

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

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.

RECORD ON APPEAL
Volume I

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SC Court of Appeals

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- STATE OF SOUTH CAROLINA
COUNTY OF HORRY

STEPHANIE A. SMITH on behalf of
herself and all others similarly situated,

Plaintiff,

Vs.

PROGRESSIVE HALCYON
INSURANCE COMPANY n/k/a
PROGRESSIVE DIRECT INSURANCE
CO., PROGRESSIVE MAX and
PROGRESSIVE CASUALTY
INSURANCE COMPANY,

Defendants.

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
C/A NO.: 2010-CP-26-10502

ORDER GRANTING
CLASS CERTIFICATION

FILED
Horry County
2013 FEB 14 AM 10:53
LAUREN HUGGINS, WARD
CLERK OF COURT

This matter came before the Court pursuant to Plaintiff's Motion For Class Certification filed on August 29, 2011. A hearing was held on October 31, 2012. Present at the hearing were Val Stieglitz on behalf of the Defendants and Nate Fata and Charles V. Leonard on behalf of the Plaintiff. After conducting a rigorous analysis and reviewing the arguments of counsel and the Memorandum and Exhibits attached thereto, the Court grants the Motion.

FACTS

This class action addresses Progressive's alleged underpayment of automobile med pay benefits to South Carolina insureds with health insurance compared to insureds without health insurance. The Second Amended Complaint asserts Progressive is violating policy language and South Carolina statutory law in processing and paying South Carolina med pay claims. Progressive Casualty Insurance Company ("Progressive Casualty") adjusts all med pay claims for the four Progressive auto insurance carriers doing business in South Carolina: Progressive

Direct, Progressive Max, Progressive Northern and United Financial Casualty. The Defendants, collectively, are referred to as "Progressive."

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.

Progressive Casualty is the hub of all claims handling. Since 2008 Progressive Casualty has operated the National Med Pay Unit in Jacksonville, Florida to handle all South Carolina med pay claims. The Progressive Casualty unit which adjusted the Plaintiff's claim has a team of fourteen adjusters who handle med pay claims in fifteen states, including South Carolina. Progressive established The National Med Pay Unit in 2008 to consolidate and systematically adjust claims by region.

POLICY LANGUAGE

The policy language at issue for the Class is as follows:

If you pay the premium for this coverage, we will pay the reasonable **expenses incurred** for necessary medical services received within three years from the date of a motor vehicle accident because of bodily injury . . . (Emphasis added)

The policies do not define "incur" or state when "incurred" will be measured. According to Progressive Casualty's deposition testimony, for all med pay claimants under all South Carolina Progressive policies, Progressive Casualty uniformly interprets the policy phrase "expenses incurred" to mean either: (1) for those claimants with health insurance, the amount of the medical bill after any adjustment is applied due to a health insurance carrier's contract with

the medical provider; or (2) for those claimants without health insurance, the amount of the medical bill. In other words, if a hospital bill is credited with a contractual adjustment from Blue Cross or Medicare, Progressive pays the lower, adjusted bill amount and takes advantage of the health insurance carrier's adjustment. For the identical claim, Progressive pays less to a claimant with health insurance than it pays to an uninsured claimant. Smith pays a premium for the health insurance.

Stephanie Smith was in an automobile wreck on February 23, 2009. She suffered personal injuries. At the time of the collision, she was driving a 1997 Saab insured by Progressive. 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. (Smith Policy and Progressive 386). Stephanie Smith initially submitted medical bills exceeding Five Thousand Dollars (\$5,000) to Progressive Casualty and received less than Three Thousand Dollars (\$3,000) from Progressive. The difference was due to credits toward medical bills from Ms. Smith's health insurance companies' contractual adjustments with the medical providers. Progressive Casualty's med pay adjuster, Dorothy Lange, marked down the claim for benefits in an amount equal to the health insurance adjustments.

Dorothy Lange is an experienced med pay adjuster who began working at Progressive in 2005. (Depo. Lange, Pg. 10, lines 9-12). Her job in the National Med Pay Unit is to make sure medical bills are processed. (Depo. Lange, Pg. 32, lines 13-15). Her testimony revealed that she reviews medical bills to determine only if the insured paid the bills out of her own pocket or if Progressive Casualty needs to pay them. (Depo. Lange, Pg. 33, lines 4-9). As part of the claims process Lange enters three pieces of data into the computer: the hospital bill, the total charge and the amount paid to the medical provider from all sources. (Depo. Lange, Pg. 88, lines 21-25). She

does not review the medical bills for any other reason. She processes the med pay claims in each of the 15 states the same way. (Depo. Lange, Pg. 39, lines 10-13).

She does not determine whether a medical procedure was necessary. (Depo. Lange, Pg. 38, line 25 – Pg. 39, line 2). In fact, she does not know anyone at Progressive who determines whether a medical procedure is necessary. (Depo. Lange, Pg. 39, lines 10-13). The only question Dorothy Lange answers is whether a bill is paid or unpaid. (Depo. Lange, Pg. 44, lines 8-15). Neither Lange nor any other adjuster determines whether a bill is too high. (Depo. Lange, Pg. 46, line 16 – Pg. 47, line 6). Progressive's processing of med pay claims has not changed since the institution of the National Med Pay Unit in 2008. (Depo. Lange, Pg. 61, lines 7-11). The systematic adjustment practices of Progressive have been well-documented.

In processing the Smith claim, Lange followed Progressive Casualty's standard operating procedure. Progressive has adopted a two page standard operation procedure (SOP) for adjusting all South Carolina med pay claims. (Exhibit E to Plaintiff's Memorandum). The short SOP provides that med pay allows the insured to recover the "same damage paid under health insurance."

Contrary to Defendants' arguments, Peter Goodchild, Dorothy Lange's supervisor, testified that the medical bill is proof that the insured incurred a medical expense and that liability to the medical provider arises on the date of service. (Depo. Goodchild, Pg. 10, line 9 – Pg. 11 line 3). An insurance explanation of benefits documentation is not required. (Depo. Goodchild, Pg. 11, lines 21-23). Peter Goodchild, Defendants' 30(b)(6) designee, is not aware of any instance in which a medical bill was repriced. (Depo. 30(b)(6) Goodchild, Pg. 15, lines 19-21).

"Incurred" is not defined in the South Carolina policy but is defined in the Progressive Virginia and Massachusetts policy. (Depo. 30(b)(6) Goodchild, Pg. 22, line 6). Peter Goodchild arranged a meeting with other National Med Pay supervisors to discuss the meaning of the word

"incurred." Progressive uses the same definition of "incurred" for each Progressive insured. (Depo. 30(b)(6) Goodchild, Pg. 23, lines 11-24).

As for the statutory issues in the case, Progressive admits that South Carolina Code Ann. §38-77-144 prevents a set off and subrogation. (Depo. 30(b)(6) Goodchild, Pg. 24, lines 12 – Pg. 25, line 25). Additionally, Progressive does not send blank proof of loss forms to the claimants. However, according to Elizabeth Zaner, the head of the National Med Pay Unit, Progressive requires written proof of loss. (Depo. Zaner, Pg. 89, lines 8-15).

The Second Amended Complaint sets forth the following causes of action.

1. Declaratory Judgment;
2. Breach of Contract;
3. Unjust Enrichment;
4. Bad Faith and Contractual Interference; and
5. Unfair Trade Practices.

The Plaintiff is requesting declaratory relief to adjudicate the practices of Progressive Casualty at the National Med Pay Unit in light of the statutory prohibition of set offs and subrogation, the statutory requirements on blank proof of loss forms and the policy language. The Plaintiff asserts, *inter alia*, that declaratory relief is applicable due to the ongoing claims processing Progressive Casualty must undertake for claimants during the three (3) years following a med pay occurrence. Thus, a declaration on the issues raised will affect any past or pending claims as well as future claims submitted by Class Members within three (3) years of the med pay incident.

The Declaratory Judgment Act, S.C. Code Ann. §15-53-80, provides that "...all persons shall be made parties who have or claim any interest which would be affected by the declaration..." Because Progressive Casualty's National Med Pay Unit's actions and adjusting

procedures are at the center of this controversy, it is a proper party.

Progressive Casualty has a:

1. systematic adjusting process;
2. using the same software and South Carolina SOP;
3. with few if any variations among South Carolina insureds;
4. requiring medical bills only;
5. with medical bill charges and amounts paid by all sources typed into the software program.

Class proof as to damages is easily retrievable. Progressive Casualty has been able and is able to document reduction amounts for Class Members.

STANDARD OF REVIEW

The prerequisites of South Carolina Rules of Civil Procedure Rule 23 are:

- (a) the class is so numerous that joinder of all members is impracticable;
- (b) there are questions of law or fact common to the class;
- (c) the claims or defenses of the representative parties are typical of the claims or defenses of the class;
- (d) the representative parties will fairly and adequately protect the interests of the class; and
- (e) in cases in which the relief primarily sought is not injunctive or declaratory with respect to the class as a whole, the amount in controversy exceeds one hundred dollars for each member of the class.

In ruling on a motion for class certification, the merits of the case are not to be considered by the trial court. *Tilley v. Pacesetter Corp.*, 333 S.C. 33, 508 S.E.2d 16 (1988). Rather, the appropriate inquiry is whether or not the case is suitable for treatment as a class action. This action is well suited for class treatment. It is well settled in South Carolina that Rule 23 is more

expansive than its federal counterpart, Rule 23 of the Federal Rules of Civil Procedure. South Carolina has repeatedly stated the class action provide the prosecution of small claims, judicial efficiency and the conservation of judicial resources. See *Littlefield v. South Carolina Forestry Commission*, 337 S.C. 348, 523 S.E.2d 781 (1999). In 2010 the Supreme Court reiterated that class actions are favored in this state and that we have a more expansive view of class actions than our federal counterpart. *Guazia v. South Carolina State Plastering, LLC*, 390 S.C. 562, 703 S.E.2d 197 (2010).

CONCLUSIONS OF LAW

After considering the parties oral arguments, memoranda, exhibits and proposed Orders, this Court finds that the Plaintiff has established each of the five required elements to certify a Class pursuant to South Carolina Rules of Civil Procedure.

A. Numerosity

By letter stipulation, the Defendants do not contest numerosity. Nonetheless, under the Court's analysis, the class is so numerous that joinder of all members of the class is impracticable. No definite standard exists as to what size class satisfies the requirements of Rule 23(a)(1). *Haywood v. Barnes*, 109 F.R.D. 568, 576 (E.D.N.C. 1986). However, where the class numbers at least 40, joinder is usually impracticable, and where the class numbers in the hundreds, joinder is clearly impracticable. See, e.g., *Swanson v. American Consumer Industries*, 415 F.2d 1326, 1333 (7th Cir. 1969) (reversing denial of class certification in a securities case involving 151 class members). The Defendants' discovery responses indicate there are easily hundreds of class members. (Exhibit L to Plaintiff's Memorandum, Defendants' Fourth

Supplemental Response to Interrogatory 6). As a result, the numerosity test has been met and, accordingly, the first prong of Rule 23, SCRCF is met.¹

B. Commonality

Common questions of law and fact exist as to all members of the class. The commonality requirement is liberally construed and given permissive application so that common questions have been found to exist in a wide range of contexts. *Haywood v. Barnes*, 109 F.R.D. 568, 577 (E.D.N.C. 1986). See also *McGann v. Mungo*, 287 S.C. 561, 568, 340 S.E.2d 54, 157-58 (Ct.App. 1986) holding:

It is important to note that the subsection does not demand all questions of law and fact to be common, only that there be common issues among the class. **In fact, a single common issue will suffice if it is important enough.** (Emphasis added).

In this case, common issues abound as to all insureds. The common issues include:

- a. Whether the Plaintiff and the Class are entitled to declaratory relief to determine whether Progressive's practice of underpaying med pay claims violates statutory laws concerning claims adjustment, regulatory law, the common law, or the insurance policies.
- b. Whether the Progressive Insurance Companies' practice of reducing payments for medical services, treatments, and/or supplies provided to their med pay insureds violated S.C. Code Ann. §38-59-10 et seq.
- c. Whether the Plaintiff and Class are entitled to declaratory relief conforming the policies to the express statutory provisions which prohibits set offs and subrogation.
- d. Whether the Plaintiff and the Class are entitled to damages, punitive damages, statutory penalties, attorney fees, and/or interest against the Defendants under S.C. Code Ann. §38-59-10 et seq. and S.C. Code Ann. §38-77-144 and the policy language.

¹ A class action may proceed upon estimates as to the size of the proposed class. *In re Alcoholic Beverages Litigation*, 95 F.R.D. 321 (E.D.N.Y. 1982); *Leist v. Shawano Cty*, 91 F.R.D. 64 (D. Wis. 1981); *Amswiss Int'l Corp. V. Heublein, Inc.*, 69 F.R.D. 663 (N.D. Ga. 1975).

e. Whether the Class is entitled to a declaration that their losses are fixed in the amount of their medical bills due to Defendants' failure to provide a blank proof of loss pursuant to statute.

f. Whether the Defendants' definition of the undefined term "incurred" constitutes a breach of policy obligations.

To summarize, the commonality requirement of Rule 23, SCRCF has been satisfied. Furthermore, the nature of this case makes class certification appropriate. See, *Kennedy v. S.C. Retirement System*, 24 Employee Benefits Cas. (BNA) 2859 (S.C. 2000), *withdrawn on unrelated grounds and superseded by substitute opinion*, 345 S.C. 339, 549 S.E.2d 243, *rehearing denied*, 349 S.C. 339, 534 S.E.2d 322 (2001). In the original *Kennedy* opinion, the Supreme Court stated:

We believe the current case especially appropriate for class treatment. The number of potential plaintiffs is very large, there is one main issue of law, that issue is identical for each plaintiff, all injuries result from the same misapplication of the statute by the Retirement System, and individual calculation of damages would be simple.

See, also *Littlefield v. South Carolina Forestry Commission*, 337 S.C. 348, 521 S.E.2d 781 (1999).

As the Supreme Court has previously recognized, this type of case is ideal for class certification. At the National Med Pay Unit, Progressive Casualty has a systematic and uniform practice of adjusting med pay claims. The claims of the individual Class Members are small. A primary issue is the definition of the undefined term "incurred" and when "incurred" is to be measured. Answering this common issue alone justifies class certification. As in *Kennedy*, the calculation of damages should be simple. Progressive has the amount of the class member reductions at its disposal.

Progressive argues that a review of the policy indicates hypothetical situations in which the claims of Class Members are not common. However, the facts in the record indicate the National Med Pay Unit's systematic adjusting process with little to no variation. Progressive

logs in the actual charges and pays only the allowed amount based on its interpretation of "incurred". If an amount was paid, Progressive has determined the claim or charge was compensable, and, therefore, policy exclusions cannot apply. No proof of loss forms are sent to any Class Member. The adjusting process is identical for all South Carolina insureds. Progressives' interpretation of "incurred" has been uniformly applied to all Class Members and is the same. Even with Progressive's arguments, the Court may answer common questions for the insureds, including: when "incurred" is measured and the application of the statutes to Progressive's practices.

C. Typicality

The Plaintiff has established typicality. The tenets of commonality and typicality most often are dealt with as one in terms of class certification. *General Telephone Company of the Southwest v. Falcon*, 457 U.S. 147, 158 (1982) (The commonality and typicality requirements of Rule 23(a) tend to merge.). The "typicality" requirement of Rule 23(a)(3), SCRCR requires that the claims or defenses of the class be typical. To satisfy the typicality requirement, the named representatives' claims must be similar enough to those of the class to assure that the class' interests are vigorously prosecuted. 7A Charles Alan Wright & Arthur R. Miller, Federal Practice & Procedure, 1764 (2d. Ed. 1986).

Here, the claims of the representative party are typical of the claims of the class. Progressive Casualty processed the Smith claim in the same way in which it processes all claims. Accordingly, a common set of facts applies to all class members in accordance with *Littlefield, supra*. Progressive's payments to Smith were reduced under the same process in which Progressive reduced payments to other Class Members. There is no individual advantage to proceeding separately; in fact, there is a distinct disadvantage as the individual damages of any

one class member may be relatively small when compared with potential costs of bringing this action, making the expense and burden of this litigation unjustifiable for individual actions.

Defendants' arguments that Plaintiff's claims are not typical are misplaced. The testimony of Progressive is that Plaintiff's claims were treated in the same manner in which all other South Carolina claims are adjusted. The reductions to other insureds' payments have been noted in the Defendants' discovery responses. Moreover, there has been no showing of any antagonism.

D. Adequacy of Representation

The Plaintiff has established the representation element that is required to certify the case as a class action. South Carolina Rule of Civil Procedure 23(a)(4) requires that the named plaintiff fairly and adequately protect the interests of the class. That protection involves two factors: (1) counsel must be qualified, experienced and generally able to conduct the proposed litigation; and (2) plaintiffs' claims must be sufficiently interrelated and not antagonistic to the class claims. *Lott v. Westinghouse Savannah River Co.*, 200 F.R.D. 539 561 (D.S.C. 2000).

Stephanie Smith can and has fairly and adequately protected the interests of the class. Her claims are typical of the class in that she and all members of the class were subjected to the same claims adjusting processes. She was subjected to the same definition of "incurred" and she like the other class members can apply the same statutory law to Progressives' practices.

Smith's claim was adjusted by Progressive Casualty. She, on behalf of others, is seeking declaratory relief as to the adjustments process employed by Progressive Casualty. She has been involved in the litigation for over two years. She has provided information and has sat for two depositions. She has and will continue to fairly and adequately protect the interests of the class. (Smith Affidavit, Exhibit I to Plaintiff's Memorandum).

Progressives' argument on antagonism is not persuasive. Smith's interest for full payment under her policy of insurance is in line with an insured's expectations under its policy: that it receive the benefits paid for. In addition, the statutory laws should be applied uniformly for all Progressive insureds.

As for her legal representation, Plaintiff's counsel, Leonard and Fata, have over a decade of experience in class actions and complex litigation. They have handled other consumer class actions in the past. The class has been adequately represented. (Fata Affidavit, Exhibit J to Plaintiff's Memorandum).

E. Amount in Controversy

The final prong of Rule 23, SCRCF requires that each class member have a claim in excess of One Hundred Dollars (\$100.00) if the primary relief requested is not declaratory. However, this action seeks significant declaratory relief due to the open claims and the ongoing claims adjustment practice of Progressive Casualty. The first claim asserted is for declaratory relief. In addition, it is undisputed that the reductions assessed against Stephanie Smith exceed One Thousand Dollars (\$1,000). The average class member has a reduction of at least One Thousand Dollars (\$1,000) based on Defendants' discovery responses. (Defendants' Fourth Supplemental Response to Interrogatories and Defendants' Response to Supplemental Interrogatory, Exhibit K to Plaintiff's Memorandum). The declaratory relief sought coupled with the monetary relief requested satisfies the final prong of Rule 23, SCRCF.

CLASS DEFINITION

A proper class definition describes the class in objective terms, capable of membership without regard to the merits of the proposed class membership claims or the particular relief they

seek. See *Herbert B. Newberg and Alba Conte Newberg* in *Class Actions*, Fourth § 6.14 (3d. ed. 1994).

The Plaintiff and the Class have a justiciable controversy involving Progressive Casualty's claims adjusting process. Ms. Smith has a direct link or connection with Progressive Casualty. Class Members have had their med pay claims adjusted by Progressive Casualty. Because Progressive Casualty is a sister company with the other South Carolina Progressive Defendants and has handled the claim adjustment process for them, the Class is certified on all causes of action to include all claims adjusted by Progressive Casualty.

The Class is defined as follows:

All insureds of Progressive Halcyon Insurance Company n/k/a Progressive Direct, Co., Progressive Max, and Progressive Casualty who (1) submitted claims to any of the Progressive Insurance Companies, including Progressive Casualty, under the med pay provision of the respective South Carolina policies during the time period of November 8, 2007 to the date of this Order, and (2) whose claims were adjusted by Progressive Casualty, and (3) who did not receive payment in the amount of their medical bills, and (4) whose med pay policy limits were not exceeded.

The above class definition is supported by the record.

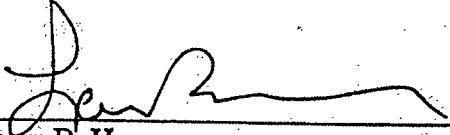
NOW, THEREFORE, IT IS HEREBY ORDERED that:

1. The Plaintiff's Motion for Class Certification is granted;
2. The Class definition in this Order is approved;
3. Stephanie Smith is appointed as Class Representative;
4. Nate Fata and Charles V. Leonard are appointed as Class Counsel;
5. Defendants shall provide electronically to Class Counsel the names and last known addresses of the Class Members within forty five (45) days of this Order; and
6. Class Counsel shall cause an Opt-Out Notice of Class Action to be sent to Class Members within sixty (60) days of receipt of the electronic Class list data from Defendants. The Notice shall advise the members of the facts of this case and their right to opt out within thirty

(30) days if they choose not to participate pursuant to *Salmonsens v. CGD*, 377 S.C. 442, 661 S.E.2d 81 (2008).

AND IT IS SO ORDERED.

This 4 day of Feb, 2013.



Larry B. Hyman
Presiding Judge, Fifteenth Judicial Circuit

STATE OF SOUTH CAROLINA)

COUNTY OF HORRY)

STEPHANIE A. SMITH, on behalf of)
herself and all others similarly situated,)

Plaintiff,)

vs.)

PROGRESSIVE HALCYON)
INSURANCE COMPANY n/k/a)
PROGRESSIVE DIRECT INSURANCE)
CO., PROGRESSIVE MAX and)
PROGRESSIVE CASUALTY)
INSURANCE COMPANY,)

Defendants.)

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
CASE NO.: 2010-CP-26-10502

ORDER SUBSTITUTING COUNSEL

FILED
HORRY COUNTY
13 APR 26 PM 2:57
KELLY HUGGINS-WARD
CLERK OF COURT

The Defendants, Progressive Halycon Insurance Company n/k/a Progressive Direct Insurance Co., Progressive Max and Progressive Casualty Insurance Company, seek a substitution of counsel in the matter referenced above.

Defendants were originally represented by Val H. Stieglitz, Esquire and Paul A. Dominick, Esquire of Nexsen Pruet, LLC. Defendants seek to substitute Thomas C. Brittain, Esquire and A. Preston Brittain, Esquire of The Brittain Law Firm, PA.

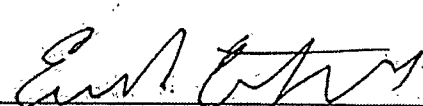
Attached is a Notice of Substitution of Counsel, signed by Val H. Stieglitz, Esq., Thomas C. Brittain, Esq. and A. Preston Brittain, Esq. agreeing to this substitution of counsel.

The Brittain Law Firm, PA is aware of current filings on behalf of these Defendants and is prepared to move forward so as to keep this substitution from causing any delay.

Myrtle Beach, SC

March 23, 2013

APRIL



Val H. Stieglitz, Esq.

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT

STEPHANIE A SMITH on behalf of
herself and all others similarly situated,

Plaintiff,

v.

PROGRESSIVE HALCYON
INSURANCE COMPANY, n/k/a
PROGRESSIVE DIRECT INSURANCE
CO., PROGRESSIVE MAX, and
PROGRESSIVE CASUALTY
INSURANCE,

Defendants.

Case No. 2010-CP-26-18502

[DEFENDANTS' PROPOSED]
ORDER ON MOTION FOR
RECONSIDERATION AND TO ALTER
OR AMEND THE COURT'S ORDER
GRANTING CLASS CERTIFICATION

This matter is before the Court on Defendants' Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification (the "Motion"). After considering the parties' written submissions, hearing oral argument on the Motion, and conducting a rigorous analysis of the facts and law, the Court GRANTS the Motion, VACATES its February 14, 2013 Order (the "Order"), and DENIES Plaintiff's Motion for Class Certification.

BACKGROUND

I. Plaintiff's Insurance Policy And Med-Pay Claim

Between January and June 2009, Plaintiff was insured under an automobile insurance policy issued by Defendant Progressive Max (the "Policy"). Plaintiff was not insured by, and did not otherwise have any relationship with, with any other Progressive entity, including Progressive Casualty or Progressive Direct.¹ Among other things, Plaintiff's Progressive Max

¹ Except when referring to a specific Defendant, the Court collectively refers to Defendants as "Progressive."

Policy provided coverage for med-pay claims, subject to the terms and conditions set forth in the Policy, along with any exclusions. Specifically, the Policy provided that, if Plaintiff paid the med-pay premiums, Progressive would "pay the reasonable expenses incurred for necessary medical services received within three years from the date of a motor vehicle accident because of bodily injury: 1. sustained by an insured person; and 2. caused by that motor vehicle accident." Policy, Part II, Insuring Agreement. The Policy further provided that Progressive, or someone acting on its behalf, would determine "whether the expenses for medical services are reasonable," and whether the services provided were "necessary." *Id.*

In February 2009, Plaintiff was injured in an automobile accident and subsequently, through her attorney, made a med-pay claim under the Policy. The Progressive claims adjuster handling Plaintiff's claim, Ms. Dorothy Lange, examined Plaintiff's claim in light of her Policy language and determined what "reasonable" expenses Plaintiff had "incurred" for "necessary" medical services arising from her automobile accident. *Aff. of D. Lange* ¶ 6. In doing so, Ms. Lange determined that Plaintiff was entitled to reimbursement for all of her out-of-pocket medical payments, deductibles, and co-payments. *Id.* In addition, Ms. Lange determined that Plaintiff was entitled to reimbursement of all payments that her private health insurer, Blue Cross, had paid Plaintiff's medical providers. *Id.*

The only amount Ms. Lange deducted from Progressive's payment to Plaintiff was the difference between the amounts Plaintiff's medical providers originally billed for their services and the amount Blue Cross actually paid, pursuant to its third-party contracts with the medical providers. *Id.* ¶ 7. Ms. Lange deducted this amount because she determined that because neither Plaintiff nor Blue Cross actually paid those amounts, they were not expenses that Plaintiff had "incurred." *Id.* ¶¶ 7, 8.

II. Progressive's Med-Pay Adjustment Methodology

While Progressive only reduced Plaintiff's med-pay reimbursement based on the medical expenses it determined she did not "incur," Progressive reduces other South Carolina med-pay claims for a number of reasons. The record shows that Progressive adjusts med-pay claims based on at least 39 Policy provisions to determine whether insureds are owed the full amounts they request. For example, Progressive may pay a class member less than the total amount the class member was billed because some of the medical services the insured obtained did not occur "within three years from the date" of the motor vehicle accident in question. See Policy, Part II, Insuring Agreement. Likewise, Progressive may not have paid the insured the full amount billed because in adjusting the claim, Progressive ascertained that (i) the insured did not sustain "bodily injury," (ii) the bodily injury sustained was not the result of the "motor vehicle accident" at issue, or (iii) the insured was not, in fact, injured. See *id.*

Perhaps most crucially, pursuant to insuring agreement in the Policy, Progressive only reimburses insureds the "reasonable" amounts they incur for medical treatment.² Policy, Part II,

² As discussed below, Plaintiff disputes this point, arguing that "Progressive has never declined or reduced a claim based upon the reasonable and necessary clause within the policy." Pl.'s Supp. Br. in Opp'n to Defs.' Mot. for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification ("Plaintiff's Supplemental Brief"), at 2. But the evidence Plaintiff cites does not support this assertion. Instead, the adjusters whose testimony Plaintiff cites uniformly testified only that they could not recall specific instances in which they personally adjusted med-pay claims based on reasonableness – not that Progressive uniformly does not or "has never" adjusted med-pay claims by first determining whether the amounts are reasonable. See Dep. of L. Felton at 16:1-7 ("Q. Have you ever determined whether an expense is reasonable? A. If something is something I don't understand, I will talk to my manager about it. Q. Do you recall any situations where you had to determine – A. No, I don't."); Dep. of K. Braden at 12:20-24 ("Q. Can you ever recall in the last 18 months of adjusting claims for South Carolina claimants or any other claimants whether you determined that a medical service was not necessary? A. I don't recall."); Dep. of E. Dennis at 26:19-22 ("Q. In your four years with the med pay unit, have you taken any South Carolina Med Pay bill and not paid it because it was unreasonable or unnecessary? A. I don't recall."); Dep. of R. Cole at 25:10-12 ("Q. Have you ever returned a bill or reduced a bill because it was unreasonable or unnecessary? A. I don't

Insuring Agreement. To determine whether the amount an insured seeks is "reasonable,"

Progressive's employees use software called Mitchell DecisionPoint. See Dep. Tr. of P.

Goodchild (corporate representative) at 31:15-32:21, 45:24-46:4; *see also* Dep. Tr. of R. Cole at 9:2-21 (testifying that claims must "go through Mitchell first" to determine whether the charges are "usual and customary"). Once the DecisionPoint software audits the medical bill, the adjuster must review the audit and approve the amount to be reimbursed. Dep. of P. Goodchild (individually) at 18:1-9. The Progressive employee responsible for supervising med-pay claims in South Carolina, Peter Goodchild, explained how this process works:

Q. What happens where there is a reduction to a doctor's bill? Say the bill is \$1,000 and Mitchell says: 'Well, I think it should be \$400;' you don't know how that is calculated or determined; you don't know the nuts and bolts of Mitchell's programming?

But what happens, does the check just get spit out or – the Mitchell-allowed amount?

A. The adjuster would approve that amount that was allowed for payment, and they would issue that payment.

Id.

III. Plaintiff's Claims, the Court's February 14 Order, and Progressive's Motion

Plaintiff contends that Progressive breached the Policy terms and violated South Carolina law by reimbursing her the amounts she and her health insurer actually paid for her medical expenses, rather than the amounts her medical providers billed. Second Am. Compl. ¶¶ 13, 17, 18. Plaintiff asserts claims against Progressive for breach of contract, unjust enrichment, bad faith, and unfair claims practices/tortious interference. *Id.* ¶¶ 53-74. She also seeks a declaratory

recall."); Dep. of D. Lange (August 3, 2011) at 78:10-13 (testifying that she personally has not determined that a medical bill she received in connection with a med-pay claim was unreasonable).

judgment. *Id.* ¶¶ 47-52. Plaintiff asserts her claims on behalf of herself and a purported class. *Id.* ¶ 24.

On February 14, 2013, the Court entered an Order certifying a class, which the Court defined as follows:

All insureds of Progressive Halcyon Insurance Company n/k/a Progressive Direct, Co., Progressive Max, and Progressive Casualty who (1) submitted claims to any of the Progressive Insurance Companies, including Progressive Casualty, under the med pay provision of the respective South Carolina policies during the time period of November 8, 2007 to the date of this Order, and (2) whose claims were adjusted by Progressive Casualty, and (3) who did not receive payment in the amount of their medical bills, and (4) whose med pay policy limits were not exceeded.

Id. at 13.

On February 22, 2013, Progressive timely filed its Motion, arguing that the Court should reconsider its Order because Plaintiff cannot meet the criteria for class certification set forth in SCRCP 23(a). On May 24, 2013, Progressive submitted a memorandum of law in support of the Motion. On May 29, 2013, the Court heard oral argument from the parties.

Thereafter, the parties filed several additional briefs addressing some of the issues raised in Progressive's Motion and during oral argument. On May 30, 2013, Plaintiff filed her Supplemental Brief. On June 5, 2013, Progressive filed a response to Plaintiff's Supplemental Brief. On June 19, 2013, Plaintiff filed another brief, styled Plaintiff's Memorandum in Reply to Defendants' Memorandum of Law in Support of Defendants' Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification ("Plaintiff's Supplemental Reply"). In that brief, Plaintiff proposed that the Court alter the definition of the class certified in the Order to add a fifth condition of membership. Specifically, Plaintiff proposed the following revised class definition:

All insureds of Progressive Halcyon Insurance Company n/k/a Progressive Direct Co., Progressive Max, and Progressive Casualty who (1) submitted claims to any of the Progressive Insurance Companies, including Progressive Casualty, under the med pay provision of the respective South Carolina policies during the time period of November 8, 2007 to the date of this Order, and (2) whose claims were adjusted by Progressive Casualty, and (3) who did not receive payment in the amount of their medical bills, (4) whose med pay policy limits were not exceeded, and (5) whose file or claim contains documentation or reference to proper health insurance.

Pl.'s Supp. Reply at 4 (emphasis added). On July 17, 2013, Progressive filed its Reply Memorandum in Further Support of Defendants' Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification ("Defendants' Reply"), in which Progressive argued, among other things, that Plaintiff's new proposed definition would not remedy the flaws Progressive contends render this case unsuitable for class treatment. Defs.' Reply at 5-6.

Having considered the parties' oral arguments and written submissions, and having further reviewed the evidentiary record, the Court finds this matter ripe for disposition.

DISCUSSION

"[A] class action is 'an exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only.'" *Broussard v. Metneke Discount Muffler Shops, Inc.*, 155 F.3d 331, 345 (4th Cir. 1998) (citation omitted).³ As a result, the proponent of class certification bears the burden of proving all five prerequisites set forth in SCRPC 23:

³ Plaintiff argues that the Court should not consider federal precedent because South Carolina takes a "more expansive view of the class action device." See Pl.'s Supp. Reply at 1-2. But Plaintiff does not explain why this purported divergence matters in this case. The chief distinction between SCRPC 23 and Federal Rule of Civil Procedure 23 is that SCRPC 23 does not contain the predominance requirement set forth Federal Rule 23(b)(3). See *Guazla v. South Carolina State Plastering, LLC*, 390 S.C. 562, 576, 703 S.E.2d 197, 204 (S.C. 2010). Progressive, however, does not argue that Plaintiff has not satisfied this predominance requirement. Instead, Progressive argues that Plaintiff has not satisfied her burden under SCRPC

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

Gardner v. South Carolina Dep't of Rev., 353 S.C. 1, 20-21, 577 S.E.2d 190, 200 (S.C. 2003).

The purpose of these requirements is to "effectively 'limit the class claims to those fairly encompassed by the named plaintiff's claims.'" *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2550 (2011) (construing Federal Rule 23(a)). Failure to establish even one of the requirements requires the Court to deny class certification. *Waller v. Seabrook Island Property Owners Ass'n*, 300 S.C. 465, 467, 388 S.E.2d 799, 800-801 (1990). Moreover, as a threshold matter, the proponent of class certification must propose an adequate class definition. *Amselmo v. West Paces Hotel Group, LLC*, No. 9:09-cv-2466-MBS, 2011 WL 1049195, at *18 (D.S.C. Mar. 18, 2011); see also *Solo v. Bausch & Lomb, Inc.*, Nos. 2:06-MN-77777-DCN, 2:06-CV-02716-DCN, 2009 WL 4287706, at *3 (D.S.C. Sept. 25, 2009) ("Although not specifically mentioned in the rule, the definition of the class is an essential prerequisite to maintaining a class action") (quoting *Roman v. ESB, Inc.*, 550 F.2d 1343, 1348 (4th Cir. 1976)).

23(a), which is materially identical Federal Rule 23(a). Accordingly, the Court finds that it is appropriate to consider federal cases construing Federal Rule 23(a) in analyzing whether Plaintiff has met her burden under SCRCF 23(a). See *Gardner v. Newsome Chevrolet-Buick*, 304 S.C. 328, 330-31, 404 S.E.2d 200, 201 (1991); see also *Middleton v. SunStar Acceptance Corp.*, No. 98-CP-07-1131, 2000 WL 33385388, at *3 n.3 (S.C. Comm. Pl. Jan. 13, 2000) ("As the South Carolina Reporter's Notes indicate, South Carolina's Rule 23 is 'drawn principally from Federal Rule 23. Citations to federal case law and the federal rules are based on the principal that interpretations of the federal rule provide guidance in interpreting the South Carolina rule absent material differences.'") (internal citations omitted)).

To determine whether the class certification proponent has discharged her burden, the Court must conduct a "rigorous analysis" of the relevant facts. *Waller*, 300 S.C. at 467, 388 S.E.2d at 801. After conducting such an analysis, this Court concludes that Plaintiff has not met her burden of demonstrating the proposed class meets the adequacy, commonality, or typicality requirements of SCRCP 23(a). In addition, the Court concludes that class definition Plaintiff proposed in her Supplemental Reply does not adequately address the flaws Progressive identified, which renders this case unsuitable for class treatment.

I. Plaintiff Has Not Demonstrated Adequacy.

Plaintiff has not demonstrated that she would fairly and adequately represent the members of the class for two reasons. First, Plaintiff does not have a viable individual claim and thus cannot prosecute claims on behalf of the class members. Second, Plaintiff's individual circumstances cause her interests to diverge from those of the class members.

A. Plaintiff She Has No Viable Individual Claims.

Under South Carolina law, a named plaintiff must have a viable individual claim against the defendant to have standing to represent a purported class. See *Gardner*, 353 S.C. at 23 n.14, 577 S.E.2d at 200; *Ferguson v. Charleston Lincoln Mercury, Inc.*, 349 S.C. 558, 566, 564 S.E.2d 94, 98 (2002). The basis for Plaintiff's claims is that Progressive allegedly did not pay her the amount she "incurred" for medical expenses because it paid her the amount her health insurer actually paid for those services, as opposed to what her medical providers billed. Second Am. Compl. ¶ 18. Under South Carolina law and the plain language of the Policy, however, Plaintiff did not "incur" expenses that her medical providers billed but that her health insurer did not actually pay. See Policy, Part II, Insuring Agreement (providing that Progressive would pay only

amounts Plaintiff "incurred"); *Gordon v. Fid. & Cas. Co. of N. Y.*, 238 S.C. 438, 441, 120 S.E.2d 509, 510 (1961).

Interpreting virtually identical policy language, the South Carolina Supreme Court has held that an insured does not "incur" expenses when the insured has "no obligation . . . to pay for the treatment" she receives. *Gordon*, 238 S.C. at 441, 120 S.E.2d at 510. In April 2013, a federal district court sitting in South Carolina and interpreting South Carolina law reached the same conclusion. See *Barker v. Washington Nat'l Ins. Co.*, No. 9:12-cv-1901-PMTD, 2013 WL 1767620, at *5 (D.S.C. Apr. 24, 2013). In *Barker*, the plaintiff was insured under a "Limited Benefit Health Coverage" insurance policy, which provided that the insurer would pay the plaintiff's "expenses incurred," pursuant to certain policy terms. *Id.* at *1. After obtaining medical services, the plaintiff – a Medicare beneficiary – submitted claims to the insurer based on the amounts his medical provider billed for the services he obtained. *Id.* The insurer, however, only reimbursed the plaintiff for the amounts Medicare actually paid, in accordance with the contract between Medicare and the provider. *Id.* at *2. The plaintiff sued the insurer, alleging that this method of reducing his claim was improper. *Id.* But the court disagreed, holding that the plaintiff did not "incur" the difference between what the medical provider billed and what the third-party payor paid. See *id.* at **6-7. Instead, the court held that the plaintiff "was never obligated to pay more than the amount that the hospital had agreed to accept as full payment under Medicare." *Id.* at *6. To the contrary, the court reasoned that "the benefits available under the policy are limited to those expenses for which the plaintiff was obligated to pay." *Id.* at *7.

This case is no different than *Barker*. In both cases, the plaintiff's insurer was required only to reimburse the plaintiff for medical expenses actually "incurred." Likewise, in both cases, the plaintiff's third-party payor (in *Barker*, Medicare; here, Blue Cross) had an arrangement with

the plaintiff's medical provider under which the third-party payor paid the medical provider an amount less than the total amount the medical provider billed. Finally, in both cases, the plaintiff undisputedly reimbursed the plaintiff the full amount that his or her third-party payor actually paid his or her medical provider. *See* Dep. Tr. of S. Smith at 55:12-56:15 (testifying that Plaintiff has no medical expenses outstanding associated with her insurance claim). Because the facts of this case are materially identical to the facts in *Barker*, the outcome likewise should be the same: Plaintiff did not "incur" the difference between what her medical provider billed and what Blue Cross paid, and she thus is not entitled to recover that amount from Progressive.

Making this determination now, in considering whether class certification is appropriate, is neither inappropriate nor premature. To the contrary, the South Carolina Supreme Court has made clear that a named plaintiff in a purported class action does not adequately represent the interests of the absent class members when the named plaintiff lacks a viable individual claim against the defendant. *See Ferguson*, 349 S.C. at 566, 564 S.E.2d at 98 (holding that purported class action cannot proceed when sole named plaintiff dies before class certification and thus has no viable claim against defendant); *see also Gardner*, 353 S.C. at 23 n.14, 577 S.E.2d at 201 (rejecting plaintiff's request to accept "juridical links doctrine" in class action context because doctrine "runs counter to this Court's previous decisions which hold that a plaintiff may not sue a defendant unless the plaintiff has suffered an injury at the hands of the defendant"). This precedent is consistent with persuasive federal authority. *See, e.g., McClain v. South Carolina Nat'l Bank*, 105 F.3d 898, 903 (4th Cir. 1997) (affirming denial of class certification because named plaintiff did not suffer damages caused by defendant and thus had no viable claim). Moreover, ruling on the legal sufficiency of Ms. Smith's claim now, in connection with deciding whether she can adequately represent the proposed class, will resolve Plaintiff's individual claim

without implicating the Due Process concerns associated with binding the absent class members. See Fed. R. Civ. P. 23 advisory comm. note (2003) ("The party opposing the class may prefer to win dismissal or summary judgment as to the individual plaintiffs without certification and without binding the class that might have been certified.").

Because Plaintiff has no viable claim against Progressive in her own right, she cannot adequately represent the purported class. See *Broussard*, 155 F.3d at 345 (stating that Rule 23 is not a device by which plaintiffs can "strike [defendants] with selective allegations, which may or may not have been available to named plaintiffs").

B. Plaintiff Is An Inadequate Class Representative For Additional Reasons.

Upon further consideration of the record, the Court holds that Plaintiff also is not an adequate class representative for additional reasons. First, Plaintiff cannot represent class members who were insured by Progressive Casualty or Progressive Direct, rather than Progressive Max. It is undisputed that Progressive Max was the only Progressive company that issued an insurance policy to Plaintiff, who had no relationship – contractual or otherwise – with Progressive Casualty or Progressive Direct. Aff. of Michael R. Uth ¶ 5 (attached as Ex. D). As the South Carolina Supreme Court wrote in *Gardner*, "a plaintiff may not sue a defendant unless the plaintiff has suffered an injury at the hands of the defendant." 353 S.C. at 23 n.14, 577 S.E.2d at 201 (citing *Edisto Fleets, Inc. v. South Carolina Tax Comm'n*, 256 S.C. 350, 182 S.E.2d 713 (1971); *Furman Univ. v. Livingston*, 244 S.C. 200, 136 S.E.2d 254 (1964)). Because Plaintiff indisputably suffered no injury "at the hands of" Progressive Casualty or Progressive Direct, she cannot assert claims against Progressive Casualty or Progressive Direct and thus cannot represent a class including insureds of Progressive Casualty or Progressive Direct. See *Gardner*, 353 S.C. at 23 n.14.

Second, Plaintiff also is an inadequate class representative because she is a former Progressive Max policyholder, but she seeks to represent a class of current policyholders. As a former policyholder, Plaintiff has no standing to seek prospective relief, such as a declaratory judgment. See *Newman v. Richland Cnty. Historic Preservation Cmt.*, 325 S.C. 79, 74 (1997) (holding that plaintiff lacked standing to assert declaratory judgment claim because she had no "personal stake in the subject matter of [the] lawsuit"). Her interests, therefore, diverge from those of the class members she seeks to represent.

II. Plaintiff Did Not Satisfy Her Burden Of Demonstrating Commonality.

The South Carolina Supreme Court has held that "[c]ommonality is met only where the class shares a determinative issue." *Gardner*, 353 S.C. at 21-22, 577 S.E.2d 190, 201. In cases where the "factual differences" between class members' claims "are the crux of a predominant legal issue," commonality does not exist. *Id.* Put differently, to satisfy the commonality requirement, a plaintiff seeking class certification must affirmatively prove the class members "suffered the same injury" and share a "common contention" that "is capable of classwide resolution – which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Wal-Mart Stores*, 131 S. Ct. at 2551; see also *id.* ("Rule 23 does not set forth a mere pleading standard."). "A question is not common if its resolution turns on a consideration of the individual circumstances of each class member." *Burton v. Chrysler Grp. LLC*, No. 8:10-cv-00209-MCL, 2012 WL 7153877, at *3 (D.S.C. Dec. 21, 2012). The commonality requirement thus "ensure[s] that only those plaintiffs . . . who can advance the same factual and legal arguments may be grouped together as a class." *Broussard*, 155 F.3d at 340. As the leading scholar of South Carolina civil procedure has observed:

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

James F. Flanagan, South Carolina Civil Procedure § 23.B.3 (2010).

Plaintiff contends that she has satisfied her burden of demonstrating commonality because the central question in this case – whether Progressive improperly reduced med-pay reimbursements by paying insureds less than the full amounts their medical providers billed – is a common issue. Based on the Court's review of the evidence, however, the answer to that question is not common; instead, it will vary depending on each class member's unique circumstances. Moreover, at least two of the claims that Plaintiff purports to assert on behalf of the absent class members cannot be resolved on a classwide basis because their viability necessarily turns on individualized circumstances.

A. The Class Does Not Share a Determinative Issue.

Plaintiff alleges that Progressive paid her less than the amount she was billed because it paid her the amount her health insurer contracted with her healthcare provider to pay for the services rendered. *See* Second Am. Compl. ¶ 18. Consequently, Plaintiff's claim that Progressive wrongly paid her less than the full amount she was billed turns on whether the expenses Plaintiff "incurred" in connection with receiving medical services were, as Plaintiff alleges, the full amount she was billed; or, as Progressive contends (and this Court holds), the amount her health insurer actually paid.

Progressive has demonstrated, however, that the class certified in the February 14 Order is not limited to Progressive insureds whom Progressive paid less than the amounts they were billed as a result of third-party payor contracts with their providers. Indeed, upon further review of the record, Plaintiff presented no evidence to show that the actual members of the class

predominantly would be such insureds. Rather, the proposed class includes all Progressive insureds in South Carolina whom Progressive paid less than the total amounts the insureds were billed, regardless of the reasons for the difference.⁴ See Feb. 14 Order at 13. The evidence shows that Progressive has made such "reduced" payments for a number of other reasons grounded in the Policy's terms, depending on the circumstances surrounding each class member's claim, and there is no evidence as to how many different circumstances actually are reflected in the members of the class. Thus, Plaintiff has failed to meet her burden of showing that her central contention in this case – that Progressive underpays med-pay benefits to South Carolina insureds with health insurance in breach of the Policy or in violation of South Carolina law – is common to the class the Court certified in the Order.

1. Whether Expenses Are Reasonable And Services Are Necessary Depends On Individualized Facts.

Both the class certified in the Order and the class Plaintiff now proposes would include insureds who, unlike Plaintiff herself, allegedly were paid less than the total amounts their medical providers billed because Progressive determined that the billed amounts were not "reasonable" or that the services provided were not "necessary." *Id.* ¶¶ 28-29; Policy Part II, Insuring Agreement (stating that Progressive "will pay the reasonable expenses incurred for necessary medical services"); see, e.g., See Dep. Tr. of P. Goodchild (corporate representative) at 31:15-32:21, 45:24-46:4; Dep. of P. Goodchild (individually) at 18:1-9; Dep. Tr. of R. Cole at 9:2-21 (testifying that claims must "go through Mitchell first" to determine whether the charges are "usual and customary"); Dep. Tr. of E. Zancr at 29:14-31:13 (discussing Progressive determination of "reasonable expenses" for "necessary medical services"); 46:12-16 (stating that

⁴ As discussed below, the revision to the class definition proposed in Plaintiff's Supplemental Reply does not affect this conclusion.

based on plain language of policy. Progressive will pay "reasonable expenses incurred for necessary medical service within three years"). 63:4-5 (stating that Progressive would pay insured "[w]hatever we were - reasonable and necessary amount that [insured was] legally obligated to pay"). Determining whether Progressive was entitled to pay those class members amounts less than they were billed depends on the interpretation of different Policy terms than those implicated by Plaintiff's claim - namely, "reasonable" and "necessary," rather than "expenses incurred." See Dep. Tr. of D. Lange at 21:18-21, 25:1-4 (stating that claims adjustment requires review of actual policy language) (attached as Ex. F); Dep. Tr. of E. Zaner at 27:16 - 28:3 (same). Progressive employs the DecisionPoint software to determine whether expenses are "reasonable." Dep. Tr. of P. Giordchild (corporate representative) at 31:15-32:21, 45:24-46:4.

Plaintiff argues that the Court need not concern itself with this issue because, according to Plaintiff, Progressive does not, in fact, make determinations regarding the reasonableness of medical expenses or the necessity of medical services when adjusting med-pay claims. See Pl.'s Supp. Br. at 2; Pl.'s Supp. Reply at 2-3. In other words, Plaintiff argues that Progressive simply ignores the provision of its own Policy that permits it to reduce payments to its insureds based on the reasonableness of the expenses. For this unusual proposition, Plaintiff cites testimony from several adjusters stating that they do not recall specific instances in which they personally made reasonableness determinations. See Dep. of L. Felton at 16:1-7 ("Q. Have you ever determined whether an expense is reasonable? A. If something is something, I don't understand. I will talk to my manager about it. Q. Do you recall any situations where you had to determine - A. No, I don't."); Dep. of K. Braden at 12:20-24 ("Q. Can you ever recall in the last 18 months of adjusting claims for South Carolina claimants or any other claimants whether you determined

that a medical service was not necessary? A. I don't recall."); Dep. of E. Dennis at 26:19-22 ("Q. In your four years with the med pay unit, have you taken any South Carolina Med Pay bill and not paid it because it was unreasonable or unnecessary? A. I don't recall."); Dep. of R. Cole at 25:10-12 ("Q. Have you ever returned a bill or reduced a bill because it was unreasonable or unnecessary? A. I don't recall."); Dep. of D. Lange (August 3, 2011) at 78:10-13 (testifying that she personally has not determined that a medical bill she received in connection with a med-pay claim was unreasonable).

The evidence Plaintiff cites is not convincing. None of these witnesses testified that Progressive categorically does not – or did not, within the class period – make determinations about the reasonableness of expenses or the necessity of services when it adjusts med-pay claims in South Carolina. The fact that certain individual adjusters did not personally recall specific incidences of performing such tasks, among the thousands or tens of thousands of adjustments they each have performed, is both unsurprising and not compelling. This is especially so in light of the unequivocal language in the Policy stating that Progressive will make such determinations and the uncontroverted evidence from Progressive's supervisor of med-pay claims in South Carolina that Progressive makes these determinations as a matter of policy." Dep. Tr. of P. Goodechild (corporate representative) at 31:15-32:21, 45:24-46:4.

Because Plaintiff does not contend that Progressive wrongfully reduced her med-pay reimbursement based on the "reasonable" or "necessary" terms of the Policy, resolving her claim would not resolve the claims of these class members. Instead, to resolve these class members' claims, the factfinder would have to determine, on an individual basis, whether Progressive properly concluded that the amount a given class member was billed was unreasonable, that the

services the class member received were unnecessary, or both.⁵ Courts around the country repeatedly have held that class certification is improper under such circumstances. *E.g., Great Lakes Anesthesia, PLLC v. State Farm Mut. Auto. Ins. Co.*, No. 11-10658, 2011 WL 4507417, at *1 (E.D. Mich. Sept. 29, 2011) (noting that determinations regarding what is reasonable and necessary were individual questions); *Johnson v. GEICO Cas. Co.*, 673 F. Supp. 2d 255, 273 (D. Del. 2009) (explaining that "individualized inquiries would be required to determine whether each class member's individual claim was actually medically necessary and their expenses reasonable"); *Ostrof v. State Farm Mut. Auto. Ins. Co.*, 200 F.R.D. 521, 528-529 (D. Md. 2001) (denying class certification because individualized factors involved in determining whether insurer paid "reasonable and necessary" expenses precluded commonality finding); *Ross-Randolph v. Allstate Ins. Co.*, No. DKC 99-3344, 2001 WL 36042162, at *7 (D. Md. May 11, 2001) (collecting cases reaching the same conclusion).

This Court will not depart from this established precedent. Instead, the Court holds that this issue alone is sufficient to destroy commonality, rendering class treatment inappropriate and requiring the Court to vacate its Order.

2. Resolving Plaintiff's Claim Would Not Resolve A Number Of Other Determinative Issues Under The Policy.

In addition to the individualized "reasonable" and "necessary" inquiries implicated by Plaintiff's proposed class, the factfinder also would have to resolve a number of other individualized issues to dispose of each class member's claims because the Policy language makes clear that Progressive may have paid the class members less than the full amounts they

⁵ Similarly, resolving Plaintiff's claim that Progressive violated Code § 38-77-144, which provides that med-pay coverage "is not subject to a set-off," would not resolve the individual claims of class members whose expenses Progressive deemed "unreasonable" or whose services Progressive deemed "unnecessary."

were billed for still other reasons. With its memorandum in support of its Motion, Progressive identified 39 Policy provisions under which Progressive could reduce the amount it reimburses an insured below the amount the insured's medical provider billed.

Plaintiff does not dispute that these 39 provisions are in the Policy; that Progressive applied any of those provisions in connection with her claim; or that the application of any of those provisions would be an individual issue that the Court could not resolve collectively. Instead, Plaintiff contends that these Policy provisions are irrelevant to the Court's decision because they relate only to "threshold coverage issues."⁶ See Pl.'s Supp. Br. at 1. According to Plaintiff, "Progressive's Standard Operating Procedures require that these issues be filtered prior to making any determination of whether medical bills should be processed." *Id.* Assuming that Plaintiff is correct that all 39 of the provisions are "threshold coverage issues," Plaintiff still does not explain why this renders these Policy provisions irrelevant. Regardless of when Progressive determines whether a claim meets the criteria in the Policy, it nevertheless makes that determination when adjusting a med-pay claim. In doing so, Progressive may either reduce a claim or reject it. In any event, each of these Policy provisions provides a basis for Progressive to reimburse an insured for a med-pay claim in an amount less than the amount the insured's medical provider billed.

Like reductions based on the "reasonableness" of each insured's medical expenses, reductions based on these 39 Policy provisions are inherently individualized. To resolve each class member's claims, the factfinder would have to delve into each class member's unique circumstances. And because Plaintiff does not contend that Progressive reduced her med-pay reimbursement based on any of these 39 provisions, the Court could not answer any of the

⁶ Unlike with respect to the "reasonableness" inquiry discussed above, Plaintiff does not contend that Progressive ignores these Policy provisions in practice.

questions posed by other class members by adjudicating Plaintiff's claims - which is precisely the objective of a class action. *See Gardner*, 353 S.C. at 22, 577 S.E.2d at 201 ("Requiring such individualized examination negates the benefits of a class action suit...."). Accordingly, the Court holds that there is no commonality.

3. Authority Relied Upon By Plaintiff Does Not Apply.

In arguing that she met her burden of demonstrating commonality, Plaintiff relies on the decision in *Littlefield v. South Carolina Forestry Commission*, 337 S.C. 348, 523 S.E.2d 781 (1999). Upon further review, however, the Court finds the *Littlefield* decision does not apply in this case. In *Littlefield*, the court held the class certification was appropriate because the only issue in the case was whether state agencies' interpretation of a statute governing the method of calculation of unused annual leave violated equal protection, 337 S.C. at 350, 523 S.E.2d at 782. Accordingly, in that case - unlike this one - there was, in fact "one main issue of law which [was] identical for all plaintiffs," all injuries resulted from the same conduct, and calculation of damages would not be difficult. *See id.* at 337 S.C. at 355, 523 S.E.2d at 784.

For the reasons described above, that is not the situation here. To the contrary, this is a case in which "the varying claims presented by the proposed class will require . . . intensive, individual fact-finding." *See Martin v. State Farm Mut. Auto. Ins. Co.*, 809 F. Supp. 2d 496, 510 (S.D. W. Va. 2011) (denying motion for class certification because claims that insurer did not make uninsured motorist coverage available to purported class at "commercially reasonable rates" implicated multitude of individual issues that precluded finding of commonality under *Wal-Mart*). Rather than demonstrating that the purported class members "suffered the same injury," the evidence shows that "because of the varying factual scenarios between putative class members, there are a wide variety of possible injuries - including no injury at all - caused by"

Progressive's alleged conduct. See *Martin v. JTH Tax, Inc.*, No. 9:10-cv-03016-DCN, 2013 WL 442425, at *6 (D.S.C. Feb. 5, 2013).

Consequently, "[t]his is not a typical class action where minor factual differences exist among the individualized cases of class members." See *Gardner*, 353 S.C. at 22, 577 S.E.2d at 201. To the contrary, the "factual differences" in this case "are the crux of a predominant legal issue" – i.e., whether Progressive breached the Policy or violated South Carolina law by paying the purported class members amounts less than they were billed. *Id.* On that basis, this Court adopts the reasoning of the South Carolina Supreme Court in *Gardner*, the facts of which are analogous to the facts here, and reaches the same conclusion: class certification is inappropriate.

B. Plaintiff's Unjust Enrichment Claim Does Not Implicate Common Issues.

The Court also holds that class certification is inappropriate because of the overwhelming individual issues implicated by Plaintiff's unjust enrichment claim. Plaintiff alleges, on behalf of herself and the purported class, that Progressive was unjustly enriched by "the reduced payments to the Plaintiff and class members under the medical payments portion of their insurance policies with [Progressive]." Second Am. Compl. ¶ 59. In other words, Plaintiff contends that Progressive was unjustly enriched as a result of its payments to the class members resulting from the myriad unique circumstances surrounding each class member's claims to Progressive.

Unjust enrichment is an equitable doctrine, which permits recovery of the amount that the defendant has been unjustly enriched at the expense of the plaintiff. *Dema v. Tenet Physician Servs. Hilton Head, Inc.*, 383 S.C. 115, 125, 678 S.E.2d 430, 434 (2009); *Ellis v. Smith Grading & Paving, Inc.*, 294 S.C. 470, 474, 366 S.E.2d 12, 15 (Ct. App. 1988). To recover for unjust enrichment on a classwide basis, Plaintiff must prove -- for each class member -- that (i) the class member conferred a benefit on Progressive; (ii) Progressive realized that benefit; and (iii) Progressive retained the benefit under circumstances that make it "inequitable" for Progressive to

do so "without paying . . . its value." *Sauner v. Public Serv. Auth.*, 354 S.C. 397, 409, 581 S.E.2d 161, 167 (2003).

By its very nature, an unjust enrichment claim is unsuitable for resolution on a classwide basis because adjudicating it would require the factfinder to investigate the individualized circumstances surrounding each class member's claims. In particular, the factfinder would have to determine – based on each class member's unique circumstances – whether, by paying each class member an amount less than the full amount the class member was billed (as opposed to the amount the class member or her health insurer actually paid) "it would be inequitable" for Progressive to retain the class member's premium payments. Making such a determination would require the factfinder to consider, among other things:

- Whether Progressive paid the class member an amount less than what she was billed (as opposed to what she or her health insurer paid) because that was the amount her healthcare provider contracted to receive from her third-party payor;
- Whether Progressive paid the class member an amount less than what she was billed (as opposed to what she or her health insurer paid) because it rightly determined that her medical expenses were unreasonable;
- Whether Progressive paid the class member an amount less than what she was billed (as opposed to what she or her health insurer paid) because it rightly determined that her medical treatment was unnecessary in one or more respects;
- Whether Progressive paid the class member an amount less than what she was billed (as opposed to what she or her health insurer paid) because the class member otherwise was not entitled to coverage under the Policy;

- Whether the class member had to pay any money out-of-pocket as a result of Progressive paying her less than the amount she was billed;
- Whether the class member reaped a windfall as a result of Progressive paying her any amount of money in connection with her claim because she paid no money (or less money than Progressive paid her) for the medical services she received; and
- Whether the class member derived any benefits from paying premiums to Progressive, other than Progressive paying the expenses she actually incurred from receiving medical services in connection with her claim.

Put succinctly, there is no single question the factfinder can answer in addressing Plaintiff's individual claims that also will answer all of these questions with respect to each and every class member. Accordingly, Plaintiff's unjust enrichment claim renders class certification inappropriate. *See Melton ex rel. Dutton v. Carolina Power & Light Co.*, 283 F.R.D. 280, 290 n.7 (D.S.C. 2012) (concluding that because unjust enrichment and other claims required the factfinder to make numerous "individualized determinations").

C. Plaintiff's Bad Faith And Tortious Interference Claims Do Not Implicate Common Issues.

For similar reasons, the Court holds that Plaintiff's bad faith claim is not amenable to class treatment. To state a claim for bad faith, Plaintiff must prove – with respect to herself and the purported class – that Progressive refused to pay each class member the benefits owed the class member under the Policy as a result of Progressive's "bad faith or unreasonable action in breach of an implied covenant of good faith and fair dealing." *See Temple v. Mut. of Omaha Ins. Co.*, No. 4:11-cv-00128-RBH, 2013 WL 314750, at *4 (D.S.C. Jan. 28, 2013) (construing South Carolina law). As a result, to resolve the class members' claims, the factfinder would be required

to determine, with respect to each class member, whether Progressive acted in "bad faith" or "unreasonably." Given the myriad differing situations in which the class members find themselves, as described above, the factfinder could not possibly make such a determination simply by resolving Plaintiff's claim. *See Gardner*, 353 S.C. at 22-23, 577 S.E.2d at 201 (denying class certification because factfinder would have to determine individually whether class members were "prejudiced" by defendant's alleged conduct).

Plaintiff's tortious interference claim precludes class certification for similar reasons as her bad faith claim. Namely, it would require the factfinder to determine whether Progressive intentionally procured the breach of its own contracts with the class members (assuming, for the sake of argument, that a party to a contract can state a claim for tortious interference with her own contract). *See Self v. Norfolk So. Corp.*, Nos. 1:06-cv-1730-MBS and 1:06-cv-2101-MBS, 2007 WL 540373, at *4 (D.S.C. Feb. 15, 2007). Accordingly, Plaintiff has not shown that commonality exists with respect to her bad faith or tortious interference claims.

III. Plaintiff Did Not Satisfy Her Burden Of Demonstrating That Her Claims Are Typical of the Class Members' Claims.

To meet the typicality threshold, Plaintiff must prove that her "interest in prosecuting [her] own case . . . simultaneously tend[s] to advance the interests of the absent class members." *See Dieter v. Microsoft Corp.*, 436 F.3d 461, 466 (4th Cir. 2006) (holding that named plaintiffs in antitrust class action were not typical of some purported class members because proving absent class members' claims would require "new and different proof" than evidence required to prove named plaintiffs' claims). Plaintiff thus must prove that she "possess[es] the same interest" and "suffer[ed] the same or similar injury" as the class members. *See Burton*, 2012 WL 7153877, at *3 (citing *McClain*, 105 F.3d at 903). When "variation" between a named plaintiff's claims and those of the purported class members "strikes at the heart of the respective causes of

actions," courts "have readily denied class certification. See *Dietz*, 436 F.3d at 467 (citing cases).

For the same reasons Plaintiff is an inadequate class representative and there is no commonality, Plaintiff's claims are atypical. Even if Plaintiff could prove her own claim (and she cannot), doing so would not resolve the claims of class members who are situated differently than Plaintiff. Plaintiff, therefore, has not – and cannot – establish typicality. See *Burton*, 2012 WL 7153877, at *5 (denying class certification because court found "it would be forced to sort through individualized questions . . . to determine whether each class member has a cognizable" claim); *Biggerstaff v. Voice Power Telecomm. Inc.*, No. 2002-CP-10-1351, 2003 WL 25564250, slip op. at 5 (9th Jud. Cir. Oct. 13, 2003) (denying class certification on lack of typicality grounds because "each specific fact of each member of the putative class will have to be examined to determine" liability).

IV. Plaintiff's Proposed Class Definition Is Not Adequate.

In addition to the explicit requirements set forth in SCRCP 23(a), the Court also must consider whether Plaintiff's proposed class definition is adequate. See *Cuming v. South Carolina Lottery Comm'n*, No. 3:05-cv-03608-MBS, 2008 WL 906705, at *1 (D.S.C. Mar. 31, 2008). Crafting an adequate class definition is not merely a ministerial act; it is essential to ensuring that the class action device accomplishes its goal of efficiently resolving a large number of claims in a single proceeding. If the Court must conduct individual inquiries for each potential class member merely to determine whether he or she is a member of the class, then the class definition is not "sufficiently definite so that it is administratively feasible for the [C]ourt to determine whether a particular individual is a member." See *id.* (citing 7A Charles Alan Wright, *et al.*, *Federal Practice & Procedure* § 1760 (2d ed. 1986 & Supp. 2007)); see also *Flanagan* § 23.B.1

("Many of the problems about the 'class' aspect of the representative suit are traceable to vague and ambiguous pleadings that make the class too expansive and difficult to determine its membership."). Unless the flaws in the class definition are remediable, class certification under those circumstances is improper. *See Cuming*, 2008 WL 906705, at *1.

In this case, the class definition Plaintiff proposed in her Supplemental Reply – like the class certified in the Order – is overly broad. The proposed class would include insureds of three different insurers – Progressive Casualty, Progressive Direct, and Progressive Max (the only insurer with whom Plaintiff had a relationship) – who received payments from Progressive in amounts less than they were billed for medical services for any reason. As discussed above, Plaintiff failed to demonstrate that the proposed class implicates a common question that the Court can resolve simply by adjudicating Plaintiff's claim. To the contrary, simply to determine whether a particular individual is a member of a class Plaintiff theoretically could represent – that is, a class limited to individuals whom Progressive reimbursed in amounts matching what third-party payors paid the individuals' medical providers – the Court would have to conduct "extensive factual inquiry[ies]." As a result, the class definition is inadequate. *See id.*

Plaintiff takes two different approaches to addressing the problems with the class definition. First, Plaintiff argues that this flaw in the class definition is not dispositive because "[t]he reasons for any write-downs to a medical bill are coded and explained in the Explanation of Benefits [EOB] to the insured." Pl.'s Supp. Br. at 2. This argument, however, merely underscores the inadequacy of the class definition. There is no evidence that EOBs contain detailed information about the reasons for payment reductions. In other words, Plaintiff has introduced no evidence indicating that the EOB differentiates between a reduction based on a third-party payor contract with the medical provider (as in Plaintiff's case) and a reduction based

on Progressive's determination that the insured's medical expenses were unreasonable. Moreover, even if the EOBs provided such detail, the evidence shows that the only way to identify class members based on EOBs would be to conduct a manual, file-by-file review of all of the EOBs. See Dep. Tr. of M. Silver at 27:19-28:6 (testifying that Progressive cannot ascertain "the number of persons who submitted claims and . . . didn't receive the maximum policy limits . . . and they received a payment that was less than one or more of their medical bills.").

Second, after the Court heard oral argument on Progressive's Rule 59(e) motion, Plaintiff proposed a new class definition, presumably in an effort to address Progressive's arguments regarding overbreadth. Specifically, Plaintiff proposed adding a fifth condition of class membership: to be a class member, the insured's file must contain documentation or reference to health insurance. Pl.'s Supp. Reply at 4. According to Plaintiff, this additional condition of class membership will "cull out claimants without health insurance who had a reduction." *Id.* At best, this proposal is a half-measure. As an initial matter, there is no way to determine which insureds' files contain documentation relating to health insurance without reviewing each of the files. Moreover, Plaintiff presents no evidence regarding how many potential class members might not have health insurance and thus would be excluded based on this condition. Dep. Tr. of M. Silver at 19:8-23. Put differently, there is no evidence indicating that after reviewing all of the potential class members' files for evidence of health insurance, a significant number of potential class members would be eliminated.

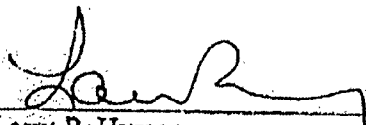
Ultimately, Plaintiff does not dispute that the only way to identify the class members in this case would be to conduct a manual file review. Instead, Plaintiff argues that the necessity of such a review is no bar to class certification reviewing "several hundred files . . . is not a large task for sophisticated insurance companies." Pl.'s Supp. Reply at 4. Plaintiff's assertion is based

on two misunderstandings of the law. First, the duty to review the files and identify the class members does not fall on Progressive; it falls on Plaintiff. See *Oppenheimer Fund, Inc. v. Sanders*, 437 U.S. 340, 358 (1978) (stating "general rule" that "representative plaintiff should perform the tasks" required to identify and notify class members, "for it is he who seeks to maintain the suit as a class action and to represent other members of his class"). More to the point here, however, the relative burden associated with conducting a manual file review is not the pertinent issue; a class definition that requires individualized factfinding to ascertain the proposed class members precludes class certification. See, e.g., *Burton*, 2012 WL 7153877, at *2 (denying class certification because, among other reasons, because based on proposed class definition, "it would be difficult to analyze . . . records . . . to determine whether a particular individual is a class member"); *Solo*, 2009 WL 4287706, at *6 (denying class certification because "[i]n order to ascertain who falls within the class, the court would have to make thousands of fact-intensive inquiries"); *Cuming*, 2008 WL 906705, at *1 (same). Accordingly, the Court holds that the class definition in the Order and the alternate class definition proposed in Plaintiff's Supplemental Reply are inadequate and that class certification thus is inappropriate.

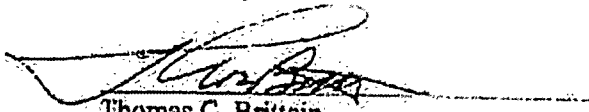
CONCLUSION

For these reasons, the Court **GRANTS** Defendants' Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification, **VACATES** its February 14, 2013 Order, and **DENIES** Plaintiff's Motion for Class Certification.

This 20 day of Aug, 2013.


Larry B. Hyman
Presiding Judge, Fifteenth Judicial Circuit

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STATE OF SOUTH CAROLINA)
COUNTY OF HORRY)

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
CIVIL ACTION NO.: 2010-CP-26-

STEPHANIE A. SMITH on behalf of
herself and all others similarly situated,

Plaintiff,

-vs-

PROGRESSIVE HALCYON
INSURANCE COMPANY, n/k/a
PROGRESSIVE DIRECT INSURANCE
CO., and PROGRESSIVE MAX,

Defendants.

COMPLAINT

*** Jury Trial Requested ***

CLERK OF COURT
JANUARY - 8 AM 8:59
COUNTY

NOW COMES the Plaintiff, above-named, complaining of the Defendants, above-named,
and does allege and show unto this Honorable Court as follows:

PARTIES

1. That the Plaintiff is a citizen and resident of the County of Horry, State of South Carolina.
2. That the Defendants, Progressive Halcyon Insurance Company n/k/a Progressive Direct Insurance Company and Progressive Max, (collectively referred to as "Progressive") are, upon information and belief, corporations organized and existing pursuant to the laws of the some other state, but conduct insurance business within the County of Horry, State of South.

JURISDICTION

3. That this Honorable Court has jurisdiction of the parties and the subject matter herein set forth, and venue is proper.

FACTS

4. That the Plaintiff was involved in a motor vehicle accident on February 23, 2009.
5. As a result of the aforesaid motor vehicle accident, the Plaintiff suffered personal injuries and received medical treatment for those injuries.
6. At the time of the accident, the Plaintiff was driving a 1997 Saab that was insured through the Defendants, under Progressive policy number 55010273-0.
7. The aforementioned insurance policy provided for medical payments coverage up to Ten Thousand and 00/100 (\$10,000.00).
8. The medical payments coverage or personal injury protection ("med pay or PIP") provides for the Defendants to pay reasonable expenses incurred for necessary medical services due to bodily injury received within three (3) years from the date of a motor vehicle accident.
9. The Plaintiff received bodily injuries in the aforesaid automobile accident, and received treatment for her injuries.
10. The Plaintiff made a claim under the policy for medical payments coverage by submitting her medical documentation, including medical bills totaling at least Five Thousand One Hundred Two and 00/100 (\$5,102.00) Dollars, to the Defendants.
11. The Plaintiff's claim was processed by Progressive's central office, Progressives' National Med Pay Unit. Upon information and belief, Progressive or Progressive's vendor used a standard software program to adjust Plaintiff's claim.
12. Defendants requested copies of Plaintiff's Explanation of Benefits (EOB's) from the Plaintiff's health insurance company.
13. The Defendants paid Two Thousand Four Hundred Eighty-Six and 67/100 (\$2,486.67) Dollars of the Ten Thousand and 00/100 (\$10,000.00) Dollars available in medical

payments coverage. Thereafter, the Plaintiff made inquiries as to the Defendants' reason for failing to pay the full amount of the Plaintiff's medical bills.

14. The Defendants failed to provide a valid reason to the Plaintiff for the reduction.

15. The Defendants have continued to deny benefits due to the Plaintiff despite processing part of Plaintiff's claim.

16. Upon information and belief, Progressive's standard practice of documenting loss under the med pay or PIP provisions is to request written health insurance documentation of such loss from its insureds.

17. The Plaintiff is informed and believes that the Defendants' practice regarding medical payments claims is to refuse to pay the full amount of the medical bills submitted under the medical payments provisions of their insured's policies. Progressive's failure to pay the entire amount of medical bills submitted by policyholders is based upon an arbitrary formula which is systematically applied to each policyholder who presents a medical payments claim. In essence, Progressive's National Med Pay Unit is attempting to enforce an artificially low medical provider pricing standard on South Carolina insureds. In addition, the adjustment process reduces payments based on health insurance information in violation of state law.

18. The Plaintiff is informed and believes that there are at least 100 other South Carolina policyholders who submitted a claim to Progressive under the personal injury protection or med pay provision of their insurance policy who did not receive payment in the amount of their medical bills.

19. The class is so numerous that joinder of all such parties is impractical.

20. The Plaintiff and those policyholders are similarly situated.

21. There are questions of law or fact common to the class. The claim of the representative party is typical of the claims of the class. The named Plaintiff will fairly and adequately protect the interests of the class and the amount in controversy for each class member exceeds One Hundred and 00/100 (\$100.00) Dollars.

22. The Class is defined as all Progressive insureds in the State of South Carolina who are residents of South Carolina and who submitted claims to any of the Progressive Insurance Companies under the personal injury protection or med pay provision of their respective South Carolina policies during the time period of October 1, 2007 to present and who did not receive payment in the amount of their medical bills.

23. Progressive Insurance Company acknowledges receipt of health claims by the Plaintiff and the Plaintiff Class and responded to the claim for personal injury protection benefits reimbursement with Progressive's standard request for the insured's health insurance Explanation of Benefits form (EOBs). Upon information and belief, Progressive uses the health insurance information and improperly reduces the amounts otherwise due based on that health insurance information. Such adjusting is directly contrary to South Carolina statutory law which mandates that Plaintiff's med pay or personal injury protection not be subject to subrogation or set off or health insurance reduction.

24. Upon information and belief, Progressive does not furnish a blank form to the insureds for proof of loss.

25. Upon information and belief, Progressive or its third party vendor systematically uses software which reduces arbitrarily the amounts paid under PIP or med pay coverage based on diagnosis codes and health insurance reimbursement amounts. Progressive systematically underpays its insureds without determining whether a provider's charge is unreasonable for the

locale and without contesting the same.

26. Upon information and belief, Progressive employs a system whereby they reduce payments under the policy by settling off or reducing amounts payable by amounts paid by health insurance carriers or other persons for such medical bills and/or by systematically reducing amounts payable through the use of a third party medical bill reduction software. Moreover, none of the policy exclusions are applicable.

27. Progressive has employed this reduction methodology ("Reduction Methodology") to reduce Progressive payments to its insureds.

28. The Reduction Methodology was used in a scheme to deceive, mislead and systematically underpay the Plaintiff Class.

29. Upon information and belief, the Nationwide Processing Office has used a Reduction Methodology, based on arbitrary, capricious and otherwise unfair claims adjustment approach to target and reduce the amount paid to Progressive policyholders. This Reduction Methodology is used on a systematic basis to increase the profits of Progressive. The Reduction Methodology is contrary to South Carolina statutory mandates.

30. As a result of the Reduction Methodology, Progressive Insurance Companies have systematically and arbitrarily adjusted claims downward and paid the Plaintiff and Plaintiff Class members less than the full amount to which they were entitled to recover.

31. In an effort to underpay, Progressive has treated its insureds adversely and underpaid their claims. Progressive Insurance Company's common pattern of practice of doing business relies on this unlawful, arbitrary and capricious Reduction Methodology.

32. At all times material, Progressive Insurance Companies knew or should have known that the Reduction Methodology was incapable of meeting its obligations under the

insurance policies and/or the law.

33. As discussed more fully below, the Progressive Insurance Companies, together with their employees and agents both known and unknown, engaged in the following regular and repeated violations of law at all material times during the class Period: (A) acting in concert with each other through the use of a systematic and arbitrary claims processing tool that furthered the Progressive Insurance Companies' common scheme to deceive, mislead, and systematically underpay the Plaintiff and the class members; (B) accepting, condoning, or permitting their employees' and agents' conduct described herein that constitutes a breach of its duty to the Plaintiff and the class members; (C) providing encouragement and substantial assistance to each other and their employees and agents in accomplishing the unlawful conduct described herein; and (D) conducting activities in conjunction with all of the named Defendants and employing, engaging, or supervising their employees and agents to carry out such lawful conduct as described herein.

34. S.C. Code Ann. §38-59-10 provides as follows: When an insurer under an insurance policy requires a written proof of loss after the notice of the loss has been given by the insured or beneficiary, the insurer or its representative shall furnish a blank to be used for that purpose. If the forms are not furnished within twenty days after the receipt of the notice, the claimant is considered to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proofs of loss written proof covering the occurrence, character, and extent of the loss for which claim is made. The twenty-day period after notice of loss to furnish forms applies to all types of insurance unless a lesser time period is specifically provided by law. (Emphasis added)

35. The Defendants did not and do not furnish proof of loss forms to the Plaintiff or Plaintiff Class within twenty days.

36. By statute, the Plaintiff and Plaintiff Class are considered to have complied with the requirements of the policy covering the occurrence, character and extent of the loss.

37. In addition, S.C. Code Ann. §38-77-144 provides, in pertinent part, as follows: If an insurer sells no-fault insurance coverage which provides personal injury protection, medical payment coverage, or economic loss coverage, the coverage shall not be assigned or subrogated and is not subject to a set off or health insurance reductions to the medical bills of the Plaintiff and Plaintiff Class.

38. The Defendants, contrary to statutory law, set off or reduce amounts payable under the Progressive policies based on health insurance payments or health insurance coding/reductions to the medical bills of the Plaintiff and Plaintiff Class. Thus, Plaintiff and Plaintiff Class are penalized for having health insurance. In addition, the Progressive policy language violates §38-59-20 inasmuch as it attempts to incorporate health insurance payments and issues into the policy, contrary to statute.

39. The Progressive Policies must comply with state laws and may be conformed to ensure such compliance.

40. Such common issues of law and fact include, but are not limited to,

a. Whether the Progressive Insurance Companies' Reduction Methodology for reducing claims for medical services, treatments, and/or supplies provided to their PIP insureds violated S.C. Code Ann. §38-59-10 et seq.

b. Whether the Plaintiff and the Class are entitled to damages, statutory penalties, attorney fees, and/or interest against the Progressive Insurance Companies for using their

Reduction Methodology to systematically underpay PIP claims in violation of S.C. Code Ann. §38-59-20 et seq. and S.C. Code Ann. §38-77-144.

c. Whether the Plaintiff and the Class are entitled to declaratory relief to determine whether the Progressive Insurance Companies' use of the Reduction Methodology violates statutory laws concerning claims adjustment, statutory law, regulatory law, the common law, or the insurance policy.

d. Whether the Plaintiff and Class are entitled to declaratory relief conforming the policies to the express statutory provisions which prohibits both a set off and a health insurance reduction.

41. Based on the facts and circumstances set forth herein, the Plaintiff's claims are typical of the claims of the class members.

42. Based on the facts and circumstances set forth herein, the Plaintiff will fairly and adequately protect and represent the interests of each class member.

43. The Plaintiff seeks to have the Defendants' practice declared violative and unlawful.

FOR A FIRST CAUSE OF ACTION AGAINST DEFENDANTS
-DECLARATORY JUDGMENT-

44. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated verbatim herein.

45. The Plaintiff and class are informed and believe that the Defendants' practices systematically violate the law and the contracts the Defendants have with the Plaintiff and various members of the class.

46. The Plaintiff and class have been damaged monetarily by failing to receive the entire amounts owed under the medical payments provisions of their policy(ics). The Plaintiff and Plaintiff Class are entitled to damages, prejudgment interest thereon plus costs.

47. The Plaintiff and Class are entitled to an Order declaring Progressive's Reduction Methodology to be violative of S.C. Code Ann. §38-59-10 et seq. by reducing amounts paid due to health insurance reductions or set offs.

48. The Plaintiff and Class are informed and believe they are entitled to an Order which conforms the policies to state law, including S. C. Code Ann. §38-59-10.

49. The Plaintiff and class are informed and believe that they are entitled to judgment by the Court declaring the Defendants' practices described above, violate the terms of the contract made between it and its policyholders; the Defendants' practices are unlawful and violate, inter alia, S.C. Code Ann. §38-59-70 and/or §38-72-144; and the Defendants must pay the amounts owed under the policies of the Plaintiff and Class, plus interest and attorney fees.

FOR A SECOND CAUSE OF ACTION AGAINST DEFENDANTS
-BREACH OF CONTRACT-

50. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated verbatim herein.

51. The Defendants have breached their contract of insurance and the breach and refusal to policy benefits to Plaintiff and Plaintiff class is without reasonable cause and in bad faith.

52. As a direct and proximate result of Defendants' breach, Plaintiff and Plaintiff Class have been deprived of benefits lawfully due under the contract of insurance; suffered the

loss of the use of the insurance proceeds; and have been compelled to retain attorneys to enforce their rights under their insurance policy(ies) with Defendants.

53. That the Plaintiff and class are informed and believe that they are entitled to judgment against the Defendants for actual, consequential and punitive damages, plus interest, and attorneys' fees and costs.

FOR A THIRD CAUSE OF ACTION
-UNJUST ENRICHMENT-

54. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated verbatim herein.

55. Plaintiff and class are informed and believe that the Defendants have been unjustly enriched at the expenses of the Plaintiff and class.

56. Such unjust enrichment is in the form of reduced payments to the Plaintiff and class members under the medical payments portion of their insurance policies with Defendants.

57. The Defendants should be held responsible for all medical bills submitted by the Plaintiff and class, up to the maximum benefit provided under their policy(ies).

58. Plaintiff and class are informed and believe that they are entitled to judgment against the Defendant in an amount to be determined by the trier of fact, representing monies the Defendants should have paid under the medical payments provisions of Plaintiff and class' policy(ies) with Defendants.

59. That Defendants' conduct has damaged the Plaintiff and class.

60. The Plaintiff and Plaintiff Class are entitled to damages, prejudgment interest and costs.

FOR A FOURTH CAUSE OF ACTION
-BAD FAITH TORT-

61. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated verbatim herein.

62. The refusal and failure of the Defendants to pay benefits due under the policy of insurance constitute an unreasonable and/or bad faith to pay insurance proceeds.

63. As a direct and proximate result of Defendants' breach, Plaintiff and class have been deprived of benefits lawfully due under the contract of insurance; suffered the loss of the use of the insurance proceeds; and have been compelled to retain attorneys to enforce their rights under their insurance policy(ies) with Defendants.

64. Plaintiff and Plaintiff Class are entitled to damages, punitive damages, plus costs.

FOR A FIFTH CAUSE OF ACTION
-UNFAIR CLAIMS PRACTICES-

65. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated verbatim herein.

66. Progressive's actions and employment of a Reduction Methodology and without the submission of claim forms, constitute an unfair claims practice in violation of, inter alia, S.C. Code Ann. §38-59-10 et seq. and §38-77-144.

67. Plaintiff and Plaintiff Class suffered damages as a result of Progressive's volative actions.

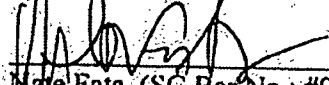
68. Plaintiff and Plaintiff Class are entitled to damages, attorney's fees per statute, punitive damages plus costs.

PRAYER

WHEREFORE, the Plaintiff prays for the following:

- a. Declaratory relief requested herein;
- b. An order requiring Defendants to recalculate monies owed under their insureds' policy(ies) for medical payments claims;
- c. An order certifying the class;
- d. Judgment against Defendants for actual damages, plus interest thereon, and punitive damages;
- e. Judgment against Defendants for actual damages, punitive damages for the individual class representative, and attorneys' fees as allowed by law;
- f. The costs of this action; and
- g. And for such other and further relief as this Court might deem just and proper.

Respectfully submitted,



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Surfside Beach, South Carolina
November 6, 2010

STATE OF SOUTH CAROLINA)
COUNTY OF HORRY)

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
CIVIL ACTION NO.: 2010-CP-26-10502

STEPHANIE A. SMITH on behalf of
herself and all others similarly situated,

Plaintiff,

-vs-

PROGRESSIVE HALCYON
INSURANCE COMPANY, n/k/a
PROGRESSIVE DIRECT INSURANCE
CO., PROGRESSIVE MAX, and
PROGRESSIVE CASUALTY
INSURANCE COMPANY,

Defendants.

**AMENDED
COMPLAINT**

*** Jury Trial Requested ***

FILED
11 MAY 31 AM 10:36
CLERK OF COURT

NOW COMES the Plaintiff, above-named, complaining of the Defendants, above-named,
and does allege and show unto this Honorable Court as follows:

PARTIES

1. That the Plaintiff is a citizen and resident of the County of Horry, State of South Carolina.
2. That the Defendants, Progressive Halcyon Insurance Company n/k/a Progressive Direct Insurance Company, Progressive Max, and Progressive Casualty Insurance Company (collectively referred to as "Progressive") are, upon information and belief, corporations organized and existing pursuant to the laws of the some other state, but conduct insurance business within the County of Horry, State of South.

JURISDICTION

3. That this Honorable Court has jurisdiction of the parties and the subject matter herein set forth, and venue is proper.

FACTS

4. That the Plaintiff was involved in a motor vehicle accident on February 23, 2009.

5. As a result of the aforesaid motor vehicle accident, the Plaintiff suffered personal injuries and received medical treatment for those injuries.

6. At the time of the accident, the Plaintiff was driving a 1997 Saab that was insured through the Defendants, under Progressive policy number 55010273-0.

7. The aforementioned insurance policy provided for medical payments coverage up to Ten Thousand and 00/100 (\$10,000.00).

8. The medical payments coverage or personal injury protection ("med pay or PIP") provides for the Defendants to pay reasonable expenses incurred for necessary medical services due to bodily injury received within three (3) years from the date of a motor vehicle accident.

9. The Plaintiff received bodily injuries in the aforesaid automobile accident, and received treatment for her injuries.

10. The Plaintiff made a claim under the policy for medical payments coverage by submitting her medical documentation, including medical bills totaling at least Five Thousand One Hundred Two and 00/100 (\$5,102.00) Dollars, to the Defendants.

11. The Plaintiff's claim was processed by Progressive's central office, Progressives' National Med Pay Unit. Upon information and belief, Progressive or Progressive's vendor used a standard software program to adjust Plaintiff's claim.

12. Defendants requested copies of Plaintiff's Explanation of Benefits (EOB's) from the Plaintiff's health insurance company.

13. The Defendants paid Two Thousand Four Hundred Eighty-Six and 67/100 (\$2,486.67) Dollars of the Ten Thousand and 00/100 (\$10,000.00) Dollars available in medical payments coverage. Thereafter, the Plaintiff made inquiries as to the Defendants' reason for failing to pay the full amount of the Plaintiff's medical bills.

14. The Defendants failed to provide a valid reason to the Plaintiff for the reduction.

15. The Defendants have continued to deny benefits due to the Plaintiff despite processing part of Plaintiff's claim.

16. Upon information and belief, Progressive's standard practice of documenting loss under the med pay or PIP provisions is to request written health insurance documentation of such loss from its insureds.

17. The Plaintiff is informed and believes that the Defendants' practice regarding medical payments claims is to refuse to pay the full amount of the medical bills submitted under the medical payments provisions of their insured's policies. Progressive's failure to pay the entire amount of medical bills submitted by policyholders is based upon an arbitrary formula which is systematically applied to each policyholder who presents a medical payments claim. In essence, Progressive's National Med Pay Unit is attempting to enforce an artificially low medical provider pricing standard on South Carolina insureds. In addition, the adjustment process reduces payments based on health insurance information in violation of state law. Progressive insureds who have health insurance receive lower payments under the PIP/med pay provision than Progressive insureds who do not have health insurance.

18. The Plaintiff is informed and believes that there are at least 100 other South Carolina policyholders who submitted a claim to Progressive under the personal injury protection or med pay provision of their insurance policy who did not receive payment in the amount of their medical bills.

19. The class is so numerous that joinder of all such parties is impractical.

20. The Plaintiff and those policyholders are similarly situated.

21. There are questions of law or fact common to the class. The claim of the representative party is typical of the claims of the class. The named Plaintiff will fairly and adequately protect the interests of the class and the amount in controversy for each class member exceeds One Hundred and 00/100 (\$100.00) Dollars.

22. The Class is defined as all Progressive insureds in the State of South Carolina who are residents of South Carolina and who submitted claims to any of the Progressive Insurance Companies under the personal injury protection or med pay provision of their respective South Carolina policies during the time period of October 1, 2007 to present and who did not receive payment in the amount of their medical bills and whose personal injury protection or med pay policy limits were not exceeded by payments from Defendants.

23. Progressive Insurance Company acknowledges receipt of health claims by the Plaintiff and the Plaintiff Class and responded to the claim for personal injury protection benefits reimbursement with Progressive's standard request for the insured's health insurance Explanation of Benefits form (EOBs). Upon information and belief, Progressive uses the health insurance information and improperly reduces the amounts otherwise due based on that health insurance information. Such adjusting is directly contrary to South Carolina statutory law which mandates that Plaintiff's med pay or personal injury protection not be subject to subrogation or

set off or health insurance reduction.

24. Upon information and belief, Progressive does not furnish a blank form to the insureds for proof of loss.

25. Upon information and belief, Progressive or its third party vendor systematically uses software which reduces arbitrarily the amounts paid under PIP or med pay coverage based on diagnosis codes and health insurance reimbursement amounts. Progressive systematically underpays its insureds without determining whether a provider's charge is unreasonable for the locale and without contesting the same.

26. Upon information and belief, Progressive employs a system whereby they reduce payments under the policy by setting off or reducing amounts payable by amounts paid by health insurance carriers or other persons for such medical bills and/or by systematically reducing amounts payable through the use of a third party medical bill reduction software. Moreover, none of the policy exclusions are applicable.

27. Progressive has employed this reduction methodology ("Reduction Methodology") to reduce Progressive payments to its insureds.

28. The Reduction Methodology was used in a scheme to deceive, mislead and systematically underpay the Plaintiff Class.

29. Upon information and belief, the Nationwide Processing Office has used a Reduction Methodology, based on arbitrary, capricious and otherwise unfair claims adjustment approach to target and reduce the amount paid to Progressive policyholders. This Reduction Methodology is used on a systematic basis to increase the profits of Progressive. The Reduction Methodology is contrary to South Carolina statutory mandates.

30. As a result of the Reduction Methodology, Progressive Insurance Companies

have systematically and arbitrarily adjusted claims downward and paid the Plaintiff and Plaintiff Class members less than the full amount to which they were entitled to recover.

31. In an effort to underpay, Progressive has treated its insureds adversely and underpaid their claims. Progressive Insurance Company's common pattern of practice of doing business relies on this unlawful, arbitrary and capricious Reduction Methodology.

32. At all times material, Progressive Insurance Companies knew or should have known that the Reduction Methodology was incapable of meeting its obligations under the insurance policies and/or the law.

33. As discussed more fully below, the Progressive Insurance Companies, together with their employees and agents both known and unknown, engaged in the following regular and repeated violations of law at all material times during the class Period: (A) acting in concert with each other through the use of a systematic and arbitrary claims processing tool that furthered the Progressive Insurance Companies' common scheme to deceive, mislead, and systematically underpay the Plaintiff and the class members; (B) accepting, condoning, or permitting their employees' and agents' conduct described herein that constitutes a breach of its duty to the Plaintiff and the class members; (C) providing encouragement and substantial assistance to each other and their employees and agents in accomplishing the unlawful conduct described herein; and (D) conducting activities in conjunction with all of the named Defendants and employing, engaging, or supervising their employees and agents to carry out such lawful conduct as described herein.

34. S.C. Code Ann. §38-59-10 provides as follows: When an insurer under an insurance policy requires a written proof of loss after the notice of the loss has been given by the insured or beneficiary, the insurer or its representative shall furnish a blank to be used for that

purpose. If the forms are not furnished within twenty days after the receipt of the notice, the claimant is considered to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proofs of loss written proof covering the occurrence, character, and extent of the loss for which claim is made. The twenty-day period after notice of loss to furnish forms applies to all types of insurance unless a lesser time period is specifically provided by law. (Emphasis added)

35. The Defendants did not and do not furnish proof of loss forms to the Plaintiff or Plaintiff Class within twenty days.

36. By statute, the Plaintiff and Plaintiff Class are considered to have complied with the requirements of the policy covering the occurrence, character and extent of the loss.

37. In addition, S.C. Code Ann. §38-77-144 provides, in pertinent part, as follows; "If an insurer sells no-fault insurance coverage which provides personal injury protection, medical payment coverage, or economic loss coverage, the coverage shall not be assigned or subrogated and is not subject to a set off." Health insurance reductions or set offs to the medical bills of the Plaintiff and Plaintiff Class violate this statutory provision.

38. The Defendants, contrary to statutory law, set off or reduce amounts payable under the Progressive policies based on health insurance payments or health insurance coding/reductions to the medical bills of the Plaintiff and Plaintiff Class. Thus, Plaintiff and Plaintiff Class are penalized for having health insurance. In addition, the Progressive policy language violates §38-59-20 inasmuch as it attempts to incorporate health insurance payments and issues into the policy, contrary to statute.

39. The Progressive Policies must comply with state laws and may be conformed to ensure such compliance.

40. Such common issues of law and fact include, but are not limited to,
- a. Whether the Progressive Insurance Companies' Reduction Methodology for reducing claims for medical services, treatments, and/or supplies provided to their PIP insureds violated S.C. Code Ann. §38-59-10 et seq.
 - b. Whether the Plaintiff and the Class are entitled to damages, statutory penalties, attorney fees, and/or interest against the Progressive Insurance Companies for using their Reduction Methodology to systematically underpay PIP claims in violation of S.C. Code Ann. §38-59-20 et seq. and S.C. Code Ann. §38-77-144.
 - c. Whether the Plaintiff and the Class are entitled to declaratory relief to determine whether the Progressive Insurance Companies' use of the Reduction Methodology violates statutory laws concerning claims adjustment, statutory law, regulatory law, the common law, or the insurance policy.
 - d. Whether the Plaintiff and Class are entitled to declaratory relief conforming the policies to the express statutory provisions which prohibits both a set off and a health insurance reduction.
41. Based on the facts and circumstances set forth herein, the Plaintiff's claims are typical of the claims of the class members.
42. Based on the facts and circumstances set forth herein, the Plaintiff will fairly and adequately protect and represent the interests of each class member.
43. The Plaintiff seeks to have the Defendants' practice declared violative and unlawful.

FOR A FIRST CAUSE OF ACTION AGAINST DEFENDANTS
-DECLARATORY JUDGMENT-

44. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated verbatim herein.

45. The Plaintiff and class are informed and believe that the Defendants' practices systematically violate the law and the contracts the Defendants have with the Plaintiff and various members of the class.

46. The Plaintiff and class have been damaged monetarily by failing to receive the entire amounts owed under the medical payments provisions of their policy(ies). The Plaintiff and Plaintiff Class are entitled to damages, prejudgment interest thereon plus costs.

47. The Plaintiff and Class are entitled to an Order declaring Progressive's Reduction Methodology to be violative of S.C. Code Ann. §38-59-10 et seq. by reducing amounts paid due to health insurance reductions or set offs.

48. The Plaintiff and Class are informed and believe they are entitled to an Order which conforms the policies to state law, including S. C. Code Ann. §38-59-10.

49. The Plaintiff and class are informed and believe that they are entitled to judgment by the Court declaring the Defendants' practices described above, violate the terms of the contract made between it and its policyholders; the Defendants' practices are unlawful and violate, inter alia, S.C. Code Ann. §38-59-70 and/or §38-72-144; and the Defendants must pay the amounts owed under the policies of the Plaintiff and Class, plus interest and attorney fees.

FOR A SECOND CAUSE OF ACTION AGAINST DEFENDANTS
-BREACH OF CONTRACT-

50. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated verbatim herein.

51. The Defendants have breached their contract of insurance and the breach and refusal to policy benefits to Plaintiff and Plaintiff class is without reasonable cause and in bad faith.

52. As a direct and proximate result of Defendants' breach, Plaintiff and Plaintiff Class have been deprived of benefits lawfully due under the contract of insurance; suffered the loss of the use of the insurance proceeds; and have been compelled to retain attorneys to enforce their rights under their insurance policy(ies) with Defendants.

53. That the Plaintiff and class are informed and believe that they are entitled to judgment against the Defendants for actual, consequential and punitive damages, plus interest, and attorneys' fees and costs.

FOR A THIRD CAUSE OF ACTION
-UNJUST ENRICHMENT-

54. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated verbatim herein.

55. Plaintiff and class are informed and believe that the Defendants have been unjustly enriched at the expenses of the Plaintiff and class.

56. Such unjust enrichment is in the form of reduced payments to the Plaintiff and class members under the medical payments portion of their insurance policies with Defendants.

57. The Defendants should be held responsible for all medical bills submitted by the Plaintiff and class, up to the maximum benefit provided under their policy(ies).

58. Plaintiff and class are informed and believe that they are entitled to judgment against the Defendant in an amount to be determined by the trier of fact, representing monies the Defendants should have paid under the medical payments provisions of Plaintiff and class' policy(ies) with Defendants.

59. That Defendants' conduct has damaged the Plaintiff and class.

60. The Plaintiff and Plaintiff Class are entitled to damages, prejudgment interest and costs.

FOR A FOURTH CAUSE OF ACTION
-BAD FAITH TORT-

61. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated verbatim herein.

62. The refusal and failure of the Defendants to pay benefits due under the policy of insurance constitute an unreasonable and/or bad faith to pay insurance proceeds.

63. As a direct and proximate result of Defendants' breach, Plaintiff and class have been deprived of benefits lawfully due under the contract of insurance; suffered the loss of the use of the insurance proceeds; and have been compelled to retain attorneys to enforce their rights under their insurance policy(ies) with Defendants.

64. Plaintiff and Plaintiff Class are entitled to damages, punitive damages, plus costs.

FOR A FIFTH CAUSE OF ACTION
-UNFAIR CLAIMS PRACTICES-

65. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated verbatim herein.

66. Progressive's actions and employment of a Reduction Methodology and without the submission of claim forms, constitute an unfair claims practice in violation of, inter alia, S.C. Code Ann. §38-59-10 et seq. and §38-77-144.

67. Plaintiff and Plaintiff Class suffered damages as a result of Progressive's volative actions.

68. Plaintiff and Plaintiff Class are entitled to damages, attorney's fees per statute, punitive damages plus costs.

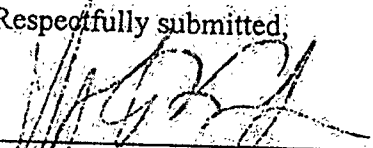
PRAYER

WHEREFORE, the Plaintiff prays for the following:

- a. Declaratory relief requested herein;
- b. An order requiring Defendants to recalculate monies owed under their insureds' policy(ies) for medical payments claims;
- c. An order certifying the class;
- d. Judgment against Defendants for actual damages, plus interest thereon, and punitive damages;
- e. Judgment against Defendants for actual damages, punitive damages for the individual class representative, and attorneys' fees as allowed by law;
- f. The costs of this action; and

g. And for such other and further relief as this Court might deem just and proper.

Respectfully submitted,


Nate Fata (SC Bar No.: #9866)

NATE FATA, P.A.

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Surfside Beach, South Carolina
May 25 2011

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
CIVIL ACTION NO.: 2010-CP-26-10502

STEPHANIE A. SMITH on behalf of
herself and all others similarly situated,

Plaintiff,

-vs-

PROGRESSIVE HALCYON
INSURANCE COMPANY, n/k/a
PROGRESSIVE DIRECT INSURANCE
CO., PROGRESSIVE MAX, and
PROGRESSIVE CASUALTY
INSURANCE COMPANY,

Defendants.

**SECOND
AMENDED
COMPLAINT**

*** Jury Trial Requested ***

12 JAN 27 PM 2:06
CLERK OF COURT

NOW COMES the Plaintiff, above-named, complaining of the Defendants, above-named,
and does allege and show unto this Honorable Court as follows:

PARTIES

1. That the Plaintiff is a citizen and resident of the County of Horry, State of South Carolina.
2. That the Defendants, Progressive Halcyon Insurance Company n/k/a Progressive Direct Insurance Company, Progressive Max and Progressive Casualty Insurance Company (collectively referred to as "Progressive") are, upon information and belief, corporations organized and existing pursuant to the laws of the some other state, but conduct insurance business within the County of Horry, State of South Carolina. They are part of the Progressive Group of Insurance Companies. Progressive Casualty adjusts all the South Carolina med pay

claims of the other Defendants, using the same adjusting procedures and policy language interpretation. This case centers on Progressive's adjusting of South Carolina med pay claims in violation of the policy language and South Carolina statutory law.

JURISDICTION

3. That this Honorable Court has jurisdiction of the parties and the subject matter herein set forth, and venue is proper.

FACTS

4. That the Plaintiff was involved in a motor vehicle accident on February 23, 2009.

5. As a result of the aforesaid motor vehicle accident, the Plaintiff suffered personal injuries and received medical treatment for those injuries.

6. At the time of the accident, the Plaintiff was driving a 1997 Saab that was insured through the Defendants, under Progressive policy number 55010273-0.

7. The aforementioned insurance policy provided for medical payments coverage up to Ten Thousand and 00/100 (\$10,000.00).

8. The medical payments coverage or personal injury protection ("med pay or PIP") provides for Defendants to pay reasonable expenses incurred for necessary medical services due to bodily injury received within three (3) years from the date of a motor vehicle accident.

9. The Plaintiff received bodily injuries in the aforesaid automobile accident, and received treatment for her injuries.

10. The Plaintiff made a claim under the policy for medical payments coverage by submitting her medical documentation, including medical bills totaling more than Five Thousand Dollars to the Defendants.

11. The Plaintiff's claim was processed by the Progressive Group of Insurance Companies' central office, Progressives' National Med Pay Unit. The National Med Pay Unit is run by Progressive Casualty which adjusts the South Carolina medical payment claims of all Progressive Group of Insurance Companies. Progressive Casualty adjusts and pays the South Carolina med pay claims. Progressive Casualty is the agent or representative of the other Defendants.

12. Defendants requested copies of Plaintiff's Explanation of Benefits (EOB's) from the Plaintiff's health insurance company.

13. Initially the Defendants paid Two Thousand Four Hundred Eighty-Six and 67/100 (\$2,486.67) Dollars of the Ten Thousand and 00/100 (\$10,000.00) Dollars available in medical payments coverage. Thereafter, the Plaintiff made inquiries as to the Defendants' reason for failing to pay the full amount of the Plaintiff's medical bills.

14. The Defendants failed to provide a valid reason to the Plaintiff for the reduction.

15. The Defendants have continued to deny benefits due to the Plaintiff despite processing part of Plaintiff's claim.

16. Upon information and belief, Progressive's standard practice of documenting loss under the med pay provisions is to request written health insurance documentation of such loss from its insureds.

17. The Plaintiff is informed and believes that the Defendants' practice regarding medical payments claims is to refuse to pay the full amount of the medical bills submitted under the medical payments provisions of their insured's policies. Progressive's failure to pay the entire amount of medical bills submitted by policyholders is based upon an arbitrary formula which is systematically applied to each policyholder who presents a medical payments claim. In

addition, the adjustment process reduces payments based on health insurance information in violation of state law. Progressive insureds who have health insurance receive lower payments under the PIP/med pay provision than Progressive insureds who do not have health insurance.

18. The policies contain the following language, "If you pay the premium for this coverage, we will pay the reasonable expenses incurred for necessary medical services received within three years from the date of a motor vehicle accident because of bodily injury". The policies do not define "incurred," or when "incurred" will be determined. Progressive Casualty has unilaterally interpreted the term "incurred" in the South Carolina policies to mean the allowed amount under the health insurance carrier's contract with a provider. The definition ascribed by Progressive Casualty to "incurred" is self-serving, illogical, and reflects the patent ambiguity in the policy language for all South Carolina med pay policies issued by the Defendants.

19. The policies contemplate that an insured incurs a liability to a medical provider at the time services are rendered and not months later when a bill is paid in part by a collateral source, such as health insurance.

20. There are at least 300 other insureds of the Progressive Group of Insurance Companies' South Carolina policies who submitted a claim under the med pay provision of their insurance policy who did not receive payment in the amount of their medical bills, i.e., the payment was reduced, and who did not exhaust their med pay limits.

21. The class is so numerous that joinder of all such parties is impractical.

22. The Plaintiff and those insureds are similarly situated.

23. There are questions of law or fact common to the class. The claim of the representative party is typical of the claims of the class. The named Plaintiff will fairly and

adequately protect the interests of the class and the amount in controversy for each class member exceeds One Hundred and 00/100 (\$100.00) Dollars.

24. The Class is defined as all Progressive Group of Insurance Companies' insureds who submitted claims to any of the Progressive Insurance Companies under the med pay provision of the respective South Carolina policies during the time period of October 1, 2007 to present and whose claims were adjusted by Progressive Casualty or another adjusting arm of Progressive and who did not receive payment in the amount of their medical bills and whose med pay policy limits were not exceeded by payments from Defendants.

25. Defendants acknowledge receipt of health claims by the Plaintiff and the Plaintiff Class and responded to the claim for medical payments benefits reimbursement with Progressive's standard request for the insured's health insurance Explanation of Benefits form (EOBs). Progressive uses the health insurance information and improperly reduces the amounts otherwise due based on that health insurance information or collateral source information. Such adjusting is directly contrary to South Carolina statutory law which mandates that Plaintiff's med pay not be subject to subrogation or set off or health insurance reduction. Progressive is subrogating in their policy interpretation by attempting to "step into the shoes" of the health insurance carrier for the contractual adjustments.

26. Defendants do not furnish a blank form to the insureds for proof of loss.

27. Defendants require proof of loss for med pay claims in the form of medical bills.

28. Upon information and belief, Progressive or its third party vendor systematically uses software which reduces arbitrarily the amounts paid under med pay coverage based on diagnosis codes and health insurance reimbursement amounts. Progressive systematically underpays its insureds without determining whether a provider's charge is unreasonable for the

locale and without contesting the same.

29. Upon information and belief, Progressive employs a system whereby they reduce payments under the policy by setting off or reducing amounts payable by amounts paid by health insurance carriers or other persons for such medical bills and/or by systematically reducing amounts payable through the use of a third party medical bill reduction software.

30. Progressive has employed this reduction methodology ("Reduction Methodology") to reduce Progressive payments to its insureds.

31. The Reduction Methodology was used in a scheme to deceive, mislead and systematically underpay the Plaintiff Class.

32. Upon information and belief, the Defendants and National Med Pay Unit has used a Reduction Methodology, based on arbitrary, capricious and otherwise unfair claims adjustment approach to target and reduce the amount paid to Progressive policyholders. This Reduction Methodology is used on a systematic basis to increase the profits of Progressive. The Reduction Methodology is contrary to South Carolina statutory mandates and policy language.

33. As a result of the Reduction Methodology, Defendants have systematically and arbitrarily adjusted claims downward and paid the Plaintiff and Plaintiff Class members less than the full amount to which they were entitled to recover.

34. In an effort to underpay, Progressive has treated its insureds adversely and underpaid their claims. Defendants' common pattern of practice of doing business relies on this unlawful, arbitrary and capricious Reduction Methodology and illogical policy interpretation.

35. At all times material, Defendants knew or should have known that the Reduction Methodology was incapable of meeting the obligations under the insurance policies and/or the law. Progressive Casualty intentionally has interfered with the contractual rights of the Class.

36. As discussed more fully below, the Progressive Group of Insurance Companies, together with their employees and agents both known and unknown, engaged in the following regular and repeated violations of law at all material times during the class Period: (A) acting in concert with each other through the use of a systematic and arbitrary claims processing tool and an arbitrary, illogical definition of "incurred" that furthered the Progressive Group Insurance Companies' common scheme to deceive, mislead, and systematically underpay the Plaintiff and the class members; (B) accepting, condoning, or permitting their employees' and agents' conduct described herein that constitutes a breach of its duty to the Plaintiff and the class members; (C) providing encouragement and substantial assistance to each other and their employees and agents in accomplishing the unlawful conduct described herein; and (D) conducting activities in conjunction with all of the named Defendants and employing, engaging, or supervising their employees and agents to carry out such lawful conduct as described herein.

37. S.C. Code Ann. §38-59-10 provides as follows: When an insurer under an insurance policy requires a written proof of loss after the notice of the loss has been given by the insured or beneficiary, the insurer or its representative shall furnish a blank to be used for that purpose. If the forms are not furnished within twenty days after the receipt of the notice, the claimant is considered to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proofs of loss written proof covering the occurrence, character, and extent of the loss for which claim is made. The twenty-day period after notice of loss to furnish forms applies to all types of insurance unless a lesser time period is specifically provided by law. (Emphasis added).

38. The Defendants did not and do not furnish proof of loss forms to the Plaintiff or Plaintiff Class within twenty days.

39. By statute, the Plaintiff and Plaintiff Class are considered to have complied with the requirements of the policy covering the occurrence, character and extent of the loss.

40. In addition, S.C. Code Ann. §38-77-144 provides, in pertinent part, as follows; "If an insurer sells no-fault insurance coverage which provides personal injury protection, medical payment coverage, or economic loss coverage, the coverage shall not be assigned or subrogated and is not subject to a set off." Health insurance subrogation, reductions or set offs to the medical bills of the Plaintiff and Plaintiff Class violate this statutory provision.

41. The Defendants, contrary to statutory law, set off or reduce amounts payable under the Progressive policies based on health insurance payments or health insurance coding/reductions to the medical bills of the Plaintiff and Plaintiff Class. Thus, Plaintiff and Plaintiff Class are penalized for having health insurance or a secondary source for payment of medical bills. In addition, the Progressive policy language violates §38-59-10 et seq. inasmuch as it attempts to incorporate health insurance payments and issues into the policy, contrary to statute.

42. The Progressive Policies must comply with state laws and may be conformed to ensure such compliance.

43. Such common issues of law and fact include, but are not limited to,

a. Whether the Progressive Insurance Companies' Reduction Methodology for reducing claims for medical services, treatments, and/or supplies provided to their med pay/PIP insureds violated S.C. Code Ann. §38-59-10 et seq.

b. Whether the Plaintiff and the Class are entitled to damages, statutory penalties, attorney fees, and/or interest against the Defendants for using their Reduction Methodology to systematically underpay med pay/PIP claims in violation of S.C. Code Ann. §38-59-10 et seq.

and S.C. Code Ann. §38-77-144 and policy language.

c. Whether the Plaintiff and the Class are entitled to declaratory relief to determine whether the Progressive Insurance Companies' use of the Reduction Methodology violates statutory laws concerning claims adjustment, statutory law, regulatory law, the common law, or the insurance policies.

d. Whether the Plaintiff and Class are entitled to declaratory relief conforming the policies to the express statutory provisions which prohibits both a set off and a health insurance reduction.

e. Whether the Defendants' arbitrary, illogical definition of an undefined term "incurred" constitutes bad faith or a breach of policy obligations.

f. Whether the Class is entitled to a determination in that their losses are fixed in the amount of their medical bills due to Defendants' failure to provide a blank proof of loss.

44. Based on the facts and circumstances set forth herein, the Plaintiff's claims are typical of the claims of the class members.

45. Based on the facts and circumstances set forth herein, the Plaintiff will fairly and adequately protect and represent the interests of each class member.

46. The Plaintiff seeks to have the Defendants' practice declared violative and unlawful.

FOR A FIRST CAUSE OF ACTION AGAINST DEFENDANTS
-DECLARATORY JUDGMENT-

47. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated verbatim herein.

48. The Plaintiff and class are informed and believe that the Defendants' practices systematically violate the law and the contracts the Defendants have with the Plaintiff and various members of the class.

49. The Plaintiff and class have been damaged monetarily by failing to receive the entire amounts owed under the medical payments provisions of their policy(ies). The Plaintiff and Plaintiff Class are entitled to damages, prejudgment interest thereon plus costs.

50. The Plaintiff and Class are entitled to an Order declaring Progressive's Reduction Methodology to be violative of S.C. Code Ann. §38-59-10, 38-77-144, et seq. and/or policy language by reducing amounts paid due to health insurance reductions or set offs. In addition the Court should declare the Defendants' definition of "incurred" to be unreasonable and indicative of a patent ambiguity or a latent ambiguity.

51. The Plaintiff and Class are informed and believe they are entitled to an Order which conforms the policies to state law, including S. C. Code Ann. §38-59-10 et seq.

52. The Plaintiff and class are informed and believe that they are entitled to judgment by the Court declaring the Defendants' practices described above, violate the terms of the contract made between it and its policyholders; the Defendants' practices are unlawful and violate, inter alia, S.C. Code Ann. §38-59-10 et. seq. and/or §38-77-144; and the Defendants must pay the amounts owed under the policies of the Plaintiff and Class, plus interest and attorney fees.

FOR A SECOND CAUSE OF ACTION AGAINST DEFENDANTS
-BREACH OF CONTRACT-

53. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated

verbatim herein.

54. The Defendants have breached their contract of insurance and the breach and refusal to policy benefits to Plaintiff and Plaintiff class is without reasonable cause and in bad faith.

55. As a direct and proximate result of Defendants' breach, Plaintiff and Plaintiff Class have been deprived of benefits lawfully due under the contract of insurance; suffered the loss of the use of the insurance proceeds; and have been compelled to retain attorneys to enforce their rights under their insurance policy(ies) with Defendants.

56. That the Plaintiff and class are informed and believe that they are entitled to judgment against the Defendants for actual, consequential and punitive damages, plus interest, and attorneys' fees and costs.

FOR A THIRD CAUSE OF ACTION
-UNJUST ENRICHMENT-

57. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated verbatim herein.

58. Plaintiff and class are informed and believe that the Defendants have been unjustly enriched at the expenses of the Plaintiff and class.

59. Such unjust enrichment is in the form of reduced payments to the Plaintiff and class members under the medical payments portion of their insurance policies with Defendants.

60. The Defendants should be held responsible for all medical bills submitted by the Plaintiff and class, up to the maximum benefit provided under their policy(ies).

61. Plaintiff and class are informed and believe that they are entitled to judgment

against the Defendant in an amount to be determined by the trier of fact, representing monies the Defendants should have paid under the medical payments provisions of Plaintiff and class' policy(ies) with and/or adjusted by Defendants.

62. That Defendants' conduct has damaged the Plaintiff and class.

63. The Plaintiff and Plaintiff Class are entitled to damages, prejudgment interest and costs.

FOR A FOURTH CAUSE OF ACTION
-BAD FAITH TORT-

64. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated verbatim herein.

65. The refusal and failure of the Defendants to pay benefits due under the policy of insurance constitute an unreasonable and/or bad faith to pay insurance proceeds.

66. As a direct and proximate result of Defendants' breach, Plaintiff and class have been deprived of benefits lawfully due under the contract of insurance; suffered the loss of the use of the insurance proceeds; and have been compelled to retain attorneys to enforce their rights under their insurance policy(ies) with Defendants.

67. Plaintiff and Plaintiff Class are entitled to damages, prejudgment interest, punitive damages, plus costs.

FOR A FIFTH CAUSE OF ACTION
-UNFAIR CLAIMS PRACTICES AND TORTIOUS INTERFERENCE-

68. Not inconsistent herewith, the Plaintiff, on behalf of herself and behalf of others similarly situated, incorporates each and every allegation in the above paragraphs, as if repeated verbatim herein.

69. Progressive's actions and employment of a Reduction Methodology and without the submission of proof of loss forms, constitute an unfair claims practice in violation of, inter alia, S.C. Code Ann. §38-59-10 et seq. and §38-77-144.

70. Plaintiff and Plaintiff Class suffered damages as a result of Progressive's violative actions.

71. Plaintiff and Plaintiff Class are entitled to damages, attorney's fees per statute, prejudgment interest, punitive damages plus costs.

72. In addition, Progressive Casualty is liable to the Plaintiff and Class for tortious interference with contracts.

73. By using its absurd definition of "incurred", Progressive Casualty has interfered with the contractual rights and procured a breach of the insurance contracts by all Progressive insurers doing business in South Carolina and for which Progressive Casualty adjusts med pay claims.

74. The Plaintiff and the Class have suffered damages as a result of the interference and Progressive Casualty is liable for the same, punitive damages plus interest, costs and attorney fees.

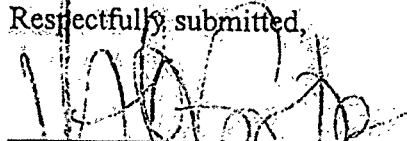
PRAYER

WHEREFORE, the Plaintiff prays for the following:

- a. Declaratory relief requested herein;
- b. An order requiring Defendants to recalculate monies owed under their insureds' policy(ies) for medical payments claims;
- c. An order certifying the class;

- d. Judgment against Defendants for actual damages, plus interest thereon, and punitive damages;
- e. Judgment against Defendants for actual damages, punitive damages for the individual class representative, and attorneys' fees as allowed by law;
- f. The costs of this action; and
- g. And for such other and further relief as this Court might deem just and proper.

Respectfully submitted,


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NATE FATA, P.A.

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Surfside Beach, South Carolina
January 25, 2012

STATE OF SOUTH CAROLINA

COUNTY OF HORRY

STEPHANIE A SMITH on behalf of herself and
all others similarly situated,

Plaintiff,

v.

PROGRESSIVE HALCYON INSURANCE
COMPANY, n/k/a PROGRESSIVE DIRECT
INSURANCE CO., PROGRESSIVE MAX, and
PROGRESSIVE CASUALTY INSURANCE
COMPANY,

Defendants.

IN THE COURT OF COMMON PLEAS

FIFTEENTH JUDICIAL CIRCUIT

Case No. 2010-CP-26-10502

**DEFENDANTS' ANSWER TO PLAINTIFF'S
SECOND AMENDED COMPLAINT**

The Defendants PROGRESSIVE HALCYON INSURANCE COMPANY, n/k/a PROGRESSIVE DIRECT INSURANCE CO., PROGRESSIVE MAX, and PROGRESSIVE CASUALTY INSURANCE COMPANY ("collectively "Defendants," and individually "Progressive Direct," "Progressive Max," and "Progressive Casualty"), answer the Plaintiff's Second Amended Complaint herein as follows:

FOR A FIRST DEFENSE

1. Each and every allegation contained in the Second Amended Complaint not hereinafter specifically admitted is denied, and strict and competent proof of such allegation is demanded.

2. The Defendants admit, upon information and belief, the allegations of Paragraph 1.

3. The Defendants admit the allegations of Paragraph 2, to the extent they allege that the Defendants are corporations organized and existing under the laws of a State other than South Carolina, that the Defendants sell insurance policies in South Carolina, that they are affiliated with the Progressive Group of Insurance Companies, and that Progressive Casualty adjusts the South Carolina MedPay claims made under South Carolina policies issued by Progressive Direct and Progressive Max, using the same adjusting procedures and policy language interpretation. The remaining allegations of Paragraph 2 are denied, and the Defendants state that this case centers on the Plaintiff's attempt to obtain money that she is not entitled to receive under her policy with Progressive Max.

4. The Defendants admit, upon information and belief, the allegations of Paragraph 3.

5. The Defendants admit the allegations of Paragraph 4.

6. The Defendants admit the allegations of Paragraph 5.

7. The Defendants admit the allegations of Paragraph 6 insofar as they allege that the Plaintiff was driving a 1997 Saab that was insured under Progressive Max policy number 55010273-0; they deny that the Plaintiff was driving any vehicle that was insured by Progressive Direct or Progressive Casualty; any allegations inconsistent with the foregoing are denied.

8. The Defendants admit the allegations of Paragraph 7 insofar as they allege that Progressive Max policy number 55010273-0 provided medical payments coverage with a policy limit of \$10,000.00, subject to the terms of coverage set forth in the applicable policy. Any allegations inconsistent with the foregoing are denied.

9. Answering the allegations of Paragraph 8, the Defendants admit that certain medical expenses are payable within three years of the date of the motor vehicle accident, as provided by and subject to the terms of the Plaintiff's Progressive Max policy, and crave reference to the specific terms of the said policy; the Defendants deny that the policy provided PIP coverage for the Plaintiff.

10. The Defendants admit the allegations of Paragraph 9, upon information and belief.

11. The Defendants admit the allegations of Paragraph 10 insofar as they allege that the Plaintiff made a claim for medical payments under her Progressive Max policy, and that her attorney made two separate submissions purporting to be her medical bills. Any allegations inconsistent with the foregoing are denied.

12. The Defendants admit the allegations of Paragraph 11 insofar as they allege that the Plaintiff's claim was adjusted by an adjuster in the Progressive Casualty National Medical Unit, which adjusts South Carolina MedPay claims arising under policies issued by all companies affiliated with The Progressive Group of Insurance Companies. The remaining allegations of said paragraph are denied.

13. The Defendants admit the allegations of Paragraph 12 to the extent that a Progressive Casualty adjuster requested said copies; all allegations inconsistent with the foregoing are denied.

14. The Defendants admit the allegations of Paragraph 13 insofar as they allege that the Plaintiff was paid \$2,486.67 based upon her attorney's initial submission of medical bills, that the Plaintiff's Progressive Max policy had limits of \$10,000.00, and that the Plaintiff's attorney

made inquiry as to the amount that was paid. All allegations inconsistent with the above are denied.

15. The Defendants deny the allegations of Paragraph 14.

16. The Defendants deny the allegations of Paragraph 15, and state further that the Plaintiff has been paid all sums due under her Progressive Max policy.

17. The Defendants deny the allegations of Paragraph 16.

18. The Defendants deny the allegations of Paragraph 17.

19. The Defendants admit the allegations of Paragraph 18 insofar as they allege that the quoted language appears in the Plaintiff's policy with Progressive Max, and that this policy does not define "incurred" or when "incurred" will be determined. The remaining allegations of said paragraph are denied.

20. The allegations of Paragraph 19 do not require a response, as they are merely conclusory statements by counsel, and not allegations of fact. To the extent that these allegations do require a response, they are denied.

21. The Defendants lack sufficient information upon which to form a belief as to the allegations of Paragraph 20, in that, as has been testified to herein, this data is collected and compiled in terms of *features* that are opened on claims, and not based upon the number of Insureds who give rise to claims. The Defendants admit, upon information and belief, and based upon present information, that more than 300 *features* have been opened in connection with MedPay claims under policies issued in South Carolina by companies affiliated with The Progressive Group of Insurance Companies, and in which payment was made in an amount less

than the total of the medical bills entered by the adjuster handling the claim, and policy limits had not been exhausted. Any allegations inconsistent with the foregoing are denied.

22. The Defendants deny the allegations of Paragraph 21.

23. The Defendants deny the allegations of Paragraph 22.

24. The Defendants deny the allegations of Paragraph 23.

25. The allegations of Paragraph 24 do not require a response, as they merely state the scope of the Plaintiff's definition of the proposed Class, and do not contain allegations of fact. To the extent that a response is required, the Defendants admit that the Plaintiff alleges and seeks to certify a Class as described in this paragraph, but deny that such a Class exists or should be certified under the applicable law.

26. The Defendants admit the allegations of Paragraph 25 insofar as they allege that Progressive Casualty received the claim submitted by the Plaintiff under her Progressive Max policy. The remaining allegations of said paragraph are denied.

27. The Defendants admit the allegations of Paragraph 26, that the policy does not require submission of a proof of loss form, and therefore no form is provided.

28. The Defendants deny the allegations of Paragraph 27.

29. The Defendants deny the allegations of Paragraph 28.

30. The Defendants deny the allegations of Paragraph 29.

31. The Defendants deny the allegations of Paragraph 30.

32. The Defendants deny the allegations of Paragraph 31.

33. The Defendants deny the allegations of Paragraph 32.

34. The Defendants deny the allegations of Paragraph 33.

35. The Defendants deny the allegations of Paragraph 34.

36. The Defendants deny the allegations of Paragraph 35.

37. The Defendants deny the allegations of Paragraph 36.

38. The Defendants admit the allegations of Paragraph 37, insofar as it purports to set forth language from the referenced statute.

39. The Defendants admit the allegations of Paragraph 38, that the subject policies do not require submission of a proof of loss form, and therefore no such form was provided.

40. The allegations of Paragraph 39 do not require a response, as they are merely conclusory statements by counsel, and not allegations of fact. To the extent that a response is required, they are denied.

41. The Defendants admit the allegations of the first sentence of Paragraph 40, insofar as it purports to set forth language from the referenced statute. The allegations of the second sentence of said paragraph are denied.

42. The Defendants deny the allegations of Paragraph 41.

43. The Defendants admit the allegations of Paragraph 42 insofar as they allege that policies issued by the Defendants must conform to State laws, and state further that the Plaintiff's Progressive Max policy (as well as all policies issued by all the Defendants) was approved by the relevant South Carolina regulatory authorities and does comply with State law; the remaining allegations of said paragraph do not require a response, as they merely state a legal conclusion. To the extent the remaining allegations require a response, they are denied.

44. The Defendants deny the allegations of Paragraph 43, and all its subparts.

45. The Defendants deny the allegations of Paragraph 44.

46. The Defendants deny the allegations of Paragraph 45.

47. The Defendants admit the allegations of Paragraph 46 that the Plaintiff seeks to have the Defendants' practices declared violative and unlawful, but deny that any legal basis exists for making such a declaration.

AS TO THE FIRST CAUSE OF ACTION
(Declaratory Judgment)

48. In response to Paragraph 47, the Defendants restate and incorporate by reference the responses to the allegations contained in Paragraphs 1 through 47.

49. The Defendants deny the allegations of Paragraph 48.

50. The Defendants deny the allegations of Paragraph 49.

51. The Defendants deny the allegations of Paragraph 50.

52. The Defendants deny the allegations of Paragraph 51.

53. The Defendants deny the allegations of Paragraph 52.

AS TO THE SECOND CAUSE OF ACTION
(Breach of Contract)

54. In response to Paragraph 53, the Defendants restate and incorporate by reference the responses to the allegations contained in Paragraphs 1 through 52.

55. The Defendants deny the allegations of Paragraph 54.

56. The Defendants deny the allegations of Paragraph 55.

57. The Defendants deny the allegations of Paragraph 56.

AS TO THE THIRD CAUSE OF ACTION
(Unjust Enrichment)

58. In response to Paragraph 57, Defendants restate and incorporate by reference the responses to the allegations contained in Paragraphs 1 through 57.

- 59. The Defendants deny the allegations of Paragraph 58.
- 60. The Defendants deny the allegations of Paragraph 59.
- 61. The Defendants deny the allegations of Paragraph 60.
- 62. The Defendants deny the allegations of Paragraph 61.
- 63. The Defendants deny the allegations of Paragraph 62.
- 64. The Defendants deny the allegations of Paragraph 63.

AS TO THE FOURTH CAUSE OF ACTION
(Bad Faith Tort)

65. In response to Paragraph 64, the Defendants restate and incorporate by reference the responses to the allegations contained in Paragraphs 1 through 64.

- 66. The Defendants deny the allegations of Paragraph 65.
- 67. The Defendants deny the allegations of Paragraph 66.
- 68. The Defendants deny the allegations of Paragraph 67.

AS TO THE FIFTH CAUSE OF ACTION
(Unfair Claims Practices and Tortious Interference)

69. In response to Paragraph 68 of the Second Amended Complaint, Defendants restate and incorporate by reference the responses to the allegations contained in Paragraphs 1 through 68.

- 70. The Defendants deny the allegations of Paragraph 69.
- 71. The Defendants deny the allegations of Paragraph 70.
- 72. The Defendants deny the allegations of Paragraph 71.
- 73. The Defendants deny the allegations of Paragraph 72.
- 74. The Defendants deny the allegations of Paragraph 73.

75. The Defendants deny the allegations of Paragraph 74.

FOR A SECOND DEFENSE
(Rule 12(b)(6), SCRCF)

76. The Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

77. The Second Amended Complaint must be dismissed pursuant to Rule 12(b)(6) of the South Carolina Rules of Civil Procedure, for failure to state a claim upon which relief can be granted.

FOR A THIRD DEFENSE
(No Private Right of Action)

78. The Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

79. No private cause of action exists for an alleged violation of the Improper Claims Practices Act, S.C. Code Ann. § 38-59-20 *et. seq.*, and all claims based thereupon must be dismissed.

80. Even if a private cause of action did exist, no claim would lie against Progressive Direct or progressive Max, neither of which adjusted this claim.

FOR A FOURTH DEFENSE
(S.C. Code Ann. § 38-77-144)

81. The Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

82. Pursuant to the applicable legal authority, Section 38-77-144 does not prevent the adjusting practices utilized by Progressive Casualty, and all claims based thereupon must be dismissed.

FOR A FIFTH DEFENSE
(Waiver)

83. The Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

84. The Defendants state that the allegations set forth in the Second Amended Complaint are barred, in whole or in part, by the doctrine of waiver.

FOR A SIXTH DEFENSE
(Estoppel)

85. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

86. Defendants state that the allegations set forth in the Second Amended Complaint are barred, in whole or in part, by the doctrine of estoppel.

FOR A SEVENTH DEFENSE
(Unclean Hands)

87. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

88. Defendants state that the allegations set forth in the Second Amended Complaint are barred, in whole or in part, by the doctrine of unclean hands.

FOR AN EIGHTH DEFENSE
(Lack of Standing)

89. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

90. Defendants state that the Plaintiff and/or some or all of the putative class members lack standing to maintain the causes of action asserted herein against one or more of the Defendants, and this action must, therefore, be dismissed.

FOR A NINTH DEFENSE
(Failure to Mitigate / Avoid Damages)

91. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

92. Defendants state that to the extent the named Plaintiff or any putative class member has suffered any damages, which Defendants deny, they have failed to mitigate or avoid their damages, and may not recover therefore.

FOR A TENTH DEFENSE
(No Damages)

93. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

94. The Plaintiff has not sustained any damages, and therefore may not recover herein; to the extent that any class member received MedPay benefits in an amount sufficient to cover any sums owed to any medical provider, plus out-of-pocket expenses and copays, said class member has not sustained any damages, and may not recover herein.

FOR AN ELEVENTH DEFENSE
(Collateral Estoppel and/or Res Judicata)

95. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

96. Defendants may have a defense of res judicata or collateral estoppel with respect to Plaintiff and/or all or some of the putative class members.

FOR A TWELFTH DEFENSE
(Accord and Satisfaction)

97. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

98. Defendants plead the defense of accord and satisfaction with respect to Plaintiff and/or all or some of the putative class members, to the extent that their claims have been fully compromised or resolved, whether with Defendants, or a third party.

FOR A THIRTEENTH DEFENSE
(Good Faith)

99. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

100. Defendants, at all times referenced herein, acted in good faith and dealt fairly and reasonably with Plaintiff and the putative class members, in accordance with the applicable law and/or the terms and conditions of the applicable insurance policies, and no recovery may be had herein.

FOR A FOURTEENTH DEFENSE
(Payment)

101. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

102. Defendants plead the defense of payment with respect to Plaintiff and/or all or some of the putative class members, to the extent that they have accepted payment under their insurance policies.

FOR A FIFTEENTH DEFENSE
(Abandonment)

103. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

104. Defendants plead the defense of abandonment with respect to Plaintiff and/or all or some of the putative class members.

FOR A SIXTEENTH DEFENSE
(Credit, Set-Off, Recoupment)

105. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

106. Plaintiff's claims, and/or those of putative class members, are barred in whole or in part by the credit(s), setoff(s) and/or recoupment(s) to which Defendants are entitled, to the extent that any component part of a claim was overpaid.

FOR A SEVENTEENTH DEFENSE
(Fraud)

107. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

108. Defendants plead the defense of fraud, of the putative class members, to the extent that any fraudulent claim has been presented to Defendants.

FOR AN EIGHTEENTH DEFENSE
(Statute of Limitations and/or Laches)

109. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

110. Defendants plead the defense of statute of limitations and/or laches with respect to the claims of the Plaintiff and/or all or some of the putative class members.

FOR A NINETEENTH DEFENSE
(Release)

111. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

112. To the extent Plaintiff's claims and/or those of the putative class members have been fully compromised or resolved, whether with Defendants or a Third Party, the claims are barred by release.

FOR A TWENTIETH DEFENSE
(Policy Exclusions)

113. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

114. Plaintiff's claims, and/or the claims of the putative class members, may be barred, in whole or in part, by the provisions, terms, conditions, exclusions and/or deductibles under their insurance policies, all of which are hereby incorporated by reference as if each were fully set forth herein.

FOR A TWENTY-FIRST DEFENSE
(Failure to Exhaust or Exclusivity of Policy Remedies)

115. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

116. The claims of the Plaintiff and the putative class members may be barred, in whole or in part, by their failure to exhaust and/or the exclusivity of remedies contained in the applicable policy.

FOR A TWENTY-SECOND DEFENSE
(Discretion)

117. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

118. This Court should exercise its discretion and decline to issue the declaratory judgment and associated relief which Plaintiff requests in this case, as such relief is not justified under the applicable law.

FOR A TWENTY-THIRD DEFENSE
(Failure to Meet Class Certification Standards)

119. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

120. This lawsuit is not appropriate for and does not meet the standards for class certification under applicable law.

FOR A TWENTY-FOURTH DEFENSE
(Plaintiff Not Proper Class Representative)

121. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

122. The named Plaintiff is not a proper or adequate representative of the purported class under the applicable law, and may not be approved as such.

FOR A TWENTY-FIFTH DEFENSE
(Lack of Privity)

123. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

124. The Plaintiff lacks privity to assert any cause against Progressive Direct or Progressive Casualty, or act as a representative for claims against these entities, as her sole contract was with Progressive Max.

FOR A TWENTY-SIXTH DEFENSE
(Constitutional Limitations on Punitive Damages)

125. The above responses and defenses are incorporated fully as if stated verbatim herein.

126. An award of punitive damages would violate the Fifth Amendment and the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution, and Article 1, Section 3 of the South Carolina Constitution in that:

- (a) Any award of punitive damages serving a compensatory function is inconsistent with due process guarantees;
- (b) Any award of punitive damages based upon the wealth of the Defendants violates due process guarantees;
- (c) The jury's unfettered power to award punitive damages in a discretionary amount completely lacks meaningful standards, is unconstitutionally vague, and is inconsistent with due process guarantees;
- (d) Even if a standard governing the imposition of punitive damages exists, such "standard" is void for vagueness; and
- (e) Plaintiffs' claim for punitive damages violates the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution in that the amount of punitive damages is based upon the wealth of the Defendants.

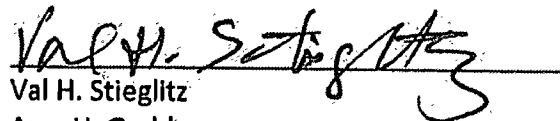
FOR A TWENTY-SEVENTH DEFENSE
(Reservation of Rights)

127. Defendants repeat and reallege each and every response heretofore contained in this Answer as if fully set forth herein verbatim.

128. Defendants reserve the right to assert, via amended pleadings, any and all additional and/or further defenses as may be revealed by additional information and/or documentation produced and/or acquired through discovery or otherwise herein.

129. Defendants reserve the right to serve amended pleadings to assert any and all other applicable defenses, to assert any and all applicable cross claims and/or counterclaims, and to implead other applicable and/or necessary third and/or fourth parties should that become essential.

WHEREFORE, having fully answered the Second Amended Complaint herein, the Defendants pray that the Second Amended Complaint be dismissed, for such costs and attorney's fees as a provided by law, and for such other and further relief as this Honorable Court may deem proper.



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Attorneys for Defendants

February 8, 2012

and other reductions which violate the law and the policy language. In essence the health insured class members get paid much less than the uninsured policyholders for the same claim. There are more than a thousand class members so joinder is impractical and numerosity exists. The class representative can fairly and adequately represent the Class and has retained experienced class counsel to do so, and the amount in controversy for each class member exceeds \$100. In addition, the Amended Complaint seeks declaratory and injunctive relief.

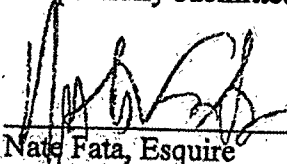
The Class is defined as any and all Progressive insureds in the State of South Carolina who are residents of South Carolina and who submitted claims to any of the Progressive Insurance Companies under the personal injury protection or med pay provision of their respective South Carolina policies during the time period of October 1, 2007 to present and who did not receive payment in the amount of their medical bills and whose personal injury protection or med pay policy limits were not exceeded by payments from Defendants.

Consultation with Defendant's counsel would serve no useful purpose.

This Motion is based on the depositions, discovery responses, pleadings and all matters to be raised at the hearing.

WHEREFORE, the Plaintiff Class Representative requests that this Court enter an Order certifying the class.

Respectfully submitted,



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Attorneys for Plaintiffs

Surfside Beach, South Carolina

August 24, 2011

pursuant to Joint Servicing Agreements. Progressive Casualty through the Joint Servicing Agreements, attached at **Exhibit "B"**, provides sales services, advertising services, underwriting services, reinsuring, premium billing and collections, commission payments and claims and policy payments. Progressive Casualty is the hub of all improper claims handling. Progressive Casualty operates the National Med Pay Unit in Jacksonville, Florida. Progressive Casualty has a team of fourteen adjusters who handle med pay claims in fifteen states, including South Carolina. The National Med Pay Unit was established in 2007-2008 so that Progressive could consolidate its claims adjusting for all its carriers under the Progressive Casualty umbrella and systematically adjust claims by region.

POLICY LANGUAGE

The policy language at issue for the Class is as follows:

If you pay the premium for this coverage, we will pay the reasonable **expenses incurred** for necessary medical services received within three years from the date of a motor vehicle accident because of bodily injury . . . (Emphasis added)

The policies do not define when "incurred" will be measured. According to Progressive Casualty's deposition testimony, for all med pay claimants under all South Carolina Progressive policies, Progressive Casualty uniformly interprets the policy phrase "expenses incurred" to mean either: (1) for those claimants with health insurance, the allowable amount under a health insurance carrier's contract with the medical provider; or (2) for those claimants without health insurance, the amount of the medical bill. In other words, if a hospital bill is reduced by a contractual adjustment from Blue Cross or Medicare, Progressive pays the lower, adjusted amount and takes advantage of the health insurance carrier's adjustment. Progressive pays less to an insured with health insurance than it pays to an uninsured claimant for an identical claim.

CLASS FACTS

Stephanie A. Smith was in an automobile wreck on February 23, 2009. She suffered personal injuries. At the time of the collision, she was driving a 1997 Saab that was insured through the Defendants. The Progressive policy is entitled Progressive Direct on the front page and is underwritten by Progressive Max Insurance Company and Progressive Direct Insurance Company. See Exhibit A, Policy and see Progressive 386. Stephanie Smith submitted medical bills exceeding Five Thousand Dollars (\$5,000) to Progressive Casualty and received less than Three Thousand Dollars (\$3,000) due to Progressive's improper med pay reductions.

Dorothy Lange, Stephanie A. Smith's claim adjuster, began working at Progressive in 2005. Lange Dep. p. 10, ln. 9-12. Her job in the national med pay unit is to make sure medical bills are processed. Lange Dep. p. 32, ln. 13-15. She reviews medical bills only to determine if the insured paid the bills out of her own pocket or if she (Dorothy) needs to pay them. Lange Dep. p. 33, ln. 4-9. The information Lange enters into the computer is the hospital bill, total charge and amount allowed, which is the amount paid from all sources to the provider. Lange Dep. p. 88, ln. 21-25. She does not review the medical bills for any other reason. She handles the med pay claims in each of the 15 states the same way. Lange Dep. p. 37, ln. 20-22. She does not determine whether a medical procedure was necessary. Lange Dep. p. 38, ln. 25 -- p. 39, ln. 2. She does not know anyone at Progressive who determines that a medical procedure was not necessary. Lange Dep. p. 39, ln. 10-13. The only question Dorothy Lange answers is whether a bill is paid or unpaid. Lange Dep. p. 44, ln. 8-15. Neither Lange nor any other adjuster determines whether a bill is too high. Lange Dep. p. 46, ln. 16 -- p. 47, ln. 6. Progressive's handling of med pay claims has not changed since 2009. Lange Dep. p. 61, ln. 7-11.

Progressive has adopted standard operation procedures (SOP) for adjusting South Carolina med pay claims. The SOP provides to recover same damage paid under health insurance. Exhibit

“_____”. Dorothy Lange does not know what that means. Lange Dep. p. 100, ln. 1-18.

Peter Goodchild, Dorothy Lange’s supervisor, testified that the medical bill is proof that the insured incurred a medical expense. Goodchild Dep. p. 10, ln. 9 -- p. 11, ln. 3. EOB’s are not required. Goodchild Dep. p. 11, ln. 21-23. Peter Goodchild is not aware of any instance in which a medical bill was repriced. Goodchild Dep. p. 15, ln. 19-21. All documents for med pay claims are scanned in. Goodchild 30(b)(6) Dep. p. 14, ln. 6-8.

Incurred is not defined in the South Carolina policy but is defined in the Virginia and Massachusetts policy. Goodchild 30(b)(6) Dep. p. 22, ln. 6. Progressive uses the same definition of incurred for each Progressive insured. Goodchild 30(b)(6) Dep. p. 23, ln. 11-24. The liability to the medical provider arises on the date of the medical service. Goodchild 30(b)(6) Dep. p. 35, ln. 22 -- p. 36, ln. 2.

Progressive does not determine when an insured is legally obligated to a medical provider. Goodchild 30(b)(6) Dep. p. 37, ln. 24 -- p. 38, ln. 8.

Progressive admits that the statute prevents a set off. Goodchild 30(b)(6) Dep. p. 24, ln. 12-- p. 25, ln. 25.

Progressive does not pay for health insurance contractual adjustments.

CLASS CLAIM

The Class claims are as follows:

1. Declaratory Judgment;
2. Breach of Contract;
3. Unjust Enrichment;
4. Bad Faith; and
5. Unfair Trade Practices.

CLASS WIDE PROOF

Class Proof is easily retrievable on liability, the Defendants have a:

1. systematic adjusting system;
2. using the same software;
3. with no variations among South Carolina insureds;
4. requiring medical bills only;
5. with medical bill charges typed into the software program;
6. using a uniform definition of "incurred";
7. in which none of the policies state when incurred is to be determined.

CLASS DEFINITION

The Class is defined as all Progressive Group of Insurance Companies' insureds who submitted claims to any of the Progressive Insurance Companies under the med pay provision of the respective South Carolina policies during the time period of October 1, 2007 to present and whose claims were adjusted by Progressive Casualty and who did not receive payment in the amount of their medical bills and whose med pay policy limits were not exceeded by payments from Defendants.

RULE 23 REQUIREMENTS ARE MET

The prerequisites of South Carolina Rules of Civil Procedure Rule 23 are met in this action:

- (a) the class is so numerous that joinder of all members is impracticable;
- (b) there are questions of law or fact common to the class;

- (c) the claims or defenses of the representative parties are typical of the claims or defenses of the class;
- (d) the representative parties will fairly and adequately protect the interests of the class; and
- (e) . . . the amount in controversy exceeds one hundred dollars for each member of the class.

In ruling on a motion for class certification, the merits of the case are not to be considered by the trial court. *Tilley v. Pacesetter Corp.*, 333 S.C. 33, 508 S.E.2d 16 (1988). Rather, the appropriate inquiry is whether or not the case is suitable for treatment as a class action. This action is extremely well suited for class treatment.

Set forth below is a brief discussion of each element and the support for meeting this procedural threshold.

1. With over 1,000 Class Members, the Class is so numerous that joinder of all members is impractical. The Defendants do not contest numerosity.
2. There are questions of law or fact common to the Class, including, but not limited to, the uniform practice of reducing payments to insureds due to improper claims adjusting, health insurance, set offs or reductions.
3. The claims of the representative parties are typical of the claims of the Class. Stephanie Smith has suffered from the same violative Progressive conduct as the other Class Members.
4. The amount in controversy for each Class Member exceeds One Hundred Dollars (\$100.00). The amount in controversy for each Class Member, when viewed in light of the Plaintiff with all relief requested including punitive damages, costs and attorney fees exceeds One Hundred Dollars (\$100.00) per person. Stephanie Smith's under payment easily exceeds One Thousand Dollars (\$1,000).

Plaintiff now more fully demonstrates to the Court how each of the prerequisites have been met pursuant to Rule 23, SCRCF.

A. Numerosity

The class is so numerous that joinder of all members of the class as Petitioner herein is impracticable. No definite standard exists as to what size class satisfies the requirements of Rule 23(a)(1). *Haywood v. Barnes*, 109 F.R.D. 568, 576 (E.D.N.C. 1986). However, where the class numbers at least 40, joinder is usually impracticable, and where the class numbers in the hundreds, joinder is clearly impracticable. *See, e.g., Swanson v. American Consumer Industries*, 415 F.2d 1326, 1333 (7th Cir. 1969) (reversing denial of class certification in a securities case involving 151 class members). The discovery responses indicate there are over 1,000 Class Members. See Defendant's discovery responses, Fourth Supplemental Responses Interrogatory Number 6. As a result, the numerosity test has been met and, accordingly, the first prong of Rule 23, SCRCF is met.¹ The Defendants do not contest numerosity.

B. Commonality

Common questions of law and fact exist as to all members of the class. The commonality requirement is liberally construed and given permissive application so that common questions have been found to exist in a wide range of contexts. *Haywood v. Barnes*, 109 F.R.D. 568, 577 (E.D.N.C. 1986). See also *McGann v. Mungo*, 287 S.C. 561, 568, 340 S.E.2d 54, 157-58 (Ct.App. 1986) holding:

It is important to note that the subsection does not demand all questions of law and fact to be common, only that there be common issues among the class. **In fact, a single common issue will suffice if it is important enough.** (Emphasis added).

In this case, common issues abound as to all insureds. See Second Amended Complaint at

¹ A class action may proceed upon estimates as to the size of the proposed class. *In re Alcoholic Beverages Litigation*, 95 F.R.D. 321 (E.D.N.Y. 1982); *Leist v. Shawano Cty*, 91 F.R.D. 64 (D. Wis. 1981); *Amswiss Int'l Corp. V. Heublein, Inc.*, 69 F.R.D. 663 (N.D. Ga. 1975).

Paragraph 43. The common issues include:

- a. Whether the Progressive Insurance Companies' practice of reducing claims for medical services, treatments, and/or supplies provided to their med pay/PIP insureds violated S.C. Code Ann. §38-59-10 et seq.
- b. Whether the Plaintiff and the Class are entitled to damages, statutory penalties, attorney fees, and/or interest against the Defendants for their practice of systematically underpaying med pay/PIP claims in violation of S.C. Code Ann. §38-59-10 et seq. and S.C. Code Ann. §38-77-144 and policy language.
- c. Whether the Plaintiff and the Class are entitled to declaratory relief to determine whether the Progressive Insurance Companies' practice of underpaying med pay claims violates statutory laws concerning claims adjustment, statutory law, regulatory law, the common law, or the insurance policies.
- d. Whether the Plaintiff and Class are entitled to declaratory relief conforming the policies to the express statutory provisions which prohibits both a set off and a health insurance reduction.
- e. Whether the Defendants' arbitrary, illogical definition of an undefined term "incurred" constitutes bad faith or a breach of policy obligations.
- f. Whether the Class is entitled to a determination in that their losses are fixed in the amount of their medical bills due to Defendants' failure to provide a blank proof of loss.

The Plaintiff is requesting declaratory relief to adjudicate the practices of Progressive in light of the statutory prohibition of med pay set offs and the policy language.

To summarize, the commonality requirement of Rule 23, SCRPC has been satisfied. Furthermore, the nature of this case makes class certification appropriate. See, *Kennedy v. S.C. Retirement System*, 24 Employee Benefits Cas. (BNA) 2859 (S.C. 2000), *withdrawn on*

unrelated grounds and superseded by substitute opinion, 345 S.C. 339, 549 S.E.2d 243, *rehearing denied*, 349 S.C. 339, 534 S.E.2d 322 (2001). In the original *Kennedy* opinion, the Supreme Court stated:

We believe the current case especially appropriate for class treatment. The number of potential plaintiffs is very large, there is one main issue of law, that issue is identical for each plaintiff, all injuries result from the same misapplication of the statute by the Retirement System, and individual calculation of damages would be simple.

See, also *Littlefield v. South Carolina Forestry Commission*, 337 S.C. 348, 521 S.E.2d 781 (1999).

As the Supreme Court has previously recognized, this type of case is ideal for class certification. A primary issue whether the undefined term incurred can be construed in favor of Progressive to disadvantage those who have health insurance. The calculation of damages should be simple. Progressive has the amount of the Class Member reductions at its disposal. Answering this common issue alone justifies class certification.

C. Typicality

The tenets of commonality and typicality most often are dealt with as one in terms of class certification. *General Telephone Company of the Southwest v. Falcon*, 457 U.S. 147, 158 (1982) (The commonality and typicality requirements of Rule 23(a) tend to merge.). The "typicality" requirement of Rule 23(a)(3), SCRPC requires that the claims or defenses of the class be typical. To satisfy the typicality requirement, the named representatives' claims must be similar enough to those of the class to assure that the class' interests are vigorously prosecuted. 7A Charles Alan Wright & Arthur R. Miller, Federal Practice & Procedure, 1764 (2d. Ed. 1986).

Here, the claims and defenses of the representative parties are typical of the claims and defenses of the class. Class Representative Smith has suffered from the underpayment. Accordingly, a common set of facts applies to all class members in accordance with *Littlefield, supra*. There is no individual advantage to proceeding separately; in fact, there is a distinct disadvantage as the individual damages of any one class member may be relatively small when

compared with potential costs of bringing this action, making the expense and burden of this litigation unjustifiable for individual actions. Further, judicial economy requires that the Court not be required to try each undecided case since to do so would take years.

D. Adequacy of Representation

South Carolina Rule of Civil Procedure 23(a)(4) requires that the named plaintiff fairly and adequately protect the interests of the class. That protection involves two factors: (1) counsel must be qualified, experienced and generally able to conduct the proposed litigation; and (2) plaintiffs' claims must be sufficiently interrelated and not antagonistic to the class claims. *Lott v. Westinghouse Savannah River Co.*, 200 F.R.D. 539 561 (D.S.C. 2000).

Here, there is no argument that Petitioner will not fairly and adequately protect the interest of the class. Petitioner's claims are typical of the class in that Petitioner and all members of the class sustained damages arising out of Defendant's uniform conduct towards the Petitioner and all members of the class as set forth in the Second Amended Complaint. Petitioner's claims are typical of the class in that Petitioner and the other class members were subjected to the same conduct and underpayment. Moreover, Petitioner has and will continue to fairly and adequately protect the interests of the class. She has provided information and has sat for two depositions. **Exhibit "___"**, Smith Affidavit. Petitioner's counsel have over a decade of experience in class actions and complex litigation. **Exhibit "___"**, Fata Affidavit.

E. Amount in Controversy

The final prong of Rule 23, SCRPC requires that each class member have a claim in excess of One Hundred Dollars (\$100.00). Here, it is undisputed that the reductions assessed against Stephanie Smith exceed One Thousand Dollars (\$1,000). The average insured has a reduction of at least One Thousand Dollars (\$1,000) based on Defendants' discovery responses.

The other relief sought includes punitive damages, attorney fees plus costs. As a result, the final prong of Rule 23, SCRCP has been met.

REQUESTED RELIEF

The Court should certify the Class to address Progresses' class wide practices.

Respectfully submitted,

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Attorneys for Plaintiff

Surfside Beach, South Carolina
October __, 2012

STATE OF SOUTH CAROLINA

COUNTY OF HORRY

STEPHANIE A SMITH on behalf of herself and
all others similarly situated,

Plaintiff,

v.

PROGRESSIVE HALCYON INSURANCE
COMPANY, n/k/a PROGRESSIVE DIRECT
INSURANCE CO., PROGRESSIVE MAX, and
PROGRESSIVE CASUALTY INSURANCE,

Defendants.

IN THE CIRCUIT COURT

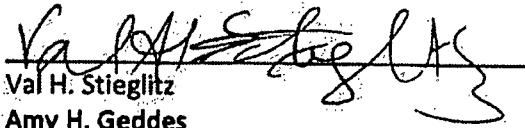
Case No. 2010-CP-26-10502

**DEFENDANTS' MOTION FOR SUMMARY
JUDGMENT AS TO ALL CAUSES OF ACTION**

HORRY COUNTY
12 OCT 31 PM 2:15
MELANIE JUBINS-WARD
CLERK OF COURT

The Defendants hereby move the Court for an Order, pursuant to SCRCP 56(b), for Summary Judgment in their favor as to all Causes of Action, on the grounds that there is no genuine issue of material fact that the Defendants' construction and application of the term "incurred" in the insurance policy herein is the sole reasonable construction and application thereof; and that the Plaintiff was reimbursed for all expenses that she "incurred," within the meaning of the applicable insurance policy and under South Carolina law, thereby entitling the Defendants to judgment as a matter of law as to all Causes of Action herein. This Motion is based upon the pleadings and record herein, the Affidavits attached hereto, such additional affidavits or other evidentiary materials as may be submitted prior to or at the hearing hereon, and the applicable law, including the precedents of the South Carolina Supreme Court.

The Defendants specifically reserve the right to move as to the specific, individual Causes of Action at a later date, if necessary.



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Attorneys for Defendants

October  2012

Columbia, South Carolina

STATE OF SOUTH CAROLINA

COUNTY OF HORRY

STEPHANIE A SMITH on behalf of herself and
all others similarly situated,

Plaintiff,

v.

PROGRESSIVE HALCYON INSURANCE
COMPANY, n/k/a PROGRESSIVE DIRECT
INSURANCE CO., PROGRESSIVE MAX, and
PROGRESSIVE CASUALTY INSURANCE,

Defendants.

IN THE CIRCUIT COURT

Case No. 2010-CP-26-10502

DEFENDANTS' BRIEF IN SUPPORT OF THEIR
MOTION FOR SUMMARY JUDGMENT AS
TO ALL CAUSES OF ACTION

HORRY COUNTY
12 OCT 31 PM 2:13
CLERK OF COURT

The Defendants, Progressive Halcyon Insurance Company, n/k/a Progressive Direct Insurance Co. ("Progressive Direct"), Progressive Max, and Progressive Casualty Insurance ("Progressive Casualty"), referred to herein collectively as "Progressive," submit this brief in support of their Motion for Summary Judgment as to all causes of action.

INTRODUCTION

This case involves MedPay benefits reimbursed to the Plaintiff under an auto insurance policy she had with Defendant Progressive Max, which provided reimbursement for reasonable medical expenses "incurred." The Plaintiff claims that she should be reimbursed not only for charges she did actually incur, but also for charges she did not incur, as that term has been interpreted and applied by standard authorities as well as the South Carolina Supreme Court.

The material facts are undisputed: the Plaintiff had a valid policy with Defendant Progressive Max, had an auto accident, was entitled to file a MedPay claim under her policy,

submitted medical bills, and received a reimbursement from Progressive Max for the full amount that Plaintiff paid on those medical bills.

A certain portion of the medical bills was not paid because this portion was not "incurred" under South Carolina Supreme Court precedent and the plain meaning of the term as it was not an amount that Plaintiff actually paid, or was ever obligated to pay. The Plaintiff contends in this action, though, that despite not paying for this disputed portion of the medical bills, or ever being obligated to do the same, she somehow "incurred" this amount thereby triggering reimbursement from Progressive Max. This issue is ripe for judgment as a matter of law,¹ and this Motion for Summary Judgment is made on the ground that, as a matter of law, the Plaintiff was indeed reimbursed all that she "incurred," and therefore all her claims fail.²

FACTUAL BACKGROUND

A. The Plaintiff Had a Policy With Just One Defendant – Progressive Max. She Had No Contract With The Other Defendants, And Progressive Direct Has No Relationship To This Claim At All.

The three Defendant companies are separate and distinct legal entities. The Plaintiff had an auto policy with Defendant Progressive Max from January 2009 through July 2009. (A copy of her policy is attached as *Exhibit 1*). She never had a policy with either of the other two Defendants – Progressive Direct or Progressive Casualty. Defendant Progressive Direct had no

¹ The Plaintiff has filed a Motion for Class Certification. This Motion for Summary Judgment is inextricably linked to the class certification issues, though, and should be decided prior to, or contemporaneously with, the Motion for Class Certification. *Player v. Maher Terminals, Inc.*, 841 F.2d 1123 (4th Cir. 1988) (unpublished) (Rule 23 does not preclude a Court from considering a motion for summary judgment before class certification is decided); *Wright v. Schock*, 742 F.2d 541 (9th Cir. 1984).

² The Defendants do not believe it will be necessary to proceed beyond this issue. However, the Plaintiff has named three separate Defendants, and asserted six causes of action against each Defendant. Each Defendant has individual, particularized grounds for Summary Judgment as to each specific claim, independent of the over-arching, global ground that the Plaintiff was indeed reimbursed all that she "incurred." The Defendants do not waive these additional arguments and specifically reserve their right to move for Summary Judgment on these additional particularized grounds, directed to each individual cause of action, in the event this case survives the instant Motion.

connection with the Plaintiff or involvement in the handling of her claim. Defendant Progressive Casualty's sole connection is that its employee adjusted the Plaintiff's MedPay claim, under a contractual arrangement with Progressive Max, by which Progressive Casualty provides claim adjustment services for Progressive Max. (Affidavit of Michael R. Uth, *Exhibit 2*).

B. The Plaintiff's MedPay Policy with Progressive Max Entitled Her to Recover Reasonable Medical Expenses That She "Incurred."

Provided several conditions of coverage were met, the Plaintiff's Progressive Max policy provided MedPay coverage.³ The MedPay portion of the Plaintiff's Progressive Max policy provided as follows:

Part II – MEDICAL PAYMENTS COVERAGE

INSURING AGREEMENT

If you pay the premium for this coverage, we will pay the reasonable expenses incurred for necessary medical services received within three years from the date of a motor vehicle accident because of bodily injury:

- 1. sustained by an insured person; and***
- 2. caused by that motor vehicle accident.***

We, or someone on our behalf, will determine:

- 1. whether the expenses for medical services are reasonable; and***
- 2. whether the medical services are necessary.***

(See Pages 6 and 7 of policy, Exhibit 1)/ (Emphasis added.)

As can be seen, the operative concept of the insuring agreement is reasonable expenses that were "incurred."

³ For example, the policy had to be in force; the claim had to be for covered treatment received within three years of an auto accident, for injuries caused by the accident; the claim had to be within policy limits; the insured must have met their duty to report promptly and provide requested information.

The Policy then enumerates various exclusions to coverage. (See page 7 of the policy).

C. The Plaintiff Had An Auto Accident, Submitted a MedPay Claim, and Was Reimbursed The Medical Expenses That She Had Incurred.

The Plaintiff was involved in a minor auto accident on February 23, 2009, and received medical treatment.⁴ She contacted Progressive Casualty and her MedPay claim was opened. She retained an attorney, who ultimately submitted two batches of medical bills to Progressive Casualty – the first batch in 2009, and the second batch in 2011.

The Plaintiff's MedPay claim was adjusted by Progressive Casualty employee Dorothy Lange. Ms. Lange is an experienced claims adjuster who worked in Progressive Casualty's National Medical Unit in Jacksonville, Florida. This unit was formed in June, 2008. Ms. Lange was part of a team that handled MedPay claims from 15 States, including South Carolina. The team leader was Medical Supervisor Peter Goodchild. (*Exhibit 3*, 10/19/11 Deposition of P. Goodchild, pg. 5, lines 2-24; *Exhibit 4*, 10/19/11 Rule 30(b)(6) Deposition of P. Goodchild, pgs. 7-8).

Ms. Lange ultimately determined that the Plaintiff was entitled to be reimbursed a total of \$3,759.21 on her MedPay claim, because the medical bills submitted by her attorney showed that was the total that the Plaintiff had "incurred," and thus the amount the Plaintiff was entitled to receive under the Progressive Max policy. Reimbursing the Plaintiff more than she actually "incurred" would have been a windfall, outside and beyond the requirements of the policy. (Affidavit of Dorothy Lange, *Exhibit 5*).

In making this determination, Ms. Lange reimbursed all the out-of-pocket payments, deductibles, and balances due shown by the Plaintiff's medical bills. She also paid the Plaintiff

⁴ After which she sued the other driver involved. That claim has been settled, with Ms. Smith receiving a net recovery of some \$18,000.00 to \$19,000.00. (*Exhibit 6*, 6/20/12 Deposition of S. Smith, pg. 17, lines 3-25; pg. 18; line 1).

whatever sums her private health insurer (Blue Cross) had paid to her medical providers – even though the Plaintiff had not herself paid her providers these sums. Ms. Lange determined these to be expenses that the Plaintiff had “*incurred*,” and which were therefore reimbursable under her policy.

There was only one item in the Plaintiff’s claim that Ms. Lange did not approve for reimbursement: *the sums by which the Plaintiff’s providers had discounted their charges, based on the providers’ agreements with Blue Cross*. Progressive Casualty does not view this contractual discount between the medical provider and the patient’s private health insurer as a charge “*incurred*” by a policyholder, and therefore does not reimburse it.

A brief explanation of how a MedPay claim works will assist the Court in understanding how this interpretation of “*incurred*” works in practicality.

D. How Does A Typical MedPay Claim Work?

Progressive Casualty is typically presented with one of two basic scenarios in a MedPay claim.

In Scenario One, the MedPay insured does not carry any private health insurance. In this scenario, when their doctor charges the Progressive insured \$500 for a service, the Progressive MedPay insured is expected, and obligated, to pay the doctor the whole \$500. In this scenario, Progressive Casualty would consider their insured as having “*incurred*” a \$500 expense, and would reimburse the insured \$500.

In Scenario Two, the MedPay insured does carry private health insurance. In this scenario, the health insurance company typically has a contractual arrangement with the doctor under which the doctor has agreed to discount his customary rates for medical services when rendering

those medical services to an insured of the health insurance company. Thus, using our \$500 example, the doctor may indeed generate a bill to the patient that shows a customary rate of \$500 for the particular service; but then the bill reflects the discounted charge of \$300 for the service, based upon the arrangement in the contract between the health insurer and the provider, such that the Progressive MedPay insured is actually only responsible for and obligated to pay the provider \$300 – not \$500. In this scenario, Progressive Casualty considers the insured as having "incurred" a \$300 expense, and reimburses the insured \$300. Reimbursing the insured the entire \$500 would be a windfall, beyond what either party contracted for, or what the policy requires.

Importantly, though, if a provider claims that the Progressive insured still owes it an amount, or that the reimbursement from the Progressive insured's private health insurer was insufficient, Progressive will pay what is necessary to make sure that its MedPay insured does not owe anything to their provider. (*Exhibit 3*, 10/19/11 Deposition of P. Goodchild, p. 19, lines 10-25; p. 20, lines 1-25; p. 21, lines 1-3).

The Plaintiff in this case is in Scenario Two (she had Blue Cross health insurance through her employer), but claims that she "incurred" the whole \$500 (using our example), even though she was only responsible for paying the \$300. She claims that the difference – the \$200 – represents policy benefits that she was wrongfully denied. Each of her causes of action is based on the proposition that she "incurred" the amount of this discount, was not paid for this discount, and was therefore denied a policy benefit. The Court's construction of the term "incurred," therefore, is the linchpin to each and every cause of action.

E. The Plaintiff Was Reimbursed All Sums Except The Provider / Insurer Discounts, Which Is The Sum The Plaintiff Seeks To Recover In This Action.

There is no factual dispute as to how the definition of "incurred" was applied to the Plaintiff's claim. As described, Ms. Lange reviewed each medical bill and reimbursed all out-of-pocket payments, deductibles, and outstanding balances shown on the bills.⁵ She also reimbursed the amounts which, according to the bills, Ms. Smith's health insurer had paid to her providers. The only thing Ms. Lange did not reimburse were the amounts of the provider/insurer discounts shown on the bills. (See, D. Lange Affidavit, *Exhibit 5*).

The Plaintiff has advanced no evidence that Progressive failed to reimburse her as described by Ms. Lange, or that she owes any medical provider any sum for treatment resulting from her accident. She testified that when she received a check on her claim, she "reimbursed [herself] for some of the copays and deductibles and paid more medical bills, paid for the rental car," and is not aware of any "copays or deductibles on medical bills that were unpaid after [she] received her Progressive MedPay money." (*Exhibit 6*, 8/30/11 Deposition of S. Smith, pg. 55, lines 12-25; pg. 56, lines 1-15). No provider has taken any action to collect any sum from her, or any action against her credit. What she is seeking to recover in this action is the "difference" between the "total" charges on her medical bills, and the sum Progressive reimbursed her. (*Exhibit 6*, 6/20/12 Deposition of S. Smith, pg. 8, lines 4-11, 14-20; pg. 9, lines 14-18; pg. 11, lines 20-25; pg. 12, lines 1-9). This "difference" is the provider / Insurer discount discussed above, as all other charges were reimbursed.

Thus, the undisputed facts are:

⁵ Ms. Lange approved payment of a \$330.00 bill from the Conway ER Physicians in full, as that bill showed no provider/insurer discount. (*Exhibit 7*, 8/3/11 Rule 30(b)(6) Deposition of D. Lange, p. 65, lines 15-25; p. 66, lines 1-2).

- The Plaintiff had a MedPay policy with Progressive Max.
- The Plaintiff's policy provided for reimbursement of reasonable medical expenses "incurred."
- The Plaintiff was in an auto accident and submitted a claim, which met the conditions for MedPay coverage. Through her counsel, the Plaintiff submitted various medical bills for her treatment.
- Dorothy Lange with Progressive Casualty reviewed the bills. Some of the bills reflected the provider's customary rate for the particular service rendered, followed by the discounted charge for the service that was actually due, based upon the provider's arrangement with Blue Cross. Ms. Lange's Supervisor, Peter Goodchild, reviewed Ms. Lange's claim decisions and approved them.
- The Plaintiff was reimbursed all her out-of-pocket expenses, deductibles, and balances due any provider; she was also reimbursed for whatever sums Blue Cross had paid her providers. If she has any such expenses that are have not been reimbursed and were timely submitted, they will be paid – but she has come forward with none.
- The only sums not reimbursed were the amounts of the provider/insurer discounts.

There is no material factual issue. There is, however, one legal issue which the Defendants submit entitles them to Summary Judgment:

- Based on the way South Carolina precedent has interpreted the term, were the Insurer/provider discounts "incurred," and therefore payable under the policy?

Or were these discounts not "incurred," and therefore not payable, in which case all of the Plaintiff's claims fail?

The Defendants contend that under the law and precedents of South Carolina, as a matter of law, the insurer/provider discounts were not "incurred," and Summary Judgment should therefore be entered for the Defendants on all claims.

STANDARD OF REVIEW

"Summary judgment is appropriate when it is clear that there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law." *Duncan v. CRS Serrine Engineers, Inc.*, 337 S.C. 537, 543, 524 S.E.2d 115, 118 (S.C. App. 1999)(citing *Baird v. Charleston County*, 511 S.E. 2d 69, 74 (1999)). A motion for summary judgment shall be granted if pleadings, depositions, answers to interrogatories, admissions on file, and affidavits show that there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. *Fire Ins. Co. v. Marine Contracting and Towing Co.*, 392 S.E.2d 460, 462 (1990). "[W]hen plain, palpable, and indisputable facts exist on which reasonable minds cannot differ, summary judgment should be granted." *Staubes v. City of Folly Beach*, 331 S.C. 192, 197, 500 S.E.2d 160, 163 (S.C. App. 1998), *affirmed*, 2000 WL 294556 (March 20, 2000) (citing *Trico Surveying, Inc. v. Godley Auction Co.*, 431 S.E.2d 565 (1993)). Significantly, where the construction and enforcement of an unambiguous contract is involved, the question is one of law for the Court and is properly disposed of at summary judgment. *Hansen ex rel. Hansen v. United Services Auto Ass'n*, 350 SC 62, 68, 565 S.E.2d 114, 116 (Ct. App. 2002).

LEGAL ARGUMENT

The Plaintiff has asserted Causes of Action against each Defendant for:

- A Declaratory Judgment (seeking declarations concerning the Interpretation of "Incurred" in the policy, the Defendants' application of the term, and an Order requiring the Progressive policy to be "conformed" to comply with South Carolina law);
- Breach of Contract (claiming that the Plaintiff did not receive her policy benefits);
- Unjust Enrichment (claiming that the Defendants retained policy benefits that were rightfully due to the Plaintiff);
- Bad Faith (claiming that the Defendants refused to pay the Plaintiff her policy benefits unreasonably and in bad faith);
- Unfair Claims Practices (claiming that the Defendants violated S.C. Code Ann. section 38-59-10, *et seq.* and section 38-77-144); and
- Tortious Interference with Contract (against Progressive Casualty).

All of these claims depend upon the proposition that the negotiated discount between the Plaintiff's medical providers and Blue Cross was actually "incurred" by her. Thus, all of the Plaintiff's claims fail if her construction of "incurred" is contrary to the law and precedents of South Carolina.

I. **AS A MATTER OF LAW, THE PLAINTIFF WAS REIMBURSED ALL THAT SHE "INCURRED," RECEIVED ALL HER POLICY BENEFITS, AND SUMMARY JUDGMENT IS PROPER; THE COURT WOULD HAVE TO IGNORE SOUTH CAROLINA SUPREME COURT PRECEDENT TO FIND OTHERWISE.**

As noted, there are no factual disputes concerning what the Plaintiff was reimbursed under the policy. Judgment as a matter of law is proper here because controlling South Carolina precedent has held "incurred" to be unambiguous and to apply only to expenses that a MedPay insured actually owes or pays. As the Plaintiff did not pay or owe the Insurer/provider discounts, she therefore did not "incur" them.

A. **Interpretation of an unambiguous term in an insurance policy is a matter of law;**

An Insurance policy is a contract. When a contract is unambiguous, construction is a matter of law for the Court, and may be resolved through summary judgment. *Hope Petty Motors of Columbia, Inc. v. Hyatt*, 310 S.C. 171, 425 S.E.2d 786 (Ct. App. 1992); *Thomas v. Jeffcoat*, 230 S.C. 126, 94 S.E.2d 240 (1956); *Rhame v. National Grange Mutual Ins. Co.*, 238 S.C. 539, 121 S.E.2d 94 (1961); *Employers Reinsurance Corp. v. Marsh*, 1992 WL 192372 (4th Cir. 1992); *Hansen ex rel. Hansen v. United Services Auto. Ass'n*, 350 S.C. 62, 565 S.E.2d 114 (Ct. App. 2002).

B. The term "incurred" is unambiguous, and therefore properly construed as a matter of law:

The term "incurred" in the Progressive Max policy is unambiguous for two reasons: First, the South Carolina Supreme Court has held the term to be so clear as not to require judicial construction. Second, the word has a plain, ordinary meaning, as reflected in numerous dictionary definitions, and words that have plain meanings are not ambiguous.

i) The South Carolina Supreme Court has held that "Incurred" is not ambiguous and means expenses a MedPay Insured has paid or owes:

In *Gordon v. Fid. & Cas. Co. of NY*, 238 S.C. 438, 441, 120 S.E.2d 509, 512 (1961), the South Carolina Supreme Court held that the term "Incurred" in a MedPay policy was not ambiguous or uncertain, but instead was "too plain to call for judicial construction." Applying the plain meaning of the word, the Supreme Court held that the Plaintiff in *Gordon* had not "incurred" medical charges which he was not obligated to pay – which is precisely the situation in the case at bar.

Thus, *Gordon* disposes of the Plaintiff's claims entirely.

In *Gordon*, a career soldier had a MedPay policy with Fidelity & Casualty. The policy required the insurer to pay "reasonable expenses incurred" – language identical to the language in the Plaintiff's Progressive Max policy. The soldier was hospitalized in an army hospital for

treatment of certain injuries. He was not charged and had no obligation to pay for his treatment, though, due to his military status. Nonetheless, he submitted a claim under his MedPay policy for the value of the treatment, contending that he had *incurred* the charges even though he had not paid them and was not obligated to pay them. Fidelity & Casualty denied the claim, and Gordon sued. The South Carolina Supreme Court held that:

- “*Incurred*” is not an ambiguous term, but instead has a plain meaning – so plain as to not even require judicial construction.
- Looking to such sources as Webster’s and Black’s Law Dictionary, “*incurred*” revolves around an obligation to pay; “*incur* emphasizes the idea of liability”; *incur* means “to have liabilities thrust upon one by act or operation of law.”
- Fidelity & Casualty had contractually limited its obligation to paying “all reasonable expenses *incurred*,” and because the soldier had not actually paid anything and did not owe anything, he had not *incurred* any “expense within the meaning of the provision of the policy.” Thus, Fidelity & Casualty was correct in refusing to pay the claim.

The *Gordon* holding was reiterated in *McMehan v. York County Council*, 281 S.C. 249, 252, 315 S.E.2d 127, 129 fn 1 (Ct. App. 1984), where the Court of Appeals quoted approvingly from the *Gordon* language. See also, *Davis v. Southern Life Ins. Co.*, 249 S.C. 194, 153 S.E.2d 399 (1967).

The Plaintiff in the case at bar is attempting to do exactly what the S.C. Supreme Court held the *Gordon* Plaintiff could not do – recover sums that she was never actually obligated to pay her medical providers, and did not pay her medical providers. The *Gordon* Court held that such sums were not actually “*incurred*,” and therefore were not payable under policy language identical to the Progressive Max policy language.

In short, the Plaintiff’s case can survive Summary Judgment only if this Court ignores the holding in *Gordon*.

II) Dictionary and reference sources approved by the South Carolina Supreme Court define "incurred" in the same way as the Gordon Court:

Even if the *Gordon* case did not exist, Summary Judgment would still be proper, because "*incur*" has a plain, ordinary meaning which compels the conclusion that the insurer/provider discount is not, in fact, "*incurred*." The plain meaning of the term is evident by reference to standard dictionaries.

South Carolina courts have repeatedly recognized that dictionaries are appropriate places to find the plain, ordinary meaning of words. For example: *Heilker v. Zoning Bd. Of Appeals for City of Beaufort*, 346 S.C. 401, 409, 552 S.E.2d 42, 46 (Ct. App. 2001)(dictionaries useful to determine meanings of words where there is no applicable case authority); *Super Duper, Inc. v. Pennsylvania Nat'l Mut. Cas. Ins. Co.*, 385 S.C. 201, 210, 683 S.E.2d 792, 796 (2009)(looking to Webster's Dictionary for definition of the term "misappropriation"); *S.C. Farm Bureau Mut. Ins. Co. v. Oates*, 356 S.C. 378, 382-383, 588 S.E.2d 643, 646 (Ct. App. 2003)(using Black's Law Dictionary to determine the common definition of "abuse," for purposes of ascertaining whether exclusion in insurance policy applied); *Estate of Chappell v. Gillespie*, 327 S.C. 617, 624, 491 S.E.2d 267, 270 (Ct. App. 1997)(referencing the Oxford English Dictionary, the American Heritage Dictionary, and Black's Law Dictionary for meaning of "create"); *State v. Varvil*, 338 S.C. 335, 343, 526 S.E.2d 248, 252 (Ct. App. 2000)(consulting Webster's Dictionary for meaning of "repeatedly"); *State v. Ellisor*, 259 S.C. 364, 368-369, 192 S.E.2d 188, 189 (1972)(applying definitions of "physically" and "unable" from the Oxford English Dictionary); *Santee Cooper Resort, Inc. v. SC Public Service Commission*, 298 S.C. 179, 184, 379 S.E.2d 119, 122 (1989)(looking to Black's Law Dictionary for meaning of word "stay"). The Plaintiff herself agrees that it is logical to look to a dictionary for the definition of a word: "*That's going to be the best possible definition*

understood by the largest number of people.” (Exhibit 6, 8/30/11 Deposition of S. Smith, p. 72, lines 17-15; p. 73, lines 1-21.)

Standard dictionaries provide a plain meaning of the word “*incurred*” that is consistent with the *Gordon* definition. For example: Webster’s Dictionary: “*to become liable or subject to; to bring down upon ones’ self; to encounter; to contract; as, to incur debt...*”; Oxford English Dictionary: “*to run into; to render oneself liable to (damages); to run or fall into (some consequence usually undesirable or injurious); to become through one’s own action liable or subject to; to bring upon oneself...*”; American Heritage Dictionary: “*to come into or acquire (some consequence, usually undesirable or injurious): to incur a huge number of debts; to become liable or subject to through one’s own action; bring or take upon oneself: to incur his displeasure.*”

All of these definitions are completely inconsistent with the Plaintiff’s argument that she “*incurred*” the Insurer/provider discount even though she never paid it, and never had an obligation to pay it. In contrast, these definitions are completely consistent with the Progressive Casualty interpretation that the Plaintiff was, indeed, reimbursed all that she had “*incurred*.”

Black’s Law Dictionary also addresses the definition of “*incurred*.” This reference is particularly significant because Progressive Casualty Medical Supervisor Peter Goodchild consulted Black’s when the Progressive Casualty National Medical Unit began to adjust MedPay claims in 2008 and took on the task of developing a working definition of “*incurred*.” (*Exhibit 4*, 10/19/11 Rule 30b6 deposition of P. Goodchild, pg. 80, lines 20-25, through 8. 84, line 6; pg. 97, lines 1-11.) Also, as noted, the *Gordon* Court adopted the Black’s Law Dictionary definition of the term. Black’s Law Dictionary (8th ed. 2004) defines “*incur*” as follows: “to suffer or bring on

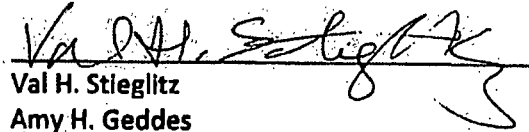
oneself (a liability or expense)." Again, this is completely consistent with the way Progressive Casualty applied the term to the Plaintiff's claim.

C. Under the foregoing authorities, the Defendants are entitled to Summary Judgment as to all claims because, as a matter of law, the Plaintiff was reimbursed all that she "incurred."

As discussed above, the South Carolina Supreme Court has held that the term "incur" in a MedPay policy that provides reimbursement of medical expenses "incurred," is not ambiguous, and that under its plain meaning a MedPay insurer is not required to reimburse sums that were not actually paid by or owed by an Insured. Unless this Court wishes to ignore *Gordon*, therefore, it must grant Summary Judgment as to all the Plaintiff's claims, because it is undisputed that she has been reimbursed all that she actually paid or owed any medical provider, and thus all that she "incurred." All of the Plaintiff's claims rest upon the proposition that she has been denied policy benefits to which she was entitled. Since no further policy benefits are due as a matter of law, however, she has no claims against the Defendants.

CONCLUSION

For the reasons set forth above, the Defendants' Motion for Summary Judgment should be granted.



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Attorneys for Defendants

October 30, 2012
Columbia, South Carolina

STATE OF SOUTH CAROLINA

COUNTY OF HORRY

STEPHANIE A SMITH on behalf of herself and
all others similarly situated,

Plaintiff,

v.

PROGRESSIVE HALCYON INSURANCE
COMPANY, n/k/a PROGRESSIVE DIRECT
INSURANCE CO., PROGRESSIVE MAX, and
PROGRESSIVE CASUALTY INSURANCE,

Defendants.

IN THE CIRCUIT COURT

Case No. 2010-CP-26-10502

DEFENDANTS' MEMORANDUM IN
OPPOSITION TO PLAINTIFF'S MOTION FOR
CLASS CERTIFICATION

FILED
12 NOV - 2 PM 2:17
CLERK OF COURT
HORRY COUNTY

Plaintiff Stephanie Smith ("Plaintiff") purports to bring this action on behalf of an overly broad and ill-defined class of individuals, many of whom lack even a tangential connection to Plaintiff's claims, based upon an interpretation of a term in a MedPay policy that has been rejected by the South Carolina Supreme Court.¹ Moreover, the Plaintiff cannot satisfy the fundamental requirements under SCRCP 23 for class certification that the proposed class share common claims, that the class representative's claims be typical of the claims of other class members, and that the class representative be "adequate." Accordingly, this case should not be certified as a class action.

¹ The Defendants have filed a Motion for Summary Judgment on the dispositive issue that the South Carolina Supreme Court's holding in *Gordon v. Fidelity & Casualty Co.*, 238 S.C. 438, 120 S.E.2d 509 (1961) controls this case, and the Plaintiff has no claim under this precedent. The Court should consider Defendants' Motion for Summary Judgment before deciding class certification, as the issues are so inextricably intertwined. *Player v. Maher Terminals, Inc.*, 841 F.2d 1123 (4th Cir. 1988)(unpublished)(holding that Rule 23 does not preclude Court from considering summary judgment prior to class certification); *Wright v. Schock*, 742 F.2d 541 (9th Cir. 1984.)

A. Plaintiff's Purported Claims

This case involves the medical payment ("MedPay") coverage portion of an auto insurance policy the Plaintiff had with Defendant Progressive Max Insurance Company ("Progressive Max") from January through July, 2009.² Through her attorney, the Plaintiff made a claim on her Progressive Max MedPay coverage following a minor auto accident in February 2009. Her attorney ultimately submitted one group of medical bills in 2009, and another group of medical bills in September, 2011. Progressive paid the full amount due under the policy on both sets of bills (\$3,759.21) – and, more importantly, the full amount that the Plaintiff had actually paid or was responsible for paying. But the Plaintiff now claims that Progressive should have reimbursed her *above and beyond* the contractually-required amount of her bills, and more than she actually paid or was responsible for paying, based on her own flawed and nonsensical interpretation of the term "*incurred*" in her Progressive Max policy;³ an interpretation that is not only unsupported by any recognized authority, but is in direct contravention to the South Carolina Supreme Court's prior determination of the meaning of "*incurred*."

1. Plaintiff's Progressive Max Policy Covered Certain Expenses "Incurred."

The MedPay provision in Plaintiff's Progressive Max policy reads as follows:

Part II – MEDICAL PAYMENTS COVERAGE

² A copy of the Progressive Max policy at issue is attached hereto as *Exhibit 1*. The Plaintiff never had any policy or contractual relationship with Defendants Progressive Direct or Progressive Casualty. (Affidavit of Dorothy Lange, *Exhibit 2*; Affidavit of Michael R. Uth, *Exhibit 3*).

³ As explained in Progressive's separately filed Motion for Summary Judgment, Plaintiff's definition of "*incurred*" is contrary to all authority and incorrect as a matter of law. The Defendants' Motion for Summary Judgment in itself dooms the Plaintiff's Motion for Class Certification. Obviously, a Plaintiff without a viable cause of action cannot maintain a class action. The Motion for Summary Judgment therefore disposes not only of the Plaintiff's individual claims but her adequacy as a class representative as well.

INSURING AGREEMENT

If you pay the premium for this coverage, we will pay the reasonable expenses incurred for necessary medical services received within three years from the date of a motor vehicle accident because of bodily injury:

- 1. sustained by an insured person; and***
- 2. caused by that motor vehicle accident.***

We, or someone on our behalf, will determine:

- 1. whether the expenses for medical services are reasonable; and***
- 2. whether the medical services are necessary.***

(See Pages 6 and 7 of policy, Exhibit 1). (Emphasis added.) This coverage – which itself contains various conditions – is subject then to various enumerated exclusions. (See page 7 of the policy, *Exhibit 1*).

Plaintiff's policy therefore covers reasonable and necessary *medical expenses* that are *incurred* by an insured, that are *caused* by an auto accident, that are *received within three years* of an auto accident, and which are not subject to an *exclusion*. The fundamental issue in this case is whether Progressive reimbursed the Plaintiff for the medical expenses she "*incurred.*" Under the sole reasonable interpretation of the word "*incurred,*" Progressive did, in fact, reimburse any and all medical expenses incurred by the Plaintiff arising from her auto accident, thereby fulfilling its policy obligations. Based solely on her own personal definition of "*incurred,*" though, the Plaintiff claims that Progressive did not reimburse her for all the medical expenses that she "*incurred.*" As will become clear, however, not only is the Plaintiff's individual claim fatally defective, but her attempt to concoct a class based upon her personal and exaggerated definition of "*incurred*" (which has been rejected by the South Carolina Supreme Court) is fatally flawed as well.

2. Plaintiff's MedPay Claim

The Plaintiff was injured in an auto accident on February 23, 2009. Following this accident, she saw various medical providers and submitted a claim under her MedPay coverage. Plaintiff had a \$10,000 MedPay policy limit. (Most MedPay insureds have lower limits).

In addition to MedPay coverage through her Progressive auto policy, Ms. Smith also had private health insurance through Blue Cross Blue Shield to cover her medical bills. (*Exhibit 4*, 6/1/12 Rule 30(b)(6) Deposition of D. Lange, p. 38, lines 4-8). This is not an uncommon scenario – many Progressive MedPay insureds carry private health insurance. As typically happens in this situation, Ms. Smith's medical providers generated bills in one amount, but these charges were then discounted to reflect certain discounts that her medical providers had contracted for with her private health insurance company. The result was that Ms. Smith was actually obligated to her medical providers for less than the initial amount of the charges shown on her medical bills.⁴ Of course, Plaintiff never owed or was responsible for the amount of this contractual discount between her provider and her medical insurance carrier, and no provider took any action to recover these sums. But it is precisely this discount – which she never owed and never paid – which the Plaintiff claims that she “*incurred*” and is entitled to recover here.⁵

⁴ Ms. Smith also sued the at-fault driver of the other car in her accident. She has received an estimated \$19,000 (after legal fees) in settlement of that claim. (*Exhibit 5*, 6/20/12 Deposition of S. Smith, pg. 17, lines 3-25; pg. 18, line 1).

⁵ It is undisputed that while Progressive follows this adjusting approach, it also pays any amounts that a medical provider disputes, or which an insured owes a provider, so that its insured has no remaining obligation to any provider. (*Exhibit 6*, 10/19/11 Deposition of P. Goodchild, p. 19, lines 10-25; p. 20, lines 1-25; p. 21, lines 1-2; *Exhibit 7*, 8/3/11 Rule 30(b)(6) Deposition of D. Lange, p. 111, lines 4-20; p. 123, lines 1-8).

The Plaintiff's attorney submitted various medical bills to Progressive as part of the Plaintiff's MedPay claim. The Affidavit of Dorothy Lange (attached hereto as *Exhibit 2*, and filed in support of Defendants' Motion for Summary Judgment,) describes how she approved reimbursement for all sums that the Plaintiff had paid or was obligated to pay any of her medical providers, plus the amounts that her Blue Cross insurance had paid to her providers. Thus, the Plaintiff was actually reimbursed more than she had directly paid out-of-pocket. Progressive reimburses either to its insured, or its insured's health insurers, the amount that these health insurers have paid the medical providers (unless otherwise directed by the insured or their attorney) in order to comply with S.C. Code Ann. 38-77-144, which provides that "medical payment coverage ... is not subject to a setoff."⁶ (*Exhibit 8*, 10/19/11 Rule 30(b)(6) Deposition of P. Goodchild, p. 24, lines 12-25; p. 25, lines 1-22).

The Plaintiff seeks even more, though, claiming that she "incurred" the insurer/provider discount amounts, even though she never paid these sums and has not demonstrated that she owes them.

3. Plaintiff's Proposed Class Definition Is Overbroad And Not Properly Defined:

The Plaintiff, both in her Second Amended Complaint and her Motion for Class Certification, defines the proposed class as follows:

"All Progressive insureds in the State of South Carolina who are residents of

⁶ S.C. Code Ann. § 38-77-144 provides that "medical payment coverage...is not subject to a setoff." In *State Farm Mut. Auto Ins. Co. v. Richardson*, 313 S.C. 58, 437 S.E.2d 43(1993), the S.C. Supreme Court held that Section 38-77-144 applies only to prevent a tortfeasor from reducing his liability to his victim, by setting off against his liability the payments made to the victim by the victim's medical insurance. The statute is not a general prohibition against any reduction of a MedPay insurance payment for any other reason. See also, in accord, *Rowzie v. Allstate Ins. Co.*, 556 F.3d 465 (4th Cir. 2009). Thus, this statute does not apply in this case, as this case does not involve a set-off against a tortfeasor's liability to the Plaintiff. Even assuming, however, that this provision could be relevant to this case, it is undisputed that Progressive does reimburse its insureds for the payments that their own health insurers make to the insureds' providers, and did so with the Plaintiff. Thus, no setoff occurs at all.

South Carolina and who submitted claims to any of the Progressive Insurance Companies under the medpay provision of their respective South Carolina policies during the time period of October 1, 2007 to present and who did not receive payment in the amount of their medical bills and whose medpay policy limits were not exceeded by payments from the Defendants."

Second Amended Complaint ¶ 24.

There are several fundamental flaws with this proposed class definition.

First, it is undisputed that Plaintiff is only a *former* policyholder of *one* Defendant – Progressive Max. This fact creates two specific disabilities: a) she cannot represent policyholders of a different company than the company with which she had a policy; and b) because she holds no current policy, she has no standing with respect to any relief going forward (such as the relief sought in her Declaratory Judgment/Injunctive Relief counts.) This is because she has no personal stake whatsoever in the future construction or handling of Progressive Max policies, no longer being a Progressive Max policyholder herself.

Second, Plaintiff's proposed class definition assumes that all persons who were reimbursed less than the amount of their total submitted medical bills received the lesser payment due to the same reason as the Plaintiff – that is, because of a discount applied pursuant to the provider's agreement with a medical insurer. In fact, though, there are many possible reasons for a reduced payment – and this is an Inherently individualized Inquiry for each policyholder.⁷

Third, the record shows that while the adjusting approach described above has been utilized for Progressive MedPay claims since mid-2008, there is no evidence of any common or

⁷ Note that the proposed definition also exceeds the applicable limitations period. The Plaintiff commenced this action on November 8, 2010, so that the class period could only extend back to November 8, 2007.

consistent MedPay adjusting policy or approach prior thereto.⁸

At most, therefore, the Plaintiff could only represent a class of South Carolina Progressive Max policyholders who, within the three-year limitations period and from formation of the National Medical Unit forward, submitted a valid claim under their MedPay coverage but had their reimbursement reduced based solely upon a discount pursuant to their medical insurers' agreement with the provider, who were not subject to any exclusions, and whose reduction exceeded \$100.00.⁹ This is the only group of people with whom the Plaintiff could possibly share any common characteristics. But the Plaintiff's proposed class definition would allow her to also represent broad groups of people with whom she does not share any common characteristics. The Court should reject her efforts to "represent" persons with whom she has no commonality.

B. The Plaintiff Fails To Meet The "Commonality," "Typicality," and "Adequacy" Requirements For Class Certification, And Plaintiff's Motion For Class Certification Should Be Denied

Class certification in South Carolina is governed by SCRCP 23. The Plaintiff is required to show five specific elements¹⁰, and it is the Plaintiff's burden to show each of these elements. *Gardner v. Dept. of Revenue*, 353 S.C. 1, 20, 577 S.E. 2d 190, 200 (2003); *Ferguson v. Charleston Lincoln-Mercury, Inc.*, 344 S.C. 502, 510, 544 S.E.2d 285, 289 (Ct. App. 2001). These elements are not optional. The showing is not satisfied by speculation that facts "might" develop, or that

⁸ The testimony is that adjusting of MedPay claims was consolidated into a National Medical Unit in June, 2008; the procedures under which the Plaintiff's claim was handled were only developed in mid-2008. Prior to that time, claims were handled at the various local State levels. (*Exhibit 8*, 10/19/11 Rule 30(b)(6) Deposition of P. Goodchild, p. 61, lines 20-25; p. 62, lines 1-8; p. 67, lines 14-25; p. 68, lines 1-5; p. 72, lines 11-21; p. 85, lines 14-21; *Exhibit 9*, 10/19/11 Deposition of E. Zaner, p. 18, lines 2-25; p. 19, lines 1-11.)

⁹ See discussion regarding the \$100.00 threshold on page 20 herein.

¹⁰ These elements are: numerosity, commonality, typicality, adequacy of the class representative, and the \$100.00 amount in controversy.

the necessary showing "might" be made in the future. To the contrary, the Court must conduct a "rigorous analysis to determine that each prerequisite is satisfied." *Gardner*, 353 S.C. at 20, 577 S.E. 2d at 200. Failure to satisfy just one prerequisite is fatal. *Id.*; *Waller v. Seabrook Island Property Owners Ass'n*, 300 S.C. 465, 388 S.E.2d 799, (1990).

In the case at bar, the Plaintiff falls short of the most basic requirement – a showing that a proposed class is even definable. The proposed class is riddled with the kinds of individualized issues that consistently cause South Carolina Courts – like Courts in every jurisdiction – to reject class status. In conducting its analysis, it is proper for the Court to go beyond the pleadings and probe the relevant facts. *Wal-Mart Stores, Inc. v. Dukes*, 131 S.Ct. 2541 (U.S. 2011); *Castano v. American Tobacco Company*, 84 F.3d 734, 744 (5th Cir. 1996). Such probing will reveal numerous deficiencies here. As discussed below, Plaintiff cannot meet the requirements for certifying a class.

1. **The Plaintiff Has No Claim – And Is Therefore "Inadequate" - Because Her Construction Of The Term "Incurred" Has Been Rejected By The South Carolina Supreme Court;**

The most basic flaw with the Plaintiff's effort to pursue a class action, is that she has no individual right of action under the precedents of the South Carolina Supreme Court. The Plaintiff bases her claim on a definition of "incurred" which would cover not only expenses that she paid and/or is liable for paying – but would extend also to expenses that she did not pay and has no liability for paying. This was precisely the claim made by the Plaintiff in *Gordon v. Fidelity & Casualty Co.*, 238 S.C. 438, 120 S.E.2d 509 (1961), which our Supreme Court soundly rejected.

In *Gordon*, the Plaintiff had a MedPay policy with Fidelity & Casualty that covered "reasonable expenses incurred." This is identical to the language in the Plaintiff's Progressive Max MedPay coverage. The *Gordon* Plaintiff received free medical care by virtue of his military status, then sought to recover under his MedPay coverage for the value of the medical services rendered. The South Carolina Supreme Court unanimously rejected this claim, holding that the Plaintiff had "incurred" nothing because he had neither actually paid for the services for which he was seeking reimbursement, nor did he owe anything for them.

This is the identical situation in the instant case: here, the Plaintiff seeks to recover (as "incurred" expenses) charges that she did not actually pay, and does not owe. The South Carolina Supreme Court has, however, held that such charges are not "incurred" expenses under a MedPay policy. (The Defendants have raised this issue through a separately-filed Motion for Summary Judgment, but it is also appropriate at the class certification stage to assess whether the Plaintiff even has an individual claim, much less a claim on behalf of a class, as relevant to the "adequacy" requirement of SCRCP 23.)

It is well-established that a person who has no cause of action may not pursue a claim in a representative capacity. *C.J.S. Parties 34; Dvorkin v. Illinois Bell Tel.*, 340 N.E.2d 98 (Ill. App. 1975); 32 Am. Jur.2d *Federal Courts* 1651). A purported class representative who does not herself have a cause of action is the paradigm of an inadequate representative.

2. The Plaintiff Cannot Establish Commonality – And Instead Proposes a Class That Covers Widely Uncommon Characteristics:

Plaintiff proposes a class consisting of all Progressive insureds who received payments under their MedPay policy in an amount less than the medical bills submitted, and were within their policy limits. This definition would cover not only insureds that had policies with different

companies than Plaintiff, but insureds whose payments were reduced for reasons **completely unrelated and irrelevant** to the reason for which Plaintiff's payment was reduced; namely, the contractual discount agreed to by her medical providers and her health insurer. Simply put, Plaintiff's proposed class is far too broad, which results in a complete lack of commonality.

Plaintiff must show that a common, outcome-determinative issue unites the class. *Gardner*, 353 S.C. at 21-22, 577 S.E. 2d at 200-201. A question is not "common" if a jury could answer the question differently as to different class members. *Id.* A representative Plaintiff "cannot establish commonality...if the Court must investigate each Plaintiff's individual claim. *Id.* (quoting *Peoples v. Wendover Funding, Inc.*, 179 F.R.D. 492, 498 (D. Md. 1998)). However, this is precisely the situation here.

Determining who belongs in Plaintiff's purported class and who does not, inevitably brings a host of individualized questions into play, which prevents certification of a class defined as broadly as the one proposed by Plaintiff. A simple review of the policy (*Exhibit 1*) shows that there are numerous scenarios which can explain why a reduction might have been made to the medical bills submitted by a proposed class member. It is obvious, therefore, that this case would require each and every claim to be reviewed, analyzed, and litigated in a series of "mini-trials" in order to determine whether each claim does, indeed, share common characteristics with Ms. Smith's claim. The necessity of such "mini-trials" for each purported class member establishes that class certification is inappropriate.

While it would be difficult to anticipate and identify all of the individual issues that would need to be determined in order to evaluate each proposed class member's potential

claim, some of the key individualized issues that would arise in these "mini-trials" include the following:

- Whether an insured did or did not have private health insurance in force that covered the medical service provided is a critically important issue that would need to be determined in every case.
- Whether an insured had Medicare and/or Medicaid coverage would also need to be determined, as the Centers for Medicare & Medicaid Services and State governments that administer Medicare and Medicaid apply different processes and procedures with respect to medical bills and providers than do other health insurers.
- Whether the insured was treated by a provider in the Coventry Network of providers that gives negotiated discounts to Progressive insureds would also need to be determined for each purported class member, as this could obviously be a reason that a payment was less than the original amount of the bill for medical services, which has nothing to do with any "reductions" to the Plaintiff's reimbursement.¹¹
- Whether "third-party medical bill reduction software" was used in adjusting the insured's MedPay claim. The Second Amended Complaint asserts that the claims of the purported class were adjusted by use of such software, but the

¹¹ Progressive has created a network of medical providers who agree to treat Progressive insureds at discounted charges. This is called the "Coventry Network." If the insured consents to be treated by a provider who is a member of the Coventry Network, their bills will reflect the discounts these providers have agreed to with Progressive. The insured will not be obligated to pay the provider the amount of the discount; i.e., if a Coventry Network doctor discounts a charge from \$100 to \$60, the Progressive insured will only be required to pay the doctor the \$60 that he or she incurred. (*Exhibit 7*, 8/3/11 Rule 30b6 Deposition of D. Lange, p. 102, lines 6-25; p. 103, lines 1-16.)

undisputed testimony is that no such software was used in adjusting the Plaintiff's claim; claims adjuster Dorothy Lange made her own decisions about what to reimburse the Plaintiff, not relying on any software or program to determine what amount to reimburse. (*Exhibit 7*, 8/3/11 Rule 30b6 Deposition of D. Lange, p. 51, lines 3-10; p. 86, line 9; p. 87, lines 2-24; p. 116, line 25; p. 117, lines 1-6.) The policy allows Progressive to review charges for "reasonableness," and this is sometimes done – but not in the Plaintiff's claim.

- Whether an expense was "reasonable," whether the medical services were "necessary," and whether they were for injuries related to the automobile accident at issue, are key conditions to coverage, and are exactly the types of questions that would require the Court to conduct "mini-trials" for each of the purported class members. If the answer to any of these questions was "No," that could have resulted in an insured being paid less than the original amount of a bill.
- The policies of the purported class members vary in terms of their limits, other important respects, each of which can affect the analysis of a purported class member's claims. For example, the application of an exclusion in a particular instance could result in an insured being paid less than the amount of a medical bill. All coverage issues presented by the policy have to be investigated before claims are paid. (*Exhibit 7*, 8/3/11 Rule 30(b)(6) Deposition of D. Lange, p. 18, lines 8-10; p. 21, lines 18-21; p. 24, lines 1-25; p. 25, lines 1-4; p. 70, line 16; p.

107, lines 10-11; *Exhibit 9*, Deposition of E. Zaner, p. 27, lines 16-20; p. 28, lines 1-3; p. 29, lines 1-24; p. 31, lines 1-12.)

- Some insureds may have submitted medical bills received outside of their policies' "three years from the date of the motor vehicle accident" limit, which may also have resulted in reduced payments.
- At times, Progressive may receive duplicate bills for the same services, which would result in one or more duplicate bills not being reimbursed by Progressive.
- The timing of when a particular medical expense was "incurred" is also a potentially important issue that would require a factual determination in every case.
- Plaintiff alleges that the members of the class were "deceived" and "misled." (See, Second Amended Complaint ¶ 31, 36.) Determining whether such an allegation is true with respect to a particular class member would obviously require an individualized factual determination with respect to each claim by each insured. See, e.g., *Gunnells v. Healthplan Services, Inc.*, 348 F.3d 417, 435 (4th Cir. 2003) (fraud and negligent misrepresentation could not "satisfy Rule 23's predominance and commonality requirements" because "establishing these elements requires an individualized inquiry"); *Broussard v. Meinke Discount Muffler Shops*, 155 F.3d 331, 342 (4th Cir. 1998) ("because reliance must be applied with factual precision, plaintiffs' fraud and negligent misrepresentation claims do not provide a suitable basis for class-wide relief") (citations omitted).

- Similarly, Plaintiff's "bad faith tort" claim (Fourth Cause of Action) would require individualized determinations that make it unsuitable for class adjudication. South Carolina defines bad faith as "a knowing failure on the part of the insurer to exercise an honest and informed judgment toward processing a claim." *Doe v. South Carolina Med. Malpractice Liab. Joint Underwriting Ass'n*, 347 S.C. 642, 649, 557 S.E.2d 670, 674 (2001)(emphasis added). An insurer acts in bad faith when "there is no reasonable basis to support the insurer's decision." *Cock-n-Bull Steak House v. General Ins. Co.*, 321 S.C. 1, 6, 466 S.E.2d 727, 730 (1996). Determining whether the facts support a particular claims decision, or whether there was any reasonable basis for the insurer's decision on each claim, clearly requires an individual assessment of the facts of each claim. *Comer v. Life Ins. Co. of Alabama*, 2010 WL 233857 (D.S.C. 2010)(finding bad faith cause of action not appropriate for class determination and denying motion for class certification as to it). "Unlike determining liability based on a uniform course of contract interpretation, the bad faith claim compels the court to consider any reason for not paying the alleged benefits owed under the contract" which renders bad faith claims "atypical of one another" and "ill-suited to class-wide resolution." *Id.* 2010 WL 233857 at *5.

In short, Plaintiff proposes an overly broad class lacking in commonality. There is simply no "common, outcome derivative issue that unites the class." To the contrary, there could be any number of reasons that an insured was paid less than the original amount of a bill for medical services – including many reasons that have absolutely nothing to do with Plaintiff's

claims in this action. In order to adjudicate this case as a class action, using the class definition proposed by the Plaintiff, the Court would need to investigate each class member's individual claims, thereby destroying the utility – and feasibility – of class litigation. Certification of such a class is therefore inappropriate under South Carolina law.

3. The Plaintiff's Claims And Interests Are Not Typical Of The Claims Of The Class:

"Typicality" requires that the claims of the class representative have the same essential characteristics of those of the class as a whole. *Broussard v. Meineke Discount Muffler Shops*, 55 F.3d 331,340 (4th Cir. 1998). As stated in the discussion above of the commonality prong, Plaintiff's proposed class definition envisions her representing people with whom she shares *no* essential characteristics. Typicality is lacking for these same reasons.

In addition, the Plaintiff is directly antagonistic to those class members who – unlike Plaintiff – would prefer Progressive to pay the insured only the amount the insured actually owes the doctor, and thereby preserve the insured's policy limits to cover additional bills incurred under the same claim. Plaintiff proposes a definition of "incurred" which accelerates the exhaustion of policy limits for policyholders with low-limit, policies. Plaintiff had a policy with a "high-end" limit of \$10,000 (Second Amended Complaint, ¶ 7). By urging that Progressive be required to pay all amounts billed regardless of whether the insured is responsible for the bill, she stands in opposition to the interests of Progressive insureds with lower-limits, who would prefer to have their coverage preserved to cover as many bills as possible. (*Exhibit 9*, Deposition of E. Zaner, p. 39, lines 18-25; p. 40, lines 1-9; p. 43, lines 21-25; p. 44, lines 1-8.) Additionally, Progressive being forced to pay for expenses that were never actually "incurred" could impact rates, which would not affect Plaintiff because she is no longer

a policyholder. (*Exhibit 10*, Deposition of D. Kirk, pg. 19, lines 3-25; pg. 20, lines 1-15; pg. 32, lines 23-25; pg. 33, lines 1-6). A rate increase would, however, obviously negatively affect those members of the class who still hold policies with Progressive.

Plaintiff must present concrete evidence to show the existence of putative class members who share her grievances, rather than ask the Court to merely presume that others do. See generally, *Pipes v. Life Investors Ins. Co. of America*, 254 F.R.D 544, 549-550 (E.D. Ark 2008) (Where Plaintiff presumed the existence of putative class members who shared his grievances, but failed to present evidence of such, the typicality element was not met). Since there is no showing that Plaintiff is typical of any other Progressive MedPay insured, and it is instead clear that her position is directly antagonistic to potential class members with low limits as well as to those who are still policyholders, her request for class certification must be denied.

Plaintiff also fails to satisfy the typicality prong because she was represented by counsel during the claim process, which makes her highly unusual and not at all "typical." Unlike a typical claimant, who does not retain an attorney and therefore does not have to pay an attorney, the Plaintiff had to pay a fee to her attorney out of her reimbursement from progressive, which could obviously affect the issue of whether her net reimbursement covered all reimbursable expenses. Also, in a typical claim, the Progressive adjuster deals directly with the claimant to obtain medical and other relevant information. That was not possible in this claim. This further differentiates Plaintiff from the other purported class members.

4. **The Plaintiff Cannot Fairly and Adequately Protect the Interests of the Class Because She Has no Individual Claim, and Asserts Interests Which are Antagonistic with the Interests of the Purported Class:**

The issue of whether a named-Plaintiff will adequately protect the interests of a proposed class turns on the specific circumstances of each case. *Waller*, 300 S.C. at 468, 388 S.E.2d at 801. In determining whether a particular named-Plaintiff will adequately represent class members pursuant to Rule 23(a)(4), the Court must consider, among other things, whether the named-Plaintiff has interests that are antagonistic or adverse to those of the rest of the proposed class. *Id.* If the Plaintiff has interests that conflict with other class members, that Plaintiff is not considered to be an adequate representative. *Id.* Further, as a threshold matter, the Plaintiff must herself have a claim.

One form of "antagonism" frequently held to be sufficient to disqualify a proposed representative arises when the proposed representative is advancing a claim or interest which conflicts with the economic interests of others in the proposed class. *Id.* In order to qualify as a sufficient representative for the class, a Plaintiff must demonstrate that they have no interest that is antagonistic to or in conflict with the interests of the unnamed members of the class. *Id.* Absent this showing, a Plaintiff is not fairly and adequately able to protect the interests of the purported class. *Id.*

In applying this binding precedent to the facts at hand, there are at least four (4) reasons why Ms. Smith does not qualify as an adequate class representative:

1. Plaintiff is not an adequate representative to maintain this action because it is uncontested that she received all policy benefits due, has no damages, and therefore has no claim.¹² She has no economic loss to pursue, and therefore no standing in this suit, and

¹² This issue is thoroughly discussed in Defendants' Motion for Summary Judgment. The Court cannot evaluate whether the Plaintiff meets the "adequacy" requirement without considering whether the Plaintiff even has a claim, which is the issue raised in Defendants' Summary Judgment Motion.

therefore no individual claim. As stated in 4 S.C. Juris. Actions 23, "*Standing to sue is a fundamental requirement for instituting an action. Standing requires an interest in the subject matter of the action, and the interest must be a personal stake.*" Since Ms. Smith has been made completely whole because Progressive reimbursed her for all of her medical expenses and out-of-pocket costs incurred under her MedPay claim, she has not sustained any damages and therefore has no standing. See *Edisto Fleets, Inc., v. South Carolina Tax Commission*, 256 S.C. 350, 354, 182 S.E.2d 713, 714 (1971) (A plaintiff cannot maintain a class action where the record indicates he was not directly harmed by defendants' actions); *Furman University v. Livingston*, 244 S.C. 200, 204, 136 S.E.2d 254, 256 (1964) (only a taxpayer directly affected by erroneously paying taxes has a right to seek a refund). A class representative with no standing is inadequate, because they have no personal right to bring a claim.

2. Ms. Smith clearly is not an adequate representative with respect to any claims against Progressive Direct or Progressive Casualty, since she has never had any relationship with either of those companies. Plaintiff's policy was with Progressive Max. Without a contractual relationship, much less a cause of action against Progressive Direct or Progressive Casualty, she cannot represent insureds that have policies with (or potential claims against) those companies.

3. As discussed above in the "commonality" analysis, Ms. Smith is unable to adequately represent the class because the interpretation of Progressive's policy obligations that she is advancing materially prejudices class members with low-limit policies. This is a direct financial conflict that makes Ms. Smith antagonistic to other members of the class, and thus ineligible to act as a class representative. See *Waller*, 300 S.C. at 469, 388 S.E.2d at 802

(Court held that a Plaintiff who owned marsh-front property could not adequately represent the interests of a class consisting of all property owners in a real estate development, in stacking an assessment because the assessment made against all property owners provided a benefit to the beachfront property owners, which it did not provide to the marsh-front property owners. Consequently, the beach front property owners would no doubt find the marsh-front property owners' class action repugnant and adverse to their interests). Many more Progressive insureds have MedPay policy limits in amounts that are at least less than half of the limits Plaintiff had in her Progressive Max policy – and the relief she is seeking would therefore be economically adverse to their interests. Added to this "antagonism" is the fact that, as discussed above, Ms. Smith's approach could potentially impact rates for existing or future policyholders.

4. Finally, Ms. Smith is not an adequate representative because she is no longer a Progressive policyholder. This fact has repercussions with respect both to her antagonistic relationship to the class she proposes to represent, and her standing to proceed with her claims. Under basic principles of standing, a person who is no longer "in the shoes" of the people she claims to represent cannot represent them.

Plaintiff requests declaratory relief related to Progressive policies. However, Plaintiff does not have a Progressive policy. She is therefore seeking relief which will not affect her whatsoever, and she cannot fairly and adequately represent the interests of a class of people to which she does not belong. See Pipes, 254 F.R.D at 550 (Court denied class certification where, *inter alia*, the proposed class representative was not a policyholder and his position would result in increased rates for existing policyholders. Court held this issue was a conflict of

interest that went to the very heart of the litigation - since the proposed class representative's claim for monetary relief would negatively impact the economic interests of current policyholders, who have an interest in affordable insurance rates, he was antagonistic to the rest of the proposed class and could not represent them); see also, *Ihrke v. Northern States Power Co.*, 459 F.2d 566 (8th Cir. 1972), *vacated on the merits as moot*, 93 S.Ct. 66, 409 U.S. 815, 34 L.Ed.2d 72 (U.S. 1972)(Appellate Court affirmed determination that a claim by certain customers against a utility, seeking a declaratory judgment that the rules and regulations of the utility were unconstitutional because utility services could be terminated without adequate prior notice or a fair and impartial hearing, could not be maintained as a class action on behalf of all persons residing in the city who had made an application for utility services. The purported class representative's claims that the utility should set up a pre-termination hearing procedure would not be typical of other members, who might oppose the additional expense involved in setting up such a procedure because it could result in a rate increase. The Court determined that this difference in interests created a conflict between the claims of the purported class representative and some of the proposed class members, which made the Plaintiff ineligible as an adequate class representative).

The same rationale applies here, where Ms. Smith is no longer a policyholder of any Defendant, yet seeks relief that is prospective in nature and detrimental to the financial interests of those people who are existing Progressive policyholders. Under these circumstances, Ms. Smith is antagonistic to other class members, and her motion for class certification must therefore be denied.

5. **Plaintiff's Proposed Class Violates SCRCP 23's "Amount in Controversy" Requirement:**

SCRCP 23(a)(5) provides that: *In cases in which the relief primarily sought is not injunctive or declaratory with respect to the claims as a whole, the amount in controversy [must exceed] one hundred dollars for each member of the class."*

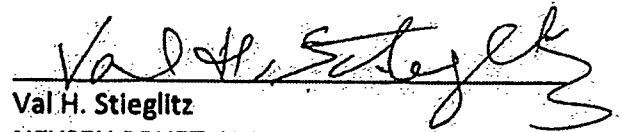
The primary relief sought in this action is clearly monetary, and not declaratory in nature. Plaintiff wants Progressive to pay her (and her purported class) the difference between the original amounts shown on bills generated by her providers, and the amounts of those bills for which she was actually responsible (her medical insurance having paid the difference). This means she wants money damages. Even her "Declaratory Judgment" cause of action seeks a declaration that she and the other members of the class are owed money.

SCRCP 23(a)(5) clearly applies, which means that if any class were certified, it would need to exclude all individuals whose MedPay claims were reduced by \$100.00 or less. (The Plaintiff may contend that attorneys' fees and punitive damages should be added to each individual class member's "amount in controversy," thereby lifting each member's claim over the \$100.00 threshold. However, the South Carolina Supreme Court has held that attorneys' fees and punitive damages may not be considered in determining the "amount in controversy." *Gardner v. Newsome Chevrolet-Buick, Inc.*, 304 S.C. 328, 404 S.E.2d 200 (1991).) Thus, each claimant must have experienced a reduction in excess of \$100.00 in order to qualify as a member of any class.

CONCLUSION

The Plaintiff's purported class cannot be certified without departing far-and-wide from South Carolina law, and becoming an endless quagmire of individualized inquiries. For the

reasons set forth above, the Plaintiff fails to meet the well-established requirements for class certification, and her Motion for Class Certification should be denied.



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Attorneys for Defendants

October 30, 2012

Columbia, South Carolina

STATE OF SOUTH CAROLINA

COUNTY OF HORRY

IN THE CIRCUIT COURT

STEPHANIE A SMITH on behalf of herself
and all others similarly situated,

Plaintiff,

v.

PROGRESSIVE HALCYON INSURANCE
COMPANY, n/k/a PROGRESSIVE DIRECT
INSURANCE CO., PROGRESSIVE MAX,
and PROGRESSIVE CASUALTY
INSURANCE,

Defendants.

Case No. 2010-CP-26-10502

**DEFENDANTS' MOTION FOR
RECONSIDERATION AND TO ALTER
OR AMEND THE COURT'S ORDER
GRANTING CLASS CERTIFICATION**

Defendants Progressive Halcyon Insurance Company n/k/a Progressive Direct Insurance Co., Progressive Max, and Progressive Casualty Insurance (collectively "Progressive") pursuant to SCRCP 59(e), respectfully request that the Court reconsider, alter, and amend its Order Granting Class Certification (the "Order"), as set forth below. Progressive also respectfully requests that the Court stay Item 5 of its Order pending resolution of this Motion for Reconsideration and any subsequent appeal. Progressive received written notice of entry of the Order on February 14, 2013, and this motion is timely served.

Progressive respectfully submits that the Court should reconsider, alter, or amend its Order because the Order does not address crucial issues Progressive raised in its opposition brief, which demonstrate that class certification is inappropriate in this case. Moreover, a number of conclusions in the Order are inconsistent with the record evidence. Specifically, the Order errs with respect to the following issues:

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CLERK OF COURT

- (1) The proposed class (and the class as defined in the Order) is not readily ascertainable. As for each purported class member, an individual, non-speculative determination must be made as to whether the medical-payment discount or reduction at issue occurred due to a health insurance carrier's contract with the medical provider, as alleged by Plaintiff, or for another reason that is not at issue in this lawsuit (e.g., submission of double bills for the same treatment). Such a determination must be made individually to determine standing to pursue a claim in this action, and Plaintiff has failed to show -- because she cannot -- that such a determination can be made without requiring individual mini-trials. These individual issues will dominate the class proceedings.
- (2) Plaintiff is inadequate and atypical because she has no viable claim in her own right; namely, Plaintiff's claim fails as a matter of law because she is seeking to recover medical expenses that she did not "incur" because she was not obligated to pay them and did not pay them. This issue is governed directly by the South Carolina Supreme Court's decision in *Gordon v. Fid. & Cas. Co. of NY*, 238 S.C. 438, 441, 120 S.E.2d 509, 512 (1961), and Plaintiff has offered no basis for this Court to ignore this controlling precedent.
- (3) Plaintiff's proposed class definition (and the class as defined in the Order) is fatally overbroad because it includes individuals insured by insurers other than Progressive Max (Plaintiff's insurer) and under policies different than Plaintiff's policy.
- (4) Plaintiff's proposed class definition (and the class as defined in the Order) is fatally overbroad because it exceeds the applicable limitations period.

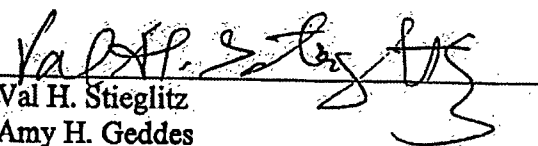
- (5) Plaintiff lacks standing to seek prospective relief in her own right (and thus cannot represent a purported class seeking prospective relief) because she is not a current Progressive policyholder.
- (6) Plaintiff lacks standing to assert claims on behalf of purported class members who are not insured by Plaintiff's insurer, Progressive Max.
- (7) Plaintiff is inadequate and atypical because her interests are different from and antagonistic to purported class members. Plaintiff has failed to show that any other class members support her position. In fact, many purported class members have economic interests directly contrary to Plaintiff's position -- rather than seeking a windfall payment for medical expenses they do not owe, these purported class members may prefer to preserve their coverage limitations by only seeking payment from Progressive for medical expenses they actually have incurred (e.g., medical expenses for which they have actual payment liability to the medical provider).
- (8) There is no commonality because there is no evidence that Progressive used a uniform claims-adjustment process before mid-2008, thus requiring the factfinder to ascertain, if the class is certified, the claims adjustment process used between November 8, 2007 (the earliest date within the limitations period) and the present for each claim submitted by each purported class member.
- (9) There is no commonality because, if the class is certified, the factfinder must ascertain, on an individual, non-speculative basis, whether a given policyholder's medical expenses were "reasonable" and "necessary" under that policyholder's policy.

- (10) There is no commonality because, if the class is certified, the factfinder must ascertain, on an individual, non-speculative basis, the reason or reasons Progressive paid less than the total amount billed by a given policyholder's medical provider.
- (11) There is no commonality because, if the class is certified, the factfinder must determine, on an individual, non-speculative basis, whether a given policyholder submitted medical bills outside of the applicable coverage period, or otherwise failed to meet a condition of coverage set forth in the policy.
- (12) There is no commonality because, if the class is certified, the factfinder must determine, on an individual, non-speculative basis, whether Progressive "deceived" or "misled" a given policyholder.
- (13) There is no commonality because, if the class is certified, the factfinder must determine, on an individual, non-speculative basis, whether Progressive was unjustly enriched with respect to each claim submitted by each purported class member.
- (14) There is no commonality because, if the class is certified, the factfinder must determine, on an individual, non-speculative basis, whether Progressive had a reasonable basis for its payment decision regarding each claim submitted by each purported class member.
- (15) There is no record evidence supporting the conclusion in the Order that the average medical-payment reduction exceeds \$1,000, nor does the record contain evidence suggesting that the average medical-payment reduction exceeds \$100, as required for class certification under SCRCP 23; nor does the class definition in

the Order require the class members to meet this threshold requirement.

Progressive requests a hearing to consider this motion, and reserves its right to submit a memorandum in support of this motion pursuant to a schedule established by the Court.

Respectfully submitted, this 22nd day of February, 2013.



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STATE OF SOUTH CAROLINA)

COUNTY OF HORRY)

STEPHANIE A. SMITH, on behalf of)
herself and all others similarly situated,)

Plaintiff,)

vs.)

PROGRESSIVE HALCYON)
INSURANCE COMPANY n/k/a)
PROGRESSIVE DIRECT INSURANCE)
CO., PROGRESSIVE MAX and)
PROGRESSIVE CASUALTY)
INSURANCE COMPANY,)

Defendants.)

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
CASE NO.: 2010-CP-26-10502

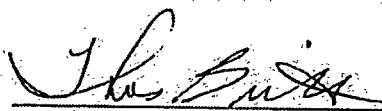
NOTICE OF APPEARANCE

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MELANIE HUGGINS-WARD
CLERK OF COURT

TO: ALL INTERESTED PARTIES:

NOW COMES THOMAS C. BRITTAIN, ESQUIRE and A. PRESTON BRITTAIN, ESQUIRE on behalf of Defendants Progressive Halycon Insurance Company n/k/a Progressive Direct Insurance Co., Progressive Max and Progressive Casualty Insurance Company and notifies the Court that they will be representing said Defendants in the above-referenced case.

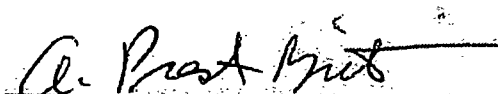
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Myrtle Beach, SC
March 7, 2013

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STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT

STEPHANIE A SMITH on behalf of
herself and all others similarly situated,

Plaintiff,

v.

PROGRESSIVE HALCYON
INSURANCE COMPANY, n/k/a
PROGRESSIVE DIRECT INSURANCE
CO., PROGRESSIVE MAX, and
PROGRESSIVE CASUALTY
INSURANCE,

Defendants.

Case No. 2010-CP-26-10502

**MEMORANDUM OF LAW IN
SUPPORT OF DEFENDANTS'
MOTION FOR RECONSIDERATION
AND TO ALTER OR AMEND THE
COURT'S ORDER GRANTING CLASS
CERTIFICATION**

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CLERK OF COURT

Defendants Progressive Halcyon Insurance Company n/k/a Progressive Direct Insurance Co. ("Progressive Direct"), Progressive Max, and Progressive Casualty Insurance ("Progressive Casualty") (collectively "Progressive"), pursuant to SCRCF 59(e), respectfully submit this memorandum in support of their Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification. For the reasons explained below, Progressive requests that the Court reconsider, alter, and amend its February 14, 2013 Order Granting Class Certification (the "February 14 Order") by (i) denying Plaintiff's motion for class certification, and (ii) staying Item 5 of its Order pending resolution of this Motion for Reconsideration and any subsequent appeal.

INTRODUCTION

Plaintiff is a former Progressive Max policyholder who alleges that Progressive Max breached the medical payments ("med-pay") provisions of her insurance policy (the "Policy") and violated South Carolina law because it reimbursed her for medical services in amounts equal

to what her primary health insurer, Blue Cross, paid her medical providers for treating injuries she sustained in a 2009 car accident. Plaintiff asserts that Progressive Max should have paid her the full amount her medical providers billed, even though no one – neither Plaintiff nor her health insurer – actually paid that amount. In other words, Plaintiff contends that the Policy and South Carolina law oblige Progressive to provide Plaintiff with a windfall.

Plaintiff's claim runs directly contrary to the plain language of the Policy and South Carolina law and, therefore, fails on the merits. Because Plaintiff has no viable individual claim, she cannot adequately represent the class certified in the February 14 Order. On that basis alone, the Court should reconsider its order and deny class certification. But the Court also should reconsider its February 14 Order because, contrary to Plaintiff's assertions, she has not – and cannot – meet her burden of demonstrating that this case satisfies other criteria for class treatment enumerated in SCRCP 23(a) because she has not – and cannot – show that there are any determinative issues of fact or law that are common to the members of the class or that her claims are typical of the class members' claims.

The class certified in the February 14 Order includes all insureds of three different entities – two of which have no relationship with Plaintiff – “who did not receive payment” from those three entities “in the amount of their medical bills” – *regardless of why the insureds received payments less than “the amount of their medical bills.”* Determining whether each of those insureds were entitled to the full amounts they were billed, either under their insurance policies or South Carolina law, depends entirely on circumstances unique to each class member. The Progressive Policy provides numerous grounds on which Progressive may deny claims or reduce the amount it reimburses insureds for med-pay claims. Most notably, the Policy requires Progressive to reimburse insureds only for “reasonable expenses incurred for necessary medical

services.” Policy, Part II, Insuring Agreement (attached as Ex. A). Any given member of the class that the Court certified may have received payments from Progressive less than the “amount of their medical bills” because her expenses were unreasonable or the services she received were unnecessary, rather than because Progressive reimbursed her in the amount her third-party payor paid. Alternatively, the class member may have received such a payment for any number of other reasons based on the Policy language. By her own admission, Plaintiff’s claims implicate none of those issues; it is based entirely on her allegation that she was entitled to reimbursement for the full amount her medical providers billed her. Accordingly, Plaintiff has failed to prove that the members of the class she defines share in common the central, determinative issue relating to the reason each of their claims allegedly was not paid in full.

This is just one example of the numerous individual issues permeating this case. Resolving Plaintiff’s claim would not answer any of the questions necessary to resolve the class members’ claims without the factfinder first conducting an individualized inquiry for each class member regarding the basis for Progressive’s payment decision and whether that decision complied with the Policy language and South Carolina law. This case, therefore, is profoundly unsuited to class adjudication. Accordingly, Progressive respectfully requests that the Court reconsider, alter, and amend its February 14 Order to deny Plaintiff’s motion for class certification.

BACKGROUND

I. Plaintiff’s Insurance Policy And Med-Pay Claim

Between January and June 2009, Plaintiff was a Progressive Max insured. Plaintiff had no relationship, contractual or otherwise, with any other Progressive entity, including Progressive Casualty or Progressive Direct. Among other things, Plaintiff’s Progressive Max

Policy provided coverage for med-pay claims, subject to the terms and conditions set forth in the Policy, along with any exclusions. Specifically, the Policy provided that, if Plaintiff paid the med-pay premiums, Progressive would “pay the reasonable expenses incurred for necessary medical services received within three years from the date of a motor vehicle accident because of bodily injury: 1. sustained by an insured person; and 2. caused by that motor vehicle accident.” Policy, Part II, Insuring Agreement.¹ The Policy further provided that Progressive, or someone on its behalf, would determine “whether the expenses for medical services are reasonable,” and whether the services provided were “necessary.” *Id.*

In February 2009, Plaintiff was injured in an automobile accident and subsequently, through her attorney, made a med-pay claim under the Policy. The Progressive claims adjuster handling Plaintiff’s claim, Ms. Dorothy Lange, examined Plaintiff’s claim in light of her Policy language and determined what “reasonable” expenses Plaintiff had “incurred” for “necessary” medical services arising from her automobile accident. Aff. of D. Lange ¶ 6 (attached as Ex. B). In doing so, Ms. Lange determined that Plaintiff was entitled to reimbursement for all of her out-of-pocket medical payments, deductibles, and co-payments. *Id.* In addition, Ms. Lange determined that Plaintiff was entitled to reimbursement of all payments that her private health insurer, Blue Cross, had paid Plaintiff’s medical providers. *Id.* In other words, Progressive paid Plaintiff not only the amounts she paid herself for medical treatment, but the amounts her health insurer paid on her behalf.

The only amount Ms. Lange deducted from Progressive’s payment to Plaintiff was the difference between the amounts Plaintiff’s medical providers originally billed for their services and the amount Blue Cross actually paid, pursuant to its third-party contracts with the medical

¹ None of the evidence on which Progressive relies is new; all of the evidence was adduced before the Court’s February 14 Order.

providers – the amount that neither Plaintiff nor her health insurer is obligated to pay. *Id.* at ¶ 7. Ms. Lange deducted this amount because she determined, in accordance with the plain language of Plaintiff's insurance Policy and South Carolina law, that because neither Plaintiff nor her health insurer actually paid those amounts, they were not expenses that Plaintiff had "incurred." *Id.* at ¶¶ 7, 8. Plaintiff is not aware of any medical expenses that she still owes. Dep. Tr. of S. Smith at 56:1-15 (attached as Ex. C).

II. Plaintiff's Claims And The Court's February 14 Order

Plaintiff contends that Progressive breached the Policy terms and violated South Carolina law by reimbursing her the amounts she and her health insurer actually paid for her medical expenses, rather than the amounts her medical providers billed. Second Am. Compl. ¶¶ 13, 17, 18. Plaintiff asserts claims against Progressive for breach of contract, unjust enrichment, bad faith, and unfair claims practices/tortious interference. *Id.* ¶¶ 53-74. She also seeks a declaratory judgment. *Id.* ¶¶ 47-52. Plaintiff asserts her claims on behalf of herself and a purported class. *Id.* ¶ 24.

On February 14, 2013, the Court entered an Order certifying a class, which the Court defined as follows:

All insureds of Progressive Halcyon Insurance Company n/k/a Progressive Direct, Co., Progressive Max, and Progressive Casualty who (1) submitted claims to any of the Progressive Insurance Companies, including Progressive Casualty, under the med pay provision of the respective South Carolina policies during the time period of November 8, 2007 to the date of this Order, and (2) whose claims were adjusted by Progressive Casualty, and (3) who did not receive payment in the amount of their medical bills, and (4) whose med pay policy limits were not exceeded.

Id. at 13. On February 22, 2013, Progressive timely filed its motion, pursuant to SCRCP 59(e), for reconsideration and to alter or amend the February 14 Order.

ARGUMENT

"[A] class action is 'an exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only.'" *Broussard v. Meineke Discount Muffler Shops, Inc.*, 155 F.3d 331, 345 (4th Cir. 1998) (citation omitted).² As a result, the proponent of class certification bears the burden of proving all five prerequisites set forth in SCRPC 23:

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

Gardner v. South Carolina Department of Revenue, 353 S.C. 1, 20-21, 577 S.E.2d 190, 200 (2003). The purpose of these requirements is to "effectively 'limit the class claims to those fairly encompassed by the named plaintiff's claims.'" *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541, 2550 (2011) (construing Federal Rule 23(a)). Failure to establish even one of the requirements requires the Court to deny class certification. *Waller v. Seabrook Island Property Owners Ass'n*, 300 S.C. 465, 467, 388 S.E.2d 799, 800-801 (1990). Moreover, the proponent of class certification must, as a threshold matter, propose an adequate class definition. *Anselmo v. West*

² Because South Carolina's Rule 23(a) is based on the Federal Rule of Civil Procedure 23(a), South Carolina courts "look to the construction placed on the Federal Rules of Civil Procedure" when there is no South Carolina law on point. See *Gardner v. Newsome Chevrolet-Buick*, 304 S.C. 328, 330-31, 404 S.E.2d 200, 201 (1991); see also *Middleton v. SunStar Acceptance Corp.*, No. 98-CP-07-1131, 2000 WL 33385388, at *3 n.3 (S.C. Comm. Pl. Jan. 13, 2000) ("As the South Carolina Reporter's Notes indicate, South Carolina's Rule 23 is 'drawn principally from Federal Rule 23. Citations to federal case law and the federal rules are based on the principal that interpretations of the federal rule provide guidance in interpreting the South Carolina rule absent material differences.'" (internal citations omitted)).

Paces Hotel Group, LLC, No. 9:09-cv-2466-MBS, 2011 WL 1049195, at *18 (D.S.C. Mar. 18, 2011); *see also Solo v. Bausch & Lomb, Inc.*, Nos. 2:06-MN-77777-DCN, 2:06-CV-02716-DCN, 2009 WL 4287706, at *3 (D.S.C. Sept. 25, 2009) (“Although not specifically mentioned in the rule, the definition of the class is an essential prerequisite to maintaining a class action”) (quoting *Roman v. ESB, Inc.*, 550 F.2d 1343, 1348 (4th Cir. 1976)).

To determine whether the class certification proponent has discharged her burden, the Court must conduct a “rigorous analysis” of the relevant facts. *Waller*, 300 S.C. at 467, 388 S.E.2d at 801. A “rigorous analysis” of the facts of this case shows that Plaintiff has not met the commonality, typicality, or adequacy components of Rule 23(a), nor has she proposed an adequate definition of the proposed class. Accordingly, this Court should reconsider its decision certifying Plaintiff’s proposed class.

I. Plaintiff Did Not Satisfy Her Burden Of Demonstrating That She Is an Adequate Class Representative.

A. Plaintiff Cannot Adequately Represent Absent Class Members Because She Has No Viable Individual Claims.

Plaintiff is an inadequate class representative, and thus the class should not be certified, because she has no viable individual claim and no standing to represent the class. *See Gardner*, 353 S.C. at 23 n.14, 577 S.E.2d at 200; *Ferguson v. Charleston Lincoln Mercury, Inc.*, 349 S.C. 558, 566, 564 S.E.2d 94, 98 (2002). The sole basis for Plaintiff’s claims is that Progressive allegedly did not pay her the amount she “incurred” for medical expenses because it paid her the amount her health insurer actually paid, as opposed to what her medical providers billed. Second Am. Compl. ¶ 18. As Progressive explains in its Motion for Summary Judgment, Plaintiff’s individual claim fails because, under South Carolina law and the plain language of the Policy, the only expenses Plaintiff “incurred” for medical services were those her medical providers

actually paid. *See* Policy, Part II, Insuring Agreement (providing that Progressive would pay only amounts Plaintiff “incurred”); *Gordon v. Fid. & Cas. Co. of N. Y.*, 238 S.C. 438, 441, 120 S.E.2d 509, 510 (1961).

Interpreting virtually identical policy language, the South Carolina Supreme Court has held that an insured does not “incur” expenses when the insured has “no obligation . . . to pay for the treatment” she receives. *Gordon*, 238 S.C. at 441, 120 S.E.2d at 510. Little more than one month ago, a federal district court sitting in South Carolina and interpreting South Carolina law reached the same conclusion. *See Barker v. Washington Nat’l Ins. Co.*, No. 9:12-cv-1901-PMD, 2013 WL 1767620, at *5 (D.S.C. Apr. 24, 2013) (granting insurer’s motion for summary judgment and holding that insurer complied with policy language by paying requiring insurer to pay amounts insured “incurred” for medical services by paying plaintiff-insured in full the amount he was “obligated to pay”). Accordingly, Plaintiff has no viable claim against Progressive because Progressive paid Plaintiff all of the expenses she “incurred.” *See* Dep. Tr. of S. Smith at 55:12-56:15 (testifying that Plaintiff has no medical expenses outstanding associated with her insurance claim).

It is not premature to evaluate this issue at this stage of the proceedings. The South Carolina Supreme Court has made clear that a named plaintiff in a purported class action does not adequately represent the interests of the absent class members when the named plaintiff lacks a viable individual claim against the defendant. *See Ferguson*, 349 S.C. at 566, 564 S.E.2d at 98 (holding that purported class action cannot proceed when sole named plaintiff dies before class certification and thus has no viable claim against defendant); *see also Gardner*, 353 S.C. at 23 n.14, 577 S.E.2d at 201 (rejecting plaintiff’s request to accept “juridical links doctrine” in class action context because doctrine “runs counter to this Court’s previous decisions which hold that

a plaintiff may not sue a defendant unless the plaintiff has suffered an injury at the hands of the defendant"). This precedent is consistent with persuasive federal authority. *See, e.g., McClain v. South Carolina Nat'l Bank*, 105 F.3d 898, 903 (4th Cir. 1997) (affirming denial of class certification because named plaintiff did not suffer damages caused by defendant and thus had no viable claim). Ruling on the legal sufficiency of Ms. Smith's claim now, in connection with deciding whether she can adequately represent the proposed class, will resolve Plaintiff's individual claim without implicating the Due Process concerns associated with binding the absent class members. *See* Fed. R. Civ. P. 23 advisory cmte. note (2003) ("The party opposing the class may prefer to win dismissal or summary judgment as to the individual plaintiffs without certification and without binding the class that might have been certified.").

Because Plaintiff has no viable claim against Progressive in her own right, she cannot adequately represent the purported class. *See Broussard*, 155 F.3d at 345 (stating that Rule 23 is not a device by which plaintiffs can "strike [defendants] with selective allegations, which may or may not have been available to named plaintiffs"). Consequently, the Court should reconsider its conclusion in the February 14 Order that Plaintiff adequately represents the class.

B. Plaintiff Is An Inadequate Class Representative For Additional Reasons.

Plaintiff cannot represent class members who were insured by Progressive Casualty or Progressive Direct, rather than Progressive Max. *See* Feb. 14 Order at 13 (certifying class including all insured of Progressive Casualty, Progressive Direct, and Progressive Max). Despite Plaintiff's assertions, Progressive Max was the only Progressive company that issued an insurance policy to Plaintiff, who had no relationship – contractual or otherwise – with Progressive Casualty or Progressive Direct. *Aff. of Michael R. Uth* ¶ 5 (attached as Ex. D). As the South Carolina Supreme Court wrote in *Gardner*, "a plaintiff may not sue a defendant unless

the plaintiff has suffered an injury at the hands of the defendant.” 353 S.C. at 23 n.14, 577 S.E.2d at 201 (citing *Edisto Fleets, Inc. v. South Carolina Tax Comm’n*, 256 S.C. 350, 182 S.E.2d 713 (1971); *Furman Univ. v. Livingston*, 244 S.C. 200, 136 S.E.2d 254 (1964)). Because Plaintiff indisputably suffered no injury “at the hands of” Progressive Casualty or Progressive Direct, she cannot assert claims against Progressive Casualty or Progressive Direct and thus cannot represent a class including insureds of Progressive Casualty or Progressive Direct. *See id.*

Finally, Plaintiff also is an inadequate class representative because she is a *former* Progressive Max policyholder seeking to represent a class of current policyholders. See Feb. 14 Order at 13. As a former policyholder, Plaintiff has no standing to seek prospective relief, such as a declaratory judgment. *See Newman v. Richland Cnty. Historic Preservation Cmte.*, 325 S.C. 79, 74 (1997) (holding that plaintiff lacked standing to assert declaratory judgment claim because she had no “personal stake in the subject matter of [the] lawsuit”).

II. Plaintiff Did Not Satisfy Her Burden Of Demonstrating Commonality.

Plaintiff argues that she satisfied her burden of demonstrating commonality based on a list of seven common questions that the Court found applied “to all insureds.” Pl.’s Mem. of Law in Support of Mot. for Class Certification at 8-9. All seven of those questions relate to whether Progressive’s payments to the class members in amounts less than the total amounts the class members were billed – as opposed to any amounts they or their health insurers paid – violated the terms of the class members’ Progressive policies or South Carolina law. *See id.* The answers to those questions, however, will vary depending on each class member’s unique circumstances. Moreover, at least two of the claims that Plaintiff purports to assert on behalf of the absent class members cannot be resolved on a classwide basis because their viability necessarily turns on individualized circumstances.

As the leading scholar of South Carolina civil procedure has observed:

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

James F. Flanagan, South Carolina Civil Procedure § 23.B.3 (2010). In this case, Plaintiff failed first to satisfy her burden of demonstrating that there are common questions among the class members. But even if there were common questions among class members, those questions are not “sufficiently central to justify the class action.” *See id.* As Progressive explains below, because any purportedly common questions in this case are not “determinative,” the Court should reconsider its holding that Plaintiff has met her burden of demonstrating commonality. *See Gardner*, 353 S.C. at 21-22, 577 S.E.2d 190, 201.

A. The Class Does Not Share a Determinative Issue.

The South Carolina Supreme Court has held that “[c]ommonality is met only where the class shares a determinative issue.” *Id.* In cases where the “factual differences” between class members’ claims “are the crux of a predominant legal issue,” commonality does not exist. *Id.* Put differently, to satisfy the commonality requirement, a plaintiff seeking class certification must affirmatively prove the class members “suffered the same injury” and share a “common contention” that “is capable of classwide resolution – which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke.” *Wal-Mart Stores*, 131 S. Ct. at 2551; *see also id.* (“Rule 23 does not set forth a mere pleading standard.”). “A question is not common if its resolution turns on a consideration of the individual circumstances of each class member.” *Burton v. Chrysler Grp. LLC*, No. 8:10-cv-00209-MGL, 2012 WL 7153877, at *3 (D.S.C. Dec. 21, 2012). The commonality requirement

thus “ensure[s] that only those plaintiffs . . . who can advance the same factual and legal arguments may be grouped together as a class.” *Broussard*, 155 F.3d at 340.

In this action, Plaintiff alleges that Progressive paid her less than the amount she was billed because it paid her the amount her health insurer contracted with her healthcare provider to pay for the services rendered. *See* Second Am. Compl. ¶ 18. Consequently, as the Court acknowledged in the February 14 Order, Plaintiff’s claim that Progressive wrongly paid her less than the full amount she was billed turns on whether the expenses Plaintiff “incurred” in connection with receiving healthcare services were, as Plaintiff alleges, the full amount she was billed, or, as Progressive contends (based on binding South Carolina precedent) the amount her health insurer actually paid the provider. *See* Feb. 14 Order at 2 (emphasizing “expenses incurred” language when quoting Policy), 3 (explaining Progressive’s practice of paying the “adjusted bill amount” when a healthcare provider has a contract with a third-party payor), 4 (same and discussing the definition of “incurred” under other states’ laws), 9 (listing the interpretation of “incurred” as a purportedly common question).

The class certified in the February 14 Order, however, is not limited to Progressive insureds whom Progressive paid less than the amounts they were billed as a result of third-party payor contracts with their providers, and Plaintiff presented no evidence to show that the actual members of the class would be predominately such insureds. Rather Plaintiff’s proposed class includes all Progressive insureds in South Carolina whom Progressive paid less than the total amounts the insureds were billed, regardless of the reasons for the difference. *See* Feb. 14 Order at 13. Indeed, the evidence shows that Progressive has made such “reduced” payments for a number of other reasons grounded in the Policy’s terms, depending on the circumstances surrounding each class member’s claim, and there is no evidence as to how many different

circumstances actually are reflected in the members of the class. Thus, Plaintiff has failed to meet her burden of showing that her central contention in this case – that Progressive underpays med-pay benefits to South Carolina insureds with health insurance in breach of the Policy or in violation of South Carolina law (Pl.’s Mem. of Law in Support of Mot. for Class Certification at 1) – is common to the class Plaintiff actually sought to represent and that the Court certified.

1. Whether Expenses Are Reasonable And Services Are Necessary Depend On Individualized Facts.

Importantly, the class includes insureds who, unlike Plaintiff herself, allegedly were paid less than the total amounts their medical providers billed because Progressive determined that the billed amounts were not “reasonable” or that the services provided were not “necessary.” *Id.* ¶¶ 28-29; Policy Part II, Insuring Agreement (stating that Progressive “will pay the reasonable expenses incurred for necessary medical services”); *see* Dep. Tr. of E. Zaner at 29:14-31:13 (discussing Progressive determination of “reasonable expenses” for “necessary medical services”), 46:12-16 (stating that based on plain language of policy, Progressive will be “reasonable expenses incurred for necessary medical service within three years”), 63:4-5 (stating that Progressive would pay insured “[w]hatever we were – reasonable and necessary amount that [insured was] legally obligated to pay”) (attached as Ex. E).

Determining whether Progressive was entitled to pay those class members amounts less than they were billed depends on the interpretation of entirely different Policy terms than those implicated by Plaintiff’s claim – namely, “reasonable” and “necessary,” rather than “expenses incurred.” *See* Dep. Tr. of D. Lange at 21:18-21, 25:1-4 (stating that claims adjustment requires review of actual policy language) (attached as Ex. F); Dep Tr. of E. Zaner at 27:16 – 28:3 (same). Resolving Plaintiff’s claim, therefore, would not resolve the claims of these class members. Instead, to resolve these class members’ claims, the factfinder would have to

determine, on an individual basis, whether Progressive properly concluded that the amount a given class member was billed was unreasonable, that the services the class member received were unnecessary, or both.³

Courts around the country repeatedly have held that class certification is improper when courts must resolve individual issues regarding the reasonableness of expenses incurred or the necessity of services provided. *E.g., Great Lakes Anesthesia, PLLC v. State Farm Mut. Auto. Ins. Co.*, No. 11-10658, 2011 WL 4507417, at *1 (E.D. Mich. Sept. 29, 2011) (noting that determinations regarding what is reasonable and necessary were individual questions); *Johnson v. GEICO Cas. Co.*, 673 F. Supp. 2d 255, 273 (D. Del. 2009) (explaining that “individualized inquiries would be required to determine whether each class member’s individual claim was actually medically necessary and their expenses reasonable”); *Ostrof v. State Farm Mut. Auto. Ins. Co.*, 200 F.R.D. 521, 528-529 (D. Md. 2001) (denying class certification because individualized factors involved in determining whether insurer paid “reasonable and necessary” expenses precluded commonality finding); *Ross-Randolph v. Allstate Ins. Co.*, No. DKC 99-3344, 2001 WL 36042162, at *7 (D. Md. May 11, 2001) (collecting cases reaching the same conclusion). This Court should reach the same conclusion and hold the class certification is improper.

2. Resolving Plaintiff’s Claim Would Not Resolve A Number Of Other Determinative Issues Under The Policy.

In addition to the individualized “reasonable” and “necessary” inquiries implicated by Plaintiff’s proposed class, the factfinder also would have to resolve a number of other

³ Similarly, resolving Plaintiff’s claim that Progressive violated Code § 38-77-144, which provides that med-pay coverage “is not subject to a set-off,” would not resolve the individual claims of class members whose expenses Progressive deemed “unreasonable” or whose services Progressive deemed “unnecessary.”

individualized issues to dispose of each class member's claims because the Policy language makes clear that Progressive may have paid the class members less than the full amounts they were billed for still other reasons.

For example, Progressive may have paid a class member less than the total amount the class member was billed because some of the medical services the insured obtained did not occur "within three years from the date" of the motor vehicle accident in question. *See* Policy, Part II, Insuring Agreement. To ascertain whether Progressive's decision was appropriate under the Policy and South Carolina law, the Court would be obligated to conduct an individualized inquiry regarding the dates on which the class member obtained each of the medical services for which she sought coverage. That is not a common question that can be resolved on a classwide basis.

Likewise, Progressive may not have paid the insured the full amount billed because in adjusting the claim, Progressive ascertained that (i) the insured did not sustain "bodily injury," (ii) the bodily injury sustained was not the result of the "motor vehicle accident" at issue, or (iii) the insured was not, in fact, injured. *See id.* To resolve each class member's claims, the factfinder would have to delve into whether the insured actually was injured, the cause of the injury, the nature of the injury, and whether each particular service for which the insured is seeking coverage relates to a "bodily injury" suffered by the insured in connection with the covered "motor vehicle accident." None of these questions would be answered by adjudicating Plaintiff's claims. These are just a few of the Policy-based reasons why Progressive may have paid a given insured less than the total amount the insured was billed. An extensive list of such reasons is attached as Exhibit G.

3. **Authority Relied Upon By Plaintiff Is Inapplicable.**

Plaintiff ignored the myriad individual issues in this case in an attempt to convince the Court that this is a straightforward, single issue class action. The evidence proves the contrary. In arguing that she met her burden of demonstrating commonality, Plaintiff relied on the decision in *Littlefield v. South Carolina Forestry Commission*, 337 S.C. 348, 523 S.E.2d 781 (1999), which is inapplicable.

In *Littlefield*, the court held the class certification was appropriate because the only issue in the case was whether state agencies' interpretation of a statute governing the method of calculation of unused annual leave violated equal protection. 337 S.C. at 350, 523 S.E.2d at 782. Accordingly, in that case – unlike this one – there was, in fact “one main issue of law which [was] identical for all plaintiffs,” all injuries resulted from the same conduct, and calculation of damages would not be difficult. *See id.* at 337 S.C. at 355, 523 S.E.2d at 784. The commonality analysis in the South Carolina Supreme Court's *Gardner* decision is more applicable here, for the reasons explained above. *See* 353 S.C. at 22, 577 S.E.2d at 201 (reversing trial court's decision granting class certification because “determinative issues” in case were inherently individualized).

In short, “the varying claims presented by the proposed class will require . . . intensive, individual fact-finding.” *See Martin v. State Farm Mut. Auto. Ins. Co.*, 809 F. Supp. 2d 496, 510 (S.D. W. Va. 2011) (denying motion for class certification because claims that insurer did not make uninsured motorist coverage available to purported class at “commercially reasonable rates” implicated multitude of individual issues that precluded finding of commonality under *Wal-Mart*). Rather than demonstrating that the purported class members “suffered the same injury,” the evidence shows that “because of the varying factual scenarios between putative class members, there are a wide variety of possible injuries – including no injury at all – caused by”

Progressive's alleged conduct. *See Martin v. JTH Tax, Inc.*, No. 9:10-cv-03016-DCN, 2013 WL 442425, at *6 (D.S.C. Feb. 5, 2013). Consequently, "[t]his is not a typical class action where minor factual differences exist among the individualized cases of class members." *See Gardner*, 353 S.C. at 22, 577 S.E.2d at 201. To the contrary, the "factual differences" in this case "are the crux of a predominant legal issue" – *i.e.*, whether Progressive breached the Policy or violated South Carolina law by paying the purported class members amounts less than they were billed. *Id.* Because "[r]equiring such individualized examination negates the benefits of a class action suit," the Court should deny Plaintiff's motion for class certification. *Id.*

B. Plaintiff's Unjust Enrichment Claim Does Not Implicate Common Issues.

The Court also should reconsider the February 14 Order because of the overwhelming individual issues implicated by Plaintiff's unjust enrichment claim. Plaintiff alleges, on behalf of herself and the purported class, that Progressive was unjustly enriched by "the reduced payments to the Plaintiff and class members under the medical payments portion of their insurance policies with [Progressive]." Second Am. Compl. ¶ 59. In other words, Plaintiff contends that Progressive was unjustly enriched as a result of its payments to the class members resulting from the myriad unique circumstances surrounding each class member's claims to Progressive.

Unjust enrichment is an equitable doctrine, which permits recovery of the amount that the defendant has been unjustly enriched at the expense of the plaintiff. *Dema v. Tenet Physician Servs. Hilton Head, Inc.*, 383 S.C. 115, 123, 678 S.E.2d 430, 434 (2009); *Ellis v. Smith Grading & Paving, Inc.*, 294 S.C. 470, 474, 366 S.E.2d 12, 15 (Ct. App. 1988). To recover for unjust enrichment on a classwide basis, Plaintiff must prove – for each class member – that (i) the class member conferred a benefit on Progressive; (ii) Progressive realized that benefit; and (iii) Progressive retained the benefit under circumstances that make it "inequitable" for Progressive to

do so “without paying . . . its value.” *Sauner v. Public Serv. Auth.*, 354 S.C. 397, 409, 581 S.E.2d 161, 167 (2003).

By its very nature, an unjust enrichment claim is unsuitable for resolution on a classwide basis because adjudicating it would require the factfinder to investigate the individualized circumstances surrounding each class member’s claims. In particular, the factfinder would have to determine – based on each class member’s unique circumstances – whether, by paying each class member an amount less than the full amount the class member was billed (as opposed to the amount the class member or her health insurer actually paid) “it would be inequitable” for Progressive to retain the class member’s premium payments. Making such a determination would require the factfinder to consider, among other things:

- Whether Progressive paid the class member an amount less than what she was billed (as opposed to what she or her health insurer paid) because that was the amount her healthcare provider contracted to receive from her third-party payor;
- Whether Progressive paid the class member an amount less than what she was billed (as opposed to what she her health insurer paid) because it rightly determined that her medical expenses were unreasonable;
- Whether Progressive paid the class member an amount less than what she was billed (as opposed to what she her health insurer paid) because it rightly determined that her medical treatment was unnecessary in one or more respects;
- Whether Progressive paid the class member an amount less than what she was billed (as opposed to what she her health insurer paid) because the class member otherwise was not entitled to coverage under the Policy;

- Whether the class member had to pay any money out-of-pocket as a result of Progressive paying her less than the amount she was billed;
- Whether the class member reaped a windfall as a result of Progressive paying her any amount of money in connection with her claim because she paid no money (or less money than Progressive paid her) for the medical services she received; and
- Whether the class member derived any benefits from paying premiums to Progressive, other than Progressive paying the expenses she actually incurred from receiving medical services in connection with her claim.

Put succinctly, there is no single question the factfinder can answer in addressing Plaintiff's individual claims that also will answer all of these questions with respect to each and every class member. Accordingly, Plaintiff's unjust enrichment claim renders class certification inappropriate. *See Melton ex rel. Dutton v. Carolina Power & Light Co.*, 283 F.R.D. 280, 290 n.7 (D.S.C. 2012) (concluding that because unjust enrichment and other claims required the factfinder to make numerous "individualized determinations").

C. Plaintiff's Bad Faith And Tortious Interference Claims Do Not Implicate Common Issues.

For similar reasons, the Court should reconsider its February 14 Order and deny class certification because Plaintiff's bad faith claim is not amenable to class treatment. To state a claim for bad faith, Plaintiff must prove – with respect to herself and the purported class – that Progressive refused to pay each class member the benefits owed the class member under the Policy as a result of Progressive's "bad faith or unreasonable action in breach of an implied covenant of good faith and fair dealing." *See Temple v. Mut. of Omaha Ins. Co.*, No. 4:11-cv-00128-RBH, 2013 WL 314750, at *4 (D.S.C. Jan. 28, 2013) (construing South Carolina law). As

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

Plaintiff's tortious interference claim precludes class certification for similar reasons as her bad faith claim. Namely, it would require the factfinder to determine whether Progressive intentionally procured the breach of its own contracts with the class members (assuming, for the sake of argument, that a party to a contract can state a claim for tortious interference with her own contract). *See Self v. Norfolk So. Corp.*, Nos. 1:06-cv-1730-MBS and 1:06-cv-2101-MBS, 2007 WL 540373, at *4 (D.S.C. Feb. 15, 2007). Accordingly, Plaintiff cannot show that commonality exists with respect to her bad faith or tortious interference claims.

III. Plaintiff Did Not Satisfy Her Burden Of Demonstrating That Her Claims Are Typical of the Class Members' Claims.

Plaintiff's claims are not typical of those of the class because she does not "possess the same interest" and did not "suffer the same or similar injury" as the class members. *See Burton*, 2012 WL 7153877, at *3 (citing *McClain*, 105 F.3d at 903). To meet the typicality threshold, Plaintiff must prove that her "interest in prosecuting [her] own case . . . simultaneously tend[s] to advance the interests of the absent class members." *See Dieter v. Microsoft Corp.*, 436 F.3d 461, 466 (4th Cir. 2006) (holding that named plaintiffs in antitrust class action were not typical of some purported class members because proving absent class members' claims would require "new and different proof" than evidence required to prove named plaintiffs' claims).

Accordingly, when “variation” between a named plaintiff’s claims and those of the purported class members “strikes at the heart of the respective causes of actions,” courts “have readily denied class certification. *See id.* at 467(citing cases).

Plaintiff’s claim turns on whether Plaintiff’s Policy entitled Progressive to pay her the amount her health insurer paid for the medical services she received in connection with her insurance claim. *See* Second Am. Compl. ¶¶ 18, 29; Feb. 14 Order at 3 (“The difference [in the amounts Plaintiff was originally billed and Progressive paid] was due to credits toward medical bills from [Plaintiff’s] health insurance companies’ contractual adjustments with the medical providers.”). As discussed above, however, other class members may have received payments from Progressive that were lower than the amounts they were billed for any number of other reasons. *See* Exhibit G. Accordingly, the Court’s conclusion that “Progressive’s payments to [Plaintiff] were reduced under the same process in which Progressive reduced payments to Class Members” directly contradicts the record evidence. *See* Policy Part II, Insuring Agreement (stating that Progressive “will pay the reasonable expenses incurred for necessary medical services”) (*italics added*); *see* Dep. Tr. of E. Zaner at 29:14-31:13 (discussing Progressive determination of “reasonable expenses” for “necessary medical services”), 46:12-16 (stating that based on plain language of policy, Progressive will be “reasonable expenses incurred for necessary medical service within three years”), 63:4-5 (stating that Progressive would pay insured “[w]hatever we were – reasonable and necessary amount that [insured was] legally obligated to pay”); *see also* Dep. Tr. of D. Lange at 21:18-21, 25:1-4 (stating that claims adjustment requires review of actual policy language); Dep Tr. of E. Zaner at 18:16-19:3 (same).

As a result, even if Plaintiff could prove her own claim (and she cannot), doing so would not resolve the claims of class members who are situated differently than Plaintiff. Plaintiff,

therefore, has not – and cannot – establish typicality, necessitating reconsideration of the Court’s February 14 Order. *See Burton*, 2012 WL 7153877, at *5 (denying class certification because court found “it would be forced to sort through individualized questions . . . to determine whether each class member has a cognizable” claim); *Biggerstaff v. Voice Power Telecomm, Inc.*, No. 2002-CP-10-1351, 2003 WL 25564250, slip op. at 5 (9th Jud. Cir. Oct. 13, 2003) (denying class certification on lack of typicality grounds because “each specific fact of each member of the putative class will have to be examined to determine” liability).

IV. Plaintiff’s Proposed Class Definition Is Not Adequate.

Plaintiff’s overly broad proposed class definition underscores the myriad individual issues pervading this lawsuit because it includes insureds of three different insurers – Progressive Casualty, Progressive Direct, and Progressive Max (the only insurer with whom Plaintiff had a relationship) – who received payments from Progressive in amounts less than they were billed for medical services for any reason. As discussed above, Plaintiff failed to demonstrate that her proposed class implicates a common question that the Court can resolve simply by adjudicating Plaintiff’s claim. To the contrary, simply to determine whether a particular individual is a member of a class Plaintiff theoretically could represent – that is, a class limited to individuals whom Progressive reimbursed in amounts matching what third-party payors paid the individuals’ medical providers – the Court would have to conduct “extensive factual inquir[ies].” *See Cuming v. South Carolina Lottery Comm’n*, No. 3:05-cv-03608-MBS, 2008 WL 906705, at *1 (D.S.C. Mar. 31, 2008). As a result, the class definition is inadequate because it is not “sufficiently definite so that it is administratively feasible for the [C]ourt to determine whether a particular individual is a member.” *See id.* (citing 7A Charles Alan Wright, *et al.*, Federal Practice & Procedure § 1760 (2d ed. 1986 & Supp. 2007)); *see also* Flanagan § 23.B.1 (“Many of the

problems about the 'class' aspect of the representative suit are traceable to vague and ambiguous pleadings that make the class too expansive and difficult to determine its membership.”).

Moreover, the deficiencies in the class definition cannot be remedied. Even if the Court were to amend the definition of the class certified in the February 14 Order to include only insureds of Progressive Max who received payments from Progressive Max for medical services in amounts less than they were originally billed because Progressive Max reduced the payments to the amounts third-party payors paid the class members' medical providers – which is what Plaintiff alleges – the class still would be defined inadequately. The undisputed evidence shows that Progressive does not keep summary records reflecting the reasons insureds are reimbursed in amounts lower than the amounts they were billed for medical services. *See* Dep. Tr. of M. Silver at 19:8-23 (testifying that Progressive's records only show “that the amount paid was not the amount that was entered,” *i.e.*, the amount the insured was originally billed), 27:19-28:6 (testifying that Progressive cannot ascertain “the number of persons who submitted claims and . . . didn't receive the maximum policy limits . . . , and they received a payment that was less than one or more of their medical bills.”) (attached as Ex. H). Accordingly, determining which Progressive insureds are members of the class, at best, would require a manual file review. *See id.* at 40:10-15. More likely, however, Progressive would be unable to determine with certainty which insureds fall within even the narrowed class definition. In other words, because “the practical issue of identifying class members is overly problematic . . . the administrative burdens of certification may outweigh the efficiencies expected in a class action.” *See Solo*, 2009 WL 4287706, at *4 (citation omitted).

Courts regularly deny class certification in cases like this one, in which the Court would have to engage in significant individualized factfinding to ascertain the proposed class members.

See, e.g., Burton, 2012 WL 7153877, at *2 (denying class certification because, among other reasons, because based on proposed class definition, "it would be difficult to analyze . . . records . . . to determine whether a particular individual is a class member"); *Solo*, 2009 WL 4287706, at *6 (denying class certification because "[i]n order to ascertain who falls within the class, the court would have to make thousands of fact-intensive inquiries"); *Cuming*, 2008 WL 906705, at *1 (same). This Court should do the same, reconsider its finding in the February 14 Order that the class definition is adequate, and deny class certification.

CONCLUSION

For these reasons and the reasons explained in Progressive's Memorandum in Opposition to Plaintiff's Motion for Class Certification, the Court should reconsider its February 14 Order and deny Plaintiff's Motion for Class Certification.

Respectfully submitted, this 24th day of May, 2013.



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IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT
C/A NO.: 2010-CP-26-10502

FIFTEENTH JUDICIAL CIRCUIT
C/A NO.: 2010-CP-26-10502

C/A NO.: 2010-CP-26-10502

**MEMORANDUM IN OPPOSITION OF
DEFENDANTS' MOTION FOR
RECONSIDERATION AND TO
ALTER OR AMEND THE COURT'S
ORDER GRANTING CLASS
CERTIFICATION**

**DEFENDANTS' MOTION FOR
RECONSIDERATION AND TO
ALTER OR AMEND THE COURT'S
ORDER GRANTING CLASS
CERTIFICATION**

ALTER OR AMEND THE COURT'S
ORDER GRANTING CLASS
CERTIFICATION

CERTIFICATION

CLERK OF COURT
JAMES HUGGINS-WARD

13 MAY 29 AM 9:18

UNITED STATES

The Class respectfully submits this Memorandum in Opposition of Defendants' Motion For Reconsideration And To Alter Or Amend The Court's Order Granting Class Certification.

INTRODUCTION

The Defendants' Motion For Reconsideration of the Court's Order Granting Class Certification ("Certification Order") is a rehash of the arguments previously raised at the hearing and which were addressed in the Court's ruling. Defendants' arguments are without merit and ignore the substantial factual record upon which the Certification Order is grounded. In addition, the Defendants attempt to introduce new arguments and material into the record.

The testimony of the Defendants' employees and the Defendants' discovery responses provide an unequivocal factual scenario: Progressive has used a systematic approach to adjust med pay claims without variation. The elements for class certification in this context, especially in light of the relatively small amounts at issue, have been easily met.

ARGUMENT

I. The Class has been properly defined.

A. The Class is objectively ascertainable.

Progressives' argument that the Class has not been properly defined is without merit. A proper class definition describes the class in objective terms of membership without regard to the merits of the proposed class membership claims or the particular relief they seek. See Herbert B. Newberg and Alba Newberg on Class Actions, Fourth, §6.14 (3d.ed. 1994). See also Manual for Complex Litigation, Third Ed., §30.14. Progressive can easily use the objective criteria in the class definition to ascertain class membership.

Progressive knows the policyholders, the claimants, bill amounts and reduction amounts. This information is objectively ascertainable and is easily retrievable. Progressive enters into its computer system the hospital bill, total charge and amount allowed. Lange Dep. p. 88, ln. 21-25. The medical bills are not reviewed for any other reason. Lange Dep. 37 p. 37, ln. 20 to 22. Whether the reductions result in a claim is not at issue for class definition purposes. The claims or damages phase will address the recoverable damages.

B. The Class definition is not overbroad.

Any argument that the inclusion of Progressive Direct and Progressive Casualty insureds is overbroad ignores the plain facts in the record. Progressive Direct and Progressive Max underwrote the Smith Policy. The policy face page is entitled Progressive Direct, yet Defendants ignore this fact. As for Progressive Casualty, the record is unequivocal: it operates the entire business of both carriers through the Joint Servicing Agreements. In addition, Progressive Casualty operates the National Med Pay Unit which uniformly interprets "incurred" to mean the amount of the bill less any contractual adjustments. Goodchild 30(b)(6) Dep. p. 23, lines 11-24.

No different policy language is at issue. It is clear the Plaintiff has a direct relationship with all three Defendants and any adjudication of the claims will affect all three Defendants.

Furthermore, Stephanie Smith has standing to assert the claims under The Declaratory Judgment Act, S.C. Code Ann. §15-53-10 et seq. The Act is remedial and liberally construed. All three Defendants are subject to the Class' claims as they all have an interest which would be affected by a declaration. The National Med Pay Unit will be affected in its adjustment of the claims. The other Defendants, as insurance carriers, will have their policies affected. Progressive Casualty, under the Joint Servicing Agreements, will have its rights affected in its administration of the insurance business.

C. The Class scope properly begins from November 8, 2007, three years prior to the date the lawsuit was filed.

This action was commenced on November 8, 2010. The applicable statute of limitations is three years from the date of the filing of the Complaint. Therefore, the Class period of November 8, 2007 to the date of the Certification Order is an appropriate period. In addition, the claims are ongoing insofar as the Class Members are permitted to continue to submit med pay claims for medical services rendered three years from the date of the occurrence. These class claims include prospective application for payments of Class Members. The Class period has been properly defined in accordance with a three year statute of limitations.

II. The underlying merits of the claim are not to be adjudicated at the class certification phase.

Defendants argue that the Court should determine liability at the class certification phase. Defendants cite and misapply several inapposite cases in an attempt to have the Court rush to judgment on the underlying merits of the claims. However, in ruling on a motion for class certification, the merits of the case are not to be considered by the trial court. Tilley v. Pacesetter

Corp., 333 S.C. 33, 508 S.E.2d 16 (1998). Progressive ignores this precedent and urges the Court to make a premature determination. The Court should not entertain what is tantamount to a summary judgment motion until after class notice has been served and the class members have been afforded the opportunity to opt out. Salmonsens v. CGD, Inc., 661 S.E.2d 81 (S.C. 2008).

III. Stephanie Smith is an adequate class representative with typical claims.

A. Smith is an adequate class representative.

Due to Defendants' uniform practices, the claims asserted and the remedial nature of the Declaratory Judgment Act, Smith is an adequate representative. See S.C. Code Ann. §15-53-10 et seq. Smith brought the action as a policyholder. She can maintain the action regardless of whether or not she is a current policyholder. She can request the Court to address the uniform practices of Progressive as she was subjected to them. She is similarly situated to all Class Members and does not need to be a current policyholder to continue her representative capacity.

S.C. Code Ann. §15-53-30 provides, in part, "Any person interested under a written contract . . . or whose rights . . . are affected by a statute . . . contract . . . may have determined any question of construction or validity arising under the statute . . . contract and obtain a declaration of rights..." When declaratory relief is sought all persons shall be made parties who have or claim any interest which would be affected by the declaration. S.C. Code Ann. §15-53-80.

Smith has an interest in the insurance contract and under the insurance statutes at issue. She also has an interest in addressing the National Med Pay Unit's systematic adjustment of claims. The uniform policy language, the statutes' uniform application, and uniform claims adjustment practices of the Defendants suffered by Stephanie Smith make her well-suited to serve as class representative. In addition, the Defendants will all be affected by the declaration.

The Declaratory Judgment Act is remedial and is to be liberally construed. S.C. Code Ann. §15-53-130. Guimarin & Doan, Inc. vs. Georgetown Textile, 155 S.E.2d 618 (S.C. 1967).

Contrary to Defendants' contentions, Smith is not required to continue to pay for a Progressive policy when she has alleged she was harmed by Progressive. Given the statutory language and the statute's remedial purpose, Stephanie Smith may maintain a declaratory judgment action.

B. Smith's claims are typical of the Class.

Smith's claims are typical and other Class Members do not have different economic interests. Progressive argues that some Class Members may want Progressive to keep monies that could be paid to Class Members. Such a hypothetical position is nonsensical and Progressive has provided no proof or evidence to support it. Again, although Progressive raised hypothetical scenarios to advance its arguments, the record does not support them. If money is owed to a Class Member, it should be paid to the Class Member. There is no benefit to a Class Member in allowing Progressive to keep his money. If a Class Member wishes Progressive to keep his money, he can opt out.

IV. Common issues for all class members are at the center of the claims.

A. The record does not support Progressives' commonality argument.

Although the record easily supports a finding of commonality, Progressive argues hypotheticals in an attempt to avoid its systematic practices. The law regarding commonality is addressed in the Certification Order. However, each of the Defendants' assertions is fatally flawed from a factual standpoint. The record simply doesn't support Defendants' arguments.

Commonality throughout the class period has been established in the record. The policy language has not changed in the class period. The adjusting process has not changed in the class period. Dorothy Lange, Smith's adjuster, has been with Progressive since 2005 and testified that

the adjustment process has not changed. Progressive has not averred in affidavit or otherwise how the adjustment process differed at any relevant time.

Progressive asserts that there is no commonality because the fact finder must make a determination as to whether the medical bills submitted were "reasonable and necessary" under the policy. 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 National Med Pay Unit has never declined or reduced a claim based upon the reasonable and necessary clause within the policy. 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. Lange Dep. p. 24, line 5. Progressive specifically does not review the medical bills for reasonableness. Lange Dep. p. 123, line 24. Nothing in the record supports Defendants' contention. Again, Defendants advance hypothetical arguments which are not supported by the record.

Furthermore, individual findings as to why each policyholder received a payment for an amount less than the medical bill is not required. The testimony is unequivocal that the National Med Pay Unit uses a simple algorithm to pay med pay claims. The Defendants take the amount of the medical bill, then they reduce it by the amount of health insurance credit and pay the rest. Lange Dep. p. 124, lines 1-18. The formula does not vary and its application to the Class is simple.

Progressive does not individually determine different reasons to write down medical bills. That argument runs counter to the very purpose of the National Med Pay Unit, which is focused on streamlining the adjustment process for 15 different states under a common approach regardless of policy language. The National Med Pay Unit only focuses on health insurance credits. An individualized approach to the reduction determination is never conducted by

Progressive. The record is void of any such scenario. There is no basis to now exact an individual review of the claims.

Progressive asserts there is no commonality because a prospective class member may have filed a claim outside the coverage period or failed to meet a condition of coverage. In other words, Progressive contends there might not be coverage due to a policy lapse or termination. However, Progressive overlooks a fundamental part of its claims processing. Pursuant to Progressives' Standard Operating Procedure, a determination is always made as to whether there is coverage. This includes determining whether the claimant is a Progressive insured and then whether she has med pay coverage. See Exhibit E of Plaintiff's Memorandum in Support of Motion For Class Certification, South Carolina Initial Handling Guidelines, and Progressive 00543.

Additionally, a determination of whether a policyholder submitted a med pay claim outside his or her applicable coverage period is a red herring. The class definition requires the class member to be a Progressive insured. If the Class Member submitted a claim outside his/her policy coverage period, he/she would not be a Progressive insured as required by the class definition. Progressive has already evidenced its decision as to who is an insured by calculating a reduced payment.

Progressive misreads the Second Amended Complaint while asserting there can be no commonality because of the allegations related to deceit. The deceit referenced in the Complaint is a classwide deceit based on a flawed but uniform claims process which misinterprets the policy language. The Second Amended Complaint, Paragraph 36, alleges that the Defendants acted in concert with each other in a common scheme, through the use of a systematic and arbitrary claims processing tool and "an arbitrary, illogical definition of "incurred," to deceive, mislead and systematically underpay Plaintiff and the Class Members." This uniform

misinterpretation by the Defendants of their own policy language is at issue. Thus, the systematic application of Defendants' self serving definition of "incurred" militates in favor of class certification.

Progressive next argues that there can be no commonality because there must be a determination of whether Progressive was unjustly enriched with respect to each claim of the purported class member. The logic of Progressive is fatally flawed and cannot stand scrutiny. Any enrichment of Progressive will only result from its misapplication of the policy terms and violation of the law and invariably will equal the detriment to the Class. The data for each class member is readily available to Progressive. The unilateral reduction of the class member's med pay benefits will be a measure of that class member's damages. To the extent that the class member suffers a loss due to the med pay benefit reduction, Progressive has been enriched. They are homogeneous and will always be homogeneous. No separate calculation needs to be made.

Progressive also mistakenly claims commonality is lost because an inquiry must be made for each class member into the reasonableness of its decision to reduce payments to its insureds. However, reasonableness does not play a role in Progressives' decision to unilaterally reduce the amount paid to insureds. Progressive has not offered one example of how Progressive reduced a medical bill because it was unreasonably high or because the charge was for an unnecessary service. Progressive uses the same payment formula for each med pay claim which is set forth in the South Carolina SOP, Progressive 00543, "Allowed to recover for same damages paid under health insurance." Reasonableness or necessary simply do not factor into the Defendants' process on whether to pay and how much to pay, and certainly cannot be a basis to defeat class certification.

V. The requested relief easily satisfies Rule 23(e).

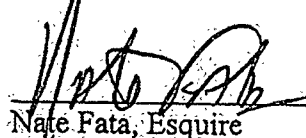
The final element of Rule 23 is easily met because declaratory relief is requested and the average class member has well more than \$100.00 at issue. As stated above, a primary remedy is a declaration under the Declaratory Judgment Act. In addition, the average class member has more than \$1,000.00 at issue.

In its Fourth Supplemental Answers to Plaintiff's First Set of Interrogatories Defendants disclose 364 Progressive Max and Progressive Direct insureds who met the Class definition for the period 2007 – August 2011. See Exhibit K to Plaintiff's Memorandum in Support of Motion For Class Certification. For that same period, Progressive disclosed the reduction amounts of approximately \$506,000. See Defendants' Supplemental Response in Defendants' Supplemental Answers to Plaintiff's Supplemental Interrogatories Number 1, Exhibit "K" to Plaintiff's Memorandum in Support of Motion For Class Certification. Using those numbers and the other numbers in the discovery responses, the average class member easily has more than \$1,000 in reductions. Smith is no different. In addition, the class member claims are open for three years and will continue to grow as class members may continue to submit medical bills. The amount of the reductions will continue to increase, further satisfying Rule 23. The last element of Rule 23 is easily met, especially in light of the average reduction amount disclosed by Defendants' discovery responses and the declaratory relief sought.

CONCLUSION

As stated above and in the Certification Order, Rule 23 has been satisfied and Defendants' Motion should be denied.

Respectfully submitted,



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May 28, 2013

) **IN THE COURT OF COMMON PLEAS**
) **FIFTEENTH JUDICIAL CIRCUIT**
) **C/A NO.: 2010-CP-26-10502**

Y

)

) **PLAINTIFFS' SUPPLEMENTAL**
) **BRIEF IN OPPOSITION TO**
) **DEFENDANTS' MOTION FOR**
) **RECONSIDERATION AND TO ALTER**
) **OR AMEND THE COURT'S ORDER**
) **GRANTING CLASS CERTIFICATION**

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In Exhibit G, "reasonableness" of the medical bill is the only one that is not a threshold coverage issue. However, it is unequivocal that Progressive has never declined or reduced a claim based upon the reasonable and necessary clause within the policy (Deposition of Lilian Felton, a National Med Pay Unit Claims Adjuster - p. 16, line 1 to p. 17, line 14; Deposition of Kimberly Braden, a National Med Pay Unit Claims Adjuster - P. 12, lines 20-24; Deposition of Elbonye Dennis, a National Med Pay Unit Claims Adjuster - P. 26, line 19 to P. 27, line 5; Deposition of Robert Cole, a National Med Pay Unit Claims Adjuster - P. 25, lines 10 - 16).

According to 30(b)(6) designee, Peter Goodchild, if a med pay file is opened, but no payment is made, it is because there was **no coverage** (Goodchild deposition pages 78 - 79). Goodchild's testimony proves there are no write downs unless the insureds meet the coverage threshold and hence, the class definition.

Defendants stated to the Court that it would be an oppressive task to sort through each claim and the matter would have to be conducted by hand. Counsel quoted testimony not previously in the record of Robert Cole, a med pay claims adjuster to support this claim. The claim of oppressiveness is unbelievable given the testimony of Dorothy Lang, the claims adjuster who adjusted the Smith claim. She states that she enters data into the Mitchell computer system.¹ This data includes codes such as X563 which is a designation for health insurance. The reasons for any write-downs to a medical bill are coded and explained in the Explanation of Benefits sent to the insured. Lang's testimony is bolstered by Peter Goodchild, Medical Supervisor over the national med pay unit. Goodchild states that he is not aware of any instance where a South Carolina med pay claim was re-priced by the Mitchell software (Goodchild deposition, p. 15, line 21.)

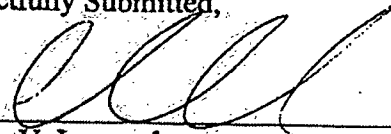
¹ At the hearing, Defense counsel intimated that Mitchell is an autonomous pre-claims processing step which is out of the control of the Progressive med pay adjusters. Lang clearly states that she enters the explanation codes into Mitchell, including a code for health insurance. There are "huge lists" of possible codes (Lang deposition p. 44-45).

The Cole testimony quoted at the hearing was not complete. Cole states that Mitchell may provide a claims write-down (which would be coded accordingly) for two reasons: membership into the Coventry Health System, or "usual and customary" which he states is the same as "reasonable and necessary." Of paramount importance, is he is not sure that the "usual and customary" code is a South Carolina designation or part of the South Carolina policy language (Cole deposition p. 9, line 9 to p. 10 line 2). Cole agrees with Lang that a Progressive Explanation of Benefits is sent to any insured who receives a med pay write-down, once again showing that tracking any class member's write-down would be an easy task (Cole, p. 13, line 18).

The Defendants gave one example, that of a man with an unrelated thumb injury, as support for disallowing the class. An unrelated injury would certainly be designated within the "huge lists" of possible codes and easily ferreted out during the claims administration of the case (See footnote supra for reference to "huge list").

In sum, the class definition in its current state is appropriate. The commonality examples given by the Defendants are filtered before a claim is paid. The one exception, reasonableness of the bill, has never been applied to a South Carolina med pay insured. Finally, the coding on the Explanation of Benefits allows the Class claims to be easily sorted during the claims process.

Respectfully Submitted,



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STATE OF SOUTH CAROLINA
COUNTY OF HORRY

STEPHANIE A SMITH on behalf of
herself and all others similarly situated,

Plaintiff,

v.

PROGRESSIVE HALCYON
INSURANCE COMPANY, n/k/a
PROGRESSIVE DIRECT INSURANCE
CO., PROGRESSIVE MAX, and
PROGRESSIVE CASUALTY
INSURANCE,

Defendants.

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT

Case No. 2010-CP-26-105

DEFENDANTS' RESPONSE TO
PLAINTIFF'S SUPPLEMENTAL
BRIEF IN OPPOSITION TO
DEFENDANTS' MOTION FOR
RECONSIDERATION AND TO ALTER
OR AMEND THE COURT'S ORDER
GRANTING CLASS CERTIFICATION

In her Supplemental Brief in Opposition to Defendants' Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification (the "Supplemental Brief"), Plaintiff argues that she has met her burden of proving commonality and ascertainability because (i) all but one of the 39 Policy provisions permitting Progressive to reduce or deny a med-pay claim are "threshold coverage issues" and thus, Plaintiff contends, are immaterial (Supplemental Br. at 1); (ii) the Court need not consider the "reasonable and necessary" provision of the Policy because Progressive allegedly has "never declined or reduced a claim based upon the reasonable and necessary clause" in the Policy (*id.* at 2 (emphasis original)); and (iii) ascertaining the class members would not be "oppressive" because "a Progressive Explanation of Benefits is sent to any insured who receives a med-pay write down" (*id.* at 2-3). None of Plaintiff's arguments is persuasive.

(1) The Class Definition Does Not Include An Exclusion Based On "Threshold Coverage Issues."

Plaintiff argues that 38 of the 39 Policy provisions under which Progressive might have reduced or denied a class member's med-pay claims are "threshold coverage issues" and that "[a]ny insured who makes a med pay claim and is excluded pursuant to [the 38 Policy provisions] would not be a part of the class as it is currently defined." Supplemental Br. at 1. Plaintiff's argument ignores the class definition that Plaintiff proposed in her Motion for Class Certification, that Plaintiff repeated in the Proposed Order she submitted to the Court, and that the Court adopted in its February 14, 2013 Order.

The class includes:

- ✓ All insureds of Progressive Halcyon Insurance Company n/k/a Progressive Direct, Co., Progressive Max and Progressive Casualty who (1) submitted claims to any of the Progressive Insurance Companies, including Progressive Casualty, under the med pay provision of the respective South Carolina policies during the time period of November 8, 2007 to the date of this Order, and (2) whose claims were adjusted by Progressive Casualty, and (3) who did not receive payment in the amount of their medical bills, and (4) whose med pay policy limits were not exceeded.

February 14 Order at 13. This class definition does not exclude Progressive insureds whom Progressive did not reimburse in the amount of their medical bills as a result of "threshold coverage issues." Accordingly, the 38 Policy provisions Plaintiff describes as "threshold coverage issues" are anything but irrelevant; any Progressive insured in South Carolina whose med-pay claim was reduced or denied based on one of these "threshold coverage issues" is a member of the certified class, even though the reasons for those insureds receiving payments less than the amounts they were billed have no commonality with the reasons for Plaintiff's reduced payment. Despite the Court's direct inquiry at the May 29, 2013 hearing, Plaintiff offers no alternative proposed class definition to remedy this problem.

(2) Progressive Adjusts Med-Pay Claims In South Carolina Based On Reasonableness Using Mitchell DecisionPoint.

As Progressive has demonstrated, one of the problems with the certified class is that it includes insureds who submitted med-pay claims that were not paid in full because the amount charged was not "reasonable," rather than because of the adjustment about which Plaintiff complains. In an attempt to rebut this argument, Plaintiff asserts in her supplemental brief that "it is unequivocal that Progressive has never declined or reduced a claim based upon the reasonable and necessary clause" in the Policy. Supplemental Br. at 2. In purported support of this assertion, Plaintiff cites the deposition testimony of four Progressive claims adjusters. Plaintiff's assertion is incorrect, however, and none of the testimony Plaintiff cites supports the notion that Progressive never made adjustments to South Carolina med-pay claims based on reasonableness. In fact, the record shows just the opposite – Progressive used the Mitchell DecisionPoint system to make such adjustments.

Each of the adjusters that Plaintiff cites testified that they *did not recall* whether they *personally* had made reasonableness adjustments to South Carolina med-pay claims; they did not testify, as Plaintiff asserts, that neither they nor any other Progressive adjuster made such adjustments to any South Carolina med-pay claim. *See, e.g.,* Dep. of L. Felton at 16:1-7 ("Q. Have you ever determined whether an expense is reasonable? A. If something is something I don't understand, I will talk to my manager about it. Q. Do you recall any situations where you had to determine – A. No, I don't.") (attached as Ex. A); Dep. of K. Braden at 12:20-24 ("Q. Can you ever recall in the last 18 months of adjusting claims for South Carolina claimants or any other claimants whether you determined that a medical service was not necessary? A. I don't recall.") (attached as Ex. B); Dep. of E. Dennis at 26:19-22 ("Q. In your four years with the med pay unit, have you taken any South Carolina Med Pay bill and not paid it because it was

unreasonable or unnecessary? A. I don't recall.") (attached as Ex. C); Dep. of R. Cole at 25:10-12 ("Q. Have you ever returned a bill or reduced a bill because it was unreasonable or unnecessary? A. I don't recall.") (attached as Ex. D). This testimony is consistent with the testimony of Dorothy Lange, the adjuster who handled Plaintiff's claim and who testified only that she personally has not determined that a medical bill she received in connection with a med-pay claim was unreasonable – not that Progressive's policy is not to make such determinations based on reasonableness. Dep. of D. Lange (August 3, 2011) at 78:10-13 (attached as Ex. E).

While individual adjusters may not recall making specific reasonableness determinations themselves, the undisputed evidence shows that Progressive nevertheless makes such determinations, using software called Mitchell DecisionPoint. *See* Dep. of P. Goodchild (corporate representative) at 31:15-32:21 (explaining how Progressive uses Mitchell Decision Point for "medical bill auditing"), 45:24-46:4 (testifying that Progressive would have adjusted Plaintiff's med-pay claim by submitting her medical bills to Mitchell DecisionPoint "to determine what the price would be, if it needed to be repriced") (attached as Ex. F). Plaintiff's questioning of Mr. Goodchild shows that Plaintiff understands this fact:

Q. What happens where there is a reduction to a doctor's bill? Say the bill is \$1,000 and Mitchell says: 'Well, I think it should be \$400;' you don't know how that is calculated or determined; you don't know the nuts and bolts of Mitchell's programming?

But what happens, does the check just get spit out or – the Mitchell-allowed amount?

A. The adjuster would approve that amount that was allowed for payment, and they would issue that payment.

See Dep. of P. Goodchild (individually) at 18:1-9 (attached as Ex. G).

Rather than acknowledging this unambiguous testimony, Plaintiff selectively relies on Mr. Goodchild's inability to recall, on command, a specific instance in which a South Carolina med-pay claim was repriced by Mitchell DecisionPoint as evidence that no such repricing had

occurred. *See* Supplemental Br. at 2 (citing Dep. of P. Goodchild (individual) at 15:21). But Mr. Goodchild did not testify that no South Carolina med-pay claim had been repriced by Mitchell; he testified only that he could not recall a specific instance of such repricing. Mr. Goodchild's inability to recall a specific instance of repricing a South Carolina med-pay claim based on reasonableness through Mitchell DecisionPoint is not probative of whether such repricing ever occurs. *See id.* at 15:19-21 ("Q. Are you aware of any instance where a South Carolina med pay claim got repriced or was repriced? A. Not a specific instance.").

Plaintiff similarly distorts the testimony of Robert Cole, a Progressive med-pay claims adjuster. *See* Supplemental Br. at 3. Contrary to Plaintiff's assertion, Mr. Cole expressly testified that med-pay claims must "go through Mitchell first" to determine whether the charges are "usual and customary." Dep. of R. Cole at 9:2-21. Mr. Cole's testimony that he was unsure of the precise language of the South Carolina Policy (*i.e.*, whether the Policy included a "usual and customary" clause, as opposed to a "reasonable and necessary" clause) does not alter his unequivocal testimony that med-pay claims from South Carolina insureds are submitted to Mitchell DecisionPoint for adjustments before they are reviewed by Progressive claims adjusters.

In sum, the undisputed record evidence shows that Progressive makes "reasonableness" adjustments to med-pay claims using Mitchell DecisionPoint. Plaintiff has presented no evidence to the contrary. These facts demonstrate the overbreadth of Plaintiff's proposed class, establishing that Plaintiff has not met her burden of proving commonality.

(3) The Class Is Not Readily Ascertainable.

Plaintiff contends that she has satisfied her burden of showing that the class is readily ascertainable because Dorothy Lange testified that "[t]he reasons for any write-downs to a medical bill are coded and explained in the Explanation of Benefits sent to the insured."

Supplemental Br. at 2. Plaintiff fails to explain, however, how such Explanations of Benefits make the class readily ascertainable. For example, Plaintiff introduces no evidence showing that the Explanations of Benefits that Progressive contain detailed information about the precise reasons for its payment reductions, allocating the reduction amounts to the reasons for the reduction.

Moreover, even if the Explanations of Benefits contain such detailed information, Plaintiff's arguments assumes that the factfinder will sift through each of the thousands of Explanations of Benefits, examining each of them to determine whether a given Explanation of Benefits demonstrates that a particular insured should be a class member. Such a fact-intensive, individualized inquiry just to determine whether a given insured is a member of the class shows that the class is not readily ascertainable. *See Solo v. Bausch & Lomb, Inc.*, Nos. 2:06-MN-77777-DCN, 2:06-CV-02716-DCN, 2009 WL 4287706, at *6 (D.S.C. Sept. 25, 2009) (denying class certification because "[i]n order to ascertain who falls within the class, the court would have to make thousands of fact-intensive inquiries"). Underscoring this point is Plaintiff's failure to acknowledge the testimony of Michael Silver, who stated that Progressive does not maintain electronic records that would enable it easily to ascertain the class members. *See Dep. of M. Silver at 19:8-23, 27:19-28:6* (attached as Ex. H).

Respectfully submitted, this 4th day of June, 2013.



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I. With South Carolina's more expansive view on class actions, Plaintiff has easily met her burden.

In 2010 the Supreme Court reiterated that class actions are favored in this state and that we have a more expansive view of class actions than our federal counterpart. Guazia v. South Carolina State Plastering, LLC, 390 S.C. 562, 703 S.E.2d 197 (2010). The Plaintiff has easily met her burden on commonality. The well documented health insurance reductions made by Progressive adjusters on a systematic basis pursuant to Standard Operating Procedures favors certification. While there might be some factual variations among class members, South Carolina case law requires just a single common issue for certification. See McGann v. Mungo, 287 S.C. 561, 568, 340 S.E.2d 54, 157-58 (Ct.App. 1986) ("It is important to note that the subsection does not demand all questions of law and fact to be common, only that there be common issues among the class. In fact, a single common issue will suffice if it is important enough.")

II. The Mitchell Myth: Defendants have no record upon which to argue.

The deposition testimony of five adjusters and their supervisor, including two 30(b)(6) deponents, confirms Progressives' systematic process to reduce payments to persons with health insurance. There is not one instance of a bill being repriced by any Mitchell software for "usual and customary charges." The Defendants have had more than two years to put any such evidence into the record. Even Peter Goodchild, the Progressive Supervisor and 30(b)(6) designee, confirmed he was unaware of any such instance. If there were Mitchell write downs for "usual and customary," then the record would be replete with examples. But as testified by Progressive, Mitchell is not used to determine the amount of what is paid.

Q: But it's not used – Mitchell is not used in determining the amount of what is going to be paid by Progressive on a Med Pay South Carolina claim?

Mr. Stieglitz: Object to the form of the question.

A: Correct

Lange 30(b)(6) Dep. p. 80, line 20-25.

Q. And I am saying: Okay, so how did the information go from that computer image of a medical bill, the amount billed, the amount paid, the balance, how does that get into Mitchell?

A. I put that into Mitchell.

Q. Okay. When do you put that into Mitchell, when you cut the check?

A. When the bill is received.

Lange 30(b)(6) Dep. p. 85, lines 17-24.

Q: So you enter the hospital bill, total charges, and then also enter in the amount allowed, which is the amount paid from all sources to that provider?

A. Correct.

Lange 30(b)(6) Dep. p. 88, lines 21-25.

Peter Goodchild, the supervisor and 30(b)(6) designee on software programs confirmed that the adjuster uses Mitchell Decision Point to pay medical bills – Mitchell does not by itself conduct an audit. "Now, Mitchell Decision Point is a tool the adjuster uses to audit medical bills." Goodchild 30(b)(6) Dep. 90, lines 11-12. (Emphasis added). The adjuster computes the reductions based on health insurance. Mitchell does not.

III. The Class definition can be restated.

The current class definition may be revised to include health insurance references or documentation as set forth in bold below:

All insureds of Progressive Halcyon Insurance Company n/k/a Progressive Direct, Co., Progressive Max, and Progressive Casualty who (1) submitted claims to any of the Progressive Insurance Companies, including Progressive Casualty, under the med pay provision of the respective South Carolina policies during the time period of November 8, 2007 to the date of this Order, and (2) whose claims

were adjusted by Progressive Casualty, and (3) who did not receive payment in the amount of their medical bills, and (4) whose med pay policy limits were not exceeded, and (5) whose file or claim contains documentation or reference to health insurance.

A proper class definition describes the class in objective terms, capable of membership without regard to the merits of the proposed class membership claims or the particular relief they seek. See *Herbert B. Newberg and Alba Conte Newberg in Class Actions*, Fourth § 6.14 (3d. ed. 1994). The additional qualifier will objectively cull out claimants without health insurance who had a reduction. The adjusters use health insurance data to reduce payments. Therefore, those claims with health insurance references are identifiable. This information will also be used for damages.

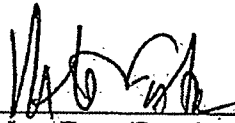
Defendants' counsel acknowledged the Class was small – hundreds, but not thousands. Progressive documents health insurance credits or reductions and has a code for such reduction, i.e., X563. With several hundred class members and with the obvious sophistication of Progressive to code claims with health insurance and calculate reduction amounts for discovery responses, the class member information is readily available. Progressive argues that the names might not be easily retrievable. Again, several hundred names or claims is not a large task for sophisticated insurance companies to review.

Defendants have already provided supplemental responses to discovery requests on numerosity and already possess the basic data. Defendants already know the amount of reductions. Because the several hundred class member files contain health insurance references and because Progressive uses a computer code to indicate a reduction for health insurance, the class membership is objectively and readily ascertainable.

CONCLUSION

Based on the above arguments, the Court should deny Defendants' Motion To Reconsider and to Alter or Amend the Court's Order Granting Class Certification in its entirety or, in the alternative, revise the Class definition with the above additional clause.

Respectfully submitted,



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