THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM BAMBERG COUNTY
Court of Common Pleas

Doyet A. Early, III, Circuit Court Judge

Case No. 2013-CP-05-63
Appellate Case No. 2016-002156

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S.C. SUPREME COURT

Janette Buchanan and Shana Smallwood,
Individually and as Co-Personal Representatives
of the Estate of James S. Buchanan, ... Respondents,

v.

The South Carolina Property and Casualty
Insurance Guaranty Association, ... Appellant.

RETURN

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II. Are the lower courts' rulings consistent with *SC Property and Cas. Ins. Guar. Ass'n v. Brock*, 410 S.C. 361, 764 S.E.2d 920 (2014)?

III. Is the foreign authority the Association cites distinct from this case in meaningful ways?

IV. Are the lower courts' rulings consistent with the Association's purpose and the public policy underlying the Act?

COUNTER-STATEMENT OF THE CASE

On January 7, 2008, a set of tandem tires separated from the axle of a log truck owned by Travis Scott and driven by Eddie Best. The tires traveled into the path of an oncoming truck Mr. Buchanan was driving. The tires struck the front of Mr. Buchanan's vehicle, breaking the front axle. Mr. Buchanan's truck crossed the centerline and struck another tractor-trailer. Mr. Buchanan's truck caught fire and he was killed.

The log truck was insured for $1,000,000 by Aequicap Insurance Co. *See AequiCap Ins. Co. v. Best*, 2013-UP-116 (S.C. Ct. App. filed March 20, 2013). In 2011, however, Aequicap went into receivership in Florida. *In re Arbitration Between General Sec. Nat. Ins. Co. and AequiCap Program Administrators*, 785 F. Supp.2d 411, 423 n. 9 (S.D.N.Y. 2011); *AequiCap Ins. Co. v. Best*, slip at 1 n. 1. The Association assumed management of the claims against AequiCap's insured, Mr. Scott, under the South Carolina Property and Casualty Insurance Guaranty Association Act (the Act). *See* S.C.

Code Ann. § 38-31-10 (2002), *et seq.*

Mrs. Buchanan brought a wrongful death action in 2008 against Mr. Best and Mr. Scott. Mrs. Buchanan settled the case against Mr. Scott and Mr. Best. The parties to the underlying tort case stipulated Mrs. Buchanan's damages were $800,000. Mrs. Buchanan received a total of $376,622 in combined workers' compensation benefits and recovery in the tort case from the co-defendants. (Settlement Agreement, ¶ 5).

On April 11, 2013, Respondents filed an action against the Association for a declaration that the Association must pay $300,000, the limit of its exposure under S.C. Code Ann. § 38-31-60 (2002). Respondents asserted the balance due them after offsetting their recovery ($376,622) from their covered claim ($800,000) was $423,378, which exceeded the statutory limit. The Association answered, claiming that the credits for amounts already received should be applied from the statutory cap, which would leave a balance of zero. The parties filed cross-motions for summary judgment.

On May 28, 2014, the court held a hearing on the motions. On September 9, 2014, the court issued an order finding the "covered claim" under the AequiCap policy was $800,000, to which an offset of $376,622 would be applied under Section 38-31-100(1), leaving $423,378 unpaid on the "covered claim." The court held the Association's obligation to pay the balance due on the covered claim is then limited by the $300,000 cap. The Association filed a motion for reconsideration which the court denied.

The Association appealed and the Court of Appeals affirmed. *Buchanan v. SC Prop. and Cas. Ins. Guaranty Ass'n*, 417 S.C. 562, 790 S.E.2d 783 (Ct. App. 2016). The Association sought rehearing and the Court of Appeals denied the request.

ARGUMENTS

The decisions by the trial court and the Court of Appeals do not directly conflict with this Court's decision in *Brock* or the plain language of the Act. In fact, those rulings are entirely consistent with, and controlled by, both the Act and *Brock*. The foreign authorities the Association cited do not support its position and are distinct from South Carolina's authority in very meaningful ways. Additionally, the Court of Appeals did not ignore anything, much less the express intent of the General Assembly or the underlying purpose of consumer protection from insolvent insurers, as this Court stated in *Hudson*.

Review is not warranted in this case. The Court of Appeals' decision does not conflict with the plain language of the Act, this Court's opinion in *Brock*, or cases from other jurisdictions. The Court should deny the petition and instruct the Court of Appeals to remit the matter to the circuit court for entry of final judgment.

I. The Courts Below Ruled Correctly and Consistently with *Brock*

In recently addressing the Act, this Court noted:

> "All rules of statutory construction are subservient to the one that legislative intent must prevail if it can be reasonably discovered in the language used, and that language must be construed in light of the intended purpose of the statute." *McClanahan v. Richland Cnty. Council*, 350 S.C. 433, 438, 567 S.E.2d 240, 242 (2002). "What a legislature says in the text of a statute is considered the best evidence of the legislative intent or will. Therefore, the courts are bound to give effect to the expressed intent of the legislature." *Id.* Thus, we must follow the plain and unambiguous language in a statute and have "no right to impose another meaning." *Id.*

Brock, at 366, 764 S.E.2d at 922 (2014).

An examination of the text of the statute reveals that the Courts below reached the correct result. The Association's responsibility regarding a "covered claim" is to pay up to the statutory cap after receiving credit against the total covered claim for any amounts the plaintiff receives. Where the amount of that covered claim is less than the statutory cap, it may well be that the recovery could take the Association's responsibility to zero. However, where, as here, the covered claim exceeds not only the cap, but the cap plus amounts recovered from other sources, the Association must provide coverage up to the statutory cap. That is what the Act requires, what the circuit court ruled, and what the Court of Appeals correctly held.

The Act

Section 38-31-20 contains the definitions applicable to the Act, and provides:

> (8) *"Covered claim" means an unpaid claim ... which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this chapter applies issued by an insurer*, if the insurer is an insolvent insurer and (a) the claimant or insured is a resident of this State at the time of the insured event, if for entities other than an individual, the residence of a claimant or insured is the state in which its principal place of business is located at the time of the insured event or (b) the claim is for first-party benefits for damage to property permanently located in this State. * * *

S.C. Code Ann. § 38-31-20(8) (2002) (emphasis added). AequiCap is an insolvent insurer and Respondents are residents of this State. Respondents' claim is a "covered claim" under the Act: The claim is (1) "unpaid"; (2) "arises out of and is within the coverage"; and (3) "is subject to the applicable limits of an insurance policy to which this chapter applies issued by an insurer," which was $1,000,000. *See Brock* (discussing Section 38-31-20(8)).

The powers and duties of the Association are found in Section 38-31-60, which provides:

> The Association:
>
> (a) is obligated *to the extent of claims existing before the determination of insolvency* and claims arising up to the earliest of the following dates:
>
> (i) thirty days after the determination of insolvency;
>
> (ii) the policy expiration date; or
>
> (iii) the date the insured replaces or cancels the policy.
>
> (iv) Notwithstanding any other provisions of this chapter, except in the case of a claim for benefits under worker's compensation coverage, any obligation of the association to or on behalf of an insured and its affiliates on all covered claims combined shall cease when ten million dollars shall have been paid in the aggregate by the association and any one or more associations similar to the association of any other state or states, to or on behalf of that insured, its affiliates, and additional insureds on covered claims or allowed claims arising under the policy or policies of any one insolvent insurer. If the association determines that there may be more than one claimant having a covered claim or allowed claim against the association, or any associations similar to the association in other states, under the policy or policies of any one insolvent insurer, the association may establish a plan to allocate amounts payable by the association in such manner as the association in its discretion considers equitable.
>
> This obligation includes only the amount each covered claim is in excess of two hundred fifty dollars *and is less than three hundred thousand dollars*. * * *

S.C. Code Ann. § 38-31-60 (a) (iv)(2002) (emphasis added). The "covered claim" here is $800,000, the amount of the settlement within the limits of AequiCap's policy. It is, therefore, "in excess of" $250,000. The obligation is then capped at $300,000.

The Act provides further that the Association:

> (b) *is considered the insurer to the extent of its obligation on the covered claims and, to this extent, has all rights, duties, and obligations of the insolvent insurer as if the*

> *insurer had not become insolvent*. However, the association has the right but not the obligation to defend an insured who is not a resident of this State at the time of the insured event unless the property from which the claim arises is permanently located in this State in which instance the association does have the obligation to defend the insured;

S.C. Code Ann. § 38-31-60(b) (emphasis added). Thus, the Association steps into the shoes of AequiCap "to the extent of its obligation on the covered claims," which is $800,000 (but then limited to $300,000 maximum exposure).

The statute next provides the Association:

> (d) shall investigate claims brought against the association and adjust, compromise, settle, and *pay covered claims to the extent of the association's obligation* and deny all other claims and may review settlements, releases, and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which these settlements, releases, and judgments may be properly contested;

S.C. Code Ann. § 38-31-60 (d) (emphasis added). The Association must therefore pay a "covered claim," but the Association's obligation is then limited to $300,000 for any one covered claim.

The Act then provides that if the Association pays on a "covered claim," the insolvent insurer's insured is deemed to have assigned any right against the assets of the insolvent insurer, including any person affiliated with the insolvent insurer whose liability obligations to other persons are satisfied in whole or in part by payments made by the Association. S.C. Code Ann. § 38-31-90(1) & (2) (2002). The Association again steps into the shoes of the insured with regards to recoverable claims back against the insolvent insurer of any affiliated individual for whom the Association has covered a loss.

The Act's offset provision is found in Section 38-31-100, which provides:

> A person, *having a claim under an insurance policy*, whether or not it is a policy issued by a member insurer, *and the claim under such other policy arises from the same facts, injury, or loss that gave rise to the covered claim against the association, is required to first exhaust all coverage and limits provided by any such policy.* Any amount payable on a covered claim under this chapter must be reduced by the full limits of such other coverage as set forth on the declarations page and the association shall receive a full credit for such limits, or, where there are no applicable limits, *the claim must be reduced by the total recovery.* Notwithstanding the foregoing, no person may be required to exhaust all coverage and limits under the policy of an insolvent insurer.

S.C. Code Ann. § 38-31-100 (1) (2002) (emphasis added). The Respondents' "claim under an insurance policy" (*i.e.*, the other coverage from a solvent insurer and the workers' compensation coverage) is $800,000. Respondents were required to "first exhaust" other coverages, which they did in the amount of $376,622. Their "claim under an insurance policy" ($800,000) was then reduced by that total recovery from those other sources, leaving $423,378 remaining on the "covered claim."

The statute next provides:

> (a) A claim under a policy providing liability coverage to a person who may be jointly and severally liable with or a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim must be considered to be a claim arising from the same facts, injury, or loss that gave rise to the covered claim against the association. Any *amount payable on a covered claim* under this chapter must be reduced by the full and combined policy limits of all joint tortfeasers.

Section 38-31-100(1)(a) (emphasis added). The amount payable on Respondent's "covered claim" is $800,000, the amount of the settlement. That amount must be reduced "by the full and combined policy limits of all joint tortfeasors," which was done here.

Section 38-31-100(1) next provides:

> (b) To the extent that the association's obligation is reduced by the application of this section, *the liability of the person insured by the insolvent insurer's policy for the claim must be reduced in the same amount.*

Section 38-31-100(1)(a) (emphasis added). Again, the liability of the person insured by AequiCap was $800,000, and that liability (of that person who should have been covered by the AequiCap policy) has been reduced by $376,622, the amount of the recovery. There remains, however, an unpaid portion of the covered claim against that person who would have been insured by the insolvent insurer, AequiCap, in the amount of $423,378.

The statute next provides:

> (2) A person having a claim which may be recovered under more than one insurance guaranty association or associations similar to the association must be required first to exhaust all coverage and limits in recovery *from the association of the place of residence of the insured* except that, if it is a first-party claim for damage to property with a permanent location, he shall be required first to exhaust all coverage and limits in recovery from the association of the location of the property, and, if it is a workers' compensation claim, he shall be required first to exhaust all coverage and limits in recovery from the association of the residence of the claimant. Any amount payable on a covered claim under this chapter must be reduced by the full amount of recovery from any other insurance guaranty association or associations similar to the association, and the association shall receive full credit for such recovery.

Section 38-31-100(2) (emphasis added). The insured under the AequiCap policy (Eddie Best) is a resident of Orangeburg, South Carolina. (MAIT Report CL-001-08; Form TR-310 Traffic Collision Report, p. 2). The Respondents exhausted the applicable workers' compensation coverage which was credited against their covered claim of $800,000.

Section 38-31-100 finally provides:

> (5) A person who has liquidated by settlement or judgment a claim against an insured under a policy issued by an insolvent insurer, and the claim is a covered claim and is also a claim within the coverage of any policy issued by a solvent insurer, must be required first to exhaust all coverage and limits provided under the policy issued by the solvent insurer before execution, levy, or any other proceedings are begun to enforce any judgment obtained against or the settlement with the insured of the insolvent insurer. *Any amount payable on a covered claim* under this chapter, whether through settlement, judgment, or otherwise, must be reduced by the full limits of such other coverage as set forth on the declarations page of the policy issued by the insolvent insurer.

S.C. Code Ann. § 38-31-100 (5) (emphasis added). Respondents have liquidated by settlement their claim against the insured under AequiCap's policy – the liquidated amount is $800,000. Their claim was a "covered claim." It was *also* a claim within the coverage of AequiCap's policy. Thus, they were required to first exhaust all coverage and limits provided by the solvent insurers, which they have done. The total amount payable under that covered claim was $800,000, and that amount was "reduced by the full limits of such other coverage," which all parties agree is $376,622. The unpaid balance on the covered claim is thus $423,378. It is against *that* amount that the cap applies.

The Association

The Association is a statutory entity designed to provide some protection for the insureds of insolvent insurance companies. *SC Property and Cas. Ins. Guar. Ass'n v. Brock*, 410 S.C. 361, 764 S.E.2d 920 (2014); *S.C. Prop. & Cas. Ins. Guar. Ass'n v. Carolinas Roofing & Sheet Metal Contractor's Self–Insurers Fund*, 303 S.C. 368, 369, 401 S.E.2d 144, 145 (1991). The purpose of the Association is to provide payment for the covered claims of insolvent insurers. *S.C. Prop. & Cas. Ins. Guar. Ass'n v. Wal-Mart Stores, Inc.*, 304 S.C. 210, 403 S.E.2d 625 (1991).

As a condition precedent to recovery from the Association, a claimant is required to first exhaust all available coverage from solvent insurers, and the Association is allowed to offset the full limits of such other coverage against the "covered claim" under the Act. *Brock*, citing Section 38-31-100. Here, Respondents exhausted the available coverage from the solvent insurers and applied those amounts to their covered claim against AequiCap's insured. Once that offset was applied, then the Association's obligations under the Act remained. The Association was then required to pay the difference between the settlement amount ($800,000) and the offset amount ($376,622), which is $423,378 (but capped at $300,000). See *Brock,* 410 S.C. at 365, 764 S.E.2d at 922 (the Association paid "the difference between the settlement amount ($185,000) and the offset amount ($93,090.45)."). That is what these statutes *plainly* say, and that is how the trial court and the Court of Appeals applied them. This should end the inquiry.

The Association's Arguments

The Association contends the courts below failed to properly apply this Court's decision in *Brock*. This Court should not be persuaded by this contention.

First, the Association's "Statement of the Question Presented" misrepresents the holding of *Brock*. The Association states the question as whether the offset should be deducted "from the total amount of stipulated damages of $800,000 instead of being deducted from the Association['s] limited obligations under the act, which are capped at $300,000 for all claims other than workers' compensation, *as this Court previously held* in [*Brock*]." (Petition, p. 1) (emphasis added). This Court held *no* such thing in *Brock*. *Brock* involved recovery for a non-work related traffic accident. The words "workers'

compensation" do not even appear in the opinion.

Further, the narrow holding of *Brock* is that the Act allows the Association to "offset all payments from all solvent insurers made to Brock as a result of this wreck." *Brock*, at 364, 764 S.E.2d at 921. That is, the Association was entitled to an offset against the settlement amount (*i.e.*, the "covered claim") the claimant received from any source, and that offset is against the total amount of the covered claim (which, in *Brock*, was $185,000). The Court described the Association's obligation in *Brock* to be $185,000 (*i.e.*, the entire settlement amount). The disagreement was over "what types of insurance coverage [the Association] may offset against" *that* obligation. The *Brock* Court stated, "this $185,000 *covered claim* should, under § 38-31-100(1), be offset by the full limits of these policies." *Brock*, at 367, 764 S.E.2d 923 (emphasis added).

Unlike *Brock*, the entire settlement (and thus the "obligation") in this case was above the Act's cap. The next step under *Brock* and the statute, then, is to apply all amounts recovered as offsets against the $800,000 covered claim to yield the sum due from the Association. Because that amount in this case ($423,378) is over the $300,000 cap, the next step is to reduce the Association's obligation to pay to that cap. That application of the statutes is consistent in every way with the plain language of the statutes as well as the narrow holding in *Brock*.

The Association wants this Court to read the words "covered claim" to mean "the Association's *net* obligation," but *those* words do not appear in the statute. The Association essentially asks the Court to rewrite Section 38-31-100(1), but amending this statute is the province of the legislature, not the courts. *Am. Petroleum Inst. v. SC Dept. of*

Rev., 382 S.C. 572, 579, 677 S.E.2d 16, 20 (2009) ("it is not the province of [the] Court to perform legislative functions."). It is also not within the Court's authority to alter the plain meaning of the Act by altering the term "covered claim" to mean "Association's net obligation under the Act." *See Alltel Comm. v. SC Dept. of Rev.*, 399 S.C. 313, 319, 731 S.E.2d 869, 873 (2012) ("Under the plain meaning rule, it not the province of the court to change the meaning of a clear and unambiguous statute."). Section 38-31-100(1) says what it says, and the meaning of "covered claim" is plain – it is the unpaid claim arising under the coverage set forth within the applicable limits of an insolvent insurer's policy. Section 38-31-20(8).

The Association also points parenthetically to *Hudson v. Lancaster Convalescent Ctr.*, 407 S.C. 112, 754 S.E.2d 486 (2014) as supporting its view. (Petition, pp. 10-11). The issue in *Hudson* was whether Section 38-31-20(8) could be construed as limiting a claim arising from the Association's own actions (*i.e.*, interest incurred due to failure to pay a lump sum workers' compensation award). This Court held the limitation that a "covered claim" would not include interest did not apply where the Association's liability was direct and not derivative. This Court held nothing more than that.

Section 38-31-100(1) must be read together with Section 38-31-60(a)(iv) (the cap provision). The statutes should also be read plainly, and against the backdrop of the legislative purpose in creating the Association. As this Court stated in *Hudson*:

> [The Association] is a last resort insurer created by the legislature to protect consumers in the event that their insurer becomes insolvent. See § 38–31–60; *South Carolina Property and Cas. Ins. Guar. Ass'n v. Carolinas Roofing and Sheet Metal Contractors Self-Insurance Fund*, 315 S.C. 555, 557, 446 S.E.2d 422, 424 (1994)("[The Association's] purpose

> is to provide some protection to insureds whose insurance companies become insolvent"). Section 38–31–60(b) provides that [the Association] "is considered the insurer to the extent of its obligation on the covered claims and, to this extent, has all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent...." *When [the Association] steps into the shoes of an insolvent insurer, its liability is derivative of the insolvent insurance company's direct liability to the consumer.* The legislature has limited this liability to a "covered claim" which is defined by § 38–31–20(8) as "... an unpaid claim ... which arises out of ... an insurance policy to which this chapter applies issued by an insurer, if the insurer is an insolvent insurer ... covered claim does not include: ... (h) any claim for interest."
>
> The legislature has chosen to define a "covered claim" as a claim arising from an insolvent insurer, yet [the Association] asks this Court to read the "covered claims" and its corresponding interest limitation to apply to claims arising from [the Association's] own actions. We decline to do so.

Hudson, at 124, 754 S.E.2d at 492 (emphasis added). The Association's derivative liability to the consumer here means the obligation to pay the *covered claim* under the insolvent insurer's policy – that covered claim in this case is $800,000. The offset provision then permits the Association to reduce the "covered claim" by the amounts Respondents received to arrive at its obligation; *that* number then is capped at $300,000.

The Courts Did Not Misapply the Act

The precise language of the offset provision is as follows:

> A person, *having a claim under an insurance policy*, whether or not it is a policy issued by a member insurer, *and the claim under such other policy arises from the same facts, injury, or loss that gave rise to the covered claim against the association, is required to first exhaust all coverage and limits provided by any such policy.* **Any amount payable on a covered claim** under this chapter must be reduced by the full limits of such other coverage as set forth on the declarations page and the association shall receive a full credit for such limits, or, where there are no applicable limits, *the claim must be reduced by the total recovery.* Notwithstanding the foregoing, no person may be required to exhaust all

coverage and limits under the policy of an insolvent insurer.

S.C. Code Ann. § 38-31-100 (1)(emphasis added). The Association essentially contends that the bolded language *really* means the Association's obligation under the Act, but that is not what the statute says plainly. Analyzing the statute sentence by sentence is helpful.

The first clause of the first sentence provides: "A person, *having a claim under an insurance policy*, whether or not it is a policy issued by a member insurer...." There is no dispute that Respondents meet this language–they are "a person," and they "have a claim under an insurance policy." Respondents had a claim from the solvent insurer as well as a workers' compensation claim.

The second clause of the first sentence provides: "and the claim under such other policy arises from the same facts, injury, or loss that gave rise to the covered claim against the association...." The claims against the other solvent insurer and the workers' compensation carrier arose from the same facts, injury or loss that gave rise to the covered claim against the Association (which derives from the claim against the insolvent insurer, AequiCap).

The third clause of the first sentence then states, "is required to first exhaust all coverage and limits provided by any such policy." The parties agreed to limit the Association's offset to the amounts actually recovered under the other policies. (App. Br. p. 11, n. 8). The phrase "any such policy" means the recovery from the solvent insurer and the workers' compensation carrier in this case.

The second sentence, which is the operative offset sentence, provides, "**Any amount payable on a covered claim** under this chapter must be reduced by the full

limits of such other coverage as set forth on the declarations page and the association shall receive a full credit for such limits, or, where there are no applicable limits, the claim must be reduced by the total recovery." (bold added). The Association points to this bolded language as the source of its argument that the offset is against the Association's obligation *after* the cap is applied. That is not what the statute says.

"Any amount payable" is followed by "on a covered claim" – this means the amount payable under the insolvent insurer's policy because "covered claim" references that insolvent insurer, not the Association. As noted above, "covered claim" is specifically defined in the Act:

> "Covered claim" *means an unpaid claim ... which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this chapter applies issued by an insurer*, if the insurer is an insolvent insurer and (a) the claimant or insured is a resident of this State at the time of the insured event, if for entities other than an individual, the residence of a claimant or insured is the state in which its principal place of business is located at the time of the insured event or (b) the claim is for first-party benefits for damage to property permanently located in this State. * * *

S.C. Code Ann. § 38-31-20(8) (2002) (emphasis added). The "covered claim" is thus: (a) the "unpaid claim"; (b) "which arises out of and is within the coverage"; and (c) is subject to the applicable limits of an insolvent insurer's policy. The "covered claim" means the $800,000 claim against AequiCap's policy limits of $1,000,000. "Payable on a covered claim" thus means payable under the AequiCap policy, not by the Association.

In its brief to the Court of Appeals, the Association asserted that:

> Reading the statute to require the offset to be deducted from a claimant's total amount of claimed damages would render the offset provision meaningless in any situation where the difference between a

> claimant's damages and the amount received from other available insurance exceeds $300,000.

(App. Br. p. 13). Precisely. The legislature drafted the statute in this manner, expressing a policy decision to protect consumers in at least the amount of $300,000 against an insolvent carrier where the damages and coverage under an applicable policy exceed that amount. If the at-fault's carrier was not insolvent, Respondents could recover all of the remaining balance on the loss up to $423,378. Under the Act, their recovery of the remaining loss is limited to $300,000.

This construction of the statute does not render the offset provision "meaningless." Had Respondents received $600,000 from other sources, then the Association's obligation in this case would have been $200,000 without concern for the cap. Because Respondents received less than $500,000 towards their $800,000 claim, the Association is required to step up at the capped amount.

Furthermore, Respondents are not being made whole - far from it. Their damages totaled $800,000 against which they received only $376,622 from other sources. Of the $423,378 balance remaining, they may only recover $300,000 from the Association, leaving them responsible for the remaining $123,378 themselves. The Act is consumer protection legislation and is supposed to provide "last resort" insurance coverage. *Hudson*. The trial court's ruling serves that goal – the Association's position does not.

What the Association advocates would render these provisions perfunctory in any case where there are other sources of coverage that provide at least $300,000 towards the covered claim. *Nothing* in the statutory scheme supports that result. The Association is

intended to provide some form of coverage for any consumer who is injured. *Hudson*. In exchange for this consumer protection, the legislature requires two things: (1) the consumer must pursue all other avenues of payment before turning to the Association; and (2) in *then* responding, the Association must provide coverage, but *that* obligation is limited to a cap of $300,000. It is not the consumer's overall recovery on a covered claim that is capped at $300,000 total, but the amount the Association must pay in order to cover damages that would have been covered by the insolvent insurer.

That is the result required by the Act, and that is the result the trial court and the Court of Appeals reached. The Court should not be persuaded to review the Court of Appeals' affirmance of the circuit court in this case. The decisions are consistent with *Brock* and *Hudson* and with the plain language of the Act.

II. The Courts Below Did Not Overlook Legislative Intent or Public Policy Underlying the Act

The Association contends "policy considerations underlying the Act require this Court to find that the amounts of other available coverage should be offset from the statutory obligation instead of the covered claim amount." (Petition, p. 9). The Association mis-states the holding of *Brock*, once again, claiming the case "demonstrates the setoff is directly tied to the obligation and not the claimed amount." (Petition, p. 9). The Associations contends hyperbolically that to "rule otherwise renders the setoff, the total potential amount of the obligation, and the policy behind the creation of the Association nullities." (Petition, p. 9). These statements are an invitation for this Court to

rewrite this statute, to ignore precise language the General Assembly chose, and to equate the terms "covered claim" with "statutory obligation." The Court should not accept this invitation. The Association's arguments exaggerate, overstate or mis-state what the trial court and the Court of Appeals actually did. They should not persuade this Court to grant review.

The "clear and unambiguous" language of the relevant statute provides that the offset for other recoveries is *not* against the Association's obligation, but against the Respondent's "covered claim" against AequiCap. S.C. Code Ann. § 38-31-100(1)(a) ("Any amount payable on a *covered claim* under this chapter must be reduced by the full and combined limits of all joint tortfeasors."). The "covered claim under this chapter" refers to the "covered claim" as defined by the Act under Section 38-31-20(8), that is "an unpaid claim ... which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this chapter applies issued by an insurer...." The "unpaid claim" is the claim against AequiCap, which in this case is $800,000.

Through the Act and the 2001 amendment, the legislature intended to require an offset against a "covered claim" before a claimant could then turn to the Association – the intent was to ensure the Association was not a first line insurer but would provide coverage for a "covered claim" only after a claimant has exhausted all other available sources. If exhausting those other sources first fully satisfied the covered claim, then the Association would owe nothing since the claimant would be made whole from those other sources. Otherwise, after exhausting the other sources, the claimant then turns to the

Association to fill the uncovered gap, but only up to the statutory limitation of $300,000.

Comparing the 2001 amendments to Section 38-31-100 to the prior version of the statute is helpful. The 2001 amendment did the following to Section 38-31-100:

(A) Added the last sentence to Part (1), which provides "Notwithstanding the foregoing, no person may be required to exhaust all coverage and limits under the policy of an insolvent insurer."

(B) Added to Part (1) the provisions of subparts (a) and (b), which state:

(a) "A claim under a policy providing liability coverage to a person who may be jointly and severally liable with or a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim must be considered to be a claim arising from the same facts, injury, or loss that gave rise to the covered claim against the association. Any amount payable on a covered claim under this chapter must be reduced by the full and combined policy limits of all joint tortfeasers."

(b) "To the extent that the association's obligation is reduced by the application of this section, the liability of the person insured by the insolvent insurer's policy for the claim must be reduced in the same amount."

(C) Part (2) was amended slightly for verbiage, and the following sentence added: "Any amount payable on a covered claim under this chapter must be reduced by the full amount of recovery from any other insurance guaranty association or

associations similar to the association, and the association shall receive full credit for such recovery."

(D) Part (4) was amended to add the underlined language as follows: "No claim held by an insurer, reinsurer, insurance pool, or underwriting association based on an assignment or on rights of subrogation, or otherwise, may be recovered from a claimant or asserted in any legal action against a person insured under a policy issued by an insolvent insurer or the association except to the extent the amount of the claim exceeds the obligation of the association under this chapter."

(E) Part (5) was amended to strike words and add underlined language as follows: " A person who has liquidated by settlement or judgment a claim against an insured under a policy issued by an insolvent insurer, and the claim is a covered claim and is also a claim within the coverage of any policy issued by a solvent insurer, ~~is~~ must be required first to exhaust ~~first his rights~~ all coverage and limits provided under the policy issued by the solvent insurer before execution, levy, or any other proceedings are begun to enforce any judgment obtained against or the settlement with the insured of the insolvent insurer. Any amount payable on a covered claim under this chapter, whether through settlement, judgment, or otherwise, must be reduced by the full limits of such other coverage as set forth on the declarations page of the policy issued by the insolvent insurer.

(F) Part (6) was added to provide, "A person having a claim against an insolvent insurer under any provision in an insurance policy is limited to ten million dollars aggregate payout from the association."

(G) Part (7) was added to provide, "A person having a net worth of greater than twenty-five million dollars and having a claim against an insolvent insurer under any provision in an insurance policy may not make a claim against the association."

Act No. 82, 2001 S.C. Acts. *None* of these amendments to Section 38-31-100 support the Association's view that its "capped obligation" under the Act must be reduced by any other recovery. (Petition, p. 11). Rather, the Association is entitled to credit against the "covered claim," which here is $800,000.

The Association points to *Hudson* and *Brock* as demonstrating the legislature intended the Association's "liability to be limited" under the Act. (Petition, pp. 10-11). The Association also asserts "[i]t is inconceivable that the General Assembly intended insureds who have applicable primary coverage equal to or in excess of $300,000 to be treated less favorably than those recovering under third party policies." (Petition, p. 11). This Court should reject these specious contentions.

Under the Association's reading of the Act, *Brock* and *Hudson*, the Association becomes a "no resort" payor *any* time there is a payment from another source that combines to exceed $300,000. (Petition, p. 11). The legislature could have written the Act that way but it chose not to. Instead, the legislature provided that the Association steps into the liability of AequiCap for the "covered claim," which is $800,000. The offsets are then applied, leaving the balance of liability for the covered claim remaining. The caps then reduce *that* amount. That is how the legislature wrote this statute, and this Court should not read it in the tortured manner the Association contends it should be read.

In its brief to the Court of Appeals, the Association asserted it "is not intended as a failsafe to guarantee a complete recovery to those unfortunate claimants" of insolvent insurers. (App. Br. p. 17). Respondents do not quarrel with this, and neither did the trial court. No "complete recovery" is being guaranteed here, nor is a "complete recovery" being made. Respondents are being left without *any* recovery of $123,378 after the caps under the Act are applied to the balance of the covered claim against AequiCap.

This Court should not be persuaded to misread section 38-31-60, *Brock* and *Hudson* to find that the Association steps up only if a claimant "be left without **any** potential source of recovery when an insurer becomes insolvent." (App. Br. p. 17). Instead the Court should deny this Petition and permit the Court of Appeals to remit the matter to the circuit court.

III. The Decisions Below Do Not Violate Public Policy

The trial court stated:

> Of note, nothing in Title 39, Chapter 10 clearly sets out that a claimant may only receive $300,000 in any event. It only limits the Association's payment to a single claimant to $300,000. If the purpose of the Act is to protect South Carolina citizens from insurance companies who become insolvent, then the Act is remedial and should be liberally construed in favor of payment to the claimant in order to best accomplish that goal.

(Order of 9/9/14, pp. 7-8). The Association did not challenge these holdings on appeal.

The trial court then stated:

> Adopting the interpretation suggestion by the Association would prevent full compensation, and in this case, any compensation from the Association. It would also work to dissuade claimants from resolving claims against joint tortfeasors who may have little proportionate liability,

> thus increasing the likelihood of protracted litigation and actually increasing the Association's exposure. As such, it is against public policy to adopt such an argument.

(Order of 9/9/12, pp. 7-8).

In this case there is no claim that Respondents did not look first to other available sources for recovery for their covered claim because they did so. After exhausting those sources, the Respondents turned to the Association, who had the obligation to respond to the remainder of the "covered claim," or $423,378. That obligation was then capped at $300,000, leaving $123,378 unpaid and not recoverable.

The Association "is a last resort insurer created by the legislature *to protect consumers* in the event that their insurer becomes insolvent." *Hudson*, 407 S.C. at 124, 754 S.E.2d at 492 (emphasis added). Consumer protection is at the heart of this statutory scheme. It is not designed to insulate the Association to the point that it may only respond to claims where the total recovery from all sources is less than $300,000. Had the General Assembly desired such a result it would have been a simple matter to draft the legislation in that fashion. It did not do so, and this Court may not read these statutes as such.

IV. The Holdings of a Majority of Other Jurisdictions Do Not Support Reversal

The Association argues that the Court of Appeals failed "to consider cases from other jurisdictions consistently interpreting the exact same language from Section 38-31-100 to mean that the amount of other available coverage should be offset from the statutory cap rather than the amount of the covered claim." (Petition, p. 7).

The Court should not be persuaded by this argument. The cases cited by the

Association are distinct from this case in meaningful ways. Contrary to the Association's statement, the language of most of the statutes in those jurisdictions is not "the exact same language" but is markedly different from the language in South Carolina's Act. Respondent thoroughly discussed each of those cases in her Respondent's brief and for brevity would invite the reader to review that discussion. (Brief of Respondent, pp. 37-49). That review reveals that the parenthetical explanations in the Petition are deceptive.

For example, *Jangula v. Arizona Property and Cas. Ins. Guar. Fund*, 88 P.3d 182 (Ariz. Ct. App. 2004) (Petition, p. 7) involved a scheme that is different from South Carolina's statute in a very meaningful way, and involved an amendment to the Act in Arizona to support the holding in that case. Nothing about *Jangula* supports the Association's position in this matter.

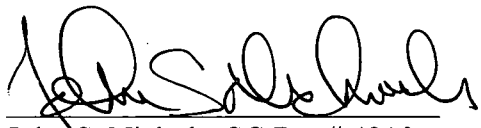
The only case that arguably supports the Association's view is the Delaware trial court's unpublished order in *Marra v. Wilson*, 2003 WL 367831 (Del. Sup. Ct. 2/20/03) (memorandum decision). However, as Respondent explained in her brief, *Marra* is apparently viewed as an outlier. *See Thomsen v. Mercer-Charles*, 901 A.2d 303, 311 (N.J. 2006) (noting *Marra* as inapposite to the Court's holding and contrary to the majority of other jurisdictions that adopted the Model Act).

Contrary to the Association's assertion, these cases involve statutory language that is different from South Carolina's Act or address different issues than the one in this case. They are all distinct from this case in very meaningful ways. The plain language of South Carolina's Act supports the trial court's ruling affirmed by the Court of Appeals. This Court should not be persuaded to review that decision.

CONCLUSION

For the reasons stated this Court should deny the Petition to review the Court of Appeals' decision in this case.

Respectfully submitted,



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November 21, 2016

THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM BAMBERG COUNTY
Court of Common Pleas

Doyet A. Early, III, Circuit Court Judge

Case No. 2013-CP-05-63
Appellate Case No. 2016-002156

Janette Buchanan and Shana Smallwood,
Individually and as Co-Personal Representatives
of the Estate of James S. Buchanan, ... Respondents,

v.

The South Carolina Property and Casualty
Insurance Guaranty Association, ... Petitioner.

PROOF OF SERVICE

The undersigned hereby certifies that on the date indicated below she served counsel for the Petitioner with a copy of the *Return to Petition for Writ of Certiorari* by mailing copies of the same by United States Mail with first class postage prepaid to the following address:

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November 21, 2016

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