THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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APPEAL FROM HORRY COUNTY
Court of Common Pleas

Larry B. Hyman, Jr., Circuit Court Judge

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Case No. 2010-CP-26-10502

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

v.

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

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# APPELLANT'S FINAL BRIEF

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## STATEMENT OF ISSUES ON APPEAL

I. As a matter of law, did the Court err in determining the merits of Smith's claim at the class certification reconsideration phase?

II. As a matter of law, did the Court err in vacating its Order granting class certification when Progressive has a written corporate policy of paying less to med pay claimants with health insurance?

## STATEMENT OF THE CASE

Plaintiff Smith ("Smith") filed a Complaint on November 8, 2010 seeking redress of Defendants' written corporate policy to underpay medical payment ("med pay") benefits on South Carolina auto insurance policies to persons with health insurance, in violation of the policy language and statutory mandates concerning adjustment of claims and med pay coverage. S.C. Code Ann. §38-77-144 provides, in pertinent part, "If an insurer sells no-fault insurance coverage which provides personal injury protection, medical payments coverage, or economic loss coverage, the coverage shall not be assigned or subrogated and is not subject to a setoff."

Progressive admits in its written standard operating procedure and deposition testimony that the statute does not allow for subrogation or set off. Yet, Progressive violates its standard operating procedure by setting off or reducing amounts due to adjustments for health insurers. A prohibition against set offs or subrogation applies to any health insurance involvement, whether it is the health insurer's payment or a credit to the bill due to health insurance.

S.C. Code Ann. § 38-59-10 requires insurance carriers to furnish proof of loss forms to an insured within twenty days of receipt of notice of a claim. If the insurer does not do so, the claimant is considered to have complied with the requirements of the policy as to the extent of loss upon submitting the proof. Because it does not send blank proof of loss forms to med pay claimants, Progressive has conceded the nature, character and extent of the loss under S.C. Code §38-59-10. These statutes, Progressives' standard operating procedure and the policy language are at the core of Smith's claim in the Second Amended Complaint.

Progressive Casualty, Progressive Max and Progressive Direct (collectively referred to as "Progressive" or "Defendants") filed their Answer to the Complaint on April 19, 2010. Thereafter, Smith filed an Amended Complaint on May 31, 2011. Smith then filed the Second Amended Complaint on January 25, 2012. Progressive filed an Answer to the Amended Complaint on June 7, 2011 and an Answer to the Second Amended Complaint on February 8, 2012. Progressive admits it sends no written proof of loss forms to med pay insureds and that its written standard operating policy is to pay less to health insured claimants due to health insurance contractual adjustments (R. p. 91 paragraph 27).

On August 29, 2011 Smith filed her Motion for Class Certification. In support, she filed her Affidavit and the Affidavit of Nate Fata on October 25, 2012. Defendants filed a Motion for Summary Judgment on October 30, 2012 along with Defendants' Memorandum in Opposition of Plaintiff's Motion for Class Certification. Smith filed her Memorandum in Support of Class Certification on October 31, 2012.

Smith's Motion for Class Certification was heard on October 31, 2012. By Order dated February 4, 2013 and filed February 14, 2013, the Court certified the Class ("Class Certification Order"). The Class was defined as:

> 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.
> (R. p. 17)

On February 22, 2013 Progressive filed a Motion for Reconsideration. Thereafter, Tommy Brittain and Preston Brittain filed a Notice of Appearance on Behalf of Defendants. An Order substituting counsel was entered on April 26, 2013.

Progressive filed a Memorandum of Law in Support of Defendants' Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification on May 24, 2013. On May 29, 2013 Smith filed a Memorandum in Opposition of Defendants' Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification. On May 29, 2013 the Court heard the Motion to Reconsider. Thereafter, the parties submitted additional briefs.

On May 31, 2013 Smith submitted her Supplemental Brief in Opposition to Defendants' Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification. On June 5, 2013 Progressive filed a response to Smith's Supplemental Brief in Opposition to Defendants' Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification. On June 20, 2013 Smith submitted a 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. On July 17, 2013 Progressive filed a Reply Memorandum in Further Support of Defendants' Motion for Reconsideration and to Alter or Amend the Court's Order Granting Class Certification.

By Defendants' Proposed Order dated August 28, 2013, the Court granted Defendants' Motion to Reconsider, vacated the February 14, 2013 Class Certification Order and held that Plaintiff had no claims (R. p. 27-30). On September 9, 2013 Smith

filed her Motion for Reconsideration and to Alter or Amend the Court's Order Denying Class Certification.

Notice of Appeal was filed on September 26, 2013.

## STATEMENT OF FACTS

Stephanie Smith was in an automobile wreck on February 23, 2009 (R. p. 74 para. 4). She suffered personal injuries (R. p. 74, para. 5). At the time of the collision, she was driving a 1997 Saab insured by Progressive (R. p. 74, para. 6). Smith had health insurance and she paid premiums for her health insurance (R. p. 475). The Progressive policy is entitled "Progressive Direct" on the front page and is underwritten by Progressive Max Insurance Company and Progressive Direct Insurance Company (R. p. 519 and 578). Progressive Casualty operates the entire business of both carriers through Joint Servicing Agreements with Progressive Max and Progressive Direct (R. p. 554-577).

Stephanie Smith submitted medical bills exceeding Five Thousand Dollars ($5,000) to Progressive Casualty yet received less than Three Thousand Dollars ($3,000) under the med pay portion of her auto policy (R. p. 7). Smith did not receive the entire amount of her bills because Progressive has a written standard operating procedure ("SOP") whereby insureds like Smith who pay for and have health insurance are paid less than those claimants who are uninsured. Progressive gets a windfall from insureds who pay health insurance premiums, by reducing payments to them from the health insurance adjustments to the medical provider charges.

The Progressive policy language at issue 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) (R. pp. 527, 528).

No different policy language is at issue. The policies do not define "incur" or state when "incurred" will be measured. The policies do not identify who must incur an expense. According to Progressive Casualty's written standard operating procedure and 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 Blue Shield, Progressive pays the lower, adjusted amount and takes advantage of the health insurance carrier's adjustment. Progressive pays less to a claimant with health insurance than it pays to an uninsured claimant for the identical claim. This standard process is referred to in the pleadings as Progressives' "Reduction Methodology."

Smith was treated by Strand Regional Specialty Associates ("SRSA") (R. p. 500). In that statement, Smith was charged for a number of services, including an outpatient visit on April 2, 2009 in the amount of $80.00 (R. p. 500). On April 16, 2009, BCBS made a payment and there was also an adjustment. Thus, two weeks after the visit, Smith's balance for that service was reduced by a $14.00 payment and a $31.00 adjustment. Under its Standard Operating Procedure or Reduction Methodology, Progressive paid $49.00 in connection with the $80.00 charge. The SOP provides that the insured is "allowed to recover the same damage paid under health insurance" (R. p. 580).

Peter Goodchild works for Progressive Casualty Insurance Company ("Progressive") as a Medical Supervisor in its National Medical Unit located in Jacksonville, Florida (R. p. 483). He has been employed by Progressive since 1999, and has worked as a Medical Supervisor in the National Medical Unit since it was formed in 2008 (R. p. 483). The National Medical Unit is a centralized unit that handles medical and PIP claims (R. p. 428, lines 2-11).

Progressive Casualty, through its National Medical Unit, processes and adjusts med pay insurance claims on policies issued by The Progressive Group of Insurance Companies ("The Progressive Group") from 35 different states. The National Medical Unit is organized into several "teams," with each team being responsible for adjusting claims from a specific group of States. Goodchild manages a team that is responsible for 15 states, including South Carolina (R. p. 483). There are 14 adjusters working on Goodchild's team including Dorothy Lange, Robert Cole, Elbonye Dennis and Lillian Felton (R. p. 483) Goodchild's team receives approximately 140 new claims every day (R. p. 484).

The National Med Pay Unit uniformly interprets "incurred" to mean the amount of the bill less any health insurance contractual adjustments (R. pp. 388-391). "Incurred" is what the insured is legally obligated for or what they have expended (R. pp. 390–391). Progressive has adopted a two page standard operation procedure (SOP) for adjusting South Carolina med pay claims. The short SOP provides that a med pay claimant is "allowed to recover the same damage paid under health insurance" (Progressive SOP).

Progressive further expounds on its standard operating procedure with another claims procedure document entitled "Quick Fact Sheet" (R. p. 579). This document has the following heading: "Can duplicate benefits paid under medical payments and incurred

health insurance costs". It further defines "incurred" as "amount paid by health carrier, copays, ded, any balance bill issues." The Quick Fact Sheet further provides "No Subro" (R. p. 579).

Dorothy Lange, Stephanie Smith's claim adjuster and corporate representative, began working at Progressive in 2005 (R. p. 311, lines 9-12). Her job in the National Med Pay Unit is to make sure medical bills are processed (R. p. 316, lines 13-15). She reviews medical bills to determine only if the insured paid the bills out of her own pocket or if she (Lange) needs to pay them (R. p. 317, lines 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 (R. p. 336, lines 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 (R. p. 318, lines 5 – 22). She does not determine whether a medical procedure was necessary (R. p. 319, line 25 - p. 320, line 14). She does not know anyone at Progressive who determines whether a medical procedure is necessary (R. p. 320, lines 10-13). The only question Lange answers is whether a bill is paid or unpaid (R. p. 321, lines 8-15). Neither Lange nor any other adjuster determines whether a bill is too high (R. p. 322, line 16 - p. 323, line 6). Progressive's handling of med pay claims has not changed since 2009 (R. p. 325, lines 7-11).

Lange testified that she enters data into the Mitchell computer platform[1] Lange testified that she enters code X563 into Mitchell if there is health insurance (R. p. 355, lines 5 – 24). The reasons for any write-downs to a medical bill are coded and explained

[1] Mitchell is a computer platform in which data is entered. Lange clearly states that she enters the explanation codes into Mitchell, including a code for health insurance (R. pp. 355-356).

in the Explanation of Benefits sent to the claimant. Dorothy Lange testified as the corporate representative that she and not the Mitchell platform determines what is to be paid (R. p. 324, lines 3 – 10). Mitchell is simply a screen that the adjuster completes (R. p. 334, lines 3 – 5). Mitchell does not make payments – checks are not issued by Mitchell (R. p. 334, lines 14-16) ("Drafts are not issued through Mitchell"). The adjuster's job is to determine what is to be paid. Lange's testimony is bolstered by the testimony of 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 (R. p. 377, lines 19 – 21). Even if there is a reduction for reasonable and customary, the medical provider is still owed and Progressive will pay the amount of the bill (R. p. 379, lines 2 – 25).

Peter Goodchild, corporate representative, testified the Mitchell platform includes all the data entry for the medical bill, the amounts paid by the health insurance carrier and the insured. Mitchell is also used to ensure the charges relate to an auto accident (R. pp. 392-393). 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" (R. p. 413, lines 11 – 12) (Emphasis added). The adjuster computes the reductions based on health insurance.

As testified by the corporate representative, all documents for med pay claims are scanned into the computer system (R. p. 387, lines 6 – 8). Medical bills are required (R. p. 375, line 3 – p. 376, line 25). The medical bill is proof that the claimant has incurred a medical expense (R. p. 375, lines 3 – 24). Progressive knows the policyholders, the claimants, bill amounts and reduction amounts. Progressives'

adjusters enter into its computer system the hospital bill, total charge and amount allowed (R. p. 336, lines 21 – 25). The medical bills are not reviewed for any other reason (R. p. 318, line 23 – p. 319, line 16). Progressive specifically does not review the medical bills for reasonableness (R. p. 349, lines 15 – 24).[2]

The deposition testimony of five adjusters, their supervisor, Peter Goodchild, and two corporate representatives 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." Progressive has never declined or reduced a claim based upon the reasonable and necessary clause within the policy. Kim Braden, a claim representative, has been adjusting over a 100 claims per month for 18 months and does not recall any instance where she thought or determined that a medical charge or expense was unreasonable (R. p. 474, lines 1 – 24). Elbonye Dennis spent four years in the Med Pay Unit and does not recall a single instance of not paying a bill because it was unreasonable or unnecessary (R. p. 464, line 15 – p. 465, line 5). Lillian Felton, a National Med Pay Unit Claims Adjuster, testified similarly (R. p. 469, line 1- p. 470, line 14); (see also Deposition of Robert Cole, a National Med Pay Unit Claims Adjuster, R. p. 459, line 10 to 16). Even Peter Goodchild, the Progressive Supervisor and corporate representative, confirmed he was unaware of any such instance (R. p. 377, lines 18 – 21). As testified by Progressives' corporate representative, Mitchell is not used to determine the amount of what is paid.

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[2] Progressive has a contract with First Health Coventry Network which provides that if a Progressive insured treats with any provider within the First Health Network, that provider has agreed to a lower, contracted rate through that network (R. p. 343, lines 10 – 17). This lower amount is initially billed (R. p. 343, line 22 - p. 344 line 4).

Q: Simple question is: You, as the med claim representative, are going to determine what is paid so long as it's within your authority?

A: Yes.

(R. p. 324, lines 3-6)

Q: You are not going to take the direction from Mitchell program and just say: "Okay, Mitchell told me to pay X." Your job is to determine what's to be paid?

A. Yes.

(R. p. 324, lines 7-10)

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

(R. p. 332, 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.

(R. p. 333, 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.

(R. p. 336, lines 21-25)

Peter Goodchild, Dorothy Lange's supervisor, testified that the medical bill is proof that the insured incurred a medical expense (R. p. 375, line 3 – p. 376, line 3). Health insurance explanation of benefits documentation is not required (R. p. 376, lines 21 – 23). Goodchild is not aware of any instance in which a medical bill was repriced (R. p. 377, lines 19 – 21). All documents for med pay claims are scanned into the computer system (R. p. 387, lines 4 – 8).

"Incurred" is not defined in the South Carolina policy. However, Progressive defined "incurred" in its Virginia and Massachusetts policy (R. p. 388, lines 1 – 24). The Virginia statute defines "incurred" to mean: "if the expense is paid by the health care insurer as the amount of the actual payment as evidenced by an explanation of benefits, remittance advice or other similar documentation" (Va. Code Ann. §38.2-2201). Progressive uses the same definition of "incurred" for each Progressive insured in all states (R. p. 389, lines 11 – 24). Goodchild testified that "incurred" could mean what was paid by the health insurer carrier (R. p. 390, lines 4 – 7). When asked how the med pay claimant has "incurred" the amount paid by his health insurer, Goodchild responded that due to the statute preventing set off the claimant is entitled to reimbursement of that medical cost (R. p. 390, line 12 – p. 391, lines 25). Goodchild interprets the word "incurred" to mean the obligation of the health insurance carrier as well as the insured (R. p. 400, lines 4 – 8).

Several years ago Progressives' adjusters and supervisors had questions on what "incurred" meant (R. pp. 414 – 416). Goodchild asked his supervisor, Zaner, what "incurred" meant (R. p. 414, lines 21-23). Adjusters asked their supervisor, Goodchild, what "incurred" meant (R. p. 415, line 4 – p. 416, line 15). Who must incur the expense is not articulated in the policy.

Progressive had a meeting to determine the meaning of the term "incurred," demonstrating the ambiguity of the term. Progressive defined "incurred" in its Standard Operating Procedure as "To recover for same damages paid under health insurance" (R. p. 341, line 23 – p. 342, line 4 and p 580). Progressive takes the amount of the medical bill,

then reduces it by the amount of health insurance credit and pays the rest (R. p. 350, lines 1-18 and p 580).

Goodchild testified that the med pay claims have been handled consistently the same way since 2008 in accordance with the SOP, that the definition of "incurred" hasn't changed, and that the policy language with respect to the term "incurred" has not changed (R. p. 404, lines 11 – 25).

The liability to the medical provider arises on the date of the medical service (R. p. 394, line 22 – p. 395, line 2). See also SRSA statement with charges on April 2, 2009 (R. p. 500). Furthermore, Progressive does not determine when an insured is legally obligated to a medical provider (R. p. 396, line 24 – p. 397, line 8). Nonetheless, Zaner, the head of the National Med Pay Unit, admitted that a med pay claimant owes the provider and has incurred an expense before the health insurer pays the bill (R. p. 443, lines 18-23). Progressive further admits that S.C. Code Ann. §38-77-144 prevents a set off (R. p. 390, line 12 – p. 391, line 25) ("Well, in South Carolina, there is a statute that prevents set-off". . .). Finally, Zaner testified that an insured would not know about any health insurance set off or reduction to med pay benefits from reading the policy (R. p. 439, line 5 – p. 440, line 10).

Progressive requires written proof of loss per the testimony of Liz Zaner, the head of the National Med Pay Unit (R. p. 445, lines 2 – 15). S.C. Code Ann. § 38-59-10 requires Progressive to send a blank proof of loss form to its claimants within twenty days of notice of the claim. However, Progressive does not send blank proof of loss forms to the claimants (R. p. 9).

Stephanie Smith seeks to redress Progressive's Reduction Methodology under five causes of action (R. pp. 73 – 86). The primary cause of action, under the Uniform Declaratory Judgment Act, seeks to declare the rights of South Carolina Med Pay Claimants under the policy language and the statutes at issue. The remaining causes of action assert claims for breach of contract, unfair claim adjusting, bad faith and unjust enrichment.

In connection with the Motion for Class Certification, Progressive stipulated to numerosity (R. p. 608). 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 (R. p. 593). For that same period, Progressive disclosed the reduction amounts of approximately $506,000 (R. p. 585-586, Number 1). Using those numbers and the other numbers in the supplemental 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 continue to grow as class members continue to submit medical bills.

## ARGUMENT

### I. THE COURT ERRED IN MAKING A MERITS DETERMINATION IN ITS RECONSIDERATION ORDER.

#### A. The Court's Merit's Determination Was Premature.

South Carolina precedent instructs the trial court to not make merits determinations at the class certification stage. Bazzle v. Green Tree Financial Corp., 351 S.C. 244, 569 S.E.2d 349, 361 (2002) ("Neither the trial court nor the reviewing court may look to the merits when determining whether to certify a class") (citing Tilley vs. Pacesetter Corp., 333 S.C. 33, 508 S.E.2d 16 (1998)). Again in 2009 the Supreme Court

reiterated, "A Court may not look to the merits when determining whether to certify a class." King v. American General Finance, 386 S.C. 82, 687 S.E.2d 321, 324 (2009) (citations omitted). At the certification hearing and in the Class Certification Order, the Court stated that a merits determination was not appropriate (R. p. 294, line 25 – p. 295, line 1; R. p. 10). The Court abused its discretion by ignoring precedent and ruling on the merits at this early stage of the litigation.

### 1. The Court's Merit's Decision At The Class Certification Phase Is An Error Of Law.

A motion for class certification is to be heard as soon as practicable pursuant to Rule 23, SCRCP. Thus, the Rule contemplates class certification will be determined at an early stage in the litigation and prior to full blown discovery. With an understanding that class certification is a preliminary procedure, South Carolina decisions have reviewed pleadings to determine whether a class should be certified. McGann v. Mungo, 287 S.C. 561, 340 S.E.2d 154 (S.C. App. 1986) ("We think the Amended Complaint sufficiently defines the alleged class at least for the present").

In the Reconsideration Order the Court became the fact finder and looked well beyond the pleadings and into the merits when it determined Smith suffered no damages (R. p. 27-30). Although the merits were never argued, the Court used the Reconsideration Order as a fact finding mission. Smith had no opportunity to argue against such findings, especially when the Court indicated at the class certification hearing that merits issues were not appropriate. (Court: But doesn't that go to the merits of the case rather than whether or not I should certify a class?) (R. p. 249, line 25 – p. 250, line 1). The Court committed an error of law by making a merits determination at the reconsideration phase. Friedberg v. Goudeau, 279 S.C. 561, 562, 309 S.E.2d 758,

759 (1983) ("It is an error of law for a Court to decide a case on a ground not before it"). Unequivocally, the Court violated the precedent set forth in Tilley, Bazzle, and King.

### 2. The Reconsideration Order Does Not Address The Issues In The Case.

The Reconsideration Order is fundamentally flawed as it does not address the core issues in the action, including the first cause of action for the declaratory relief sought by Smith and the Class. Stephanie Smith has standing to assert the claims under the Uniform Declaratory Judgment Act, S.C. Code Ann. §15-53-10 et seq. (the "Act"). The Act is remedial and is to be liberally construed, S.C. Code Ann. §15-53-130. 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 run by Progressive Casualty will be affected in its adjustment of the claims. Progressive Max and Progressive Direct, as Smith's 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. The Act expressly provides that a contract may be construed either before or after a breach, S.C. Code Ann. §15-53-40. Thus, Smith may pursue her declaration request after the breach.

In a curious change of analysis, the Court ignores the core issue of whether Progressives' written SOP violates the statutes and policy language. In the Class Certification Order, the Court acknowledged discrete issues to be answered in the litigation and enumerated them (R. p. 12-14). The statutory interplay between Progressive's Reduction Methodology and the policy language was expressly pled in the Second Amended Complaint and enumerated in the declaratory judgment cause of action.

Yet, the Court did not address the interplay and those discrete issues in the Reconsideration Order. Instead, the Court ignores Progressives' standard operating procedures, uniform definition and systematic practices and the statutes while summarily concluding Smith has no claim. Any such conclusion must only occur by the fact finder – the jury – after full discovery. By failing to address the issues or questions raised, the Court committed an error of law and abused its discretion.

### 3. The Court Erred In Converting The Reconsideration Hearing Into A Summary Judgment Motion.

In her Second Amended Complaint, Smith requested a jury trial. The Court improperly converted the Reconsideration Order into a summary judgment order in which it construed all arguments in favor of Progressive. However, the jury should be the fact finder for the material facts of the claim. For the first cause of action, the jury should answer the questions posed, See S.C. Code Ann. §15-53-90.

Summary judgment is only appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Celotex Corp. v. Catrett, 106 S.Ct. 2548, 91 L.Ed.2d 265, 477 U.S. 317, 322-24 (1986). The material facts are those identified by controlling substantive law as the essential elements of a claim or defense. Anderson v. Liberty Lobby, Inc., 106 S.Ct. 2505, 91 L.Ed.2d 202, 477 U.S. 242, 248 (1986). If any such facts are genuinely in dispute, summary judgment is inappropriate. A factual dispute is "genuine" if the evidence is such that a reasonable jury could return a verdict for the non-moving party. Id. When assessing a motion for summary judgment, the Court must make all factual inferences in favor of the party opposing the motion. Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 106 S.Ct. 1348,

89 L.Ed.2d 538, 475 U.S. 574, 587, (1986). Lastly, the Court is not to weigh the evidence nor engage in credibility determinations. Anderson, 477 U.S. 242 at 249.

As with any summary judgment motion, fair opportunity to present a scintilla of evidence must be afforded to the litigants. The Reconsideration Order afforded no such opportunity. Instead, the Court ignored the statuary interplay of S.C. Code Ann. §38-59-10 and §38-77-144 with Progressives' uniform practice and written standard operating procedure of paying "only damages allowed under health insurance." The Court did not apply the statutes to Progressives' Reduction Methodology, as requested in the Second Amended Complaint, Par. 43(a) – (f) (R. pp. 80-81).

Without addressing the applicability of the statutes, the Court cannot summarily dispose of Smith's claims. For example, if no proof of loss is submitted, then Progressive by statute has conceded the nature, character and extent of the loss, which would be the full amount of the charges, S.C. Code Ann §38-59-10. The Court did not address this systematic failure, which alone is sufficient to reverse the Court's judgment. Similarly, the Court did not address Progressives' practice of setting off payments due to health insurance in violation of S.C. Code Ann. §38-77-144. That statute provides, "If an insurer sells no-fault insurance coverage which provides personal injury protection, medical payment coverage or economic loss coverage, the coverage shall not be assigned or subrogated and is not subject to a set off." Progressive admits in its written standard operating procedure and deposition testimony that the statute does not allow for subrogation or set off ("No Subrogation") (R. p. 581). Yet, Progressive violates its standard operating procedure by using health insurance adjustments to reduce payments to claimants. A prohibition against set offs or subrogation applies to any health insurance

involvement, whether it is the health insurer's payment or a credit to the bill due to health insurance. Progressive cannot pick and choose when it will follow the statute and its SOP.

Furthermore, the jury is the appropriate fact finder for any merits determination in light of the statutes, Progressives' SOP and policy language. At this stage, the Court has interjected its opinion on the facts and rushed to judgment.

In addition, the Court did not address the request for declaratory relief as requested in the Second Amended Complaint, Paragraphs 48 – 52 (R. p. 82). The jury must review the material facts and determine the factual issues under all causes of action, including the declaratory judgment claim pursuant to S.C. Code Ann. §15-53-90.

**B. Under The Policy "Incurred" Is Ambiguous.**

**1. A Progressive Insured Incurs Liability To A Medical Provider On The Date Of Service.**

When is the medical expense incurred? The policy does not define this timing issue. From the medical provider's standpoint, it is as of the date of service, SRSA Statement. The head of the National Med Pay Unit also agrees that the obligation to the medical provider arises as of the date of service (R. p. 443, lines 18 – 23). Yet, Progressive implicitly uses different timing standards to determine when "incurred" is to be measured. For the policyholder without health insurance, "incurred" is measured on the date of service. For the health insured, "incurred" is measured after the application of health insurance and credits occur. Nothing in the policy or the statutory law of South Carolina allows Progressive to vary the timing of the determinations. Indeed, Progressives' SOP, which implicitly measures the liability to the provider after health

insurance makes payments, is directly contrary to the testimony of Zaner, who agreed that it is the date of service which matters.

South Carolina has addressed the resolution of ambiguities in insurance contracts. The rules of contract interpretation require that an ambiguous document must be construed against the drafter. Williams v. Teran, Inc., 266 S.C. 55, 60, 221 S.E.2d 526, 529 (1976) ("The rule of law is that where the contract is susceptible of more than one interpretation, a doubt shall be resolved against the party whose business it was to speak without ambiguity," which the court said was "the author of the agreement"); Mid-Continent Refrigerator Co. v. Way, 263 S.C. 101, 105, 208 S.E.2d 31, 33 (1974); Columbia East Assoc. v. Bi-Lo, Inc., 299 S.C. 515, 520, 386 S.E.2d 259, 262 (Ct. App. 1989) ("Where the contract is susceptible of more than one interpretation, the ambiguity will be resolved against the party who prepared the contract"). This general rule of contract interpretation merely compliments the more specific rule that the "[t]erms of an insurance contract must be construed liberally in favor of the insured and strictly against the insurer." Standard Fire Ins. Co. v. Marine Contracting & Towing Co., 301 S.C. 418, 420, 392 S.E.2d 460, 461 (1990). Based on the record, Progressive's multiple interpretations of incurred, and policy language, the Court erred in its policy construction as a matter of law. As stated in Whitlock v. Stewart Title, 399 S.C. 610, 732 S.E.2d 626 (2012), the specific matter of timing is an inherent part of the task of measuring damages.

The policy language acknowledges "incurred" is to be determined at the date of service – "reasonable expenses incurred for necessary medical services received within three years of the date of a motor vehicle accident ..." (R. p. 527-528). The policy

contemplates "expenses incurred" is triggered by services provided, not after the charge is processed by a health insurance carrier.

Through its corporate representative, Progressive admitted that its process does not determine when an insured is legally obligated to a medical provider (R. p. 396, line 24 – p. 397, line 8). Yet, Zaner, the head of the National Med Pay Unit testified that a claimant owes the provider and has incurred an expense before the health insurer pays the bill (R. p. 443, lines 18 – 23). Goodchild testified that the medical bill is proof that the medical expenses was incurred and that liability to the medical provider arises on the date of service (R. p. 375, line 9 – p. 376, line 3). In her deposition Zaner, the head of the National Med Pay Unit, acknowledges the claimant has liability to the provider before the health insurer processes the claim. The Strand Regional Specialty Associates' ("SRSA") statement reflects this reality. On April 2, 2009 Smith incurred several charges including an $80.00 liability for an office visit at SRSA. Two weeks later, her SRSA account balance receives a credit in the form of a payment and a credit in the form of an adjustment from BCBS (R. p. 500).

One court, citing Couch on Insurance, stated the "Plaintiff incurred such expenses at the time that she received treatment for her injuries and the fact that the bills may have already been paid by other sources, including her private health insurer, does not extinguish defendant's obligation. Todaro v. Geico General Ins. Co., 848 N.Y.S. 2d 393, 46 A.D. 3d 1086, 1088 (2007). Smith's policy cannot have a legal liability arise on the date of service and then measure "incurred" at a later date. To do so is to have multiple meanings of the same term. The policy does not describe how "incurred" will be measured. Because Progressive failed to include any such measuring language in its

policy, the term is subject to multiple interpretations and is ambiguous. Construed in light most favorable to the insured requires a ruling that "incurred" should be measured on the date medical service is rendered.

The South Carolina Supreme Court recently reviewed a title insurance issue involving when the value of any loss should be measured, Whitlock v. Stewart Title Guarantee Company, 399 S.C. 610, 732 S.E.2d 626 (2012). The Plaintiff argued the value should be measured on the date the Plaintiff purchased the property at issue and the Defendant argued the date of discovery of the title defect. The Supreme Court held, "the title policy here does not unambiguously set forth a method of valuation in line with the construction defendant urges us to adopt. Thus, we need look no further than the general rule that ambiguities in an insurance contract must be construed in favor of the insured." Whitlock v. Stewart Title Guarantee Company, 399 S.C. 610, 732 S.E.2d at 629 (2012).

Progressive was in the best position to write a contract which unambiguously described how and when "expenses incurred" would be measured. Progressive elected not to revise its policy and instead relies on a Virginia statute which sets forth the timing assessment. South Carolina has no comparable statute. To streamline its adjusting process at the National Med Pay Unit, Progressive is imposing a Virginia law on South Carolina insureds. However, Progressive did not incorporate any appropriate language into the policy to give the insured any idea as to how Progressive would ultimately be interpreting its obligations. Zaner, the head of the National Med Pay Unit, testified that an insured would not know about any health insurance set off or reduction to med pay benefits from reading the policy (R. p. 439 lines 5-24). In addition, Progressive did not

include health insurance in any portion of the "other insurance" section of the med pay medical payments coverage part of the policy (R. p. 530). It could have easily done so.

Pursuant to the Supreme Court ruling in Whitlock v. Stewart Title, the how and when incurred expenses are to be determined are open questions under the policy, creating an ambiguity that must be resolved in favor of the insureds. As the Supreme Court noted, "The specific matter of timing is an inherent part of the task of measuring damages. . ." Whitlock, 732 S.E.2d at 626.

In determining Smith has no damages the Court erred as a matter of law. First, the Court implicitly held that the policy language was unambiguous. Second, the Court construed the policy language in favor of the insurer. However, as discussed below, many other courts have held such language to be ambiguous and found liability for med pay benefits on the date of service in the amount of the bills. Even Progressive's adjusters did not know what "incurred" meant, requesting assistance from supervisors on making a determination (R. p. 414, line 7 – p. 416, line 25).

Many courts have held that a plaintiff becomes liable for medical expenses when the patient accepts treatment and the fact a plaintiff had contracted with a health insurance company to compensate her for medical expenses does not alter the fact that she was obligated to pay those expenses. In American Indemnity Co. v. Olesijuk, for instance, the court found that an insured injured on active military duty, whose hospital expenses were paid by the United States Navy, as required by statute, incurred expenses for purposes of recovery under his automobile policy's medical payments provision, 353 S.W.2d 71, 72 (Tex.Civ.App. 1961); see also Hollister v. Government Employees Ins. Co., 192 Neb. 687, 224 N.W.2d 164, 166-167 (1974), in which the court reached the

same result. In both cases, the court noted that when the serviceman was treated in the hospital, an implied contract for payment was created, and later payment or reimbursement by the government did not relieve the insurer. Hollister, 224 N.W.2d at 166.

In Kopp v. Home Mutual Insurance Co., the court held that an insured whose hospital expenses were paid by a Blue Cross hospitalization plan incurred expenses and therefore was able to recover under his automobile policy's medical payments provision, 6 Wis.2d 53, 94 N.W.2d 224 (Wis.1959). This holding has been followed by many other courts, See, e.g., Feit v. St. Paul Fire & Marine Ins. Co., 209 Cal.App.2d Supp. 825, 27 Cal.Rptr. 870, 871 (1962) (medical payment clause in automobile policy obliging insurer to pay expenses incurred for medical services did not limit recovery to expenses incurred by insured himself and did not preclude insured's recovery of sum medical services would have cost him but for membership in prepaid health plan); Masaki v. Columbia Cas. Co., 48 Haw. 136, 395 P.2d 927, 931 (1964) (insured whose treatment was covered and paid by health plan had expenses incurred on his behalf for purposes of medical payments provision of his automobile policy); see also Heis v. Allstate Ins. Co., 248 Or. 636, 436 P.2d 550 (1968) (same). Similarly, in Shanafelt v. Allstate Insurance Co., the court found:

> The primary definition of the word "incur" is "to become liable for".... Obviously, plaintiff became liable for her medical expenses when she accepted medical treatment. The fact that plaintiff had contracted with a health insurance company to compensate her for her medical expenses, or to pay directly the health care provider on her behalf, does not alter the fact that she was obligated to pay those expenses.
>
> 217 Mich.App. 625, 552 N.W.2d 671,676 (1996) (citation omitted).

Some courts deemed the medical payments provision vague in its use of the word

"incurred." Feit v. St. Paul Fire & Marine Insurance Co. 209 Cal.App.2d Supp. 825, 27 Cal.Rptr. 870, 872-72 (Cal.App. 1962). Others found the policy ambiguous in failing to specify who must incur the expenses, Id. at 872; Dutta v. State Farm Ins. Co., 363 Md. 540, 769 A.2d 948, 960-61 (2001). Feit and Black noted the absence of other insurance or coordinated coverage provisions. Feit, 27 Cal.Rptr. at 872. Black v. American Bankers Ins. Co., 478 S.W.2d 434, 435 (Tex. 1972). One court found the insured's payment of hospitalization plan premiums evidence of costs or expenses incurred by the insured. Kopp v. Home Mutual Insurance Co., 6 Wis.2d 53, 94 N.W.2d 224, 225 (Wis. 1959). In Holmes, Shanafelt, and Black, the courts found the injured insured incurred a legal obligation to pay for hospital expenses at the time the services were rendered. Holmes v. California State Automobile Ass'n, 135 Cal.App.3d 635, 185 Cal.Rptr. 521, 524 (1982); Shanafelt, 552 N.W.2d at 676; Black, 478 S.W.2d at 437.

The narrow rule to be extracted from all of these cases is that "incurred" or "actually incurred" language does not bar an insured who became liable for expenses from recovery simply because "of the availability of collateral means of discharging his liability therefor so as to have relieved him of the need to pay the charges personally." Hollister, 224 N.W.2d at 166 (quoting Dillione v. Deborah Hospital, 113 N.J.Super. 548, 274 A.2d 597, 600 (1971)).

If Progressive did not wish to honor claims of the type involved here it should exclude them specifically so that an insured with health insurance would know that she is receiving less coverage for her premium dollar than some other insured who is without outside benefits. Smith incurred premiums and she, not Progressive, should get the

benefit of those premiums by receiving the amount of any contractual credits or adjustments.

### 2. Progressive Created The Definition Of "Incurred" Through A Collaborative Effort, Demonstrating The Term's Ambiguity

The who, what, and when a medical bill is "incurred" are not defined in the policy, resulting in multiple ambiguities. As evidence that "incurred" is ambiguous, Progressive adjusters and supervisors had questions on what "incurred" meant (R. p. 414 line 7 – p. 416, line 25). Goodchild asked his supervisor, Zaner, what "incurred" meant (R. p. 414, lines 21-23). Adjusters asked their supervisor, Goodchild, what "incurred" meant (R. p. 415, lines 7-12). Progressive had a meeting to determine the meaning of the term "incurred" thereby demonstrating the ambiguity (R. p. 407, line 22 – p. 410 , line 25).

The SOP definition further illustrates the multiple definitions of "incurred." Under the SOP, "incurred" means to pay same damages as health insurance (R. p. 580). First, health insurance does not pay "damages." Second, "damages" means the medical bill amount under well-established South Carolina law. Third, if Progressive uses health insurance to reduce its payment based on the health insurers contractual adjustment, then the insured has not "incurred" the amount that the health insurance carrier paid. In other words, Progressive cannot pay the claimant for some types of credit (payment) to the account caused by the health insurer and then not pay the claimant for other types of credit to the account (contractual adjustments). Progressives' SOP definition is internally inconsistent and is nonsensical. Finally, the SOP contains a definition of "incurred" ("to pay same damages as health insurance") which conflicts with the dictionary definition, to

incur a liability. Health insurance discharges a liability in various ways, including payments and credits or adjustments.

In addition, who must incur the expense is not addressed in the policy. Progressive interprets the policy language to mean the health insurer or the Progressive insured. Yet, nothing in the policy language supports such an interpretation. And why does the claimant without health insurance incur a liability on the date of service but a claimant with health insurance is deemed to incur a liability at some later date, which is undefined? The ambiguity requires a reversal of the Court's decision.

### 3. The Court Erred In Its Reliance On Gordon.

The Reconsideration Order refers to the definition of "incur" and Gordon v. Fidelity & Casualty Co., of New York, 238 S.C. 438, 120 S.E.2d 509 (1961), Reconsideration Order p. 9. The proper application of Gordon's holding is that the liability to the provider exists as of the date of service. Unlike the medical providers to Stephanie Smith, Gordon's medical provider, the United States Government, never charged Gordon for services. In Gordon, the plaintiff was in the military. The med pay policy was sold to him by an agent who knew he would receive free medical care. The lawsuit was for fraud by the agent in deceiving him into purchasing a policy that would be of no benefit to him. He obtained medical care at a United States military hospital. There was no charge for the United States Government's services and there could be no charge pursuant to federal statute. Gordon, 120 S.E.2d at 513.

In Gordon, all parties agreed there had been no "incurred" medical charges, and once again, could not be due to federal statute. The court determined "what legal interpretations should be given to the words "expense incurred." Gordon, 238 S.C. at 443.

The Court looked at other jurisdictions and determined that free services, especially when backed by federal statute mandating that no charge could be made, do not constitute an "incurred expense." Thus, the focus of Gordon was on the term "expense," not "incur," Id. Smith "incurred" expenses on the date of the medical service. For example, under the SRSA bill a charge of $80.00 was incurred on April 2, 2009 (R. p. 500). Under Gordon, Mrs. Smith incurred the expense on the date of service and then through a collateral source the expense incurred was later paid by health insurer payments, adjustments and her payment.

Gordon also focuses on the fact that without a charge for services, there is no "obligation." Gordon, 120 S.E.2d at 512. The Black's Law Dictionary takes three pages to define "obligation." It is a debt, or any duty imposed by law, promise or contract. Black's Law Dictionary, 1223 (4th ed. 1968). It is clear that Gordon never had any obligation to a medical provider as he was protected from charge via federal statute. Mrs. Smith had no such protection. She was charged for all services rendered and was obligated to make payment or arrange for payment for all services. Under Gordon, Smith "incurred" an expense on the date of service. The fact that Smith arranged and paid for the partial discharge of her obligation to the provider through her health insurance is immaterial.

The cases relied upon in Gordon all relate to free services provided to the military. Many of the cases that cite Gordon apply to differing factual scenarios. In Hein v. American Family Mutual Insurance Company, 166 N.W.2d 363 (Iowa 1969) which cites Gordon, the court defines "incur" as to become liable for as distinguished from actually "pay for." In short, the cases that follow Gordon agree that there must be

an initial obligation to pay for the medical treatment for it to constitute an "incurred expense." The Gordon case was best summarized as follows: "This is simply another case in which a career soldier was treated in an Army hospital where the service was free, and consequently no liability was created against the insured." American Indemnity, 353 S.W.2d at 73. Smith and the Class have that initial obligation or "incurred" expense. Under Gordon, Smith incurred an expense on the date of service. Progressives' corporate representative and the head of the national med pay unit agree.

### C. Progressive Admits The South Carolina Statute Prevents Set Off Or Subrogation.

Corporate representative Goodchild flatly admits the South Carolina statute prevents set off and subrogation of med pay. Yet, inexplicably, Progressive uses a setoff of the health insurance contractual adjustment to reduce the payments to its insureds (R. p. 390, line 12 – p. 391, line 3). Progressive's SOP barring subrogation and the anti-set off statute prevents Progressive from taking a reduction for a contractual adjustment. The statute prevents any reduction due to health insurance, whether the reduction is from a payment or an adjustment. Under Progressive's own written policy of barring subrogation or set offs and S.C. Code Ann. §38-77-144, health insurance payments or adjustments should not be used in the adjustment process. To disallow one element of health insurance credits (contractual adjustments) but not another (health insurance payment) is non-sensical and violates Progressives' written SOP.

### D. The Court Erred In Determining Progressive Direct Is Not Smith's Insurer.

The Court originally found that Progressive Direct as well as Progressive Max were Smith's insurance carriers (R. p. 17) ("The Progressive Policy . . . was

underwritten by Progressive Max Insurance Company and Progressive Direct Insurance Company"). The Smith policy is entitled "Progressive Direct" on the front page (R. p. 518). In the Certification Order, the Court cited the policy face page entitled "Progressive Direct" and Progressives' documentation produced in the litigation for support of its certification of the claims against all Defendants (R. p. 7). In the Reconsideration Order, the Court found only that Progressive Max is the insurance carrier, contrary to its express findings in the Certification Order (R. p. 30). The evidence supports the Court's initial finding and is sufficient to create a clear issue of fact which cannot be resolved summarily (R. p. 7). Summarily determining Progressive Direct was not an insurer was an error of law.

## II. AS A MATTER OF LAW THE COURT ERRED IN VACATING THE CERTIFICATION ORDER BY MISAPPLYING RULE 23.

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.

Progressive stipulated to numerosity ("Progressive will not contest any aspect of the SCRCP 23(a)(1) numerosity element as it applies to Plaintiff's pending motion for Class Certification") (R. p. 608). In the Reconsideration Order, the Court addressed only the Rule 23

(a)(2)(3) and (4) elements. The Court committed an error of law by using an improper standard to deny the certification. In addition, the Court's analysis is without evidentiary support. The Court's ruling is an abuse of discretion which should be reversed. Melton v. Olenick, 379 S.C. 45, 50, 664 S.E.2d 487, 489-90 (Ct. App. 2008).

**A. There Are Common Questions Under Rule 23.**

The Court misapplied Rule 23 when abruptly finding the elements of adequacy, commonality or typicality were not met and that the class definition was flawed. In its Class Certification Order, the Court found the elements of Rule 23, SCRCP were met and defined the Class 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 (R. p. 17).

Of particular importance, the Court found Progressive Casualty had 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.

(R. p. 10)

All documents for med pay claims are scanned into the computer system (R. p. 387, lines 6 – 8). The Court determined class proof as to damages was retrievable and that Progressive Casualty has been able to document reductions (R. p. 10).

At the Reconsideration Hearing, the Court reiterated that it intended to certify the class. The Court intended to include those persons whose claims were reduced due to health insurance (R. p. 291, lines 23-25; p. 292, lines 12 – 15) ("My intention was to include in this class all persons who received benefits in an amount less than the billed amount for properly incurred medical costs.") Smith then proposed an additional class definition qualifier of "(5) whose file or claim contains documentation or reference to health insurance" (R. p. 213). This additional qualifier further narrowed the scope of an already relatively small class. Progressive admitted the class size was hundreds and not thousands (R. p. 300, lines 4 – 7). Defendants' Fourth Supplemental Response to Plaintiff's First Set of Interrogatories confirm this relatively small class.

In an abrupt change, the Court adopted a Rule 23, FRCP analysis and found "that Plaintiff has not met her burden of demonstrating the proposed class meets the adequacy, commonality or typicality requirements" (R. p. 27). In addition, the Court concluded the class definition had flaws (R. p. 27). The Court erred in misapplying the law by imposing a standard not contemplated under Rule 23, SCRCP. In effect, the Court improperly focused on the more restrictive federal requirements of predominance, superiority and manageability when analyzing the elements under Rule 23, SCRCP.

Since adopting Rule 23, SCRCP, South Carolina courts have heard many cases that have used the class action procedure to allow adequate representatives to address issues which affect a large group of citizens in our state. Littlefield vs. S.C. Forestry Commission, 377 S.C. 348, 354-55, 523 S.E.2d 784 (1999). Public policy arguments favor certification of the Class. See Grazia v. South Carolina State Plastering, LLC, 390 S.C. 562, 703 S.E.2d 197, 204 (2010), 703 S.E.2d at 204 ("The class-action device saves

the resources of both the courts and the parties by permitting an issue potentially affecting every [class member] to be litigated in an economical fashion under Rule 23"); Califano v. Yamasaki, 99 S.Ct. 2545 at 2557, 61 L.Ed.2d 176, 442 U.S. 682 at 701, (1979). In 2010 the South Carolina 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. Grazia, 390 S.C. 562, 703 S.E.2d 197 (2010). The class action device is used to address smaller wrongs that affect a large group of people. Without Rule 23, it would not be feasible to address systematic practices involving small amounts. The Court recognized this reality, "Well the problem here is obvious, if there's is no class, there's no action because of the amounts involved. Isn't that right" (R. p. 298, lines 14-18)?

Smith brought this action to address Progressives' written and admitted procedure of reducing payments to South Carolinians with health insurance. Progressive admits to such a discriminatory practice and has uniformly implemented the health insurance reduction through its standard operating procedure. Even at the Reconsideration hearing, the Court reiterated its desire to certify the class. "If it's a covered expense, medical expense, and it was billed for one amount and the benefit they received was less than that, it was reduced. That's the class that I think we should be looking at" (R. p. 292, lines 12-15). Yet, several months later the Court improperly imposed a federal analysis in its decision to vacate its earlier Order and its previous finding on commonality.

### 1. Commonality Is An Easy Hurdle Where There Is A Uniform Written Policy.

The written standard operating procedure is the common issue. All insureds with health insurance were subjected to the reduction. As a matter of law, the Court has misapplied Rule 23 on common questions of law and fact.

The well documented health insurance reductions made by Progressive adjusters on a systematic basis pursuant to a written Standard Operating Procedure favors certification – the class shares a common fact and practice. The United States Supreme Court in Walmart v. Dukes expressly recognized the class suitability of a discriminatory employment practice when the practice is pursuant to a written policy. In Wal-Mart Stores v. Dukes, 131 S.Ct. 2541, 180 L.Ed.2d 374 (2011), the United States Supreme Court did not find commonality because there was no written corporate policy to discriminate against females. Id. Commonality requires a single common question that can be resolved on a class wide basis: claims must depend upon a common contention – for example, the assertion of discriminatory bias on the part of the same supervisor. That common contention, moreover, must be of such a nature that it is capable of class wide 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, Inc. v. Dukes, 131 S.Ct. 2541, 2551, 180 L.Ed2d 374 (2011). The common question here is: under the statutes and policy language, can Progressive reduce payments to claimants due to health insurance? This question should be answered as to all class members. In pages 8 – 9 of its Certification Oder, the Court enumerated the discrete questions which can be answered for all class members (R. p. 12-13).

The Fourth Circuit recently distinguished Wal-Mart to affirm the district court's certification of a class of plaintiff advertisers whose allegations of systematic breach of contract and unfair and deceptive practices against the publishers of telephone directories. Gray vs. Hearst Communications, Inc., 2011 U.S. App. Lexis 17890 (4th Cir. 2011) (Unpublished). The Fourth Circuit held that because the defendants admitted the existence of a uniform policy that applied to all plaintiffs, the commonality element was satisfied. Id. As in Gray, Smith has shown, and Progressive admits, a written standard operating procedure (SOP) or corporate policy to discriminate or reduce payments to the health insured versus those who have no health insurance. The common thread is the health insurance reductions under the SOP.

The National Med Pay Unit, with teams of adjusters, mandates that all claims be adjusted in the same manner with respect to health insurance. While there might be some factual variations among class members as to the amounts of reductions, 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.") "Our state class action rule differs significantly from its federal counterpart. The drafters of Rule 23, South Carolina Rules of Civil Procedure (SCRCP) intentionally omitted from our state rule the additional requirements found in Federal Rule 23(B), Federal Rules of Civil Procedure (FRCP) including FRCP 23(b)(3). By omitting the additional requirements, Rule 23, SCRCP, endorses a more expansive view of class action availability than its federal counterpart." Grazia v. South Carolina

Plastering, LLC, 390 S.C. 562, 703 S.E.2d 197, 204 (2010), citing Littlefield v. S.C. Forestry Commission, 377 S.C. 348, 354-55, 523 S.E.2d 781, 784 (1999). See also McGann v. Mungo, 287, S.C. 561, 570, 340 S.E.2d 154, 159 (Ct. App. 1986); Salmenson v. CGD, Inc., 377 S.C. 442, 661 S.E.2d 81, 88, (2008). The fact that class members are entitled to different amounts of damages does not prevent them from banding together in a class action. McGann v. Mungo, 304 S.E.2d 154 at 158.

Instead of focusing on the common question, the Court erred in deviating from established precedent by applying a Rule 23(b), FRCP analysis and federal case law to answer a South Carolina common question issue. However, the federal predominance requirement is "far more demanding" than Rule 23(a)(2)'s commonality requirement. Amchem Products, Inc., 521 U.S. at 623; Messner vs. Northshore Univ. Health System, 669 F.3d 802, 814 (7th Cir. 2012).

None of the cases cited in the Reconsideration Order denied commonality when there was a written corporate policy at issue. The Reconsideration Order cites Martin v. State Farm Mutual Auto Ins. Co., 809 F. Supp. 2d 496, 510 (S.D. W.Va. 2011) which did not address a written corporate policy. (R. p. 39); Martin v. JTH Tax, Inc., No. 9: 10-CV-03016-DCN, 2013 WL 442425 at 6, (D.S.C. Feb. 5, 2013), cited without discussion, did not address a corporate policy. Thus, the one case that has an admitted corporate policy at issue is Gray vs. Hearst Communications, Inc., 2011 U.S. App. Lexis 17890 (4th Cir. 2011) (unpublished). The Court found commonality in that case under federal law, which is not as expansive as our Rule 23.

## 2. Progressives' Defense Can Only Reduce Damages.

The Court's commonality ruling is based on an illogical analysis that uses a predominance, superiority and manageability lens to obscure the SOP issue with Progressives' reasonableness defense. At the rehearing, Progressive advanced a reasonable and necessary defense to argue that some hypothetical claims might have been repriced because Progressive determined the charges were not reasonable. This argument is a red herring. Progressive has the contractual burden of proving the charges are not reasonable or the service was not necessary (R. p. 528-530). Progressive raised the policy defenses and policy terms as an affirmative defense in it its Answer (R. p. 100, Twentieth Defense).

The policy provides:

We, or someone on our behalf, will determine:

1. Whether the expense for medical services are reasonable, and
2. Whether the medical services are necessary (R. p. 528).

The policy further provides, "If an injured person incurs expenses for medical services that we deem to be unreasonable or unnecessary, we may refuse to pay for those expenses and contest them" (R. p. 530).

For the reasonable and necessary defense, Progressive must show at the time of adjusting the claim (1) it determined the expense was unreasonable, (2) it refused to pay for that expense or a portion of it, (3) it contested that expense with the provider, and (4) the provider agreed to Progressives' reasonableness argument and reduced the charge. However, the SOP requires that Progressive pay any amounts owed to the provider,

including balance bill issues. So unless the provider agrees that its initial charge was unreasonable, the initial charge stands and Progressive must pay it under its SOP.

None of the common issues of underpaying health insured claimants will be eliminated by any defense of reasonable and necessary. First, if Progressive determined a service was unnecessary, then no amount of the charge would have been paid and there would be no health insurance reduction. If Progressive reduced a payment for a service based on health insurance, then Progressive already determined the service was necessary. The Court understood this reality. (The Court: "But isn't that a question of a claim not being covered as opposed to a covered claim that was paid by Progressive but paid at a lower amount because there was a reduction for whatever reason" (R. p. 279, line 24 – p. 280, line 2).

If Progressive has some evidence that it determined a charge was unreasonable, and that it repriced the bill, then the SOP would still result in an underpayment from the repriced charge. In other words, Lange would enter the repriced amount into Mitchell, not the initial charge amount, and then she would enter the allowed amount under health insurance. Progressives' adjusters enter into the computer screen (1) the charge (or repriced amount); (2) the amount paid under health insurance; and (3) the amount owed (R. p. 336, lines 1-25). With any repricing by Progressive, the core issue of Progressive paying less to the health insureds is still the key issue. The only potential change is to damage amounts.

Nothing in Progressives' SOP requires the adjuster to determine whether a medical bill is unreasonable (R. p. 580-581). Lange testified that she only reviews the bill for the amount charged on the bill, the amount allowed, and amount paid from all

sources to the provider (R. p. 336, lines 21-25). She does not determine whether a bill is too high or whether a service was necessary (R. p. 319, line 25 – p. 320, line 5; p. 322, line 16 – p. 323, line 6). To streamline the adjusting process, only health insurance and billed amounts are reviewed by the adjusters. Instead of acknowledging this standard procedure, the Court assumes hypotheticals as facts (R. pp. 33-36). Hypothetical "individual" issues are not a basis for denying class certification. See Kohen v. PAC, Inc. Mgmt. Co., LLC, 571 F.3d 672, 679 (7th Cir. 2009). At this stage in the litigation, Progressive has not produced one example of any repricing. The Court's ruling is premised on potential individual issues and is an error of law.

If Progressive wanted its adjusters to review bills for reasonableness, its SOP would reflect at least a reference to such a procedure. There is no such procedure. The adjusters do not make such determinations. Similarly, Progressive proferred no evidence of any particular instance whatsoever in which Mitchell was used to reprice a bill. As the corporate representative stated, Mitchell does not determine the amount to be paid by Progressive on a Med Pay South Carolina claim (R. p. 332, lines 20-25). Rather, Mitchell is a template that is completed by the adjuster (R. p. 336, lines 21-25).

Progressive has already made its determination on the claims. Any repricing is known and can be extracted from Progressives' records. In other words, if any reductions occurred because of reasonableness, that computerized information is retrievable (R. p. 10). If, in some rare instance, repricing was computed automatically by computer and not by any adjuster, then the computer data will be accessible. If the repricing data is not accessible, then Progressive will fail its burden on the reasonableness defense. If no such

information exists, then there is no reasonableness reduction applicable and the health insurance reduction damage analysis is not subject to any reduction.

Even if Mitchell reduced a bill for reasonableness, that computer data is retrievable as explanation codes are generated. Health insurance coverage is noted as code X563 (R. p. 355, lines 5 – 24). Thus, all claimants with code X563 have been subjected to Progressives' SOP and have a common issue.

Even with the hypothetical reduction, the "reasonable price" would always be higher than the "same damages allowed by health insurance." There can be no instance of repricing below what health insurance allowed as that would violate Progressives' SOP, which always requires the adjuster to pay same damages under health insurance. There can only be a "reasonable" charge amount which is more than the health insurance amount, and, at best, the damages might be less but not eliminated. But, Progressive has the burden of proving this affirmative defense at trial. It raised policy language and exclusions in its Twentieth Affirmative Defense (R. p. 100).

Even if some amounts were deducted for reasonableness, those deducted amount(s) would decrease the classwide damages. But more to the point, Progressive cannot later impose more reasons for denials of the claims than existed in the data at the time of adjustment. In other words, Progressive is stuck with the data it used and its decision to short pay the claim.[3] Its information will either bear out the number of reductions or it will fall short. At this juncture, Progressive has not provided an instance

[3] The amounts already paid by Progressive are not subject to any downward future revision. Any such approach would violate the voluntary payment doctrine. See *Shockley v. Wycliffe,* 148 S.E. 476 (S.C. 1929). Progressive made the payments with full knowledge. Progressive adjusted the claims and made payments. Under the voluntary payment doctrine, Progressive cannot later claim that any reasonable and necessary defense is an additional, subsequent basis for justifying a further or additional reduction.

which support the Court's theoretical assumptions and none of the adjusters recall any instance involving "reasonable and necessary". If the reasonableness reduction occurred frequently or was more than a rare occurrence, the five adjusters and the corporate representatives would have and should have recalled some instances in their sworn testimony.

South Carolina courts have long held the variations in damages among class members do not defeat class certification. McGann, 340 S.E.2d at 158. Smith can present classwide evidence of a standard operating procedure with health insurance reductions with identified claimants with health insurance, whose limits were not exhausted. Any Progressive defense of reasonable or necessary only goes to the amount of damages. Any reasonable or necessary defense does not eliminate the common question of whether the SOP violated the policy or statutory laws of South Carolina. At this early stage in the litigation, the hypothetical example discussed in the Reconsideration Order has not been borne out with any evidence (R. p. 36, 37). To deny class certification now, because of a hypothetical individual issue that may not become actual, would be premature. Kohen v. Pac. Inv. Mgmt. Co. LLC, 571 F.3d 672, 680 (7th Cir. 2009), citing Int'l Woodworkers of America, etc. v. Chesapeake Bay Plywood Corp., 659 F.2d 1259, 1269 (4th Cir.1981); 1 Conte & Newberg, supra, § 3.25, p. 422; cf. Smilow v. Southwestern Bell Mobile Systems, Inc., 323 F.3d 32, 40 (1st Cir.2003). The case should progress with discovery so any such reasonable and necessary data, if any, is disclosed by Defendants and can be tested before the small claims of hundreds South Carolinians are summarily denied.

### 3. The Court Improperly Ignored The Common Questions.

The Reconsideration Order ignores the undisputed fact that Progressives' written Standard Operating Policy requires it to pay all claimants with health insurance less than similarly situated claimants without health insurance.

In its Certification Order, the Court enumerated the common issues:

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 aw, 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.

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.

(R. pp. 11, 12)

These questions are common to all class members. The Court sidesteps these core issues by imposing dissimilar federal cases under a flawed federal analysis. The Court erred by interjecting a Rule 23(b)(3), FRCP predominance standard to Rule 23, SCRCP.

Rule 23(b)(3), FRCP predominance requirement is "far more demanding" than even Rule 23(a)(2)'s commonality requirement. Amchem Products, Inc. v. Windsor, 117

S.Ct. 854, 136 L.Ed.2d 829, 521, U.S. 591, 609 (1997). In addition, the Court interjects a manageability and superiority standard that is (1) not present in Rule 23, SCRCP, and (2) not applicable to the facts. While Rule 23, SCRCP has no manageability or predominance requirement, the Reconsideration Order interjects these two factors in reasoning that "...to resolve these Class Members' claims, the fact finder would have to determine on an individual basis whether Progressive properly concluded that the amount given a Class Member was billed was unreasonable, that the service the Class Member received were unnecessary, or both" (R. pp. 35, 36). The Court errs in its analysis. Any repricing would only affect the amount damages and does not negate or eliminate the health insurance reduction or the common questions posed above.

### B. Smith Is A Typical And Adequate Representative.

#### 1. The Court Acknowledged At The Hearing And In The Class Certification Order That Smith Is A Typical Plaintiff.

In the Reconsideration Order, the Court concludes Plaintiff has not demonstrated adequacy because (1) she does not have a viable individual claim and (2) her individual circumstances cause her interest to diverge from the Class (R. p. 27).

As discussed earlier, the Reconsideration Order improperly adjudicated the merits in violation of South Carolina precedent on class certification. Plaintiff's claims are typical. In response to Defendants' arguments that Plaintiff is a former policyholder and had no personal stake in the lawsuit, the Court quickly recognized the typicality of Plaintiff's claims at the certification hearing.

> I mean, the only true plaintiff could be someone in Ms. Smith's case --- situation wouldn't it? Isn't that what we're left with, only people in Ms. Smith's situation (R. p. 251, lines 7-10)?

Typicality requires the named representatives' claims must be similar to those of the class. In this instance, Smith's claims are similar as they involve the same policy language, statutory interplay and Standard Operating Procedure of Progressive. The insureds must be treated similarly under the statutes and policy language. Moreover, the Uniform Declaratory Judgment Act expressly allows Smith to raise the issues asserted in the Second Amended Complaint. She has contractual rights and statutory rights like all members of the Class. The SOP requiring health insurance reductions has been uniformly applied and is subject to class wide determination.

**2. Smith Is An Adequate Class Representative.**

Smith has an individual claim as to all Progressive Defendants under the Uniform Declaratory Judgment Act (the "Act") and the four additional causes of action. The Reconsideration Order held that Smith is not an adequate representative because (1) she had no relationship with either Progressive Casualty or Progressive Direct and (2) she is a former Progressive Max policyholder and has no standing to seek prospective relief, such as declaratory judgment (R. p. 31). The Court erred in its reasoning.

The Court improperly construes the facts in concluding Smith is not a Progressive Direct insured. The Smith face page of the policy is entitled Progressive Direct and the documents produced by Progressive state the policy was underwritten by both Progressive Max and Progressive Direct (R. pp. 519, 578). Thus, factually the Court erred in its review of the evidence. Progressive Casualty operated the insurance business through the Joint Servicing Agreements (R. pp. 554, 564, 571). Under those Agreements, Progressive Casualty is responsible for all aspects of the insurance business. Progressive Casualty adjusted the Smith claim and would certainly be affected by any

declaration that its National Med Pay Unit has interfered with the contract rights of Smith and the Class under the tortious interference allegations set forth in the Second Amended Complaint (R. pp. 84, 85). Under the Act, Progressive Casualty is a proper party. S.C. Code Ann. §15-53-80 provides, "When declaratory relief is sought all persons shall be made parties who have or claim any interest which would be affected by the declaration."

Lost in the Court's analysis are Smith's claims against Progressive Max. At a minimum, Plaintiff suffered a loss and can represent the Class on common law, contractual and statutory issues with respect to Progressive Max. There is no requirement that Smith continue to renew her Progressive policy while prosecuting her claim against Progressive. Her claim arose out of the policy in place at the time of her wreck.

The Court erred in relying on Newman vs. Richland County Historic Preservation Committee, 325 S.C. 79, 84, 480 S.E.2d 72 (1997) in its standing analysis. Reconsideration Order, p 12. Newman held that a former director on a governmental committee had no standing to sue the government. Id. Smith is a contract holder. She is the very Plaintiff who is typical, as the Court recognized. She is familiar with the case and has a "personal stake in the subject matter of the lawsuit" (R. pp. 475, 476). Smith suffered from Progressives' written policy of reducing payments to claimants with health insurance. Although she paid her health insurance premiums, Progressive wants the benefit of any health insurance adjustments. The Court expressly recognized her typicality at the hearing. Progressive should not get a windfall because Smith incurred health insurance premiums.

## C. The Class Definition Meets Rule 23.

### 1. The Class Is Objectively Ascertainable.

A class is sufficiently definite if its members can be ascertained by reference to objective criteria and may be defined by reference to defendant's conduct. Hinman v. M and M Rental Center, Inc., 545 F. Supp.2d 802, 806 (N.D.Ill.2008) (citations omitted). Definiteness does not require plaintiffs to identify specific class members. Saf–T–Gard Intern., Inc., v. Wagener Equities, Inc., 251 F.R.D. 312, 315 (N.D.Ill.2008). In Hinman, the Court held membership in the class could be "ascertained by reference to objective criteria and ... defined by reference to defendant's conduct." Hinman, 545 F.Supp.2d at 806.

Smith proposed objective qualifiers for the class, without requiring any merits determination as to who has a compensable claim. The Court, intending to certify a class, appears to have desired a "fail safe" class definition which is incompatible with Rule 23, SCRCP (R. pp. 42-46). A fail safe class definition is one in which the putative class is defined by reference to the merits of the claim. Melton v. Carolina Power & Light Co., 283 F.R.D. 280, 288 (D.S.C. 2012).; citing Messner v. Northshore Univ. Health Systems; 699 F.3d 802, (7th Cir. 2012); Manual for Complex Litigation (Fourth) §21.222 (2004).

In its Order, the Court discussed the evidence of write downs but implies the Plaintiff must prove the basis for the write downs before such person is in the class. (R. p. 44). This merits based, fail safe approach of requiring proof of membership and liability at this early stage in the litigation is simply not required. There are several hundred class members as disclosed in Defendants' Fourth Supplemental Discovery Responses, Plaintiff's First Set of Interrogatories (R. pp. 589-593). They have already

been identified by Progressive and Progressive has stipulated to numerosity (R. p. 11; p. 608). Some of them may be culled out due to the additional objective criterion that the class member file reflect health insurance, e.g., in its medical bills or health insurance code X563. Yet, a file by file review is simple and is no bar to class identification. Of the several hundred features identified by Progressive in discovery responses, a review of their files for reference to health insurance is all that is necessary.

The fact that some class member may ultimately be found to have not suffered damages does not preclude class certification. See Kohen v. Pac. Inv. Mgmt. Co. LLC, 571 F.3d 672, 676 (7th Cir. 2009) ("PIMCO argues that before certifying a class the district judge was required to determine which class members had suffered damages. But putting the cart before the horse in that way would vitiate the economies of class action procedure; in effect the trial would precede the certification.")

The Court's analysis implies it cannot determine who had suffered damages from the definition and, therefore, the certification was vacated. The Court misinterprets Rule 23. At this stage in the litigation, damage determinations are not necessary. In addition, the Reconsideration Order errs in finding that a simple review of several hundred class member files for health insurance information is a bar to certifying the class. Under Oppenheimer v. Sanders, 98 S.Ct. 2380, 57 L.Ed. 253, 437 U.S. 340, 355 (1978), the Court determines who is to identify class members. Progressives' corporate representative testified that health insurance is coded (X563) and that all medical bills are scanned into the system (R. p. 355). The review of several hundred files by either Defendants or Smith is quite simple and is no bar to certification.

### 2. A Court Confronted With A Purportedly Overbroad Class Should Narrow The Class Definition, Not Decertify The Class.

Even if the class definition clearly were overbroad, this would be a compelling reason to require that it be narrowed. Kohen v. Pac. Inv. Mgmt. Co. LLC, 571, F.3d 672, 677-78 (7th Cir. 2009), (citations omitted). The Court erred as a matter of law in not narrowing the class if it felt the original class definition was too broad. In the Reconsideration Order, the Court vacated the Certification Order and stated the class definition was overly broad (R. p. 44). The South Carolina Supreme Court has held, "we see no reason the circuit court could not, as urged by plaintiffs, have redefined the class to include only former employees." Littlefield, 523 S.E.2d at 784. See also McGann v. Mungo, 287 S.C. 561, 340 S.E.2d 54, (S.C. App. 1986) (citations omitted) ("In any case the problem of determining initial membership in the class afford no basis for dismissal of the action since the circuit court can either require the plaintiffs to replead, redefine the alleged call itself or designate subclasses.") The Court erred as a matter of law and abused its discretion by not narrowing the definition if it believed the original definition was too broad.

## D. The Unjust Enrichment, Bad Faith And Tortious Interference Claims Are Well Suited For Class Treatment As They Are Grounded In The Common Issue Of Progressives' Written SOP.

In pages 20 – 23 of the Reconsideration Order, the Court erroneously concluded that unjust enrichment, bad faith and tortious interference claims were unsuitable for class treatment as the fact finder would be required to investigate individual circumstances (R. pp. 39-42). The Court misuses the point of the SOP. There are no individual issues when Progressive applied the SOP to systematically reduce payments to

claimants with health insurance. Such a policy, if it violates the contract, statutes or common law, either constitutes bad faith or unjust enrichment on a universal scale or it does not. Similarly, Progressive Casualty's use of its own definition of "incurred," and its SOP, has either tortiously interfered with the carriers' insurance contracts or has not. The evidence for all class members is the same and involves the admitted standard practices of Progressive under the SOP. These claims are subject to class treatment.

## CONCLUSION

The Court should reverse the Reconsideration Order and reinstate the Class Certification Order.

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October 31, 2014

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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APPEAL FROM HORRY COUNTY
Court of Common Pleas

Larry B. Hyman, Jr., Circuit Court Judge

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Case No. 2010-CP-26-10502

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

v.

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

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CERTIFICATE OF COUNSEL

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The undersigned certified that this Appellant's Final Brief complies with Rule 211(b), SCACR.

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