

THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

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APPEAL FROM HORRY COUNTY  
Court of Common Pleas

Larry B. Hyman, Jr., Circuit Court Judge

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Case No. 2010-CP-26-10502

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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 REPLY BRIEF OF THE APPELLANT

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## INTRODUCTION

Progressive's uniform policy of not sending proof of loss forms and reducing payments to claimants with health insurance is undisputed. The record contains no evidence to the contrary. Instead of addressing these undisputed, common facts, Progressive employs a misreading of Federal Rule 23 and federal cases and uses a superficial analysis of Gordon and Barker to argue class certification is improper and Smith loses as a matter of law.

In its Brief, Progressive completely fails to address Smith's arguments concerning S.C. Code Ann § 38-59-10, which requires Progressive to send a proof of loss form. In fact, the proof of loss statute is never mentioned in its brief. Similarly, Progressive sparingly mentions its written corporate policy of reducing payments to insureds with health insurance.<sup>1</sup> While Progressive cautiously avoids the facts of its uniform practices and the statutory interplay with the policy language, the Court is left with unanswered questions and an analysis that does not comport with South Carolina law. Likewise, Progressive ignores the facts of the cases it heavily relies upon, including Gordon and Barker, to reach its illogical conclusions on policy language and class certification.

The facts in this case require a reversal. At its core, Progressive makes two arguments; that Smith failed to state an individual claim and that the varying damage amounts due to a potential reasonableness reduction to some class members might take some effort to determine, thereby precluding commonality under Rule 23 SCRPC. Neither assertion is applicable or valid. While Progressive invites the Court to embrace a

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<sup>1</sup> Progressive first mentions its Standard Operating Procedure on page 28 of its brief.

more restrictive view of Rule 23 than even that which is embraced under the federal rules, this Court should decline the invitation and follow South Carolina precedent, which favors a more expansive view of class actions.

## **ARGUMENT**

### **I. THE MATTER IS RIPE FOR APPEAL BECAUSE THE LOWER COURT DISMISSED SMITH'S CLAIMS.**

Progressive argues this appeal should be dismissed because “The lower court has not granted Progressives’ Motion for Summary Judgment or entered final judgment in the case based on findings in its Reconsideration Order.” Respondent’s Brief, p. 12-13. Yet, Progressive then argues, “it held that she failed to state a claim as a matter of law.” Respondent’s Brief, p. 2. Progressive goes one step further and later asserts that it is required for a court to reach the merits of a Complaint when ruling on class certification. Respondent’s Brief, p. 35 (“The Court accordingly held that Smith “failed to state a claim as a matter of law”). The Reconsideration Order summarily disposed of Plaintiff’s claims even though the Court acknowledged at the class certification hearing that a merits adjudication was improper.

A reversal is warranted because the Reconsideration Order effectively ends Plaintiff’s claims. An order dismissing some, but not all, of the claims in a case, either by summary judgment or dismissal pursuant to Rule 12(b)(6), S.C.R.C.P. involves the merits “and is immediately appealable because it finally determines some substantial matter forming the whole or part of some cause of action.” Link v. School District of Pickens County, 302 S.C. 1, 393 S.E.2d 176 (1990); Anthony v. Padmar, Inc., 307 S.C. 503, 415 S.E.2d 828 (Ct. App. 1992).

## **II. SOUTH CAROLINA RULE 23 IS EASILY SATISFIED WITH PROGRESSIVE'S WRITTEN STANDARD OPERATING PROCEDURE, UNIFORM POLICY LANGUAGE, AND COMPUTERIZED DATA.**

A class action is the appropriate vehicle to address Progressive's written corporate policy which impacts several hundred South Carolinians in relatively small but important amounts. Progressives' analysis and the analysis in the Reconsideration Order is not contemplated by South Carolina jurisprudence under Rule 23, SCRCP. Instead, the Reconsideration Order and Progressive rely on a misreading of federal cases to assert a highly restrictive reading of Rule 23 which even the federal courts do not accept. In fact, Progressive attempts to require Smith to prove the entire class case, with damages, before the class is certified. Smith is not required to do so. Nonetheless, Smith can and will proffer evidence which will resolve common issues because Progressive has and can retrieve the information.

### **A. The Court Erred By Adjudicating The Merits.**

The Court erred by adjudicating the merits under Rule 23. As Smith argued in her Initial Brief, South Carolina precedent prohibits such an approach. The U.S. Supreme Court in Dukes, citing Eisen v. Carlisle Jacquelin, 417 U.S. 156 (1974), explained that while touching aspects of the merits is appropriate in some cases to determine whether Rule 23, FRCP requirements are satisfied, a merits inquiry "for any other pretrial purpose" is not permitted. Wal-Mart Stores, Inc. v. Dukes, 131 S. Ct. 2541, 2552 N.6 (2011). The federal appeals courts have interpreted footnote 6 as narrowly prescribing limits of the merits inquiry on class certification to that which is absolutely critical to determining whether Rule 23, FRCP requirements are met. Behrend v. Comcast Corp., 655 F.3d 182, 190 (3<sup>rd</sup> Cir. 2011) ("[A]t the class certification stage we are precluded

from addressing any merits inquiry unnecessary to making a Rule 23 determination” because as Dukes holds, “Eisen still prohibits “A merits inquiry for any other pretrial purpose””).

The South Carolina Supreme Court recently addressed this merits issue in the class action context and held that because time under the attorney preference statute, S.C. Code Ann. § 37-10-102, was the central issue in that case, the lower court erred in decertifying the class. King v American General Finance, 386 S.C. 82, 687 S.E.2d 321, 325 (2009). King also held the typicality requirement of Rule 23, SCRPC was “found in the common feature of the lender failing to timely provide the attorney preference disclosure” and that commonality and adequacy were also present. King, 687 S.E.2d at 325.

The King decision is applicable to this case for two reasons. First, it confirms South Carolina precedent which prohibits a court from ruling on the merits at class certification. Thus, King compels a reversal based on the lower court’s error of law. Second, it confirms the lower court committed an additional error of law by not finding a common question in the timing issue raised in Smith’s case, as more fully discussed below.

**B. Progressive Admits Common Questions.**

Smith’s case is no different than King on the timing issue. All class members have the timing issue in common under S.C. Code Ann. § 38-59-10 and policy language. Progressive does not send proof of loss forms as required by statute and then uses arbitrary timing mechanisms to measure expenses incurred. Even Progressive admits that the timing of “incurring” an expense is a common question critical to addressing the

classwide issue of ambiguous policy language. “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.” Respondent’s Brief, p. 10. The insurance policy language has already answered this question: the date of the medical service and not the date of the bill. The head of Progressives’ National Med Pay Unit, Liz Zaner, has already answered this question: the date of the medical service (R. p. 442, lines 7-25). Peter Goodchild, the Progressive supervisor and corporate representative, answered this question: the date of the medical service (R. p. 394, line 22-p. 395, line 2).

The two fields of data entered by Progressive’s adjusters into the computer, amount charged and amount to be paid from all sources, answers the question: the date of the medical service.<sup>2</sup> There would be no need to enter the amount charged into the system if that amount was never incurred (R. p. 515 -518).

This timing question of when an obligation arises has already been answered by Progressive and must be resolved in favor of the insureds. The policy cannot be interpreted to contain different timing mechanisms for different insureds. The policy language, equally applicable to all class members, is sufficiently central to justify certification. And Progressive openly acknowledges this reality in its brief. As in King, the Court should reverse the lower Court and reinstate the class certification order.

Similarly, if the Court finds Progressive’s uniform failure to send proof of loss forms to the insureds, then by statute their claims are the amount of the medical bills and may not be reduced for any reason including for health insurance, or for any

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<sup>2</sup> For the amount to be paid from all sources field, Progressive enters “amount paid by health carrier, copays, ded, any balance bill issues,” which is the amount allowed by the health insurance carrier (R. p. 579).

reasonableness or necessary defenses. The Reconsideration Order and Progressive ignore this reality and they completely ignore S.C. Code Ann. § 38-59-10. Likewise, if the Court finds Progressive's written policy to underpay health insured claimants violates the statutory law or the policy language, then all claimants will recover the underpayment and Progressive will be required to adjust future bills in the three year window in accordance with the Court's directive. Under Littlefield v. South Carolina Forestry Commission, 337 S.C. 348, 523 S.E.2d 784 (1994), there are several main issues of law identical for all plaintiffs and all injuries result from this conduct.

Even federal courts under the more restrictive Rule 23, FRCP recognize that where a question of law refers to standardized conduct by Defendants towards members of the proposed class, a common nucleus of operative facts is typically presented, and the commonality requirement is usually met. Franklin v. City of Chicago, 102 F.R.D. 944, 949 (N.D. Ill. 1984). And with the more restrictive federal rules, commonality still requires only one common question of law or fact. Baby Neal ex rel. Kanter v. Casey, 43 F.3d 48, 56 (3d Cir. 1994). The class shares determinative issues under S.C. Code Ann. § 38-59-10, the corporate policy to short pay health insured claimants and the policy language. Under Littlefield and King, the lower court committed an error of law by decertifying the class and finding common questions do not exist.

**C. The Court Should Reject Progressive's Argument That A More Restrictive Federal Analysis Is Applicable.**

The Reconsideration Order misstates and misapplies Dukes on the issue of common questions to impose a more stringent standard than that which is even contemplated by FRCP 23. Under Progressive's and the lower court's misreading of Dukes, a common question must decide the class claims "in one stroke." Dukes does not

require the claims to be decided in one stroke. Rather, the common question is to provide a “common answer apt to drive the resolution of the litigation.” Dukes, 131 S. Ct. at 2551. The common questions presented in this case are “apt to drive the resolution of the litigation.”

Several appellate courts have reviewed commonality requirements in light of Dukes. In Ross, the Seventh Circuit affirmed class certification of 1129 hourly class members who challenged Charter One’s unwritten compensation policy of failing to pay overtime. Ross v. RBS Citizens, N.A., 667 F.3d 900 (7<sup>th</sup> Cir. 2012). The Seventh Circuit interpreted the Dukes commonality ruling and held that “although there might be slight variations in how Charter One enforced its overtime policy, both classes maintain a common claim that Charter One broadly enforced an unlawful policy denying employees earned – overtime compensation. This unofficial policy is the common answer that potentially drives the resolution of this litigation.” Ross, 667 F.3d at 909 (citing Dukes, 131 S. Ct. at 2551).

In Ross the Seventh Circuit distinguished Dukes with 1.5 million nationwide claimants which were required to prove that thousands of store managers had the same discriminatory intent on preferring males over females for raises and advancements versus the Ross class of 1000 or so members, all in Illinois, and all challenging an unofficial policy to deny certain employees overtime that was due. Ross, 667 F.3d at 909. The Smith class is even smaller than that in Ross, with several hundred South Carolinians challenging Progressive’s undisputed written policy to short pay health insured claimants and its failure to send proof of loss forms.

Charter One argued that there were four ways in which employees could be denied overtime and sifting through such individualized evidence should preclude commonality. Ross, 667 F.3d at 901. The Ross court rejected Charter One's lack of commonality argument that both classes' claims "require the same significant and individualization liability inquiries that the Supreme Court found problematic in Dukes. Ross, 667 F.3d at 908. Ross found the size of the classes and the type of proof the Dukes plaintiffs were required to offer to be in stark contrast to Charter One's small class size and its policy of denying overtime pay that was lawfully due. Ross, 667 F.3d at 909. That unofficial policy was the common answer that potentially drives the resolution of the litigation in Ross. Id.

The instant class is even smaller than the classes in Ross. Progressive makes the same "sifting through such individualized evidence should preclude commonality" argument as did Charter One. As in Ross, Progressive is arguing slight variations might exist based on some potential reasonable and necessary defense. But the Ross analysis still compels a finding of common questions, especially in this small, several hundred person Progressive class. Under South Carolina's more expansive view of class actions, the lower court ruling was clearly an error of law.

**D. Common Proof Exists Despite Progressive's Reasonableness And Necessary Argument.**

Progressive attempts to avoid its written corporate policy, Standard Operating Procedure and uniform data collection of the amount charged and amount to be paid, by arguing that for some class members the reasonableness or necessary clauses in the policy might have been a reason for a reduced payment. Its logic is flawed for several reasons. There is no need for a determination as to whether the medical expenses were

reasonable or necessary under the policy. The National Med Pay Unit uses a systematic adjusting process with little to no variation. The only evidence is that the National Med Pay Unit has never declined or reduced a claim based upon the reasonable or necessary clause within the policy.<sup>3</sup> Progressive only reviews the medical bills for the purpose of determining if the insured paid the bills out of her own pocket or if the med pay unit should pay the bill (R. p. 316, line 2 -p. 317 line 16). Progressive specifically does not review the medical bills for reasonableness (R. p. 322, line 16-p. 323, line 6.) While Progressive argues its policy allows it to determine expenses as “reasonable” and necessary, the National Med Pay Unit does not do so. Nothing in the record supports Progressive’s hypothetical arguments.

Even if a few class members’ charges were contested by Progressive as “unreasonable and unnecessary”, those class members are still subjected to the written Standard Operating Procedure to reduce payments based on health insurance. The record is replete with corporate representative testimony and adjuster testimony that the written policy to underpay claimants with health insurance is always followed (R. p. 404, lines 11-25). Progressive uses uniform policy language, which it construes in its favor, when determining amounts to be paid to claimants with health insurance for all thirteen states adjusted by the Goodchild group. All class members have this uniform policy language in common. In addition, common proof of the health insurance reduction basis is found in the documentation used by Progressive to reduce payments-the medical bills and the bill amount entered into the computer and the amount to be paid from all sources. The statutes, the policy language and Standard Operating Procedure are not affected by a

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<sup>3</sup> R. p. 377, lines 19-21; R. p. 319, line 25-p. 320, line 13 and p. 332, line 16-p. 333, line 6; R. p. 469, line 1-p.470, line 14; R. p. 474, lines 20-24; R.. p. 464, line 19-p.465, line 27; R. p. 459, lines 10-16.

hypothetical reasonable or necessary defenses or damage argument for which Progressive has the contractual and legal burden of proving.

Regardless of Progressive's damages arguments, all persons would benefit now or during the three years in which they may submit claims for med pay benefits from a declaration by the court construing the statutes at issue and the policy language. On page 5 of the Class Certification Order, the lower court properly determined that a declaration of the rights of the class and Progressive will affect any past or pending class claims within three (3) years of the med pay incident. That analysis and conclusion does not change with any hypothetical reasonable and necessary argument.

**E. Progressive Admits It Has No Evidence To Support Its Reasonable And Necessary Defense.**

Progressive admits it cannot provide evidence that the reasonableness defense exists or that it would alter the common questions. In fact its adjusters are unaware of any instances in which reasonableness or necessity were assessed to a claim (R. p. 320, lines 10-13; p. 322, line 8-p.323, line 6). According to Progressive, “. . . Defendants computer databases store only the amounts entered by claims representatives/adjusters . . .” (R. p. 597 number 8). Thus, Progressive concedes it does not have any computerized data to support any reduction based on “reasonableness.”<sup>4</sup> Progressive further admits that reviewing each customer's file will not reveal evidence for its related or reasonableness defense. Respondent's Brief, p. 11 (“Even reviewing each customer's file will not reveal the answers to all of these questions”). Progressive further admits it does not keep

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<sup>4</sup> As will be borne out in discovery, any reasonable charge defense could only be applied systematically, if at all, under a uniform charge sheet or a software program, providing a retrievable, universal basis for any reductions. Adjusters do not have any discretion to determine the amount of a reasonable charge.

summary records reflecting the reasons insureds are reimbursed in amounts lower than the amounts they were billed. Respondent's Brief, p. 29.

The only documentary evidence Progressive uses to adjust a claim is the medical bill. By its very nature, the medical bill is not proof that the charge is unreasonable but rather the medical provider charges are reasonable. Even if Progressive were to find and present some evidence on reasonableness reductions, the common questions would still be resolved in this class action.

**F. Progressive's Own Documentation Defeats Its Arguments.**

Progressive's assertion that individual fact findings are necessary and onerous is without merit. Respondent's Brief p. 29. Progressive uses a code, X563, which is entered anytime a med pay insured has health insurance which paid on a medical bill.

Q: Why do you always type in X563 for amount charged?

A: To show that the patient's health insurance paid the medical bills.

(R. p. 355, lines 21-24)

Q: So when the patient has health insurance that's paying for part of the medical bill, you will also enter in explanation code X563 for that particular entry?

A: Correct.

(R. p. 355 line 25-p. 356, line 3)

A review of Exhibit 6 to Lange's 2012 deposition shows the code X563 entered and typed 16 times on the explanation of benefits for Smith's med pay claim (R. p. 516, 517). The explanation of benefits gives further clarification in the comments section where it states "Allow payments for what health insurance paid plus copays or payments." The comments, which are generated with an X563 code, essentially restate

the Progressive SOP for South Carolina and the uniform claims process used for all South Carolina med pay insureds. Exhibit 6 to the Lange deposition exemplifies why Smith, with her coded explanation of benefits, is well suited to be the class representative and that obtaining a list of other class members is simply a minor retrieval issue. Similarly, each class member has a medical bill which reflects the level of health insurance involvement. Health insurance is easily verifiable with Progressive's records. In addition, the amount of any short pay due to health insurance is readily available with the medical bill information and the information Progressive enters into its system as the amount to be paid from all sources versus the amount charged. Progressive's assertions that to recover this information is administratively infeasible are duplicitous.

Progressive is speculating on the manageability of the class claims for damages when it has already determined and documented via computer code the basis for the short pay. Speculation as to the unmanageability of a class action is insufficient to preclude certification. See McClendon v. Continental Group, Inc., 113 F.R.D. 39, 45 (D.N.J. 1986). Rather, a court should consider only concrete evidence of actual or likely management problems. Progressive admits it has no evidence to support its manageability defenses because "even reviewing each customer's file will not reveal answers of all of these questions. Respondent's Brief p. 11. Nothing in the record allows Progressive to assert a speculative manageability argument under FRCP 23. Even with such arguments, the Court has a number of management tools available to address any individualized damage issues. See In re Visa Check/Master Money Antitrust Litigation, 280 F.3d 124, 141, (2<sup>nd</sup> Cir. 2001). The McGann Court recognized this reality as more fully discussed below.

### III. THE LOWER COURT AND PROGRESSIVE ERR BY IGNORING CASE LAW DISTINGUISHING COMMON QUESTIONS FROM CALCULATION OF DAMAGES.

Progressive contends that because individual issues might exist for a reduction, which would reduce damages, commonality does not exist. Progressive argues that Smith has not proven that every member of the class is affected by its uniform written policy. Respondent's Brief p. 28. But Smith has proven just that. The deposition testimony of all adjusters and the corporate representative is that health insured claimants always get short paid. While there might be an additional basis to reduce a payment, all class members are subjected to the Standard Operating Procedure by Progressive's own design. Progressive has not offered any evidence that the Standard Operating Procedure was not followed for some claimants. The adjusters have no discretion on the health insurance issue. The existence of some possible individual issues does not defeat common issues or class certification. Moreover, our courts have refused to deny certification on that ground. McGann v. Mungo, 287 S.C. 561, 340 S.E.2d 154 (Ct. App. 1986).

In McGann, residents and owners of improved residential property in a subdivision near Columbia filed a class action concerning negligent design and construction of streets and drainage. The defendants argued each class member's differing damages prevented class certification. In rendering its decision, the South Carolina Court of Appeals stated, "The mere fact that the Plaintiffs may be entitled to different amounts of damages does not prevent them from banding together and asserting their rights jointly in one action." McGann, 340 S.E.2d at 158. McGann has been cited consistently by the South Carolina appellate courts and on many occasions by the South

Carolina Supreme Court in ruling on class certification issues. Even under the more stringent federal standard, the need for individual damage determinations does not defeat commonality. Seidman v. American Mobile Sys., 157 F.R.D. 354, 360 (E.D. Pa. 1994). Contrary to Progressive's arguments, some factual variations among class members does not defeat commonality. Rodger v. Electronic Data Sys. Corp., 160 F.R.D. 532, 538 (E.D.N.C. 1995).

There are common questions among class members capable of generating common answers. Progressive concedes health insurance triggers a reduced payment. Once a reduced payment is identified, Progressive must produce its "reasonableness" data. Smith's claims were not reviewed for "reasonableness". Progressive must provide evidence that it further reduced payment based on "reasonableness." Even if Progressive could develop evidence to support a reasonableness reduction, a declaration of Progressive obligations under the policy for the three year window going forward is unaffected by any such defense. More importantly, any reasonableness evidence could only reduce damages and not eliminate the liability under the common issues. In other words, any reasonableness or necessary reductions do not eliminate the Standard Operating Procedure of Progressive reducing payments due to health insurance and Progressive's violation of S.C. Code Ann. 38-59-10 by its failure to send proof of loss forms.

#### **IV. PROGRESSIVE AND THE LOWER COURT'S ORDER MISREAD AND MISAPPLY GORDON AND BARKER.**

Progressive has misplaced reliance upon Gordon and Barker to support its position that Smith incurred no charges for her health insurance discounts and thus has no viable individual claim. Gordon v. Fid. & Cas. Co. of N.Y., 238 S.C. 438, 120 S.E.2d

509 (1961); Barker v. Washington National Ins. Co., No. 9:12-cv-1909-PMD, 2013 WL 1767620. Progressive does not place any importance on the factual distinctions between Gordon and this matter and how such factual distinctions are critical to the ultimate outcome. Respondent's Brief, p. 15. Progressive goes further, and in a perplexing note, asserts the conclusions reached by the lower court and the Gordon court are precisely the same. They are not.

When looking at precedent, an appeals court must consider the facts supporting the precedent and whether these facts also support the lower court's decision. The facts and circumstances of both Gordon and Barker differ substantially from each other as well as this matter. Even with the critical distinctions, these two cases are useful in showing how Progressive should have written its policy to achieve its desire to reduce medical payments to policyholders who had health insurance.

**A. Gordon Defines Expense Incurred Consistent With Smith's Reading Of The Policy.**

Gordon analyzed the meaning of "expense incurred". In Gordon, there was never any **expense** because the medical services provided at the military base hospital were always free. Hence, an expense was not incurred, ever. Gordon was trying to collect the **value** of medical services which differs substantially from a bill or charge for medical services. Gordon, 120 S.E.2d at 510. Smith, on the other hand, incurred an expense on the date of service because she was charged for the medical services she obtained. For example, the bill of Strand Regional Specialty Associates with a date of service of March 11, 2009, statement date of April 14, 2009 and a charge in the amount of \$212, shows that she was billed for the medical services (R. p. 495). By virtue of being billed for the medical services, Smith "incurred" an "expense." Unlike Smith, Gordon was not billed

and, therefore, never incurred an expense. This is a key factual distinction between Gordon and Smith's claim which was overlooked in Progressive's brief.

**B. Progressive Should Look To Barker For Instruction On How A Policy Should Be Written To Properly Explain To Its Policyholders Its Payment Methodology.**

Progressive failed to consider broad factual distinctions when proclaiming Barker as indistinguishable from this case.<sup>5</sup> Once again when considering Progressive's cited cases, factual distinctions are key.

The facts in Barker cannot be reconciled with the facts of Smith. In Barker, the Plaintiff obtained a "Limited Benefit Health Coverage" insurance policy. Barker v. Washington National Ins. Co., No. 9:12-cv-1909-PMD, 2013 WL 1767620. The policy promised payments to the insured for the "expenses incurred" for medical services. Early in the life of the policy, the carrier tried to reduce the amount paid to Barker by taking advantage of his health insurance discounts. Id. Barker complained to the insurance company and ultimately to the South Carolina Department of Insurance, which resolved the issue in Barker's favor. Thereafter, he continued to receive payments based upon the full amount of the charges by the medical provider. Id.<sup>6</sup>

At a later date, Barker became eligible for Medicare. His policy had a Medicare endorsement which provided a specific formula for payment of benefits that differed from the previous formula. Barker, at 6. The policy paid less to the insured because it

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<sup>5</sup> Barker is a federal district court case and, therefore, any decision in that case is not binding on this Court. See Bazzle v. Green Tree Financial Corp 351 S.C. 244, 569 S.E2d 349, 359 (2002).

<sup>6</sup> Of interest is that the South Carolina Insurance Commission heard the appeal which sounds like the exact issue in this matter. The Commission enforced the contract whereby Barker received payment for the amount of the entire medical bill. The District Court did not provide any additional details about the issue.

took advantage of the Medicare write down. To compensate the insured for the reduction in benefit, the policy also provided for a premium reduction. Id. In Progressive's policy there is no such written policy provision or reduced premium for those with health insurance.

Despite a clear policy endorsement which changed the policy payment formula, Barker tried to decline the mandatory policy change. The insurance company implemented the change despite Barker's protest, so Barker filed suit. The Barker decision enforced the endorsement's express language which specifically addressed Medicare benefits. Barker, at 6. There was no ambiguity in the Barker endorsement language because the insurance carrier took the time to expressly articulate its calculation methodology in its endorsement language. Id.

Despite Progressive's bold assertion that Barker is indistinguishable from this case, it proves not to be true. The Barker policy contained a policy endorsement that changed its terms once a policyholder became eligible for Medicare. There is no such endorsement or change in policy terms in Progressive's policy. In fact, the insurance company in Barker, Washington National Insurance Company, was astute enough to know that policy interpretation would be held against it as the policy drafter, so it included the change as part of the policy terms. It recognized that some policyholders would eventually qualify for Medicare so it ensured the policyholder knew when, how and why they were being treated differently. Barker, at 6. Unlike Washington National Insurance Company, Progressive did not take the time to draft an endorsement. In addition, Progressive did not inform its policyholders when, how or why they would be treated differently if they had health insurance.

Washington National Insurance Company took further steps to make sure its insureds understood the policy terms. It reduced its premiums because it anticipated that reduced benefits would be paid when it took advantage of the Medicare write downs. Barker, at 6. No such reduced premiums were suggested or mandated by Progressive. Instead, Progressive wants to retain the short-pay benefits it derives from class members' payment of health insurance premiums.

Another distinguishing factor is that Barker tried to reject the mandatory policy endorsement. Rejecting the endorsement was not an option available to Barker, and hence, the determination by the Court that Washington National could, pursuant to the policy terms, take advantage of the Medicare write downs. Barker, at 1. The Progressive policy has no such policy terms although, like Washington National, it could have written the terms into the policy.

There is an additional difference between Barker and this matter. The Barker insurance policy provided a payment formula within the policy. Barker, at 6. This formula allowed the policyholder to understand, without any question, the amount of benefit to be paid and the basis for such payments. In this case, however, Progressive offers no such explanatory or unambiguous policy language. Instead it relies on its collaborative definition and the Virginia statute to define the term "expense incurred" for all South Carolina policyholders. As Elizabeth Zaner, head of the National Med Pay Unit, testified, a policyholder would not know about the reduced payments due to health insurance (R. p. 439, lines 5-9, 17-25 and p. 440, lines 1-6). Once again, Progressive chose not to enlighten its policyholders on its methodology. This is most probably due to its own confusion in how to define "expense(s) incurred." See Goodchild and Zaner

testifying that they required a division-wide meeting to determine the proper definition of the term and Zaner testifying that she does not know how an insured policyholder would know there is a reduction for health insurance set off (R. p. 407, line 16-p. 409, line 23; p. 414, line 6-p. 416, line 25; R. p. 439, lines 5-24). The plaintiff in Barker did not assert that “expense incurred” was ambiguous as Progressive asserts in its brief. Instead, Barker asserted that “will pay **100% in full** of the expenses incurred” was misleading because the “100% in full” was in conflict with the Medicare clause. Barker at 4. It was a conflicting insurance clause issue, not an issue of ambiguity with the term “incur”. Progressive’s position that the two cases are indistinguishable is simply not true.

The District Court in Barker made an analysis of whether a Medicare recipient could incur an expense. Barker, at 6. The Court cited a plethora of federal law that mandates the amount a medical provider may charge to a Medicare recipient. Such a federal statutory mandate is not present with private health insurance companies. In any event, a Medicare insured cannot be charged more than the amount dictated by Medicare and the insured is protected by federal law from any medical provider who attempts to charge more than the Medicare rate. No such laws protect those, like Smith, with standard health insurance.

One final distinction is that a Medicare recipient is billed at the Medicare rate at the time services are rendered. Smith was billed at the standard rate for the medical services at the time the services were rendered. The initial amount billed is what adjuster Lange enters into the system. This amount is later adjusted due to health insurance.

The timing of the billing is important when determining if Progressive’s use of the phrase “expense incurred” is ambiguous. The ambiguity created by the timing of the

medical bill was discussed in Appellant's Initial Brief to which Progressive replied that "this timing argument did not appear in Plaintiff's papers below." Respondent's Brief p. 17. Progressive overlooks page 2 of Plaintiff's Memorandum in Support of Class Certification where Smith states "the policies do not define **when** "incurred" will be measured" (R. p. 109).

The lower court committed an error of law by misreading and misapplying Gordon and Barker. Those decisions do not provide support for the Reconsideration Order. Barker supports the fact that Progressive should have clearly written its policy to inform its policyholders of its desires to pay less to those who have health insurance. It should have provided premium reductions for those with health insurance and informed its insureds of such reductions. It should have provided a payment formula within the policy like in Barker to further its policyholders' understanding. Simply stated, Progressive had every opportunity to write its policy so its insureds would understand its med pay payment methodology, but failed to do so at its own peril.

**V. PROGRESSIVE IGNORES ITS OWN DEFINITION OF INCURRED.**

Progressive ignores its own definition of "expense incurred." Smith believes an obligation is created when the services are rendered. Progressive argues an obligation is created after health insurance has been processed and is equal to the "legal obligation." Yet, Progressive does not pay the amount their insured owes after processing health insurance which, if utilizing its definition and its timing, would produce a med pay payment only in the amount of the copay and any balance bill amount which remains after health insurance is applied to the initial charge. The copay and balance bill amount would be the "legal obligation" according to Progressive. Instead, Progressive pays that

“legal obligation” plus the amount paid by the health insurance carrier (“ . . . Progressive Max paid the full amount of medical expenses she “incurred”). Respondent’s Brief, p. 15. It has no explanation as to why the amount paid by the health insurance could be included in the amount of “expense incurred,” when by its own argument, Smith was not legally obligated to pay the provider the entire amount allowed. There is further irony in that the Respondent’s Brief belabors the point that Smith is seeking a “windfall recovery.” Yet, the testimony of Progressive med pay adjusters clearly shows they included the duplicate benefit of health care coverage in the definition (R. p.436, lines 17-21). For all intents and purposes, Progressive’s confused internal definition creates the supposed windfall recovery, the very thing Progressive rails against in its brief.

#### **VI. ALL DEFENDANTS ARE PROPER PARTIES FOR CLASS CERTIFICATION.**

Progressive insists Smith has no relationship “contractual or otherwise” with Progressive Casualty or Progressive Direct. Progressive is misguided. Progressive claims only Progressive Max can be a named party to the action and that Progressive Direct and Progressive Casualty are properly exempt because Progressive Max is the only company that issued an insurance policy to Plaintiff. According to Progressive, there is no relationship, contractual or otherwise between Smith and Direct and Casualty.

It is simply not true that no relationship, contractual or otherwise, exists between Smith and Progressive Direct and Progressive Casualty. In the Order Granting Class Certification, the court succinctly stated Progressive Casualty’s role:

Progressive Casualty performs all insurance related functions for the four Progressive companies listed above pursuant to Joint Servicing Agreements. (Exhibit B to Plaintiff’s Memorandum.) Progressive Casualty provides the services for sales, advertising, underwriting, reinsuring,

premium billing and collections, commission payments, claims adjusting and policy payments. Policy premiums are deposited directly into the Progressive casualty account. Progressive Casualty has control over all aspects of the claims adjustment process.

(R. p.16)

Regarding Progressive Direct, the lower court stated:

The Progressive policy is entitled Progressive Direct on the front page and documentation provided to the Court states it was underwritten by Progressive Max Insurance Company and Progressive Direct Insurance Company.

(R. p. 7)

The lower court looked at the evidence and determined initially that all three, Progressive Direct, Progressive Max and Progressive Casualty, were proper parties for class certification. The Court looked at a plethora of information and documentation from Progressive and documentation relating to its relationship with Smith. The policy is entitled “Progressive Direct” and defines “we” as the “underwriting company providing the insurance, as shown on the declaration page” (R. p. 519 and 523). Progressive’s email to Smith states, “Your policy is underwritten by Progressive Max Insurance Company Progressive Direct Insurance Company” (R. p. 578). Progressive Direct, Max and Casualty insureds were properly included in the class certified under the Order Granting Class Certification.

**VII. STEPHANIE SMITH IS NOT REQUIRED TO MAINTAIN A RELATIONSHIP WITH PROGRESSIVE IN ORDER TO SERVE AS CLASS REPRESENTATIVE.**

Progressive’s position that Ms. Smith is a former policyholder and, hence, has no standing is untenable and is not based on any case law or statute. Progressive’s position, would require Smith to maintain a business relationship for the duration of the litigation

with an adverse company which failed to properly adjust and pay her med pay claim. The actions of Progressive have cost her in excess of \$3,000 and the expectation that she must continue to pay premiums to such a company is something that cannot be tolerated under the law. She brought the action as a policyholder. Because she did not want to continue to pay premiums during the pendency of the lawsuit to a company that improperly paid benefits, she changed auto insurance companies. Unlike a shareholder derivative suit, which requires existing shareholder status at the time the suit is filed, Smith can maintain the action regardless of whether she is a current policyholder. She is allowed to ask the court to address the uniform practices of Progressive as she was subjected to them. The issue is whether Progressive violated the policy terms under the med pay portion of the policy which is a common issue shared by class members. She is similarly situated to all class members and does not need to maintain her relationship with Progressive to be a class representative. Even if there are some factual variations among the class members, she is still a typical and adequate representative on the common issues. She is a proper class representative. Typicality does not mean identical. Simpson v. Specialty Retail Concepts, 149 F.R.D. 94, 99 (M.D.N.C. 1993).

**VIII. BY FOLLOWING ITS OWN POLICIES AND PROCEDURES, PROGRESSIVE ENSURES THAT IT WILL BE UNJUSTLY ENRICHED AT ITS POLICYHOLDERS EXPENSE, NEGATING THE NEED FOR INDIVIDUAL INQUIRY.**

A party is unjustly enriched when it retains benefits or money which in justice and equity belong to another. Unjust enrichment is an equitable doctrine which permits the recovery of that amount the defendant has been unjustly enriched at the expense of the plaintiff. Ellis v. Smith Grading and Paving, Inc., 294 S.C. 470, 473, 366 S.E.2d 12, 14 (Ct. App.1988).

Progressive retains a monetary benefit that belongs to its policyholders who have health insurance and who make a med pay claim. The Progressive Standard Operating Procedure and Quick Fact Sheet ensure that Progressive is enriched at the policyholder's expense each time a claim is made.<sup>7</sup>

Progressive argues that for each class member a determination must be made 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." Respondent's Brief, p. 30. Progressive is wrong. A determination of the above factors would have to be made only once and only with regard to the application of the Standard Operating Procedure. By its own definition, following the Standard Operating Procedure will result in a retained benefit that belongs to its policyholders. Once the determination has been made that Progressive follows its own SOP and quick fact sheet, there is no further need for inquiry. The unjust enrichment is systematic and automatic. This analysis is also applicable to the additional claims raised by Smith.

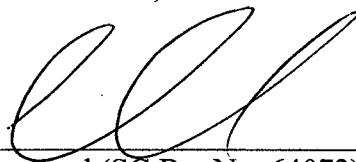
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<sup>7</sup> The SOP states the insured is "allowed to recover the same damages paid under health insurance." The Quick Fact Sheet states "can duplicate benefits paid under medical payments and incurred health insurance costs," and further defines "incurred" as "amount paid by health carrier, copays, ded, any balance bill issues" (R. p. 579, 580).

## CONCLUSION

The Reconsideration Order should be vacated in its entirety and the Order Granting Class Certification should be reinstated. In this small South Carolina class, common questions involving Progressive's uniform practice, policy language and statutes should be determined.

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October 31, 2014

THE STATE OF SOUTH CAROLINA  
In The Court of Appeals

APPEAL FROM Horry COUNTY  
Court of Common Pleas

Larry B. Hyman, Jr., Circuit Court Judge

Case No. 2010-CP-26-10502

RECEIVED

NOV 03 2014


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  
Max, and Progressive Casualty Insurance.....Respondents.

PROOF OF SERVICE

I certify that I have served the Appellant's Final Brief (15 copies), Certificate of Counsel for the Appellant's Final Brief, the Final Reply Brief of the Appellant (15 copies), and Certificate of Counsel for the Final Reply Brief of the Appellant, on the Clerk of Court, South Carolina Court of Appeals, by depositing a copy of same with FedEx Ground, postage prepaid, on October 31, 2014 addressed to 1205 Pendleton Street, Columbia SC 29201.

I certify that I have served the Appellant's Final Brief, Certificate of Counsel for the Appellant's Final Brief, the Final Reply Brief of the Appellant, and Certificate of Counsel for the Final Reply Brief of the Appellant, on the Respondents, Progressive Halcyon Insurance Company, n/k/a Progressive Direct Insurance Co., Progressive Max, and Progressive Casualty Insurance, by depositing a copy of same in the United States Mail, postage prepaid, on October 31, 2014, addressed to attorneys of record Thomas C. Brittain, Esq. and A. Preston Brittain, Esq. of The Brittain Law Firm located at 4614 Oleander Drive, Myrtle Beach SC 29577, and Jeffrey S. Cashdan, Esq. and Zachary A. McEntyre, Esq. of King & Spalding LLP located at 1180 Peachtree Street, N.E., Atlanta GA 30309 and to Natale Fata, Esq. of the Fata Law Firm, Post Office Box 16620, Surfside Beach SC 29587.



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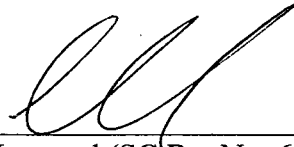
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CERTIFICATE OF COUNSEL

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The undersigned certified that this Final Reply Brief of the Appellant complies with Rule  
211(b), SCACR.

October 31, 2014



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