

THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

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SC Court of Appeals

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APPEAL FROM HORRY COUNTY  
Court of Common Pleas

Larry B. Hyman, Circuit Court Judge

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Case No. 2013-002133

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Stephanie A. Smith, on behalf of herself and all others similarly situated . . . . . Appellant

v.

Progressive Halcyon Insurance Company, n/k/a Progressive Direct Insurance Co.,  
Progressive Max, and Progressive Casualty Insurance . . . . . Respondents

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FINAL BRIEF OF RESPONDENTS

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Casualty Insurance Company*

November 6, 2014

## TABLE OF CONTENTS

TABLE OF CONTENTS.....	i
TABLE OF AUTHORITIES.....	iii
STATEMENT OF ISSUES ON APPEAL.....	1
STATEMENT OF THE CASE.....	2
FACTS.....	3
A. Plaintiff’s Insurance Policy and Claim.....	3
B. Plaintiff’s Claims and the Court’s Order Denying Class Certification.....	5
ARGUMENT.....	10
I. The Court Should Dismiss the Appeal.....	12
II. The Circuit Court Correctly Held that This Suit Is Not Maintainable as a Class Action.....	13
A. Plaintiff Bears the Burden of Affirmatively Demonstrating That Class Certification Is Appropriate.....	13
B. The Circuit Court Did Not Abuse Its Discretion in Denying Class Certification Because Plaintiff Is an Inadequate Class Representative.....	14
1. Plaintiff Never “Incurred” Unbilled Charges and Thus Has No Viable Individual Claim.....	15
2. Declining Reimbursements for Amounts Plaintiff Did Not “Incur” Does Not Constitute an Impermissible “Set-off.”.....	20
3. Even If Plaintiff Had a Viable Claim, She Cannot Represent the Putative Class Using the Class Definition She Proposes.....	22
C. Plaintiff Has Not Shown That Any Other Requirement of SCRCP 23 Is Satisfied.....	23
1. The Class Action Complaint Must Raise Questions Common to the Class, and Plaintiff’s Claim Must Be Typical of the Class.....	23
2. Plaintiff Has Not Satisfied Her Burden in This Case.....	25
3. The Lower Court’s Reasoning Applies to Every Count in the Complaint.....	30
D. The Court Did Not Commit Any Procedural Errors.....	33
1. The Lower Court Did Not Err in Reaching the “Merits” when Denying Class Certification.....	33
2. The Lower Court Did Not Make Improper “Summary Judgment” Determinations.....	35
3. The Lower Court Did Not Fail to Address Any of Plaintiff’s Claims.	

CONCLUSION.....38

## TABLE OF AUTHORITIES

### Cases

<i>Barker v. Washington Nat'l Ins. Co.</i> , No. 9:12-cv-1901-PMD, 2013 WL 1767620 (D.S.C. Apr. 24, 2013).....	8, 16, 17, 18, 19
<i>Bazzle v. Green Tree Fin. Corp.</i> , 351 S.C. 244, 569 S.E.2d 349 (2002), <i>opinion vacated by</i> 539 U.S. 444 (2003) .....	34
<i>Burton v. Chrysler Grp. LLC</i> , No. 10-cv-00209, 2012 WL 7153877 (D.S.C. Dec. 21, 2012).....	8, 25, 30
<i>Cook v. S.C. Dep't of Highways &amp; Pub. Transp.</i> , 309 S.C. 179, 420 S.E.2d 847 (1992) .....	37
<i>Cuming v. S.C. Lottery Comm'n</i> , No. 05-cv-03608, 2008 WL 906705 (D.S.C. Mar. 31, 2008) .....	31
<i>Curley v. Cumberland Farms Dairy</i> , 728 F. Supp. 1123 (D.N.J. 1990).....	35
<i>Dema v. Tenet Physician Servs. Hilton Head, Inc.</i> , 383 S.C. 115, 678 S.E.2d 430 (2009) .....	31
<i>Dieter v. Microsoft Corp.</i> , 436 F.3d 461 (4th Cir. 2006) .....	25
<i>Dutta v. State Farm</i> , 769 A.2d 948 (Md. Ct. App. 2001).....	20
<i>Eisen v. Carlisle &amp; Jacquelin</i> , 417 U.S. 156 (1974).....	34
<i>Ellis v. Smith Grading &amp; Paving, Inc.</i> , 294 S.C. 470, 366 S.E.2d 12 (Ct. App. 1988).....	31
<i>Ex parte Capital U-Drive-It, Inc.</i> , 369 S.C. 1, 630 S.E.2d 464 (2006) .....	12, 13
<i>Feit v. St. Paul Fire Ins. Co.</i> , 209 Cal. App. Supp. 2d 825 (1962).....	20
<i>Felts v. Richland Cnty.</i> , 299 S.C. 214, 383 S.E.2d 261 (Ct. App. 1989), <i>aff'd</i> , 303 S.C. 354, 400 S.E.2d 781 (1991).....	38
<i>Ferguson v. Charleston Lincoln Mercury, Inc.</i> , 349 S.C. 558, 564 S.E.2d 94 (2002) .....	8, 15
<i>Ferguson v. Charleston Lincoln/Mercury, Inc.</i> , 344 S.C. 502, 544 S.E.2d 285 (Ct. App. 2001).....	15

<i>Gardner v. Newsome Chevrolet-Buick</i> , 304 S.C. 328, 330-31; 404 S.E.2d 200, 201 (1991).....	24
<i>Gardner v. S.C. Dep't of Rev.</i> , 353 S.C. 1, 577 S.E.2d 190 (2003).....	passim
<i>Gordon v. Fid. &amp; Cas. Co. of N.Y.</i> , 238 S.C. 438, 120 S.E.2d 509 (1961).....	passim
<i>Great Lakes Anesthesia, PLLC v. State Farm Mut. Auto. Ins. Co.</i> , No. 11-10658, 2011 WL 4507417 (E.D. Mich. Sept. 29, 2011).....	27
<i>Guazia v. S.C. State Plastering, LLC</i> , 390 S.C. 562, 703 S.E.2d 197 (2010).....	7
<i>Heis v. Allstate Ins. Co.</i> , 436 P.2d 550 (Or. 1968).....	19, 20
<i>Hollister v. Gov't Emps. Ins. Co.</i> , 224 N.W.2d 164 (Neb. 1974).....	19
<i>Holmes v. Cal. State Auto. Ass'n</i> , 135 Cal. App. 3d 635, 185 Cal. Rptr. 521 (1982).....	18
<i>I'On, LLC v. Town of Mt. Pleasant</i> , 338 S.C. 406, 526 S.E.2d 716 (2000).....	36, 37
<i>Johnson v. GEICO Cas. Co.</i> , 673 F. Supp. 2d 255 (D. Del. 2009).....	27, 28
<i>King v. Am. Gen. Finance, Inc.</i> , 386 S.C. 82, 687 S.E.2d 321 (2009).....	34, 35
<i>Knowles v. Standard Sav. &amp; Loan Ass'n</i> , 274 S.C. 58, 261 S.E.2d 49 (1979).....	12
<i>Kopp v. Home Mut. Ins. Co.</i> , 6 Wis. 2d 53 (1959).....	19
<i>Lanier Const. Co. v. Bailey &amp; Yobs, Inc.</i> , 384 S.C. 275, 681 S.E.2d 909 (Ct. App. 2009).....	37
<i>Masaki v. Columbia Cas. Co.</i> , 395 P.2d 927 (Haw. 1964).....	19
<i>McClain v. S.C. Nat'l Bank</i> , 105 F.3d 898 (4th Cir. 1997).....	8, 25
<i>Melton ex rel. Dutton v. Carolina Power &amp; Light Co.</i> , 283 F.R.D. 280 (D.S.C. 2012).....	32
<i>Metz v. U.S. Life Ins. Co.</i> , 662 F.3d 600 (2d Cir. 2011).....	18

<i>Middleton v. SunStar Acceptance Corp.</i> , No. 98-CP-07-1131, 2000 WL 33385388 (S.C. C.P. Jan. 13, 2000).....	24
<i>Moultrie v. N. River Ins. Co.</i> , 272 S.C. 53, 249 S.E.2d 158 (1978) .....	22
<i>Newman v. Richland Cnty. Historic Pres. Comm'n</i> , 325 S.C. 79, 480 S.E.2d 72 (1997) .....	23
<i>Ostrof v. State Farm Mut. Auto. Ins. Co.</i> , 200 F.R.D. 521 (D. Md. 2001).....	28
<i>Pope v. Heritage Communities, Inc.</i> , 395 S.C. 404, 717 S.E.2d 765 (Ct. App. 2011).....	14, 37
<i>Ross-Randolph v. Allstate Ins. Co.</i> , No. 99-3344, 2001 WL 36042162 (D. Md. May 11, 2001).....	28
<i>Rowzie v. Allstate Ins. Co.</i> , 556 F.3d 165 (4th Cir. 2009) .....	21, 22
<i>Salmonsens v. CGD, Inc.</i> , 377 S.C. 442, 661 S.E.2d 81 (2008) .....	12
<i>Sauner v. Pub. Serv. Auth.</i> , 354 S.C. 397, 581 S.E.2d 161 (2003) .....	31
<i>Schuette v. BAMN</i> , 134 S. Ct. 1623 (2014).....	38
<i>Self v. Norfolk So. Corp.</i> , Nos. 06-cv-1730 & -2101, 2007 WL 540373 (D.S.C. Feb. 15, 2007).....	33
<i>Solo v. Bausch &amp; Lomb Inc.</i> , Nos. 06-mn-77777 & -02716, 2009 WL 4287706 (D.S.C. Sept. 25, 2009).....	30
<i>State Farm Mut. Auto. Ins. Co. v. Richardson</i> , 313 S.C. 58, 437 S.E.2d 43 (1993) .....	21, 22
<i>Temple v. Mut. of Omaha Ins. Co.</i> , No. 11-cv-00128, 2013 WL 314750 (D.S.C. Jan. 28, 2013).....	32, 33
<i>Thornton v. S.C. Elec. &amp; Gas Corp.</i> , 391 S.C. 297, 705 S.E.2d 475 (Ct. App. 2011).....	12, 13
<i>Tilley vs. Pacesetter Corp.</i> , 333 S.C. 33, 508 S.E.2d 16 (1998) .....	34, 35
<i>Waller v. Seabrook Island Prop. Owners Ass'n</i> , 300 S.C. 465, 388 S.E.2d 799 (1990) .....	7, 14, 37

*Wal-Mart Stores, Inc. v. Dukes*,  
131 S. Ct. 2541 (2011)..... 24, 30, 34, 37

*Whitlock v. Stewart Title Guarantee Co.*,  
399 S.C. 610, 732 S.E.2d 626 (2012)..... 20

**Statutes**

1997 Act No. 154..... 21

2000 Act No. 344..... 21

S.C. Code Ann. § 14-3-330..... 12

S.C. Code Ann. § 38-77-144..... passim

S.C. Code Ann. § 38-77-145..... 21

**Rules**

Federal Rule of Civil Procedure 23 ..... 7, 24

Rule 23, SCRCF ..... passim

Rule 59, SCRCF ..... 3, 6

**Other Authorities**

Flanagan, James F.,  
South Carolina Civil Procedure (2010) ..... 8, 24

## STATEMENT OF ISSUES ON APPEAL

1. Because the circuit court has not entered final judgment, is this an improper interlocutory appeal?

2. Where Plaintiff has no contractual right to recover expenses she did not incur and thus has no viable individual claim, did the circuit court properly deny class certification because Plaintiff is an inadequate class representative?

3. Where Progressive Max, and other Progressive insurance carriers, adjust individual reimbursement claims for myriad reasons other than the one at issue in Plaintiff's claim, did the circuit court properly deny class certification because Plaintiff's claims do not implicate a determinative issue that is common to the purported class members or typical of the purported class members' claims?

## STATEMENT OF THE CASE

Plaintiff contends that Progressive Max breached the terms of her automobile insurance policy and violated South Carolina law by reimbursing her for the amounts she and her health insurer actually paid for medical expenses arising out of her automobile accident in 2009. Second Am. Compl. ¶¶ 13, 17, 18 (R. pp. 75-76). Plaintiff seeks payment for the medical services at the rate that the doctors may charge others, rather than at the rate that her doctors charged her health insurance company under third-party payor contracts. *Id.* ¶ 18 (R. p. 76). In other words, Plaintiff seeks a windfall recovery; she wants payment for the “adjustments” that appeared on her medical providers’ bills in the form of discounted rates, even though no one—neither Plaintiff nor her health insurer—ever was billed for these adjustments and thus ever owed, much less paid, those amounts.

In her Complaint, Plaintiff asserted claims against Progressive Halcyon Insurance Company, n/k/a Progressive Direct Insurance Co., Progressive Max, and Progressive Casualty Insurance. *Id.* ¶ 2 (R. pp. 73-74). (These companies are referred to collectively as “Progressive” unless more specifically named.) The Complaint brought claims for declaratory judgment, breach of contract, unjust enrichment, bad faith, and unfair claims practices/tortious interference. *Id.* ¶¶ 47-74 (R. pp. 81-85). Plaintiff asserted her claims on her own behalf and on behalf of a purported class of similarly situated South Carolina residents. *Id.* ¶¶ 20-24 (R. pp. 76-77).

On November 29, 2011, after the parties engaged in extensive discovery, Plaintiff moved for class certification. On October 30, 2012, Progressive moved for summary judgment, arguing (among other things) that the Court should enter judgment in

Progressive's favor because Progressive paid Plaintiff the amounts she was owed under her insurance policy.

On February 14, 2013, the court certified the class. Shortly thereafter, on February 22, 2013, Progressive filed a motion for reconsideration under Rule 59(e), SCRCP. The court held a hearing on the motion on May 29, 2013. On August 20, 2013 the court decertified the class, ruling that Plaintiff has no viable individual claim and thus is an inadequate class representative under Rule 23(a), SCRCP 23, and that Plaintiff had not satisfied her burden of proving commonality and typicality or proposing an adequate class definition. To date, the court has not ruled on Progressive's motion for summary judgment. Final judgment therefore has not been entered. Nonetheless, on September 26, 2013, Plaintiff filed a notice of appeal.

## FACTS

### A. Plaintiff's Insurance Policy and Claim

Between January and June of 2009, Plaintiff had an automobile insurance policy issued by Progressive Max. The insurance policy provided coverage for medical claims, subject to certain terms and conditions. Specifically, the policy provided that Progressive Max would "pay the reasonable expenses *incurred* for necessary medical services received within three years from the date of a motor vehicle accident because of bodily injury." Policy, Part II, Insuring Agreement (R. pp. 527-28) (emphasis added). The policy also provided that Progressive Max, or someone on its behalf, would determine "whether the expenses for medical services are reasonable," and whether the services provided were "necessary." *Id.* (R. pp. 527-28).

In February 2009, Plaintiff was injured in an automobile accident. Through her attorney, she made a medical claim under the policy and submitted two sets of bills to

Progressive Max: one in 2009 and one in 2011. Lange Aff. ¶ 3 (R. pp. 487-88). The bills submitted to Progressive Max reflected several “adjustments.” Exs. 1 & 2 to Lange Aff. (R. pp. 491-512). These adjustments reflect discounts to the medical providers’ bills pursuant to a third-party payor contract between the medical providers and Plaintiff’s private health insurer, Blue Cross Blue Shield (“BCBS”). Lange Aff. ¶ 7 (R. p. 489). For example, one bill issued by Strand Regional Specialty Associates in April 2009 reflects that the provider’s standard charge is \$212 for an office visit for a new patient. Ex. 3 to Lange Aff. (R. pp. 513-14). Plaintiff made a co-pay of \$35; her health insurance made a payment of \$94; and the provider wrote off the remaining \$83, which it labeled “BCBS adjustment.” *Id.* (R. p. 514). The bill makes clear that no one was ever obligated to pay the \$83. *Id.* (R. p. 514). The Progressive Max claims adjuster handling Plaintiff’s claim, Ms. Dorothy Lange, authorized reimbursement to Plaintiff of the \$35 co-pay and the \$94 health insurance payment, but did not authorize payment for the \$83 BCBS adjustment. Lange Aff. ¶ 7 (R. p. 489). She determined, in accordance with the plain language of Plaintiff’s insurance policy and under South Carolina law, that neither Plaintiff nor her health insurer were ever liable for the \$83 adjustment and that the \$83 was not an expense that Plaintiff, or anyone on her behalf, had “incurred.” *Id.* ¶¶ 7, 8 (R. p. 489).

Ultimately, Progressive Max determined that Plaintiff was entitled to reimbursement for all of her out-of-pocket medical payments (including on delinquent accounts), deductibles, and co-payments. *Id.* (R. p. 489). In addition, Progressive Max determined that Plaintiff was entitled to reimbursement of all payments that BCBS had paid Plaintiff’s medical providers. *Id.* (R. p. 489). In total, Progressive Max paid

Plaintiff approximately \$3,000, which includes not only the amounts she paid for medical treatment, but also the amounts her health insurer paid on her behalf.<sup>1</sup> Progressive Max did not pay Plaintiff for the approximately \$2,000 in adjustments appearing on the bills Plaintiff submitted.

Plaintiff recovered approximately \$18,000 or \$19,000 from the other driver involved in the accident. *See* Defs' Summ. Judg. Mem. p. 4 n.4 (R. p. 124) (citing Smith Dep. pp. 17:3-25, 18:1 (June 20, 2012) (R. p. 365, lines 3-25, p. 366, line 1)). Plaintiff is not aware of any medical expenses that she still owes. Smith Dep. p. 56:1-15 (August 30, 2011) (R. p. 368, lines 1-15).

**B. Plaintiff's Claims and the Court's Order Denying Class Certification**

Despite knowing that she was reimbursed in full for every charge that was outstanding, paid by her, or paid by BCBS, Plaintiff sued Progressive, alleging that Progressive violated its insurance policy and a South Carolina law against "set-offs." Second Am. Compl. ¶¶ 17, 25, 40 (R. pp. 75-76, 77, 80) (citing S.C. Code Ann. § 38-77-144.) Plaintiff's theory is that because of the adjustments described above, motorists without health insurance (unlike Plaintiff) are billed by medical providers at higher rates

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<sup>1</sup> On appeal, Plaintiff claims Progressive Max reimbursed her for "less than \$3,000" and that she submitted "more than \$5,000" in bills from medical providers. *See* Plf's Br. p. 5. Those numbers, however, reflect only the first set of bills she submitted in 2009. *See* Second Am. Compl. ¶ 13 (R. p. 75) (Progressive Max "[i]nitially" reimbursed Plaintiff for \$2,486.67); Lange Aff. ¶¶ 3, 8 (R. pp. 487-88, 89) (Progressive Max received two batches of bills from Plaintiff, one in 2009 and the other in 2011, and reimbursed Plaintiff a total of \$3,759.21 as of September 2012). It is not clear from Plaintiff's opening brief how much she thinks she should have been reimbursed based on the combined set of bills, or if she is now contending—for the first time, and without any evidence—that Progressive Max did not reimburse her the full amount she and BCBS paid for her medical treatment. Either way, her claims lack merit. Progressive refers herein to the amount of reimbursement as roughly \$3,000 and the amount of adjustments as roughly \$2,000 to mirror Plaintiff's presentation of the case and simplify the issues on appeal.

than motorists with health insurance, and Progressive is “setting off” its customers’ claims by not paying the unbilled higher rates. *Id.* ¶ 18 (R. p. 76).

Progressive moved for summary judgment, arguing that the material facts are undisputed and that a single legal issue is dispositive of all Plaintiffs’ claims: Did Plaintiff “incur” the amounts by which the medical providers reduced their bills, which neither she nor BCBS was obligated to pay (or in fact paid). Defs’ Summ. Judg. Mem. pp. 7-9 (R. pp. 127-29). If Plaintiff did not “incur” charges for which no one was billed, Progressive is not required to pay her those amounts. *Id.* p. 9 (R. 129).

On February 14, 2013, the court certified the class. In its order, the court acknowledged that “[a] primary issue is the definition of the undefined term ‘incurred.’” Order Granting Class Cert. p. 9 (R. p. 13). Nonetheless, it did not resolve that issue; instead, it identified a list of ostensibly “common questions.” *Id.* pp. 8-9 (R. pp. 12-13). The court did not opine on whether these questions could be answered uniformly with respect to every class member by adjudicating Plaintiff’s claims.

Shortly thereafter, Progressive timely filed a motion for reconsideration under Rule 59(e), SCRCP. Progressive argued that determining, at the class certification stage, whether Plaintiff has a viable individual claim is not only permissible, but necessary. Mot. for Recons. p. 7-9 (R. pp. 171-73). That is because Plaintiff cannot be an adequate class representative if she does not have a viable claim in her own right. *Id.* (R. pp. 171-73). Progressive pointed out that under controlling South Carolina precedent, “incurred” means charges for which the insured is “liable.” *Id.* pp. 7-8 (R. pp. 171-72). Because neither Plaintiff nor her health insurer was ever liable for these charges, Plaintiff has no legally viable individual claim. *Id.* (R. pp. 171-72). Progressive also argued that because

the policy allows it to determine whether submitted claims were “reasonable” and represented medical expenses that were “necessary,” it is impossible to determine, on a class-wide basis, whether a particular insured’s claim had been adjusted for those reasons or because Progressive only paid the insured the amount the insured or the insured’s health insurer actually paid. *Id.* pp. 12-15, 20-24 (R. pp. 176-79, 184-88).

On August 20, 2013, the court below reconsidered its earlier decision and decertified the class. The court recognized that “the proponent of class certification bears the burden of proving all five prerequisites set forth in SCRCP 23.” Decert. Order p. 6. (R. p. 25). “To determine whether the class certification proponent has discharged her burden, the Court must conduct a ‘rigorous analysis’ of the relevant facts.” *Id.* p. 8 (R. p. 27) (citing *Waller v. Seabrook Island Prop. Owners Ass’n*, 300 S.C. 465, 467, 388 S.E.2d 799, 801 (1990)). Although the court acknowledged differences between South Carolina and federal law, it held that it properly could rely on federal authorities to interpret Rule 23, SCRCP. As the court explained, the only difference between Rule 23, SCRCP and Federal Rule of Civil Procedure 23 is that Rule 23, SCRCP lacks Federal Rule 23(b), which includes the requirement that common issues must predominate over individual questions. *Id.* p. 6 n.3 (R. p. 25) (citing *Guazia v. S.C. State Plastering, LLC*, 390 S.C. 562, 576, 703 S.E.2d 197, 204 (2010)). Because commonality, not predominance, is the issue in this case, federal authorities interpreting the commonality requirement are highly persuasive. *Id.* (R. p. 25).

Drawing from both state and federal law, the court concluded both that Plaintiff is an inadequate class representative and that the class petition does not sufficiently present common issues. Plaintiff is an inadequate class representative because she possesses no

viable claim in her own right. Under long-settled—and recently reiterated—principles of South Carolina law, one cannot “incur” charges for which one is not liable. *Id.* p. 9-10 (R. pp. 28-29) (citing *Gordon v. Fid. & Cas. Co. of N.Y.*, 238 S.C. 438, 441, 120 S.E.2d 509, 510 (1961); and *Barker v. Washington Nat’l Ins. Co.*, No. 9:12-cv-1901-PMD, 2013 WL 1767620, at \*5 (D.S.C. Apr. 24, 2013)). The court held that both state and federal law require it to examine the viability of Plaintiff’s claims at the class certification stage. *Id.* pp. 10-11 (R. pp. 29-30) (citing *McClain v. S.C. Nat’l Bank*, 105 F.3d 898, 903 (4th Cir. 1997); *Gardner v. S.C. Dep’t of Rev.*, 353 S.C. 1, 23 n.14, 577 S.E.2d 190, 201 (2003); and *Ferguson v. Charleston Lincoln Mercury, Inc.*, 349 S.C. 558, 566, 564 S.E.2d 94, 98 (2002)). Additionally, Plaintiff is an inadequate class representative because she is a former policyholder of Progressive Max, and thus cannot seek declaratory relief on behalf of current policyholders. *Id.* p. 12 (R. 31). Nor can she represent putative class members who were insured by Progressive Casualty or Progressive Direct, rather than Progressive Max. *Id.* p. 11 (R. p. 30).

The court also determined that Plaintiff has not satisfied her burden of demonstrating commonality. *Id.* p. 12 (R. p. 31). To bear her burden, as the proponent of class certification, Plaintiff cannot merely articulate ostensibly common questions; the questions must generate common answers. *Id.* p. 12-13 (R. pp. 31-32) (“A question is not common if its resolution turns on a consideration of the individual circumstances of each class member.”) (citing *Burton v. Chrysler Grp. LLC*, No. 10-cv-00209, 2012 WL 7153877, at \*3 (D.S.C. Dec. 21, 2012); and James F. Flanagan, South Carolina Civil Procedure § 23.B.3 (2010)). As the circuit court explained, “whether Progressive improperly reduced med-pay reimbursements by paying insureds less than the full

amounts their medical providers billed . . . will vary depending on each class member's unique circumstances.” *Id.* p. 13 (R. p. 32). That is because Progressive Max may adjust claims for various reasons, not only because of discounts based on third-party payor contracts between medical providers and health insurers. *Id.* p. 14 (R. p. 33).

For example, Plaintiff's insurance policy (the policy at issue here) allows Progressive Max to review whether expenses billed are “reasonable” and “necessary,” and adjust claims if they are not. *Id.* pp. 14-15 (R. pp. 33-34). Adjudicating Plaintiff's claim will not resolve another insured's claim that is based on Progressive Max's determination that the amount the insured “incurred” for a particular medical service was unreasonable. *Id.* pp. 16-17 (R. pp. 35-36). Plaintiff attempted to overcome this issue by asking the circuit court simply to ignore it. *Id.* at 15 (R. p. 34). Relying on self-serving excerpts from individual depositions, Plaintiff argued that in practice, Progressive does not adjust claims based on reasonableness or necessity. *Id.* (R. p. 34). The circuit court, however, found Plaintiff's argument unconvincing—noting that merely because individual adjusters do not personally recall making specific adjustments does not mean that Progressive ignores the plain language of its own insurance policy, which permits it to adjust claims based on reasonableness, necessity, and for other reasons. *Id.* (R. p. 34). The circuit court found more reliable the deposition testimony of Progressive's corporate representative (and supervisor of medical payment claims) that Progressive makes these individualized determinations as a matter of policy. *Id.* at 16 (R. p. 35). As a result, the circuit court held that Plaintiff could not satisfy either commonality or typicality. *Id.* pp. 16-24 (R. pp. 35-43).

Finally, the court found Plaintiff's proposed class definition inadequate and the class unascertainable. The court below determined that identifying the members of the proposed class based on the five criteria Plaintiff identified would require a file-by-file review and individual mini-trials on each to determine why Progressive adjusted any given claim. *Id.* pp. 24-27 (R. pp. 43-46).

The court did not issue a final judgment in Progressive's favor, or rule on Progressive's motion for summary judgment. Nevertheless, this appeal followed.

### ARGUMENT

As a threshold matter, the Court need not address the substance of Plaintiff's arguments because it should not hear this appeal at all. Plaintiff purports to appeal from the lower court's decision denying class certification, apparently on the basis that the court below effectively dismissed her claim as a matter of law. But the circuit court did no such thing. It merely held that Plaintiff is an inadequate class representative because she has no viable individual claim; it did not enter judgment against her. Because class certification orders are generally not immediately appealable, the Court should decline to hear this appeal. The class certification order will be reviewable in a proper appeal from the final judgment when one is entered below.

If the Court accepts the appeal, however, it should affirm. Under Plaintiff's insurance policy, Progressive Max must pay expenses Plaintiff "incurred." There is no dispute that Plaintiff cannot "incur" an expense she is not obligated to pay. The only apparent dispute is whether Plaintiff is obligated to pay for services at her doctors' undiscounted rates (the rates some other patients may be billed), or at her doctors' adjusted rates (the ones that she and BCBS were billed in accordance with the contract between her doctors and BCBS). But South Carolina settled this question over fifty years

ago: Plaintiff cannot incur expenses for which she is not liable. The collateral source rule is not at issue here. Put simply, Plaintiff seeks a windfall – she wants to collect from Progressive Max more than she, or anybody acting on her behalf, has been required to pay for medical services.

Plaintiff's appeal rests on one theory: That she "owed" the full amount of her doctors' services at pre-adjusted rates at the time of the medical service, which was the relevant event under the insurance policy is the date of the medical service itself. Plaintiff is wrong. Under South Carolina law, the only relevant question is when Plaintiff became obligated to pay her doctors, and she was not obligated to pay until she was billed. Furthermore, if accepted, Plaintiff's theory would be unworkable. Plaintiff has no evidence that the doctors' charges would have been different had the doctors been capable of billing her simultaneously with the provision of their services. But even if Plaintiff had such evidence, the presentation of that evidence would itself defeat class certification: for every putative class member, the trial court would have to inquire whether their bills would have been different at the time of service versus the time of billing (i.e., whether they had health insurance at the time of the medical service and whether those health insurers had third-party payor contracts with those doctors). That would be administratively infeasible, and the Court should reject Plaintiff's invitation to walk down that path.

Finally, even if Plaintiff's complaint were legally sound, her claims are unsuitable for classwide adjudication because they do not implicate dispositive, common questions that are susceptible of generating common answers. Nor are Plaintiff's claims typical of the proposed class members' claims. Some proposed class members would not be

affected by the challenged policy of adjusting claims based on health insurance discounts. That is because Progressive's insurance policy permits it to adjust claims based not only on health insurance "discounts," but also based on determinations such as the reasonableness or necessity of the expenses; whether the claim is for an auto-accident occurrence; whether the medical services are related to that auto accident; or whether the medical services were provided within the necessary timeframe under the policy. Even reviewing each customer's file will not reveal the answers to all of these questions. The lower court correctly determined class certification to be inappropriate in this case, and its order should be affirmed.

**I. THE COURT SHOULD DISMISS THE APPEAL.**

"The general rule established by the supreme court is that class certification orders are not immediately appealable." *Thornton v. S.C. Elec. & Gas Corp.*, 391 S.C. 297, 304, 705 S.E.2d 475, 479 (Ct. App. 2011) (quoting *Salmonsens v. CGD, Inc.*, 377 S.C. 442, 448, 661 S.E.2d 81, 85 (2008)) (alterations omitted). That is because "[a]n appeal ordinarily may be pursued only after a party has obtained a final judgment." *Ex parte Capital U-Drive-It, Inc.*, 369 S.C. 1, 6, 630 S.E.2d 464, 467 (2006). Courts routinely have dismissed improper attempts to appeal from interlocutory appeals on class certification. *E.g.*, *Salmonsens*, 377 S.C. at 452, 661 S.E.2d at 87; *Knowles v. Standard Sav. & Loan Ass'n*, 274 S.C. 58, 261 S.E.2d 49 (1979); *Thornton*, 391 S.C. at 304-05, 705 S.E.2d at 479.

Plaintiff may contend that her appeal falls into a statutory exception to the final judgment rule in S.C. Code Ann. 14-3-330 of the South Carolina code: An order that "involves the merits" is immediately appealable "when it finally determines some substantial matter forming the whole or part of some cause of action or defense." *Ex*

*parte Capital U-Drive-It*, 369 S.C. at 7, 630 S.E.2d at 467. But that does not mean that any order touching on merits issues is immediately appealable. “The phrase ‘involving the merits’ is narrowly construed in modern precedent.” *Id.* “An order usually will be deemed interlocutory and not immediately appealable when there is some further act that must be done by the trial court prior to a determination of the parties’ rights,” *id.* at 7, 630 S.E.2d at 467-68, such as the grant of summary judgment and the entry of final judgment.

The order below is not immediately appealable, because orders denying class certification “may be altered or amended before the decision on the merits.” *Thornton*, 391 S.C. at 304, 705 S.E.2d at 479 (quoting Rule 23(d)(1), SCRCF). Allowing an appeal from every order denying class certification would waste scarce judicial resources. The lower court’s order here denying class certification is correct, and the court is unlikely to change its mind on the issue. Nonetheless, Plaintiff’s appeal is premature. The lower court has not granted Progressive’s motion for summary judgment or entered final judgment in the case based on the findings in its order on reconsideration. This Court should dismiss the appeal.

## **II. THE CIRCUIT COURT CORRECTLY HELD THAT THIS SUIT IS NOT MAINTAINABLE AS A CLASS ACTION.**

If the Court retains the appeal, it should affirm. The court below properly held that plaintiff has no viable individual claim under South Carolina law, rendering her an inadequate class representative; and that her claims do not present a central, dispositive question that is common to the putative class members and susceptible of a common answer.

### **A. Plaintiff Bears the Burden of Affirmatively Demonstrating That Class Certification Is Appropriate.**

South Carolina requires the party seeking certification “to prove the following five elements” under Rule 23, SCRPC:

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

*Pope v. Heritage Communities, Inc.*, 395 S.C. 404, 421, 717 S.E.2d 765, 774 (Ct. App. 2011) (internal quotation marks and alterations omitted). Plaintiff, as the proponent of class certification, bears the burden of proving these elements. *See Waller v. Seabrook Island Prop. Owners Ass’n*, 300 S.C. 465, 468, 388 S.E.2d 799, 801 (1990). “In deciding whether class certification is proper, the court must apply a rigorous analysis to determine each prerequisite is satisfied.” *Gardner v. S.C. Dep’t of Rev.*, 353 S.C. 1, 20-21, 577 S.E.2d 190, 200 (2003). A plaintiff’s failure to establish even one element requires a court to deny class certification. *Waller*, 300 S.C. at 467, 388 S.E.2d at 801.

“[A] trial judge’s ruling on whether an action is properly maintainable as a class action is within his discretion.” *Id.*, 300 S.C. at 468, 388 S.E.2d at 801; *Pope*, 395 S.C. at 421, 717 S.E.2d at 774. Thus, the reviewing court “generally defer[s]” to the trial court’s exercise of that discretion “absent an error of law.” *Gardner*, 353 S.C. at 21, 577 S.E.2d at 200.

**B. The Circuit Court Did Not Abuse Its Discretion in Denying Class Certification Because Plaintiff Is an Inadequate Class Representative.**

The court below correctly held that Plaintiff is an inadequate class representative because she lacks a viable individual claim against any Progressive defendant. The South Carolina Supreme Court has made clear that a named plaintiff in a purported class action

does not adequately represent the interests of the absent class members when the named plaintiff lacks a viable individual claim against the defendant. In *Ferguson v. Charleston Lincoln Mercury*, the Court held that a purported class action could not proceed when the sole named plaintiff died before class certification, and thus had no viable claim against the defendant. 349 S.C. 558, 565-66, 564 S.E.2d 94, 98 (2002); *see also Ferguson v. Charleston Lincoln/Mercury, Inc.*, 344 S.C. 502, 510, 544 S.E.2d 285, 289 (Ct. App. 2001) (“In as much as Mr. Ferguson’s action does not survive, there is no representative party to satisfy the third and fourth requirements [of Rule 23, SCRC].”). And in *Gardner*, it rejected the plaintiff’s request to accept the “juridical links doctrine” in the class action context, because that doctrine “runs counter to this Court’s previous decisions holding that a plaintiff may not sue a defendant unless the plaintiff has suffered an injury at the hands of the defendant.” 353 S.C. at 23 n.14, 577 S.E.2d at 201 n.14. Because Plaintiff has no viable individual claim, she cannot prove the adequacy element of Rule 23(a), SCRC.

1. *Plaintiff Never “Incurred” Unbilled Charges and Thus Has No Viable Individual Claim.*

Plaintiff has no viable claim in her own right because Progressive Max paid the full amount of medical expenses she “incurred,” consistent with the plain language of the insurance policy. *See* Policy, Part II, Insuring Agreement (R. pp. 527-28) (providing that Progressive would pay only amounts Plaintiff “incurred”). Plaintiff argues that the term “incurred” is somehow ambiguous. Interpreting virtually identical policy language, however, the South Carolina Supreme Court held over fifty years ago that an insured does not “incur” expenses when the insured has “no obligation . . . to pay for the treatment” she receives. *Gordon v. Fid. & Cas. Co. of N.Y.*, 238 S.C. 438, 441, 120

S.E.2d 509, 510 (1961). The Supreme Court thus squarely addressed and rejected Plaintiff's contention that the policy's use of "incurred" is ambiguous. *Id.* at 444 ("There is no uncertainty or ambiguity in the language of the policy. It is too plain to call for judicial construction."). There is no need, therefore, to consider the extrinsic evidence Plaintiff would have this Court review in the first instance. *See* Plf's Br. pp. 26-27.

Plaintiff attempts to distinguish *Gordon* on the facts, arguing that it differs materially from this case because the medical provider there "never charged Gordon for services." Plf's Br. p. 28 (citing 120 S.E.2d at 513). But Plaintiff fails to explain how this factual distinction makes a difference. Instead, Plaintiff acknowledges that the *Gordon* court "determined 'what legal interpretations should be given to the words 'expense incurred'" and concluded that because the claimant was not charged, he had not "incurred" an "expense." *See id.* In other words, the *Gordon* court reached precisely the same conclusion that the court below reached here.

Underscoring the propriety of the *Gordon* decision (and the circuit court decision's here), a federal district court sitting in South Carolina and interpreting South Carolina law recently reached the same conclusion about the word "incurred" under circumstances indistinguishable from this case. *See Barker v. Washington Nat'l Ins. Co.*, No. 9:12-cv-1901-PMD, 2013 WL 1767620, at \*5 (D.S.C. Apr. 24, 2013) (insurer is not liable for paying pre-adjusted rates because the plaintiff "at no time was obligated to pay the total charges listed on the hospital's bill"). In *Barker*, the plaintiff was insured under a "Limited Benefit Health Coverage" insurance policy, which provided that the insurer would pay the plaintiff's "expenses incurred." *Id.* at \*1. The plaintiff (a Medicare beneficiary) obtained medical services and then submitted claims to the insurer based on

the amounts his medical provider billed for the services he obtained. The insurer, however, only reimbursed the plaintiff for the amounts Medicare actually paid, in accordance with Medicare's contract with the provider. *Id.* at \*2. The *Barker* court then held that the plaintiff did not "incur" the difference between what the medical provider billed and what Medicare paid. *See id.* at \*6-7. Instead, the court held that the plaintiff "was never obligated to pay more than the amount that the hospital had agreed to accept as full payment under Medicare." *Id.* at \*6. As the *Barker* court reasoned, the benefits available under the policy are limited to those expenses for which the plaintiff was obligated to pay." *Id.* at \*7.

Under *Gordon* and *Barker*, Plaintiff has no viable claim against Progressive because Progressive Max paid Plaintiff all of the expenses she "incurred." *See* Smith Dep. pp. 55:12-56:15 (R. p. 367, line 12-p. 368, lines 15) (no medical expenses outstanding associated with Plaintiff's insurance claim). Plaintiff simply ignores *Gordon* and *Barker*, arguing on appeal that the word "incurred" is ambiguous because it does not clarify when the medical expenses must be incurred in order to trigger Progressive's reimbursement obligation. She contends that this ambiguity is material, and that the policy must therefore be construed in her favor. Plf's Br. pp. 20-27. (This "timing" argument did not appear in Plaintiff's papers below.) Plaintiff's entire appeal thus depends on the Court accepting the proposition that she incurred expenses at the time of her treatment in the amount that her medical providers normally bill, rather than in the discounted amounts her medical providers offer to health insurers.

Plaintiff's argument has no basis in the plain language of the insurance policy or South Carolina law. Plaintiff was *never* liable for the medical services at undiscounted

rates, because her medical providers never charged her their undiscounted rates. Nor would they have. As *Barker* explains, any question of timing is irrelevant here “because the [providers] had agreed, even before rendering services to Barker, that [they] would not charge him more than the [discounted] fee.” 2013 WL 1767620, at \*4. Notably, *Barker* finds support for its holding in cases from several other courts, including the United States Court of Appeals for the Second Circuit. *Id.* at \*6 (recipient of medical treatment “did not incur more than the amounts that her physicians had agreed ahead of time they would seek from her”) (quoting *Metz v. U.S. Life Ins. Co.*, 662 F.3d 600, 602 (2d Cir. 2011)). As her own cases explain, Plaintiff incurred liability when she received treatment; and the subsequent bills merely memorialized the amount of that liability. *E.g.*, *Holmes v. Cal. State Auto. Ass’n*, 135 Cal. App. 3d 635, 639, 185 Cal. Rptr. 521, 524 (1982) (cited at Plf’s Br. p. 25) (“Here appellant at the time of her admission to the hospital expressly undertook personal liability for the expenses about to be incurred. When a legal obligation to pay was created upon the rendition of services, the Medicare agreement became applicable and the hospital was bound by [that] commitment . . .”).

Plaintiff does not contend that the relevant circumstances changed between the time she underwent medical treatment and the time she was billed for that treatment. For example, she does not argue that she was not insured by BCBS when she underwent medical treatment. Nor does she contend that the discount agreement between her medical providers and her health insurer was not in place when she received medical treatment. (Because Plaintiff did not present her “timing” theory to the lower court, no party presented evidence on either of these questions.) Without evidence of changed circumstances, “it is essentially impossible that Plaintiff would ever face liability for a

provider's hypothetical full fee." *Barker*, 2013 WL 1767620, at \*6 (internal quotation marks omitted).

Additionally, Plaintiff's theory, if accepted, would preclude class certification all on its own. The circuit court would have to answer, for every putative class member, whether, as of the date of the medical treatment (and not the bills for that treatment): (1) the putative class member had health insurance; and (2) each of the relevant medical providers had contracted for discounted rates with that health insurer. These individualized inquiries would be even more unworkable than the class action theory Plaintiff presented to the circuit court. The rule under *Gordon* and *Barker* is more simple and straightforward: Plaintiff only incurred liability for the amount actually billed and charged.

In three pages of briefing with case citations spanning twelve states, Plaintiff fails to point to a single case that finds timing to be relevant absent a showing of changed circumstances. Rather, the cases she cites focus on a separate question: *who* must have incurred the expense in order for the insured to be eligible for reimbursement. These cases generally hold that a plaintiff is entitled to reimbursement even if someone else incurred the expense on her behalf, such as a relative or another insurance company. *E.g.*, *Kopp v. Home Mut. Ins. Co.*, 6 Wis. 2d 53 (1959) (insurance must pay expense incurred by or on behalf of insured); *Hollister v. Gov't Emps. Ins. Co.*, 224 N.W.2d 164, 167 (Neb. 1974) (expense "incurred for or on [plaintiffs'] behalf" entitled them to collect under the terms of the policy); *Masaki v. Columbia Cas. Co.*, 395 P.2d 927 (Haw. 1964) (policy was ambiguous "in the failure to state by whom the expenses have to be incurred"); *Heis v. Allstate Ins. Co.*, 436 P.2d 550, 551 (Or. 1968) ("policy obligates

[insurer] to pay medical expenses incurred not only by the insured but also for the insured”); *Dutta v. State Farm*, 769 A.2d 948, 958 (Md. Ct. App. 2001) (for coverage to apply, insured need not have paid the expense herself). That question is wholly irrelevant here, where it is undisputed that *no one* ever incurred the adjusted expenses—not Plaintiff, not her friends or family, and not BCBS—and that Progressive Max paid Plaintiff all of the amounts she actually did incur.

In addition, these out-of-state cases are inconsistent with *Gordon*, which explains that to determine whether a plaintiff “incurred” expenses, the only question is whether the insured incurred liability, not whether anyone incurred liability on his behalf. *Gordon*, 238 S.C. at 441, 120 S.E.2d at 510. One case explicitly acknowledges the distinction. *Feit v. St. Paul Fire Ins. Co.*, 209 Cal. App. Supp. 2d 825 (1962) (cited at Plf’s Br. pp. 24, 25) (“While the South Carolina court in the *Gordon* case holds otherwise, we are convinced that . . . the clause in question . . . is ambiguous . . .”). In contrast to these other states, there is no common law doctrine in South Carolina holding the word “incurred” to be ambiguous—because it is not. The lone South Carolina decision Plaintiff cites in support of her argument lends it no support. See *Whitlock v. Stewart Title Guarantee Co.*, 399 S.C. 610, 732 S.E.2d 626 (2012) (addressing narrow, wholly unrelated question about the appropriate methodology for valuing losses under a title insurance policy). Accordingly, the Court should reject Plaintiff’s argument and affirm the decision below.

2. *Declining Reimbursements for Amounts Plaintiff Did Not “Incur” Does Not Constitute an Impermissible “Set-off.”*

Plaintiff contends that reductions to her claim due to health insurance constitute an impermissible set-off, whether the reduction is due to a health insurer payment or a

health insurer non-payment (i.e., a discount under third-party payor contracts). Plf's Br. pp. 29-30. Her only legal authority supporting this theory is S.C. Code Ann. § 38-77-144, which has no application to this case whatsoever.

That statute provides:

If an insurer sells no-fault insurance coverage which provides personal injury protection, medical payment coverage, or economic loss coverage, the coverage must not be assigned or subrogated and is not subject to a set-off.

S.C. Code Ann. § 38-77-144 (effective 2001). The South Carolina Supreme Court has held that this "set-off prohibition . . . appl[ies] only to the tortfeasor," not insurance companies. *State Farm Mut. Auto. Ins. Co. v. Richardson*, 313 S.C. 58, 61, 437 S.E.2d 43, 45 (1993).<sup>2</sup> In other words, the statute prohibits tortfeasors from arguing that damages assessed against them should be set-off by insurance payments; it does not prohibit insurance companies from setting off payments to their own insureds. As *Richardson* explained, before the statute was enacted, tortfeasors were statutorily entitled to have the damages assessed against them set-off by payments made to the plaintiff from his or her insurance companies. *Id.* at 60, 437 S.E.2d at 45. The legislature wished to abolish this practice, but did not intend to affect insurance companies' obligations. *Id.* In fact, a committee report adopted by both houses of the legislature explained that the statute would provide that medical coverage "may not be setoff [from the tortfeasor's liability coverage]." *Id.* at 61 n.2, 437 S.E.2d at 45 n.2 (alterations in original). The Fourth Circuit has reached the same conclusion, holding that section 38-77-144 does not

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<sup>2</sup> The quoted language refers to section "38-77-145." Enacted in 1989, the statute was originally codified as § 38-77-145; it was repealed in 1997 and recodified as § 38-77-144 in 2000. See 1997 Act No. 154, § 31; 2000 Act No. 344, § 2. The language of the two provisions is identical and the same analysis applies to both. See *Rowzie v. Allstate Ins. Co.*, 556 F.3d 165, 168 n.4 (4th Cir. 2009).

apply to insurance companies. *Rowzie v. Allstate Ins. Co.*, 556 F.3d 165, 169 (4th Cir. 2009). Because the statute does not apply here, it can have no effect on the district court's class certification decision.

But even if Plaintiff were correct that section 38-77-144 prevents Progressive from setting off its payments to Plaintiff in the amount of health insurance payments, that provision still would provide no refuge for her here because there has been no "set-off." Declining reimbursements for amounts for which no one was charged does not constitute a "set-off." A "set-off" is a reduction to recovery "by the amount of the benefits paid for economic loss by the claimant's insurer." *Moultrie v. N. River Ins. Co.*, 272 S.C. 53, 55, 249 S.E.2d 158, 158 (1978) (quoting S.C. Code Ann. § 56-11-130(b) (repealed 1989)). It has nothing to do with amounts that were not paid by, or even due from, an insurer because no liability existed for the underlying payment. Nor does the purpose behind the set-off rule support Plaintiff's argument; it was not intended to equalize treatment of insureds and non-insureds, as Plaintiff apparently believes. It was only intended to ensure that "the tortfeasor was [not] to be given credit for payment by the first party insurer." *Id.* at 56, 249 S.E.2d at 159; *Richardson*, 313 S.C. at 60-61, 437 S.E.2d at 45. Even if Progressive should be treated similarly to the tortfeasor under section 38-77-144, there is no basis to require it to reimburse Plaintiff for payments that were never due or made.

3. *Even If Plaintiff Had a Viable Claim, She Cannot Represent the Putative Class Using the Class Definition She Proposes.*

Plaintiff wishes to represent a class including all insureds of Progressive Casualty, Progressive Direct, and Progressive Max. Plf's Br. 3. But as a former insured only of

Progressive Max, she cannot represent putative class members who were insured by Progressive Casualty or Progressive Direct, rather than Progressive Max. Despite Plaintiff's assertions, Progressive Max is the only Progressive company that issued an insurance policy to Plaintiff. Plaintiff therefore had no relationship—contractual or otherwise—with Progressive Casualty or Progressive Direct. Uth Aff. ¶ 5 (R. p. 482). As the South Carolina Supreme Court explained in *Gardner*, “a plaintiff may not sue a defendant unless the plaintiff has suffered an injury at the hands of the defendant.” 353 S.C. at 23 n.14, 577 S.E.2d at 201. Because Plaintiff indisputably suffered no injury “at the hands of” Progressive Casualty or Progressive Direct, she cannot assert claims against Progressive Casualty or Progressive Direct and thus cannot represent a class including insureds of Progressive Casualty or Progressive Direct. *Cf. id.*

Nor can Plaintiff represent a class of current Progressive Max policyholders, as she is a *former* Progressive Max policyholder. *See* Decert. Order p. 12 (R. p. 31). As a former policyholder, Plaintiff has no standing to seek prospective relief in the form of a declaratory judgment. *See Newman v. Richland Cnty. Historic Pres. Comm'n*, 325 S.C. 79, 480 S.E.2d 72, 74 (1997) (holding that plaintiff lacked standing to assert declaratory judgment claim because she had no “personal stake in the subject matter of [the] lawsuit”). The lower court correctly determined that Plaintiff cannot represent the class she has proposed.

**C. Plaintiff Has Not Shown That Any Other Requirement of Rule 23, SCRCF Is Satisfied.**

Rule 23, SCRCF requires Plaintiff to demonstrate both that her claims implicate a common, dispositive issue and that they are typical of other class members' claims. Because Plaintiff has no proof that all, or even most, purported class members' claims

were adjusted because of the contested policy here (not reimbursing customers for amounts they did not incur), Plaintiff has not satisfied this burden. Nor has Plaintiff proposed a workable means by which to identify the alleged class members, rather than a manual, file-by-file adjudication of each class member's claim.

1. *The Class Action Complaint Must Raise Questions Common to the Class, and Plaintiff's Claim Must Be Typical of the Class.*

"[S]ince any competently crafted class complaint literally raises common questions," what matters is whether those questions can "generate common *answers*." *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2551 (2011) (internal quotation marks and alterations omitted).<sup>3</sup> As the leading scholar of South Carolina civil procedure has observed:

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

James F. Flanagan, *South Carolina Civil Procedure* § 23.B.3 (2010). In this case, Plaintiff failed first to satisfy her burden of demonstrating that there are common questions among the class members capable of generating common answers.

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<sup>3</sup> Because South Carolina's Rule 23(a) is based on Federal Rule of Civil Procedure 23(a), South Carolina courts "look to the construction placed on the Federal Rules of Civil Procedure" when there is no South Carolina law on point. *See Gardner v. Newsome Chevrolet-Buick*, 304 S.C. 328, 330-31, 404 S.E.2d 200, 201 (1991); *see also Middleton v. SunStar Acceptance Corp.*, No. 98-CP-07-1131, 2000 WL 33385388, at \*3 n.3 (S.C. C.P. Jan. 13, 2000) ("As the South Carolina Reporter's Notes indicate, South Carolina's Rule 23 is 'drawn principally from Federal Rule 23.' Citations to federal case law and the federal rules are based on the principal that interpretations of the federal rule provide guidance in interpreting the South Carolina rule absent material differences." (citation omitted)). As the court below noted, there is no "material difference" between commonality under Rule 23, SCRCF and Federal Rule 23. Recons. Order p. 6 n.3 (R. p. 25). And Plaintiff herself admits that federal law is persuasive by relying on it where she finds it convenient. *E.g.*, Plf's Br. p. 33.

Additionally, Plaintiff must show that her claims are typical of those of the class. To satisfy that burden, she must “possess the same interest” and “suffer the same or similar injury” as the class members. *See Burton*, 2012 WL 7153877, at \*3 (citing *McClain*, 105 F.3d at 903). To meet the typicality threshold, Plaintiff must prove that her “interest in prosecuting [her] own case . . . simultaneously tend[s] to advance the interests of the absent class members.” *See Dieter v. Microsoft Corp.*, 436 F.3d 461, 466 (4th Cir. 2006) (holding that named plaintiffs in antitrust class action were not typical of some purported class members because proving absent class members’ claims would require “new and different proof” than evidence required to prove named plaintiffs’ claims). Accordingly, when “variation” between a named plaintiff’s claims and those of the purported class members “strikes at the heart of the respective causes of actions,” courts “have readily denied class certification.” *See id.* at 467 (citing cases).

2. *Plaintiff Has Not Satisfied Her Burden in This Case.*

Plaintiff argues that she satisfied her burden of demonstrating commonality based on a list of seven questions that all boil down to asking whether Progressive violated the law. Plf’s Br. pp. 42-43. All seven of those questions relate to whether Progressive’s payments to the class members in amounts less than the total amounts reflected on the class members’ bills—as opposed to any amounts they or their health insurers actually owed or paid—violated the terms of the class members’ Progressive policies or South Carolina law. *See id.* The answers to those questions, however, will vary depending on each class member’s unique circumstances. For the same reasons, Plaintiff’s claim is not typical of the putative class.

The putative class is not limited to Progressive insureds whose claims were adjusted as a result of their providers’ contracts with health insurers (or other third-party

payors). Nor did Plaintiff present evidence to show that the class members predominately would be such insureds. Rather, Plaintiff's proposed class includes all Progressive insureds in South Carolina whom Progressive paid less than the total amounts the insureds were billed, regardless of the reasons for the difference. Plf's Br. p. 3. Indeed, the evidence shows that Progressive has made such "reduced" payments for a number of other reasons grounded in the policy's terms, depending on the circumstances surrounding each class member's claim, and there is no evidence as to how many different circumstances actually are reflected in the members of the class. *See* Decert. Order pp. 13-14 (R. pp. 32-33). Thus, Plaintiff has failed to meet her burden of showing that her central contention in this case—that Progressive supposedly underpays medical benefits to South Carolina insureds with health insurance in breach of the policy or in violation of South Carolina law—is common to the class Plaintiff actually seeks to represent.

Importantly, the putative class includes insureds who, unlike Plaintiff herself, allegedly were paid less than the total amounts their medical providers billed because Progressive determined that the billed amounts were not "reasonable" or that the services provided were not "necessary." Second Am. Compl. ¶¶ 28-29 (R. pp. 77-78); Policy Part II, Insuring Agreement (R. pp. 527-28) (stating that Progressive "will pay the reasonable expenses incurred for necessary medical services" (emphasis removed)); *see* Zaner Dep. pp. 29:14-31:13 (Oct. 19, 2011) (R. p. 432, line 14-p. 434, line 13) (discussing Progressive's determination of "reasonable expenses" for "necessary medical services"); *id.* p. 46:12-16 (R. 439, lines 12-16) (based on plain language of policy, Progressive will be responsible only for "reasonable expenses incurred for necessary medical service

within three years”); *id.* p. 63:4-5 (R. p. 441, lines 4-5) (Progressive would pay insured only “reasonable and necessary amount that [insured was] legally obligated to pay”).

Determining whether Progressive was entitled to pay those class members amounts less than they were billed depends on the interpretation of entirely different policy terms than those implicated by Plaintiff’s claim—namely, “reasonable” and “necessary,” rather than “expenses incurred.” *See* Lange Dep. pp. 21:18-21, 25:1-4 (Aug. 3, 2011) (R. p. 313, lines 18-21, p. 315, lines 1-4) (stating that claims adjustment requires review of actual policy language); Zaner Dep. pp. 27:16-28:3 (R. p. 430, line 16-p. 431, line 3) (same). Resolving Plaintiff’s claim, therefore, would not resolve the claims of these class members. Instead, to resolve these class members’ claims, the factfinder would have to determine, on an individual basis, whether Progressive properly concluded that the amount a given class member was billed was unreasonable, that the services the class member received were unnecessary, or both.

These issues do not, as Plaintiff contends (Plf’s Br. p. 41), pertain only to “damages.” They are essential to determining whether Progressive is liable to a given class member—if Progressive did not adjust a class member’s claim based on a third-party payor contract discount, then the class member is not, for liability purposes, similarly situated to Plaintiff. For that reason, courts around the country repeatedly have held that class certification is improper when courts must resolve individual issues regarding the reasonableness of expenses incurred or the necessity of services provided. *E.g., Great Lakes Anesthesia, PLLC v. State Farm Mut. Auto. Ins. Co.*, No. 11-10658, 2011 WL 4507417, at \*1 (E.D. Mich. Sept. 29, 2011) (determinations regarding what is reasonable and necessary are individualized questions); *Johnson v. GEICO Cas. Co.*, 673

F. Supp. 2d 255, 273 (D. Del. 2009) (“individualized inquiries would be required to determine whether each class member’s individual claim was actually medically necessary and their expenses reasonable”); *Ostrof v. State Farm Mut. Auto. Ins. Co.*, 200 F.R.D. 521, 528-29 (D. Md. 2001) (denying class certification because determining whether insurer paid “reasonable and necessary” expenses precluded commonality finding); *Ross-Randolph v. Allstate Ins. Co.*, No. 99-3344, 2001 WL 36042162, at \*7 (D. Md. May 11, 2001) (collecting cases). This Court should reach the same conclusion and affirm that class certification would be improper.

In addition, Progressive may have paid a class member less than the total amount the class member was billed because some of the medical services the insured obtained did not occur “within three years from the date” of the motor vehicle accident in question. *See* Policy, Part II, Insuring Agreement (R. pp. 527-28). To ascertain whether Progressive’s decision was appropriate under the policy and South Carolina law, the circuit court would be obligated to conduct an individualized inquiry regarding the dates on which the class member obtained each of the medical services for which she sought coverage. Similarly, Progressive may have reimbursed less than the full amount billed because Progressive ascertained that (i) the insured did not sustain “bodily injury,” (ii) the bodily injury sustained was not the result of the “motor vehicle accident” at issue, or (iii) the insured was not, in fact, injured. *See id* (R. pp. 527-28). To resolve each class member’s claims, the factfinder would have to delve into whether the insured actually was injured, the cause of the injury, the nature of the injury, and whether each particular service for which the insured is seeking coverage relates to a “bodily injury” suffered by the insured in connection with the covered “motor vehicle accident.” None of these

questions would be answered by adjudicating Plaintiff's claims, and none can be resolved on a classwide basis.

Plaintiff attempts to brush past each of these individualized inquiries with the assertion that her putative class action is based on a "uniform written policy"—Progressive's alleged "standard operating procedure" codifying the practice of paying insureds the discounted amounts for which their health insurers contract with medical providers. Plf's Br. pp. 34-37. In arguing at length that most courts permit class actions to be certified based on uniform written policies, Plaintiff ignores the fact that she has not proven that every member of the putative class, as defined by her, is affected by this "uniform written policy." Even if the Court were to find the policy illegal as applied to Plaintiff, the lower court still would have to conduct individualized inquiries into the reasons Progressive adjusted the claims of other class members: Was it because of the alleged "uniform written policy" against reimbursing customers for charges they never incurred—or was it because their medical bills fell outside of the three-year window, their injuries were unconnected to an auto accident, or some other reason permitted under their policy? The answers are not readily available without individualized inquiry. And if many class members are unaffected by the policy, then Plaintiff's claims are not common to or typical of the whole class.

And there is no way to tell which customers are affected by the policy merely by sifting through files or Progressive's computer data. *Cf.* Plf's Br. 40. This is true even if the class were limited solely to customers with health insurance, because that would not answer the question of why their particular claim was reduced. Progressive does not keep summary records reflecting the reasons insureds are reimbursed in amounts lower

than the amounts they were billed for medical services. *See* Silver Dep. p. 19:8-23 (July 6, 2011) (R. p. 420, lines 8-23) (Progressive’s records only show “that the amount paid was not the amount that was entered,” *i.e.*, the amount the insured was originally billed); *id.* pp. 27:19-28:6 (R. p. 421, line 19-p. 422, line 6) (Progressive cannot ascertain “the number of persons who submitted claims and . . . didn’t receive the maximum policy limits . . ., and they received a payment that was less than one or more of their medical bills.”); *id.* p. 40:10-15 (R. p. 424, lines 10-15) (determining which Progressive insureds are members of the class would, at best, require a manual file review).

Consequently, for each individual class member, the trial court would need to examine the bills to determine whether the “discounts” from health insurance showed up on those bills. Customers who submitted no such bills (whether they have health insurance or not) have no claims in common with Plaintiff. This would be an administratively onerous burden to place on the circuit court, and it defeats the point of the class action model—resolving claims “in one stroke.” *Dukes*, 131 S. Ct. at 2551. Courts regularly deny class certification where the trial court would have to engage in significant individualized factfinding to ascertain the proposed class members. *See, e.g., Burton*, 2012 WL 7153877, at \*2 (denying class certification because, among other reasons, because based on proposed class definition, “it would be difficult to analyze . . . records . . . to determine whether a particular individual is a class member”); *Solo v. Bausch & Lomb Inc.*, Nos. 06-mn-77777 & -02716, 2009 WL 4287706, at \*6 (D.S.C. Sept. 25, 2009) (denying class certification because “[i]n order to ascertain who falls within the class, the court would have to make thousands of fact-intensive inquiries”);

*Cuming v. S.C. Lottery Comm'n*, No. 05-cv-03608, 2008 WL 906705, at \*1 (D.S.C. Mar. 31, 2008) (same).

The Court should affirm the circuit court's determination that SCRCF 23 is not satisfied in this case.

3. *The Lower Court's Reasoning Applies to Every Count in the Complaint.*

None of Plaintiff's claims can be resolved on a classwide basis.

*Unjust Enrichment.* Plaintiff alleges, on behalf of herself and the purported class, that Progressive was unjustly enriched by "the reduced payments to the Plaintiff and class members under the medical payments portion of their insurance policies with [Progressive]." Second Am. Compl. ¶ 59 (R. p. 83). In other words, Plaintiff contends that Progressive was unjustly enriched as a result of its payments to the class members even though those payments implicate the unique circumstances surrounding each class member's insurance claims.

Unjust enrichment is an equitable doctrine that permits recovery of the amount that the defendant has been unjustly enriched at the expense of the plaintiff. *Dema v. Tenet Physician Servs. Hilton Head, Inc.*, 383 S.C. 115, 123, 678 S.E.2d 430, 434 (2009); *Ellis v. Smith Grading & Paving, Inc.*, 294 S.C. 470, 474, 366 S.E.2d 12, 15 (Ct. App. 1988). To recover for unjust enrichment on a classwide basis, Plaintiff must prove—for each class member—that (i) the class member conferred a benefit on Progressive; (ii) Progressive realized that benefit; and (iii) Progressive retained the benefit under circumstances that make it "inequitable" for Progressive to do so "without paying . . . its value." *Sauner v. Pub. Serv. Auth.*, 354 S.C. 397, 409, 581 S.E.2d 161, 167 (2003).

By its nature, an unjust enrichment claim is unsuitable for resolution on a classwide basis because adjudicating it would require the factfinder to investigate the individualized circumstances surrounding each class member's claims. In particular, the factfinder would have to determine—based on each class member's unique circumstances—whether, by paying each class member an amount less than the full amount reflected on the class member's bill (as opposed to the amount the class member or her health insurer actually incurred) “it would be inequitable” for Progressive to retain the class member's premium payments. Making such a determination would require the factfinder to consider whether the bills were reduced because of the policy on health insurance discounts, or because the expenses were not reasonable, or because the insured was not injured in an auto accident. There is no single question the factfinder can answer in addressing Plaintiff's individual claims that also will answer all of these questions with respect to each and every class member. Accordingly, Plaintiff's unjust enrichment claim renders class certification inappropriate. *See Melton ex rel. Dutton v. Carolina Power & Light Co.*, 283 F.R.D. 280, 290 nn.7 & 12 (D.S.C. 2012) (concluding that class certification would be inappropriate because the unjust enrichment and other claims required the factfinder to make numerous “individualized determinations”).

*Bad Faith and Tortious Interference.* For similar reasons, Plaintiff's bad faith claim is not amenable to class treatment. To state a claim for bad faith, Plaintiff must prove—with respect to herself and the putative class—that Progressive refused to pay each class member the benefits owed the class member under the Policy as a result of Progressive's “bad faith or unreasonable action in breach of an implied covenant of good faith and fair dealing.” *See Temple v. Mut. of Omaha Ins. Co.*, No. 11-cv-00128, 2013

WL 314750, at \*4 (D.S.C. Jan. 28, 2013). As a result, to resolve the class member's claims, the factfinder would be required to determine, with respect to each class member, whether Progressive acted in "bad faith" or "unreasonably." Given all the different situations in which the class members may find themselves, as described above, the factfinder could not possibly make such a determination simply by resolving Plaintiff's claim. *Cf. Gardner*, 353 S.C. at 22-23, 577 S.E.2d at 201 (denying class certification because factfinder would have to determine individually whether class members were "prejudiced" by defendant's alleged conduct).

So too Plaintiff's tortious interference claim. Adjudicating that claim would require the factfinder to determine whether Progressive intentionally procured the breach of its own contracts with the class members (assuming, for the sake of argument, that a party to a contract can state a claim for tortious interference with her own contract). *See Self v. Norfolk So. Corp.*, Nos. 06-cv-1730 & -2101, 2007 WL 540373, at \*4 (D.S.C. Feb. 15, 2007). This it cannot do without making the same individualized inquiries. Accordingly, Plaintiff cannot show that commonality or typicality exists with respect to her bad faith or tortious interference claims.

**D. The Court Did Not Commit Any Procedural Errors.**

Plaintiff is wrong that the court committed procedural error by determining that she has not stated a claim under South Carolina law. Plf's Br. p. 15. Not only is it appropriate for a court to reach the "merits" of a complaint when ruling on class certification, it is required. A class should not be certified if no class member, including the plaintiff, would have a legally viable claim. Plaintiff's other sundry claims of error likewise are unavailing. The lower court did not improperly grant summary judgment against her; it held that she failed to state a claim as a matter of law, and that she failed to

satisfy her burden of proving that class certification is appropriate. Both of these holdings were proper. Nor did the court somehow ignore Plaintiff's arguments: it simply found them unconvincing. This Court should do the same.

1. *The Lower Court Did Not Err in Reaching the "Merits" when Denying Class Certification.*

Plaintiff argues that the circuit court erred by considering the "merits" of her claims in determining that she is an inadequate class representative, based on three cases that state generally that "a court may not look to the merits when determining whether to certify a class." *King v. Am. Gen. Finance, Inc.*, 386 S.C. 82, 88, 687 S.E.2d 321, 324 (2009); *Bazzle v. Green Tree Fin. Corp.*, 351 S.C. 244, 267, 569 S.E.2d 349, 361 (2002), *opinion vacated by* 539 U.S. 444 (2003); *Tilley vs. Pacesetter Corp.*, 333 S.C. 33, 43, 508 S.E.2d 16, 21 (1998). In none of these cases is that statement explained or applied. Its meaning becomes clear, however, after looking to the case originally cited by *Tilley* in support of this proposition: *Eisen v. Carlisle & Jacquelin*, 417 U.S. 156 (1974).

In *Eisen*, the U.S. Supreme Court held that a preliminary hearing into the merits of a case, for the purpose of allocating the costs of notifying the class, is inappropriate. *Id.* at 177-78. When entertaining a motion for class certification, a trial court cannot inquire into whether the plaintiff is "more likely than not" to succeed on her claims. *Id.* The Supreme Court later explained that *Eisen* must not be read more broadly to prohibit *any* "overlap with the merits of the plaintiff's underlying claim" when making class certification rulings. *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2551-52 & n.6 (2011). Quite the contrary: "The class determination generally involves considerations that are enmeshed in the factual and legal issues comprising the plaintiff's cause of action." *Id.* at 2551-52 (internal quotation marks and alterations omitted).

Even if South Carolina has adopted a broader reading of the principles of *Eisen* than the United States Supreme Court, that still would not prohibit an inquiry into whether plaintiff has stated a viable cause of action. In *Curley v. Cumberland Farms Dairy*—which is also cited as a source of this statement in South Carolina, see *Tilley*, 333 S.C. at 43, 508 S.E.2d at 21—the court explained the difference between examining the viability of the complaint and demanding that plaintiff make a preliminary showing of meritoriousness. 728 F. Supp. 1123, 1128-29 (D.N.J. 1990). “Although the court may not look to the merits when determining whether to certify a class,” *Curley* began (relying on *Eisen*), “[o]ut of fairness to potential members of the class who may have their claims extinguished if the court certifies a class as to all claims in the second amended complaint only then to dismiss some of those claims, it is appropriate for the court to look at the allegations of the complaint only enough to determine whether the cause of action may survive a motion to dismiss.” *Id.*

That an inquiry into, at the very least, pure questions of law implicated by the plaintiff’s complaint is proper is demonstrated by *King v. American General Finance* itself, the most recent source of the statement Plaintiff relies on. Plf’s Br. p. 15. In *King*, when reviewing the class certification order, the court interpreted the proper meaning of a statute to ask whether the plaintiffs stated a claim based on that statute. 386 S.C. at 90-91, 687 S.E.2d at 324-25. That is no different from what the lower court did here: asking whether Progressive’s conduct as alleged violated the insurance policy or the prohibition against set-offs in S.C. Code Ann. § 38-77-144. Plaintiff is wrong. Examining the viability of her complaint was not only proper, it was entirely necessary.

2. *The Lower Court Did Not Make Improper “Summary Judgment” Determinations.*

Plaintiff contends that the circuit court erroneously went “beyond the pleadings” when it determined that she had not established her right to class certification. Plf’s Br. 15-16. Although Plaintiff does not reveal in what way the court erred, it is clear that, in any event, she is wrong. The court below reached two operative conclusions: (1) the word “incurred” is not ambiguous as a matter of law, and Plaintiff is not entitled to be reimbursed for amounts no one ever owed, Decert. Order pp. 9-10 (R. pp. 28-29); and (2) Plaintiff has not shown the suitability of class certification because she presented no evidence that every adjustment Progressive makes to its customers’ bills is due to the health insurance “discount” issue, *id.* pp. 14-16 (R. pp. 33-35). Contrary to Plaintiff’s contentions, Progressive squarely presented both of these issues to the district court on reconsideration. Mot. for Recons. pp. 7-8, 12-15, 20-24 (R. pp. 171-72, 176-79, 184-188). If Plaintiff thought the inquiry into either of them improper, she should have told the district court so. *Cf. I’On, LLC v. Town of Mt. Pleasant*, 338 S.C. 406, 422, 526 S.E.2d 716, 724 (2000) (preservation requirements are “meant to enable the lower court to rule properly after it has considered all relevant facts, law, and arguments”). But she did not.

In any event, both holdings clearly were within the court’s power to make. The first holding is indisputably an examination of the sufficiency of the complaint in light of the relevant law. The Second Amended Complaint is based on the theory that failing to reimburse customers for health insurance “discounts” is impermissible under the language of the Policy and S.C. Code Ann. § 38-77-144. *E.g.*, Second Am. Compl. ¶ 18 (R. p. 76). The court accordingly held that this theory failed to state a claim as a matter

of law. *Cf. Gordon*, 120 S.E.2d 518 (deciding this issue on a demurrer). As discussed above, there is nothing wrong with proceeding this way.

With respect to the second holding, Plaintiff apparently believes that it is an improper “summary judgment” determination. Plf’s Br. pp. 15-16. But she confuses summary judgment with the standard for class certification. The circuit court did not grant Progressive summary judgment. Instead, it held that Plaintiff had not met her burden of proving that the requirements of Rule 23, SCRPC are satisfied. *Cf. Pope*, 395 S.C. at 421, 717 S.E.2d at 774 (the plaintiff must “prove” she has satisfied Rule 23); *Waller*, 300 S.C. at 468, 388 S.E.2d at 801 (burden of showing compliance with Rule 23 is on the plaintiff). Whether Plaintiff has shown that Progressive never adjusts claims for reasons other than health insurance “discounts” is relevant to class certification because it determines whether the class claims can be decided “in one stroke.” *Dukes*, 131 S. Ct. at 2551. The court found that Plaintiff did not make this showing, and thus that the class could not be certified. Plaintiff’s nonspecific, conclusory claims of error must fail.

3. *The Lower Court Did Not Fail to Address Any of Plaintiff’s Claims.*

The failure to address claims raised below is not, on its own, reversible error. *Cook v. S.C. Dep’t of Highways & Pub. Transp.*, 309 S.C. 179, 184, 420 S.E.2d 847, 849 (1992) (“It was not incumbent upon the trial judge to separately address in writing every issue raised by appellant”); *e.g., Lanier Const. Co. v. Bailey & Yobs, Inc.*, 384 S.C. 275, 282, 681 S.E.2d 909, 913 (Ct. App. 2009). An appellate court does not reverse a trial court for failing to explicitly address every argument; quite the opposite. “[A]n appellate court may affirm the lower court’s judgment for any reason appearing in the record on appeal.” *I’On*, 338 S.C. at 420-21, 526 S.E.2d at 723. And in this instance, Plaintiff’s

contentions of error are particularly insubstantial. As explained above, the record amply supports the lower court's decision.

Plaintiff nonetheless inexplicably contends that the lower court failed to resolve the "core issue" of whether Progressive's conduct "violates the statutes and policy language." Plf's Br. p. 17. Of course the court resolved this issue. It held that Plaintiff did not "incur" the health insurance discounts under the policy and that Progressive need not reimburse her for expenses she did not "incur." Decert. Order 9-10 (R. pp. 28-29). Because the court held that South Carolina law compels this result, it necessarily held that South Carolina law does not also prohibit this result. *Cf. Schuette v. BAMN*, 134 S. Ct. 1623, 1639 (2014) (Scalia, J., concurring in the judgment).

Plaintiff also complains about the court's failure to specifically mention her claim for declaratory judgment. Plf's Br. pp. 16-17. But the presence of a declaratory judgment claim does not save her otherwise inadequate complaint. *See Felts v. Richland Cnty.*, 299 S.C. 214, 216, 383 S.E.2d 261, 262-63 (Ct. App. 1989), *aff'd*, 303 S.C. 354, 400 S.E.2d 781 (1991) (declaratory judgments act is "remedial and procedural in nature and does not create substantive rights or duties"). The lower court therefore had no reason to separately address it.

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Plaintiff's complaints of procedural error are frivolous. The lower court's order correctly recognized that she failed to state a claim to relief, and that she cannot litigate her claims on a classwide basis. Plaintiff has recovered everything she is entitled to under the insurance policy, and more. Plaintiff should not be awarded a windfall.

#### CONCLUSION

The decision below should be affirmed.

Respectfully submitted, this 6th day of November, 2014.



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THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

APPEAL FROM HORRY COUNTY  
Court of Common Pleas

Larry B. Hyman, Circuit Court Judge

Case No. 2013-002133

**RECEIVED**  
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**SC Court of Appeals**

Stephanie A. Smith, on behalf of herself and all others similarly situated . . . . . Appellant

v.

Progressive Halcyon Insurance Company, n/k/a Progressive Direct Insurance Co., Progressive  
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**CERTIFICATE OF COUNSEL**

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I hereby certify that Respondent's Final Brief complies with Rule 211(b) of the South  
Carolina Appellate Court Rules.



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PROOF OF SERVICE

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I hereby certify that I have filed the **Final Brief of the Respondents** by depositing the unbound original and fourteen (14) bound copies of same in the U.S. mail with sufficient first class postage attached thereto and properly addressed to The Honorable Jenny Abbott Kitchings, Clerk, South Carolina Court of Appeals, 1205 Pendleton Street, Columbia, SC 29201 this 6<sup>th</sup> day of November, 2014.

I further certify that I have served the **Final Brief of the Respondents** on Appellant Stephanie A. Smith, on behalf of herself and all others similarly situated by depositing a bound copy of same in the United States Mail, with sufficient first class postage attached thereto, on this 6<sup>th</sup> day of November 2014, addressed to Appellant's attorneys of record, Nate Fata, Esq., Nate Fata, P.A., P.O. Box 16620, Surfside Beach, SC 29587 and Charles V. Leonard, Esq., Harris & Leonard, P.A., 4615 Oleander Drive, Suite 202, Myrtle Beach, SC 29577.



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November 6, 2014