' claims.[1] The clause is limited to "disputes between the parties," and only CIGNA and Mary Black were parties to the agreement. The provisions of the arbitration clause also repeatedly refer to actions a

[1] Despite Defendants' argument regarding the elective nature of the arbitration clause, *see* Defendants' Motion to Alter or Amend, at 3–4, the Court did not rely on this fact in determining the arbitration clause was inapplicable to Plaintiffs. *See* Form 4 Order dated Sept. 4, 2020, at 4 ("[T]he arbitration provision in the Cigna Agreement . . . does not apply to the Plaintiff as the Plaintiff is not a 'party' to the agreement. In accordance [with] the terms of the agreement, the Plaintiff is, at best, a 'participant' under the agreement's terms but not a 'party'. . . . As previously stated, the Plaintiff is not a 'party' to the agreement and its provisions are not enforceable as binding on the Plaintiff."). Accordingly, Defendants' argument on this point is immaterial.

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"party," "the parties," or "Hospital" may take, which indicates that it was not intended to encompass Plaintiffs' claims. The agreement does not define "party," so in interpreting the agreement, the ordinary definition of the term (which does not include Plaintiffs) should be used. *See Plain meaning*, 11 Williston on Contracts § 32:3 (4th ed.) ("The plain, common, or normal meaning of language will be given to the words of a contract unless the circumstances show that in a particular case a special meaning should be attached to them." (footnote omitted)); *Party*, Black's Law Dictionary (11th ed. 2019) ("Someone who takes part in a transaction <a party to the contract>."). Moreover, any ambiguity as to whether "party" encompasses Plaintiffs should be resolved against Defendants. *See Contra proferentem: Ambiguities are interpreted against the drafter*, 11 Williston on Contracts § 32:12 (4th ed.) ("[I]t is a generally accepted principle that any ambiguity in that language will be interpreted against the drafter.").

The agreement does define "Participant" as "any individual . . . who is eligible and enrolled to receive Covered Services." This definition encompasses Plaintiffs, so if CIGNA and Mary Black intended to include Plaintiffs' claims in the scope of the arbitration clause, they could have used that term. Plaintiffs acknowledge that one sentence of the arbitration clause states more generally, "Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement." However, the clause also explicitly excludes "arbitration on a class basis" and states "an arbitration conducted under this provision shall not be consolidated with an arbitration involving . . . third parties." Read as a whole, the clause demonstrates the contracting parties' intent not to include claims by "Participants," and any limited, specific language to the contrary should not override this interpretation. *See The contract is to be read as a whole; the "four corners" rule*, 11 Williston on Contracts § 32:5 (4th ed.) ("A contract will be read as a whole and every part will be read with reference to the whole.").

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Because the arbitration clause, by its own terms, does not encompass Plaintiffs' claims, it cannot be enforced to compel Plaintiffs into arbitration. *See Weaver*, 847 S.E.2d at 271 ("To compel Weaver to arbitrate her claims, Appellants must demonstrate (1) there is a valid arbitration agreement, and (2) the claims fall within its scope."); 6 C.J.S. Arbitration § 18 ("[T]he doctrine of equitable estoppel is not applicable to compel arbitration, where the arbitration agreement is specifically limited to the parties who have executed the agreement, or the provision is not broad enough to indicate an intent to arbitrate with a person who did not sign the agreement." (footnote omitted)); *Hilton Head Resort Four Seasons Ctr. Horizontal Prop. Regime Council of Co-Owners, Inc. v. Resort Inv. Corp.*, 311 S.C. 394, 398, 429 S.E.2d 459, 462 (Ct. App. 1993) ("Where there has been no agreement to arbitrate, a party cannot be forced into compulsory arbitration.").

Here, as in *Weaver* and *Wilson*, applying equitable estoppel would be improper because Plaintiffs have not done, or failed to do, any act related to the execution or performance of the CIGNA agreement, and Defendants have in no way been prejudiced by Plaintiffs' conduct during the time periods covered by their claims or related to this litigation. *See Parker v. Parker*, 313 S.C. 482, 487, 443 S.E.2d 388, 391 (1994) ("Equitable estoppel occurs where a party is denied the right to plead or prove an otherwise important fact because of something which he has done or failed to do."); *id.* ("The essential element of estoppel is prejudice to the party raising the defense."). Furthermore, public policy cautions against allowing Defendants to engage in misconduct and then hide that conduct from the Court's scrutiny by enforcing an arbitration clause with respect to a nonparty. *See Wilson*, 426 S.C. at 342, 827 S.E.2d at 176 ("[Plaintiffs'] allegation that [the insurers] possibly conspired with [the agent] and others to commit fraud is misconduct that does not arise from the contract. To hold otherwise would arguably allow [the insurers] to commit unfair trade practices and conspire to destroy the businesses of other insurance agencies while shielding

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themselves from the possibility of a jury trial with an arbitration clause agreed to only by the conspiring parties.").

Finally, Defendants' argument that "any analysis as to whether Plaintiff Owens should be required to arbitrate his claims must be reviewed and decided in the context of the absolutely clear and unquestionable policy . . . favoring the arbitration of disputes" is not applicable in this context. *See* Defendants' Motion to Alter or Amend, at 3. "[T]he presumption in favor of arbitration applies to the scope of an arbitration agreement; it does not apply to the existence of such an agreement *or to the identity of the parties who may be bound* to such an agreement." *Wilson*, 426 S.C. at 337, 827 S.E.2d at 173 (quoting *Carr v. Main Carr Dev., LLC*, 337 S.W.3d 489, 496 (Tex. App. 2011)). "Even the exceptionally strong policy favoring arbitration cannot justify requiring litigants to forego a judicial remedy when they have not agreed to do so." *Id.* (quoting *Carr*, 337 S.W. at 496). In fact, "because arbitration, while favored, exists solely by agreement of the parties, a presumption *against* arbitration arises where the party resisting arbitration is a nonsignatory to the written agreement to arbitrate." *Id.* at 337–38, 827 S.E.2d at 173.

2. The Court correctly found Owens' claims are not barred by the statute of limitations.

Defendants argue Owens' claims are barred by the statute of limitations because they do not relate back to the date Plaintiffs filed their original Complaint. However, in doing so, Defendants repeat the same arguments they advanced in their Memorandum in Opposition to Plaintiffs' Motion to Amend Complaint, which this court has already declined to address until after class certification is adjudicated. *See* Order Granting Plaintiffs' Motion for Leave to Amend the Complaint, dated Apr. 23, 2020, at 2 ("[O]nce a class is certified, the period for the statute of limitations for purposes of a valid claim may be defined."). The Court reiterated its position in its recent Order denying Defendants' Motion to Dismiss. *See* Form 4 Order dated Sept. 4, 2020, at 4 ("This

Court[’s] opinion is that any statute of limitation issue fails at this time because of its relatedness to the original filing of the complaint. Factually, the issue may or may not be significant at a future time”). On this basis alone, the Court should reject Defendants’ continuing attempts to force the Court to rule on this issue now.

Nonetheless, Defendants’ argument also fails on the merits. Defendants rely on Rule 15(c), SCRCP, and *Valentine v. Davis*, 319 S.C. 169, 460 S.E.2d 218 (Ct. App. 1995), neither of which supports their position. They contend “Rule 15(c) does not permit the relation back of a new claim filed by a new plaintiff that was added to a case pursuant to an amended complaint.” Defendants’ Motion to Alter or Amend, at 5. However, Rule 15(c) does not prohibit the addition of plaintiffs in an amended complaint. Instead, it provides that “[w]henever the *claim or defense* asserted in the amended pleading arose out of the conduct, transaction or occurrence set forth or attempted to be set forth in the original pleadings, the amendment relates back to the date of the original pleading.” Rule 15(c) (emphasis added). Here, the claims in Plaintiffs’ Amended Complaint are materially unchanged from those in the original Complaint and certainly “arose out of the conduct, transaction or occurrence set forth or attempted to be set forth in the original pleadings.” *Id.* In fact, Rule 15(c) explicitly allows the relation back of claims when the party against whom the claim is asserted is changed. *See id.* (“An amendment changing the party against whom a claim is asserted relates back if the foregoing provision is satisfied and” the party has notice or knowledge of the action.). Accordingly, Defendants’ reliance on Rule 15(c) is misplaced.

Defendants’ reliance on *Valentine* is similarly misplaced. Not only does that case not address the relation back of claims when parties are added or substituted in an amended complaint, but subsequent case law stands in stark opposition to Defendants’ position. In *Patton v. Miller*, the plaintiff initially filed an action in her capacity as “next friend” to her daughter, and she later

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moved to amend her complaint to change her capacity from next friend to her individual capacity. 420 S.C. 471, 477, 479, 804 S.E.2d 252, 255–56 (2017). On appeal from the denial of the motion, the Supreme Court found,

> [Plaintiff's] individual claim . . . satisfies Rule 15(c) because it is the exact claim she made in the representative capacity. In fact, there is no difference between the old claim and the new claim except the capacity of the person bringing it. Therefore, [the] amended claims . . . relate back to the [initial date of] filing and comply with the statute of limitations.

Id. at 494, 804 S.E.2d at 264. The *Patton* court also addressed and distinguished *Valentine*, stating that opinion "stands only for the proposition that Rule 15 does not contemplate adding a new plaintiff *to assert a new claim*." *Id.* at 495, 804 S.E.2d at 264 (emphasis added). Here, however, Plaintiffs' amended complaint asserts the same claims as those contained in the original complaint. There are no new claims; instead, Plaintiffs merely "amend[ed their] complaint to assert the same claim in a new capacity." *Id.* at 496, 804 S.E.2d at 265; *see also Twelfth RMA Partners, L.P. v. Nat'l Safe Corp.*, 335 S.C. 635, 641, 518 S.E.2d 44, 47 (Ct. App. 1999) ("[Defendants] rely on *Valentine v. Davis,* 319 S.C. 169, 460 S.E.2d 218 (Ct.App.1995) for the proposition that a plaintiff may not add a new plaintiff to a case to assert a claim against the defendant. In this case, however, no new claims are being added. The court is only changing the name of the plaintiff. The subject of the claim . . . is still the same."). In adding additional putative class representatives as plaintiffs, Defendants suffer no prejudice—they will be forced to defend the same claims, asserted by the same class of plaintiffs, only represented by two additional named class representatives.

Additionally, Plaintiffs' reading of Rule 15(c) to allow the relation back of Owens' claims is consistent with the purpose of the rule:

> Rule 15(c) is based on the concept that once litigation involving particular conduct or a given transaction or occurrence has been instituted, the parties are not entitled to the protection of the statute of limitations against the later assertion by

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> amendment of defenses or claims that arise out of the same conduct, transaction, or occurrence as set forth in the original pleading.

Patton, 420 S.C. at 496–97, 804 S.E.2d at 265 (quoting *Thomas v. Grayson*, 318 S.C. 82, 88, 456 S.E.2d 377, 380 (1995)).

3. Defendants misconstrued the Court's analysis of the voluntary payment doctrine and provide no basis for alteration or amendment of the Order denying dismissal.

Defendants' objection to the Court's ruling regarding the voluntary payment doctrine is unwarranted and results from a misconstruction of, and overreaction to, the Court's language. In relevant part, the Court ruled,

> Under a 12(b) (6) analysis, [the] decision [not to dismiss due to the voluntary payment doctrine] is reasonable given the assertion that payments made by the Plaintiffs were not voluntary, as the Plaintiffs only settled with Mary Black after the hospital asserted unlawful liens against them. Plaintiffs strongly assert that payments made as a result of extortion are not considered voluntary.

Form 4 Order dated Sept. 4, 2020, at 4. Contrary to Defendant's protestations, this does not amount to a statement, implication, or accusation *by the Court* "that the payments made on behalf of Plaintiff Owens and Plaintiff Brooks were 'a result of extortion.'" Defendants' Motion to Alter or Amend, at 6. Instead, the Court merely restated *Plaintiffs'* assertion that the payments were coerced, and Plaintiffs' assertion was supported by allegations in their Amended Complaint. *See* Response in Opposition to Defendants' Motions to Dismiss, at 9 (referencing ¶¶ 26, 46, and 52 of the Amended Complaint: "As is shown by these allegations, Mary Black coerced and extorted its patients into making payments the hospital should have billed to the patients' insurers.").

The Court properly found Plaintiffs' allegations, along with the inferences reasonably drawn from those allegations, were sufficient to defeat dismissal with respect to the voluntary payment doctrine, and it did not "create facts and allegations" as Defendants claim. Defendants' Motion, at 7. *See Brazell v. Windsor*, 384 S.C. 512, 515, 682 S.E.2d 824, 826 (2009) ("If the facts and inferences drawn from the facts alleged in the complaint, viewed in the light most favorable to

the plaintiff, would entitle the plaintiff to relief on any theory, then the grant of a motion to dismiss for failure to state a claim is improper.").

4. The Court correctly ruled dismissal of Blackwell's unjust enrichment claim was inappropriate.

Plaintiffs reassert in full the arguments made in their Response in Opposition to Defendants' Motions to Dismiss and maintain that the Court properly denied dismissal of Blackwell's unjust enrichment claim. Viewing the Complaint as a whole, and in favor of the pleader, Plaintiff Blackwell has adequately pleaded a claim for unjust enrichment. Plaintiffs allege that all Defendants have been unjustly enriched because it would be inequitable to allow them to retain the benefits of their wrongful billing practices while attempting to collect from Plaintiffs a higher amount than they would have received if they had billed Plaintiffs' insurance companies. The fact that Plaintiffs allege Defendants "assert[ed] liens against Plaintiff Blackwell's potential third party automobile accident claim," Amended Complaint ¶ 40, is sufficient for purposes of the pleading stage, and Plaintiff Blackwell's unjust enrichment claim should be allowed to proceed. *Cf. Beverly v. Grand Strand Reg'l Med. Ctr., LLC*, 429 S.C. 502, 516, 839 S.E.2d 468, 475 (Ct. App. 2020) (noting that Plaintiff's complaint "alleges affirmative inequitable conduct seeking to deprive her of the benefit of her funds").

5. The Court addressed Defendants' argument regarding Blackwell and the alleged MedCost disclaimer of third-party beneficiaries, correctly finding it was beyond the proper scope of a motion to dismiss.

In reasserting this argument, Defendants continue their attempt to ignore the scope of review for dismissal and improperly interject unpled facts into the Court's analysis. As Plaintiffs previously noted, Defendants' argument relies on facts and allegations that do not appear in the Complaint and are taken from a contract that has not been proven to be in force at times relevant to this action. *See* Response in Opposition to Defendants' Motions to Dismiss, at 14.

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Notwithstanding Defendants' claim that this issue was not addressed, the Court did rule on this issue when it stated its review of the hospital service agreements "was limited to the arbitration issue. Any other consideration of the agreements goes beyond a SCRCP Rule 12(b)(6) analysis." Form 4 Order dated Sept. 4, 2020, at 3. This is an unequivocal ruling on the issue that correctly found Defendants' argument is premature. Accordingly, reconsideration on this ground is unnecessary.

6. The Court did not err by finding Plaintiffs' Complaint sufficiently pled facts against Defendants to support their claims.

Defendants argue Plaintiffs' "style of collective pleading is improper," but in doing so, they misconstrue either the effect of Plaintiffs' allegations or applicable South Carolina pleading standards. First, Defendants suggest Plaintiffs' pleadings improperly attempt to attach liability to each defendant; however, Plaintiffs have not alleged any defendant is vicariously liable for the actions of another, nor have Plaintiffs attempted to pierce the corporate veil of any defendant. Instead, Plaintiffs alleged in their Complaint that Defendants acted in concert with one another, and each defendant's liability is the result of its own conduct (although such conduct may mirror that of the other defendants). Accordingly, Defendants' cited authority is inapposite. *See Pertuis v. Front Roe Restaurants, Inc.*, 423 S.C. 640, 654, 817 S.E.2d 273, 280 (2018) (adopting the single business enterprise theory of corporate liability), *reh'g denied* (Aug. 16, 2018); *Pro Slab, Inc. v. Argos USA Corp.*, No. CV 2:17-3185-BHH, 2018 WL 6985008, at *5 (D.S.C. June 28, 2018) (rejecting the plaintiffs' pleadings, which attempted to establish an agency or alter ego relationship between defendant companies, because the plaintiffs "offer[ed] *no factual allegations* to support" such relationships), *reconsideration granted on other grounds,* No. CV 2:17-3185-BHH, 2018 WL 6985010 (D.S.C. Dec. 3, 2018).

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Defendants' alternative suggestion that collective pleading is prohibited or improper in South Carolina is equally incorrect. Defendants cannot point to any case law, statute, or rule of civil procedure prohibiting collective pleading or requiring a plaintiff to repeat allegations against individual defendants when the defendants acted in concert. The cases Defendants cite on this point are not dispositive, and in fact, *Pro Slab* supports Plaintiffs' position. There, the court cited *Connor v. Honeywell Int'l Inc.*, No. CIV.A. 2:12-1421-CWH, 2012 WL 6135193 (D.S.C. Nov. 13, 2012), which found collective Pleading to be proper:

> In *Connor*, affiliated corporate defendants sought dismissal of the plaintiff's claims . . . by claiming that it was not clear which defendant or defendants were alleged to have committed which wrong. The court stated that it was "initially inclined to allow the plaintiff an opportunity to amend the complaint to clarify which conduct was attributable to which defendant." *Id.* at *1. However, after the plaintiff represented that it was his view that the defendants were acting in concert . . . , the court found the complaint adequate. . . . Thus, the factual allegations in the plaintiffs' complaint in *Connor* supported the assertion that the defendants acted together. In contrast, here, Plaintiffs' amended complaint merely alleges the legal conclusion that the affiliated corporate entities were agents and/or alter egos and operated as one company, but the amended complaint contains *no factual allegations* to support that legal conclusion.

Pro Slab, Inc. 2018 WL 6985008, at *5. Defendants' other cited authority similarly offers no support to their position. *See Scurmont LLC v. Firehouse Rest. Grp., Inc.*, No. 4:09-CV-00618-RBH, 2010 WL 11433199, at *15 (D.S.C. May 19, 2010) (finding a lack of specific personal jurisdiction over an individual defendant because the plaintiff failed to plead facts demonstrating the defendant committed wrongful acts within South Carolina). Accordingly, the Court did not err by finding Plaintiffs sufficiently pled the allegations in their Complaint.

CONCLUSION

Based upon the foregoing, the Court should deny Defendants' Motion to Alter or Amend and adhere to its previously-entered Order denying Defendants' Motions to Dismiss.

Respectfully submitted,

/s/John B. White, Jr.

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STATE OF SOUTH CAROLINA COUNTY OF SPARTANBURG	IN THE COURT OF COMMON PLEAS SEVENTH JUDICIAL CIRCUIT
Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly situated, Plaintiffs, v. Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; and CHSPSC, LLC; Professional Account Services, Inc., Defendants.	C.A. No. 2017-CP-42-00219 **DEFENDANTS' REPLY TO PLAINTIFF'S RESPONSE IN OPPOSITION TO THE MOTION TO ALTER OR AMEND**

Defendants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital ("Mary Black"), CHSPSC, LLC ("CHSPSC"), and Professional Account Services, Inc. ("PASI") (collectively, "Defendants") hereby submit this Reply to Plaintiffs Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr.'s (collectively, "Plaintiffs") Response in Opposition to Defendants' Motion to Alter or Amend. For the reasons stated in Defendants' Motion to Alter or Amend, as well as those points and authorities set forth herein, Defendants' Motion to Alter or Amend should be granted.

I. A Rule 59(e) Motion to Alter or Amend provides the Court with a proper avenue to amend an interlocutory order.

Defendants' Motion to Alter or Amend properly requests the Court alter or amend the prior order denying the Motion to Dismiss and/or Compel Arbitration. A Rule 59(e) motion to alter or amend is "a vehicle to seek 'reconsideration' of issues and arguments." *Elam v. S.C. Dep't of Transp.*, 361 S.C. 9, 21, 602 S.E.2d 772, 778 (2004). In a motion to alter or amend, a party may "ask the court to reconsider its decision even if it means rehashing all or part of an argument previously presented." *Id*. at 21, 602 S.E.2d 772, 778-79; *see Arnold v. State*, 309 S.C. 157, 420

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S.E.2d 834 (1992) ("purpose of Rule 59(e), SCRCP, to alter or amend the judgment is to request the judge to reconsider matters properly encompassed in a decision on the merits").

The *Collins Music Co. v. IGT*, 353 S.C. 559, 560-61, 579 S.E.2d 524, 524 (Ct. App. 2002) case cited by Plaintiffs does not stand for the proposition that a court may not reconsider previously ruled upon arguments in deciding a Rule 59(e) Motion to Alter or Amend. That case involved a party who timely filed and served post-trial motions pursuant to Rule 50(b) and Rule 59 and then subsequently filed a Rule 59 motion that restated the same arguments previously raised in the other Rule 59 post-trial motions. *Id*. The issue in that case was the timing of the filing of the Notice of Appeal—not the proper scope of review of a Rule 59(e) Motion to Alter or Amend.

II. Plaintiff Owens's claims are subject to the arbitration requirement in the CIGNA Agreement.

A. Plaintiff Owens is admittedly seeking to enforce and to take a benefit from the CIGNA Hospital Services Agreement.

Plaintiff Owens undeniably bases his claims on the proposition that he is entitled to the direct benefits of the billing terms and procedures and the discounted billing rates created by the CIGNA Agreement with Mary Black. Those payment terms do not exist or arise from any other source. As admitted by Plaintiff Owens in his response to the Defendants' Motion to Alter or Amend, "Plaintiffs' success on [their claim for injunctive relief] admittedly relies on the hospital services agreement." [Plaintiffs' Response p. 6]. This admission resolves the question of whether Plaintiff Owens is attempting to enforce and take a direct benefit from the CIGNA Agreement—which contains a valid and enforceable arbitration provision. Thus, when Plaintiff Owens bases his claims on a purported entitlement to the benefits of those billing terms and discounted rates arising from the CIGNA Agreement, the doctrine of direct benefits estoppel binds him to all of the terms of the CIGNA Agreement—including the arbitration provision. *See Pearson v. Hilton Head Hosp*., 400 S.C. 281, 290, 733 S.E.2d 597, 601 (Ct. App. 2012).

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Plaintiff Owens falsely argues, with no support, that his claims are "grounded on independent South Carolina law;" however, Plaintiff Owens points to no law that creates an obligation for Mary Black to submit bills directly to CIGNA or for Mary Black to bill Plaintiff Owens at the discounted rates agreed to between Mary Black and CIGNA in the CIGNA Agreement.

Plaintiff Owens's claims for unjust enrichment and tortious interference with contractual relations likewise are premised on his assertions to take a direct benefit of the CIGNA Agreement. For example, Plaintiff Owens claims Defendants were unjustly enriched by retaining any other payment for his medical services, because, according to Plaintiff Owens, Defendants should have billed and accepted payment pursuant to the terms of the CIGNA Agreement and at the discounted rates from CIGNA. Any obligation for Mary Black to bill and accept payment from CIGNA was created solely by the agreement between CIGNA and Mary Black. There is no other source or independent legal duty for such terms.

Plaintiff Owens's claims which are uniquely based on the CIGNA Agreement distinguishes this case from the *Weaver v. Brookdale Senior Living, Inc.*, 847 S.E.2d 268, 271 (S.C. Ct. App. 2020) and *Wilson v. Willis*, 426 S.C. 326, 335, 827 S.E.2d 167, 172 (2019) cases cited by Plaintiffs. Those cases did not involve plaintiffs attempting to take a direct benefit from a contract, or to enforce the terms of the contract while also avoiding the contract's arbitration provision.

Plaintiff Owens specifically argues to the Court that he was "harmed by a failure to act in accordance with the contract." [Plaintiffs' Response p. 2]. This is simply another express acknowledgment that Plaintiff Owens's claims seek to enforce the CIGNA Agreement and recover for a purported injury that he alleges was caused by a failure to act in accordance with the CIGNA Agreement. Therefore, Plaintiff Owens's claims are the exact type of claims that are subject to direct benefits estoppel. Accordingly, Plaintiff Owens is bound by all of the terms of the CIGNA

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Agreement, including its arbitration provision, and the Court must compel Plaintiff Owens to arbitrate his claims against the Defendants.

B. The arbitration provision in the CIGNA Agreement applies and requires the Court to compel a non-signatory, like Plaintiff Owens, to arbitrate his claims pursuant to the CIGNA Agreement's arbitration provision when he seeks to enforce and to take benefit from the other provisions of that Agreement.

Plaintiffs are certainly correct in finally admitting that they are not parties to the Hospital Service Agreements between Mary Black and their health insurance companies. Since Plaintiffs are not parties to those Agreements, they have no rights under those Agreements and no rights to sue to enforce the terms of those Agreements.

However, Plaintiffs are attempting to enforce the terms of those Agreements and to sue Mary Black to gain benefit from the terms of those Agreements. Having admitted they are not parties to the Agreements, the sole basis for pursuing the claims is on the premise they are direct beneficiaries of those Agreements. While Defendants vehemently dispute that Plaintiffs are, or can be, direct beneficiaries of those Agreements, if Plaintiffs pursue claims dependent on that status, they are then bound by all of the other terms of the Agreement for which they claim beneficiary status. This means they are bound by the arbitration provisions—and, specifically, Plaintiff Owens is bound by the arbitration terms in the CIGNA Agreement.

In a case with similar operative facts and issues, *Benton v. Vanderbilt University*, 137 S.W.3d 614, 619 (Tenn. 2004), the Tennessee Supreme Court addressed a non-signatory plaintiff's ("Benton") claim against a hospital ("Vanderbilt") based upon the hospital's alleged billing practices. The court specifically addressed the plaintiff's obligation to arbitrate under the agreement from which plaintiff sought to derive the claim rights. Benton was insured by Blue Cross Blue Shield ("BCBS"), and Vanderbilt Hospital provided medical services to Benton after Benton suffered injuries in an automobile accident. *Id.* at 616. Vanderbilt and BCBS had a

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hospital services agreement between them like the CIGNA Agreement. The agreement provided that Vanderbilt would bill BCBS for the medical services rendered to BCBS insureds (like Benton) at discounted rates. *Id.* Benton later filed a lawsuit against the at-fault driver for the personal injuries he suffered in the accident, but Vanderbilt then sought to collect the amount of the hospital expenses that had not been paid by BCBS and filed a statutory Notice of Hospital Lien against any monetary recovery that Benton might receive from the at-fault driver (a collection practice that is known as balance billing). *Id.* As a result of Vanderbilt's collection actions, Benton filed a complaint asserting claims against Vanderbilt for abuse of process, breach of contract, and violation of the Tennessee Consumer Protection Act on the grounds that Vanderbilt had agreed to accept payment in full from BCBS based on the hospital services agreement between Vanderbilt and BCBS. *Id.* In response to the Complaint, Vanderbilt moved to compel Benton to arbitrate his claims pursuant to the arbitration provision in the contract between Vanderbilt and BCBS. *Id.* On appeal, the Tennessee Supreme Court held that Benton was a third-party beneficiary attempting to enforce the contract between Vanderbilt and BCBS and Benton was bound by all of that agreement's terms—including the arbitration provision. *Id.* at 620. Accordingly, the Tennessee Supreme Court compelled Benton to arbitrate his claims against Vanderbilt pursuant to the hospital services agreement between BCBS and Vanderbilt. *Id.*

Significantly, in that case Benton argued that he was not subject to the arbitration provision because it only applied to the "parties to the agreement" and he was not a party to the agreement between Vanderbilt and BCBS. *Id.* at 619. The Tennessee Supreme Court rejected this argument and agreed with the courts of Alabama, Pennsylvania, and Maryland, all of which relied on *Williston on Contracts* as well as the Restatement (Second) of Contracts, to find that as a third-party beneficiary attempting to enforce the hospital services agreement is a "party" to that agreement for the purpose of enforcing the agreement's arbitration provision. *Id.*

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Like the plaintiff in *Benton*, Plaintiff Owens's claims are based upon the fundamental assertion that Defendants are obligated by the terms of the hospital services agreement to bill his health insurance provider (CIGNA) at discounted rates, and Defendants may not seek to recover payment for the medical services rendered to Plaintiff Owens through his recovery from an at-fault driver's insurance carrier. Plaintiff Owens's claims are absolutely and fundamentally dependent upon the alleged obligation that Defendants bill CIGNA at discounted rates, and not attempt any billing to, or collection from Plaintiff Owens. That obligation—if it exists at all—is created by the CIGNA Agreement between Mary Black and CIGNA. Therefore, as a third-party beneficiary seeking to enforce the CIGNA Agreement, Plaintiff Owens is subject to all the terms and conditions of the CIGNA Agreement (including the arbitration provision). Accordingly, the Court must alter or amend its order denying Defendants' Motion to Compel Arbitration and compel Plaintiff Owens to arbitrate his claims against Defendants pursuant to the CIGNA Agreement's arbitration provision.

III. Plaintiff Owens's claims do not relate back to Plaintiff Blackwell's filing of the original complaint and are barred by the applicable statute of limitations and should be dismissed.

A. Plaintiff Owens is a new plaintiff, asserting new claims, based on new facts and, therefore, his claims do not relate back to Plaintiff Blackwell's filing of the original complaint.

This matter was originally filed by Plaintiff Blackwell on January 20, 2017. Plaintiff Blackwell's claims relate to her personal circumstances, as alleged, and she sought to represent a "class" of similarly situated persons. Her claims are each premised on the idea that Mary Black owed obligations to her based on the agreement between Mary Black and her health insurance provider (MedCost). It is fundamental that a plaintiff cannot pursue claims for a class of persons in different circumstances from herself. *See Bailey v. Patterson*, 369 U.S. 31, 32-33, 82 S. Ct. 549, 550, (1962) (stating that a named plaintiff "cannot represent a class of whom they are not a part.");

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see also In re Glob. Crossing, Ltd. Sec. Litig., 313 F. Supp. 2d 189, 207 (S.D.N.Y. 2003) ("It is well established that a plaintiff seeking to represent a class must be a member of the class he purports to represent."). Thus, Plaintiff Blackwell can only be the representative of a class of persons covered by MedCost or the agreement between Mary Black and MedCost. Neither Plaintiff Owens, nor Plaintiff Brooks, have any connection to MedCost or the MedCost Agreement and they could not be members of the class Plaintiff Blackwell allegedly represents. Thus, when Plaintiff Owens was added as a party to this case on April 24, 2020, when Plaintiff Blackwell amended her original complaint to add Plaintiff Owens as a named plaintiff, he brought new claims into the case. The issue presently before the Court is whether Plaintiff Owens's claims relate back to Plaintiff Blackwell's filing of the original complaint. They do not and cannot.

Rule 15(c) of the South Carolina Rules of Civil Procedure governs the relation back of a pleading. *Jackson v. Doe*, 342 S.C. 552, 558, 537 S.E.2d 567, 570 (Ct. App. 2000). Rule 15(c) and its relation back provision only apply, and may only validate a relation back argument, to a substitution or change in a party. *Id.* "[T]he addition of a party is not the same as a substitution or change of party." *Id.* The addition of a new party is not contemplated by Rule 15(c), and does not relate back. *Gause v. Smithers*, 384 S.C. 130, 133, 681 S.E.2d 607, 609 (Ct. App. 2009).

Plaintiff Owens is a new party, with new claims, added to this lawsuit on April 24, 2020. Plaintiff Owens's addition to this lawsuit expanded the litigation, not only to his separate claims, but also a new putative class to include patients covered by CIGNA health insurance policies. Plaintiff Owens asserts new claims based upon the application and enforcement of the CIGNA Agreement, to which Blackwell has no relation. Plaintiff Owens's claims were not, and could not have been, a part of Plaintiff Blackwell's original complaint.

Plaintiff Owens is not a substitute Plaintiff for Blackwell, and he is not a change from Blackwell. The argument that his claims are "materially unchanged from those in the original

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Complaint" and "arose out of the conduct, transaction or occurrence set forth or attempted to be set forth in the original pleadings" is patently false. [Plaintiffs' Response p. 10]. Plaintiff Owens could not even have been a member of the putative class alleged by Plaintiff Blackwell. Plaintiff Blackwell does not have standing to represent Plaintiff Owens, or his claims which are derived from the CIGNA Agreement. Plaintiff Blackwell does not have standing to enforce the CIGNA Agreement because she is not covered by a CIGNA health insurance policy and she is not a third-party beneficiary of the CIGNA Agreement. The United States Supreme Court and South Carolina courts have repeatedly recognized that a named plaintiff must have standing to represent the unnamed class members and must possess the same interest and have suffered the same injury as the unnamed class members. *See Bailey*, 369 U.S. at 32-33, 82 S. Ct. at 550; *E. Tex. Motor Freight Sys., Inc. v. Rodriguez*, 431 U.S. 395, 403 (1977) (collecting cases); *Berry v. McLeod*, 328 S.C. 435, 447 n.2, 492 S.E.2d 794, 800 n.2 (Ct. App. 1997); *Edisto Fleets, Inc. v. S.C. Tax Comm'n*, 256 S.C. 350, 354, 182 S.E.2d 713, 714 (1971). Plaintiff Blackwell lacks the ability to pursue the claims now asserted by Plaintiff Owens.

Therefore, the addition of Plaintiff Owens to this litigation added new claims that are being asserted by a new party. Claims asserted by parties added to a case do not relate back to the original filing of the complaint. *See Jackson*, 342 S.C. at 558, 537 S.E.2d at 570; *Gause*, 384 S.C. at 133, 681 S.E.2d at 609. Accordingly, Plaintiff Owens's claims are barred by the applicable statutes of limitation because his claims do not relate back to Plaintiff Blackwell's filing of the original complaint.

IV. Plaintiff Blackwell does not allege she conferred a benefit to Defendants.

It is not disputed that South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: "(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under

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conditions that make it unjust for him to retain it without paying its value." *Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994).

Plaintiff Blackwell's claim for unjust enrichment—according to the Amended Complaint and Plaintiffs' Response in Opposition to the Motion to Alter or Amend—is based upon the allegation that Defendants "assert[ed] liens against Plaintiff Blackwell's potential third party automobile accident claim." [Plaintiffs' Response P. 13; Amended Complaint ¶ 40]. However, a claim for unjust enrichment seeks to have a defendant return a benefit that would be inequitable for the defendant to retain. *Columbia Wholesale*, 312 S.C. at 261, 440 S.E.2d at 130. Plaintiff Blackwell cannot state a claim for unjust enrichment unless she can and does allege that she actually conferred a benefit that can and must be returned. She has utterly failed to make such an allegation. Indeed, she cannot make such an allegation because she never did confer any benefit upon Mary Black or the other Defendants. There is no factual allegation in either of Plaintiff Blackwell's Complaints that Defendants retain possession of anything belonging to Plaintiff Blackwell. The only allegation by Plaintiff Blackwell is that Defendants asserted a lien against her potential third-party automobile accident claim. [Plaintiffs' Response P. 13; Amended Complaint ¶ 40]. A lien does not transfer a property interest. *See Horry Cty. v. Ray*, 382 S.C. 76, 83-84, 674 S.E.2d 519, 523-24 (Ct. App. 2009) ("An equitable lien is neither an estate or property in the thing itself, nor a right to recover the thing" (citation and internal quotation marks omitted)); *Matter of Hinson*, 20 B.R. 753, 758 (Bankr. D.S.C. 1982) (a judgment lien "does not operate to give a judgment creditor a property interest in specific property" and "does not constitute a taking of property"). Thus, the mere existence of a lien is not a conference of benefit.

Plaintiff Blackwell makes no allegations through which the Court could award her restitution—the remedy for a claim for unjust enrichment—because Plaintiff Blackwell has conferred nothing to the Defendants and Defendants owe nothing to Plaintiff Blackwell.

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Therefore, Plaintiff Blackwell's claim for unjust enrichment fails as a matter of law and the Court should alter or amend its Order to dismiss Plaintiff Blackwell's claim for unjust enrichment.

V. The Court failed to address the argument that Plaintiff Blackwell is barred from enforcing the terms of the MedCost Agreement pursuant to the Agreement's express disclaimer of third-party beneficiaries.

Defendants' Motion to Dismiss and/or Compel Arbitration raised the argument that Plaintiff Blackwell's claims fail because she is not a third-party beneficiary with the right to enforce the MedCost Agreement. The Court's order denying Defendants' Motion to Dismiss and/or Compel Arbitration failed to address this argument despite the fact that the entirety of Plaintiff Blackwell's claims are dependent upon Mary Black's contract with MedCost and her alleged ability to enforce its terms. The Court's order denying Defendants' Motion to Dismiss and/or Compel Arbitration states that "[t]he allegations are that Defendants regularly refused to submit medical bills to patients' health insurance carriers and instead sought payment directly from the patients themselves. This was done despite the hospital's contracts with health insurance carriers . . . . " Thus, the MedCost Agreement is clearly integral to the Amended Complaint and essential to all of Plaintiff Blackwell's claims.

In reviewing a motion to dismiss pursuant to Rule 12(b)(6), the Court may consider a document that is incorporated into the complaint, attached to the complaint, or integral to the complaint. *See Carolina First Corp. v. Whittle*, 343 S.C. 176, 190 n.7, 539 S.E.2d 402, 410 n.7 (Ct. App. 2000) (incorporate by refence); *Brazell v. Windsor*, 384 S.C. 512, 516, 682 S.E.2d 824, 826 (2009) (incorporate by reference); *HHHunt Corp. v. Town of Lexington*, 389 S.C. 623, 629-30, 699 S.E.2d 699, 701-02 (Ct. App. 2010) (attached to the complaint); *Patterson v. Witter*, 425 S.C. 213, 235, 821 S.E.2d 677, 689 (2018) (reviewing a Rule 23 demand letter that was not attached or incorporated into the Amended Complaint and citing *L-7 Designs, Inc. v. Old Navy, LLC*, 647 F.3d 419, 422 (2d Cir. 2011) which explains that a complaint may be "deemed to include

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any written instrument attached to it as an exhibit, materials incorporated in it by reference, and documents that, although not incorporated by reference, are 'integral' to the complaint"); *see also* 61A Am. Jur. 2d Pleading § 529 ("A court may also consider an undisputedly authentic document that a defendant attaches as an exhibit to a motion to dismiss if the plaintiff's claims are based on the document.").

Plaintiff Blackwell alleges she has the right to enforce the terms of the MedCost Agreement for her own goals and benefit. However, Plaintiff Blackwell is not a party to the MedCost Agreement and she is not an intended third-party beneficiary who can sue to enforce that Agreement for her own benefit. As raised in the Motion to Dismiss, the MedCost Agreement plainly and directly expresses Mary Black and MedCost's intent to bar third-parties from enforcing the MedCost Agreement. The Court's Order does not address or decide this issue raised in the Motion, despite the law clearly establishing that the Court's determinative step in reviewing the MedCost Agreement is to review and give effect to its plain and unambiguous language. *See Whitlock v. Stewart Title Guar. Co.*, 399 S.C. 610, 614, 732 S.E.2d 626, 628 (2012).

The plain and unambiguous language of the MedCost Agreement compels the finding that Mary Black and MedCost did not express, and did not have, an intent to allow Plaintiff Blackwell to enforce the MedCost Agreement as a third-party beneficiary. *See Windsor Green Owners Ass'n, Inc. v. Allied Signal, Inc.*, 362 S.C. 12, 19, 605 S.E.2d 750, 753 (Ct. App. 2004). Since Plaintiff Blackwell lacks standing to enforce the MedCost Agreement as a third-party beneficiary, she lacks standing to enforce the terms of the agreement and pursue any of her alleged claims. Therefore, as a matter of law, Plaintiff Blackwell's claims must be dismissed. Accordingly, the Court erred in failing to address this issue because it is determinative of the claims asserted by Plaintiff Blackwell.

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CONCLUSION

Based on the foregoing, Defendants request the Court alter or amend its Order and dismiss Plaintiffs' Amended Complaint on the grounds that Plaintiffs have failed to allege facts sufficient to constitute a cause of action, or in the alternative, compel Plaintiff Owens to arbitrate his claims against Defendants.

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