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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

Case No. 2017-CP-42-00219
Appellate Case No. 2020-001613

Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and on behalf of all others similarly situated,

Respondents,

v.

Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; CHSPSC, LLC; Professional Account Services, Inc.,

Appellants,

APPELLANTS' INITIAL BRIEF

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STATEMENT OF ISSUES ON APPEAL

I. WHETHER THE CIRCUIT COURT ERRED IN DENYING DEFENDANTS' MOTION TO DISMISS OR, IN THE ALTERNATIVE, TO COMPEL PLAINTIFF OWENS TO ARBITRATE HIS CLAIMS AGAINST DEFENDANTS PURSUANT TO THE CIGNA AGREEMENT'S ARBITRATION PROVISION.

II. WHETHER THE CIRCUIT COURT ERRED IN FAILING TO DISMISS OWENS' CLAIMS ON THE GROUNDS HIS CLAIMS DO NOT RELATE BACK TO BLACKWELL'S FILING OF THE ORIGINAL COMPLAINT AND, THEREFORE, ARE BARRED BY THE APPLICABLE STATUTES OF LIMITATION.

III. WHETHER THE CIRCUIT COURT ERRED IN FAILING TO FIND THAT BLACKWELL IS NOT AN INTENDED THIRD-PARTY BENEFICIARY UNDER THE MEDCOST AGREEMENT AND, THEREFORE, LACKS STANDING TO PURSUE CLAIMS TO ENFORCE ITS TERMS.

IV. WHETHER THE CIRCUIT COURT ERRED IN FAILING TO DISMISS BLACKWELL'S CLAIM FOR UNJUST ENRICHMENT, BECAUSE BLACKWELL DID NOT ALLEGE SHE CONFERRED ANY BENEFIT TO DEFENDANTS.

V. WHETHER THE CIRCUIT COURT ERRED IN FAILING TO DISMISS BROOKS' CLAIMS BECAUSE HER CLAIMS ARE GOVERNED BY THE MEDICARE ACT AND UNDER THAT ACT AS A MATTER OF LAW DEFENDANTS WERE FIRST OBLIGATED TO PURSUE PAYMENT FROM ANY AVAILABLE AUTOMOBILE OR LIABILITY INSURANCE PRIOR TO BILLING MEDICARE.

VI. WHETHER THE CIRCUIT COURT ERRED IN FAILING TO DISMISS THE CLAIMS ASSERTED BY BROOKS AND OWENS BECAUSE THOSE CLAIMS ARE BARRED BY APPLICATION OF THE VOLUNTARY PAYMENT DOCTRINE.

VII. WHETHER THE CIRCUIT COURT ERRED IN FAILING TO DISMISS PLAINTIFFS' CLAIMS FOR TORTIOUS INTERFERENCE WITH A CONTRACT ON THE GROUNDS THAT THE AMENDED COMPLAINT DOES NOT ALLEGE ANOTHER RELEVANT CONTRACT WAS BREACHED.

VIII. WHETHER THE CIRCUIT COURT ERRED IN FINDING THAT THE AMENDED COMPLAINT STATES FACTS SUFFICIENT TO CONSTITUTE ANY VIABLE CAUSE OF ACTION AGAINST PASI OR CHSPSC.

STATEMENT OF THE CASE

This case is premised entirely on allegations that Defendants Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital ("Mary Black"); CHSPSC, LLC ("CHSPSC"); and Professional Account Services, Inc. ("PASI") (collectively, "Defendants") failed to submit bills to the applicable health insurance coverage for Plaintiffs Jo Ann Blackwell, Samuel Owens, and Michelene Brooks (collectively, "Plaintiffs") for emergency room care rendered to Plaintiffs at Mary Black following their involvement in motor vehicle collisions and, instead, submitted the bills to the Plaintiffs or asserted liens against their potential third-party automobile accident claims. The case began as a suit by only Plaintiff Jo Ann Blackwell. (R. ___). Eight (8) days after her automobile accident, which occurred on December 19, 2013, Blackwell was admitted as a patient at Mary Black. (R. ___). According to Blackwell, she had health insurance coverage through a health insurance provider (MedCost) at the time she was admitted to Mary Black. She contends that Mary Black did not submit a bill to MedCost for the medical services rendered to her and, instead, asserted a lien against her potential third-party automobile accident claim. (R. ___). Importantly, Blackwell never alleges that she actually paid the bill, or made any payment to Mary Black for the medical treatment she received.

Based on these allegations, on January 20, 2017, Blackwell filed her initial Complaint, alleging claims collectively against Defendants for (1) tortious interference with contractual relationship (her health insurance), (2) unjust enrichment, and (3) injunctive relief (to enforce the terms of the contract between Mary Black and MedCost). (R. ___). In her Complaint, Blackwell also asserted she was an appropriate representative for a class of similarly situated persons. Defendants each timely filed answers to the Complaint.

More than two years later[1], on June 28, 2019, Blackwell—without consent of Defendants or leave from the circuit court—filed a purported Amended Complaint. (R. ___). This so-called Amended Complaint attempted to add (for the first time) Michelene Brooks and Samuel H. Owens, Jr. as additional named plaintiffs with new individual claims. (R. ___). However, each of them alleged they had health insurance coverage through other insurers—not MedCost. (R. ___).

In the purported Amended Complaint Owens alleged (1) he was injured in an automobile accident on October 9, 2015, and presented for medical treatment at Mary Black; (2) at that time he was covered by valid health insurance through CIGNA HealthCare of South Carolina, Inc. ("Cigna"); (3) Defendants did not submit a bill to Cigna and, instead, asserted a lien against his third-party automobile accident claim; and (4) Owens negotiated an agreement to settle his account with Mary Black and paid Mary Black a discounted amount for the services rendered. (R. ___).

In the purported Amended Complaint Brooks alleged (1) she was injured in an automobile accident on February 26, 2016, and presented for medical treatment at Mary Black; (2) at that time she was covered for health care through Medicare; (3) Defendants did not submit a bill to Medicare and, instead, asserted a lien against her third-party automobile accident claim; and (4) Brooks negotiated an agreement to settle her account with Mary Black and paid a discounted amount to Mary Black for the services rendered. (R. ___).

Based on these additional allegations in the purported Amended Complaint, Plaintiffs asserted claims for (1) unjust enrichment, (2) tortious interference with a contract, and (3) injunctive relief. (R. ___).

[1] On October 6, 2017, Blackwell and Defendants filed a Joint Motion for Complex Case Designation. In February 2019, the case was designated as complex and assigned to the Honorable J. Mark Hayes, II.

On August 19, 2019, Defendants filed a Motion to Strike or Dismiss the Amended Complaint. (R. ___). The Motion was based on the fact that, at that time, the Amended Complaint could not be filed as a matter of right under Rule 15 and it had been filed without motion, consent, or leave of the circuit court. (R. ___).

On October 18, 2019, prior to hearing or decision on the Motion to Strike, Blackwell filed a Motion to Amend her Complaint and again attempted to add Brooks and Owens as new and additional named plaintiffs in this case. (R. ___).

On October 24, 2019, Defendants filed a Memorandum of Law in Opposition to Blackwell's Motion to Amend the Complaint, arguing: (1) Rule 15 of the South Carolina Rules of Civil Procedure does not permit Blackwell to amend the complaint nearly three years after the litigation was initiated to add new plaintiffs and claims, and any claims by new Plaintiffs would not relate back to the date of filing of the original complaint; (2) Owens' claims for tortious interference with contract and unjust enrichment are futile because those claims are barred by the applicable statutes of limitation; (3) Brooks' claims are clearly futile, and fail as a matter of law, because her claims are expressly based on purported Medicare coverage and the Medicare Act requires a hospital to attempt to collect payment from any applicable auto or liability policy prior to seeking or obtaining payment from Medicare, plus she did not exhaust her administrative remedies prior to filing suit; (4) Blackwell's claim for unjust enrichment is clearly futile, and fails as a matter of law, because the Amended Complaint did not even allege that she had provided any of the Defendants with an unjust benefit; and (5) Blackwell cannot be a representative for the purported class because her express allegations reflect plainly that she does not even qualify as a member of the Amended Complaint's newly defined and proposed class. (R. ___).

The circuit court held a hearing on Blackwell's Motion to Amend the Complaint and on April 23, 2020, the circuit court issued an order granting Blackwell's Motion to Amend the Complaint. (R. ___). On April 24, 2020, Blackwell filed her Amended Complaint and Brooks and Owens were added to the case as named plaintiffs. (R. ___).

On June 8, 2020, Defendants each filed a Motion to Dismiss the Amended Complaint pursuant to Rule 12(b)(6) or, in the alternative, to Stay the Case and Compel Arbitration (collectively, the "Motion"), asserting the following arguments:

1. Owens must be compelled to arbitrate his claims against the Defendants because he is suing to enforce the terms of an agreement that contains a valid and enforceable agreement to arbitrate claims related to that agreement;

2. Plaintiffs' Amended Complaint utterly fails to state facts sufficient to constitute any viable cause of action against CHSPSC or PASI;

3. Plaintiffs' Amended Complaint utterly fails to allege facts sufficient to constitute a cause of action for tortious interference against any Defendant;

4. Brooks fails to state facts sufficient to constitute a claim against any Defendant because Brooks' claims are governed by the Medicare Act and the law under the Act does not support the claims alleged;

5. Brooks' and Owens' claims are barred as a matter of law under the voluntary payment doctrine;

6. Owens' claims are barred as a matter of law by the applicable limitations period;

7. Blackwell's Amended Complaint fails to state facts sufficient to constitute a claim against any Defendant for unjust enrichment because she does not allege she made any payment to, or conferred any actual benefit upon any Defendant; and

8. Blackwell is not, and cannot be, an intended third-party beneficiary under the agreement between Mary Black and her insurer.

(R. ___).

On July 29, 2020, the circuit court held a hearing on the Motion. On September 4, 2020, the circuit court issued a Form 4 Order denying the Motion. (R. ___).

On September 14, 2020, Defendants jointly filed a Motion to Alter or Amend. (R. ___). On November 4, 2020, the circuit court issued a Form 4 Order denying the Motion to Alter or Amend and on December 8, 2020, the Court issued an additional formal order denying the Motion to Alter or Amend. (R. ___).

Defendants timely filed their Notice of Appeal on December 8, 2020.

This appeal first concerns the fundamental question of whether Owens, who seeks to enforce the terms of a contract between the hospital and his insurance carrier as a non-signatory, third-party beneficiary of that contract, is required to arbitrate his claims. The contract he seeks to enforce, and from which he seeks to derive direct benefit, contains an arbitration provision—which requires all disputes arising from the contract to be submitted to binding arbitration. Secondly, this appeal seeks review regarding the errors by the circuit court in refusing to grant the Motion and to dismiss the claims of each of the Plaintiffs. Defendants assert that those matters should be addressed now, in this appeal, because judicial economy requires the Court to dispose of facially defective claims which utterly fail as a matter of law.

The appealability of the denial of the arbitration issues in the Motion is clear. The resolution of the remaining issues in the Motion addressing claims that are facially inadequate, and fail as a matter of law, is also appropriate and necessary at this time. It is imprudent, and would be a waste of judicial resources, to delay consideration of the other issues addressed by the Motion when the merit of those issues are evident from the face of the Amended Complaint. Such a conclusion is all the more compelling when Plaintiffs attempt to pursue class claims in the case on

allegations by named plaintiffs that are facially defective. This Court has latitude to consider those other issues as part of this appeal, and it should exercise that discretion.

FACTUAL BACKGROUND

This matter involves claims asserted by three separate and distinct plaintiffs. Each of the named Plaintiffs alleges that he/she was involved in a motor vehicle collision, received medical care at Mary Black, had health insurance coverage at the time of treatment, and received either a bill from Mary Black or notice that Mary Black asserted an interest in their recovery from the at-fault driver (instead of Mary Black submitting the claim for the medical services directly to their health insurer). Each Plaintiff further alleges that Defendants are parties to contracts with their health insurance providers which specify the manner in which Defendants are to bill for services rendered to insureds and the contractual, discounted rates that are to apply to the bill for such services. (R. ___). The relevant facts for each Plaintiff will be addressed in turn.

I. Jo Ann Blackwell

Blackwell was allegedly injured in an automobile accident on or about December 19, 2013. (R. ___). She was admitted as a patient at Mary Black on or about December 27, 2013. (R. ___). Blackwell was released from the hospital, following her treatment there, on January 3, 2014. (R. ___). Blackwell alleges that she had health insurance coverage through MedCost at the time she was admitted to Mary Black. (R. ___). She further alleges that Mary Black had a contract with MedCost which required that bills for medical services provided to her be sent directly to MedCost, not her, and that the contract provided for discounted rates for the services. (R. ___). She alleges Defendants did not submit a bill for her treatment to her health insurance provider (MedCost) and, instead, asserted a lien against her third-party automobile accident claim. (R. ___). Blackwell does not allege she is a direct party to the Mary Black contract with MedCost. The Amended

Complaint contains no allegation that Blackwell made any payment, or gave any other benefit to Mary Black for the medical treatment rendered to her.

A. Hospital Services Agreement — MedCost

Mary Black is party to a Hospital Services Agreement with MedCost (the "MedCost Agreement"). (R. ___). That MedCost Agreement defines the terms of the relationship between Mary Black and MedCost, and includes the billing procedures and negotiated rates that MedCost will pay on behalf of its insureds for covered services. The MedCost Agreement also contains a plain and unambiguous express provision directly stating Mary Black's and MedCost's intent to bar third parties from enforcing the MedCost Agreement. (R. ___). This intent is unequivocally expressed in Section 10.9 of the MedCost Agreement, which states:

> This Agreement is entered into by and between the parties hereto for their benefit. **There is no intent by either party to create or establish a third party beneficiary status** or rights in a Covered Person, Employer, subcontractor, or other third party to this Agreement, except as such rights are expressly created and as set forth herein, and **no such third party shall have any rights to enforce any right to enjoy any benefit created or established under this Agreement**.

(R. ____) (emphasis added).

II. Samuel H. Owens, Jr.

On October 9, 2015, Owens was admitted to Mary Black following an automobile accident. (R. ___). Owens alleges that at the time of his medical treatment he had valid health insurance coverage through Cigna. (R. ___). Owens alleges that Mary Black had a contract with Cigna which required that bills for medical services provided to him be sent directly to Cigna, not him, and that the contract provided for discounted rates for the services. (R. ___). Owens alleges that Defendants did not submit the bill for his services to Cigna, but rather sought payment by asserting a lien against his claims against the at-fault driver in the collision. (R. ___). Owens admits that

on or about October 14, 2016, he negotiated an agreement to settle his account with Mary Black for a discounted payment of $4,543.38. (R. ___). More than three years after the date Owens alleges he paid Mary Black and settled his account, on October 18, 2019, Blackwell filed the Motion to Amend the Complaint and to add Owens and his separate claims to this case. (R. ___).

A. Hospital Services Agreement — Cigna Agreement

Mary Black is party to a Hospital Services Agreement with Cigna (the "Cigna Agreement"). (R. ___). That Cigna Agreement defines the terms which control various aspects of the relationship between Mary Black and Cigna, including billing practices and the negotiated rates that Cigna will pay on behalf of its insured for covered services. Owens' claims against Defendants arise out of the Cigna Agreement, because his claims are based upon his purported ability to enforce the negotiated rates that Cigna will pay on behalf of its insured for covered services. He has specifically asserted a claim for injunctive relief to enforce the terms of the Cigna Agreement. (R. ___). Therefore, Owens—a non-signatory to the Cigna Agreement—is suing to enforce the Cigna Agreement as a third-party beneficiary.

Section 6 of the Cigna Agreement contains the following dispute resolution provision:

> 6.2.2 Arbitration. . . . **Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement**. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator. The parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision shall not be consolidated with an arbitration involving other hospitals or third parties, and that the arbitrator shall be without power to conduct an arbitration on a class basis. Judgment upon the award rendered by the arbitrator may be entered in any court of competent jurisdiction. The Agreement will remain in full force and effect during any such period of arbitration unless otherwise terminated under the terms of this Agreement.

(R. ____) (emphasis added).

III. Michelene Brooks

On February 26, 2016, Brooks was admitted to Mary Black following an automobile accident. (R. ___). Brooks alleges that at the time of her medical treatment she was covered for health care services through Medicare. (R. ___). Brooks alleges that Defendants did not submit the bills for her health care services to Medicare, but instead sought collection of the amounts due by asserting a lien against her recovery from the at-fault driver in the accident. (R. ___). Brooks further admits that on or about September 26, 2017, she negotiated an agreement to settle her account by Mary Black accepting a discounted payment of $4,991.22. (R. ___).

STANDARD OF REVIEW

A. Motion to Compel Arbitration

The Court reviews the denial of a motion to compel arbitration *de novo*. *New Hope Missionary Baptist Church v. Paragon Builders*, 379 S.C. 620, 625, 667 S.E.2d 1, 3 (Ct. App. 2008). When reviewing a motion to compel arbitration "[i]t is the policy of this state and federal law to favor arbitration[,] and 'any doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration.'" *Landers v. Fed. Deposit Ins. Co.*, 402 S.C. 100, 109, 739 S.E.2d 209, 213 (2013) (quoting *Am. Recovery Corp. v. Computerized Thermal Imaging, Inc.*, 96 F.3d 88, 92 (4th Cir. 1996)). "[T]he party resisting arbitration bears the burden of proving that the claims at issue are unsuitable for arbitration." *Hall v. Green Tree Servicing, LLC*, 413 S.C. 267, 271, 776 S.E.2d 91, 94 (Ct. App. 2015) (alteration in original) (quoting *Dean v. Heritage Healthcare of Ridgeway, LLC*, 408 S.C. 371, 379, 759 S.E.2d 727, 731 (2014)). A non-signatory who is suing to enforce an agreement is bound by the other terms of that agreement—including an agreement to arbitrate disputes arising from the agreement. *Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 288, 733 S.E.2d 597, 600 (Ct. App. 2012) (quoting *Int'l Paper Co. v. Schwabedissen Maschinen & Anlagen GMBH*, 206 F.3d 411, 416 (4th Cir. 2000)).

B. Motion to Dismiss[2]

A motion to dismiss must be granted if the facts alleged in the complaint, and inferences reasonably deducible therefrom, do not entitle the plaintiff to the relief sought. *Chewning v. Ford Motor Co.*, 346 S.C. 28, 32-33, 550 S.E.2d 584, 586 (Ct. App. 2001). In addition to review of the allegations in the complaint, when deciding the motion to dismiss a court may also consider documents incorporated into the complaint by reference, documents attached to the complaint itself, matters of which the court may take judicial notice, and documents submitted by the party moving to dismiss the complaint so long as the documents are integral to the complaint. *See Carolina First Corp. v. Whittle*, 343 S.C. 176, 190 n.7, 539 S.E.2d 402, 410 n.7 (Ct. App. 2000); *Brazell v. Windsor*, 384 S.C. 512, 516, 682 S.E.2d 824, 826 (2009); *HHHunt Corp. v. Town of Lexington*, 389 S.C. 623, 629-30, 699 S.E.2d 699, 701-02 (Ct. App. 2010); *see also Patterson v. Witter*, 425 S.C. 213, 235, 821 S.E.2d 677, 689 (2018) (acknowledging that the court may consider documents that are integral to the complaint when reviewing a motion to dismiss); *Goines v. Valley Cmty. Servs. Bd.*, 822 F.3d 159, 164 (4th Cir. 2016) (same).

ARGUMENTS

The cornerstone of this appeal is the error by the circuit court in denying the Motion and refusing to compel the claims brought by Owens to arbitration. The denial of that Motion is immediately appealable, as provided in S.C. CODE ANN. § 15-48-200. The circuit court's decision to refuse to compel Owens to arbitrate his claims and deny the Motion must be reversed.

[2] The Court may exercise its discretion to review the other interlocutory issues raised in Defendants' Motion because issues raised in an interlocutory order that are not directly appealable can be considered by the Court when raised in tandem with an immediately appealable issue. *See Ferguson v. Charleston Lincoln Mercury, Inc.*, 349 S.C. 558, 565, 564 S.E.2d 94, 98 (2002); *Cox v. Woodmen of World Ins. Co.*, 347 S.C. 460,469, 556 S.E.2d 397, 402 (Ct. App. 2001).

At the same time, the decision by the circuit court in denying other parts of the Motion should be addressed by the Court now, as part of this appeal, because reversal of the other erroneous decisions by the circuit court is in the interest of justice and judicial economy.

I. The circuit court erred in failing to compel Owens to arbitrate his claims against Defendants.

A. Owens is equitably estopped from avoiding the arbitration provision in the Cigna Agreement because he is seeking to take a direct benefit from that Agreement.

The circuit erred in failing to find that Owens' claims are subject to the arbitration provision in the Cigna Agreement. Owens is bound to arbitrate his claims and is equitably estopped from avoiding the obligation to arbitrate his claims pursuant to the arbitration provision in the Cigna Agreement, because his claims all involve his effort to enforce terms of that Agreement and to derive direct benefit therefrom.

Owens undeniably bases his claims on the proposition that he is entitled to the direct benefits of the billing terms and procedures, and the discounted billing rates, created by and set forth in the Cigna Agreement. (R. ____; Amended Complaint ¶ 28). Owens' cause of action for so-called Injunctive Relief is nothing more than an unabashed, overt demand to enforce the Defendants' Agreement with his insurer (Cigna). Those payment terms do not exist or arise from any other source. Owens admitted as much to the circuit court when he said, "Plaintiffs' success on [their claim for injunctive relief] admittedly relies on the hospital services agreement." (R. ____; Plaintiffs' Memorandum in Opposition to Defendants' Motion to Alter of Amend p. 6). Furthermore, Owens specifically argued to the circuit court that he was "harmed by [Mary Black's] failure to act in accordance with the contract." (R. ____; Plaintiffs' Memorandum in Opposition to Defendants' Motion to Alter of Amend p. 2). Thus, it is undeniable that Owens' claims arise from the Cigna Agreement, and Owens seeks to enforce the terms of that Agreement and to recover

what damages he alleges to be caused by Defendants' failure to act in accordance with the Cigna Agreement.

In denying the Motion and refusing to compel Owens to arbitrate his claims against Defendants, the circuit court placed improper significance on its belief that Owens is not a party to the Cigna Agreement. However, the circuit court failed to conduct the required analysis under the principles of direct benefits estoppel and failed to apply those important principles to compel a non-signatory to arbitration. When Owens (a non-signatory to the Cigna Agreement) seeks to take direct benefits from the Cigna Agreement, and to enforce the terms contained therein, the doctrine of direct benefits estoppel binds him to all of the terms within the Cigna Agreement—including the arbitration provision. *See Pearson*, 400 S.C. at 288-90, 733 S.E.2d at 600-01. Under the direct benefits estoppel framework "[a] nonsignatory is estopped from refusing to comply with an arbitration clause 'when it receives a 'direct benefit' from a contract containing an arbitration clause.'" *Id.* at 290, 733 S.E.2d at 601 (quoting *Int'l Paper Co. v. Schwabedissen Maschinen & Anlagen GMBH*, 206 F.3d 411, 418 (4th Cir. 2000)). "'To allow [a plaintiff] to claim the benefit of the contract and simultaneously avoid its burdens would both disregard equity and contravene the purposes underlying enactment of the Arbitration Act.'" *Id.* (quoting *Int'l Paper*, 206 F.3d at 418).

In addition to his direct claim to enforce the Cigna Agreement, Owens' claim for unjust enrichment is clearly based on his alleged right to enforce the payment terms of that Agreement (including the payment rates negotiated between Mary Black and Cigna). Therefore, to hold other than that Owens is estopped from avoiding the obligation to arbitrate set forth in that Agreement would be to disregard the doctrine of direct benefits estoppel. Owens cannot enforce or derive benefit from some terms of the Cigna Agreement while simultaneously avoiding compliance with

the other terms—including the arbitration provision. *See Pearson*, 400 S.C. at 295, 733 S.E.2d at 604 ("[A] party may not rely on the contract when it works to its advantage, and repudiate it when it works to its disadvantage."). Thus, Owens is estopped from avoiding the application of the Cigna Agreement's arbitration provision.

The court in *Pearson*, 400 S.C. at 296-97, 733 S.E.2d at 605, applied the direct benefits estoppel framework to find a doctor (Pearson) was equitably estopped from asserting that, as a nonsignatory, he was not bound by the arbitration provision in a contract between a hospital and a medical professional placement company (Locum). The court found that although Pearson was a nonsignatory to the contract between the hospital and Locum, "he received a benefit due to the contract, in that he was able to work at the [h]ospital and receive payment for his work." *Id*. at 296, 733 S.E.2d at 605. The court stated that "[i]f not for that contract, then Dr. Pearson would have had to make separate arrangements with the [h]ospital in order to work there" and Pearson knowingly accepted the benefits of the contract between the hospital and Locum. *Id*. at 296-297, 733 S.E.2d at 605. The court found that in Pearson's complaint he was either seeking a benefit under the hospital's contract with Locum or he was attempting to hold the hospital accountable under his contract with Locum. *Id*. at 297, 733 S.E.2d at 605. Therefore, the *Pearson* court held that direct benefits estoppel applied in such circumstances and barred Pearson from avoiding the arbitration clause in the contract between the hospital and Locum. *Id*.

In a case with similar operative facts and issues, *Benton v. Vanderbilt University*, 137 S.W.3d 614, 619 (Tenn. 2004), the Tennessee Supreme Court addressed a non-signatory plaintiff's ("Benton") claim against a hospital ("Vanderbilt") based upon the hospital's alleged billing practices. The court specifically addressed the plaintiff's obligation to arbitrate under the agreement from which plaintiff sought to derive the claim rights. Benton was insured by Blue

Cross Blue Shield ("BCBS"), and Vanderbilt Hospital provided medical services to Benton after Benton suffered injuries in an automobile accident. *Id.* at 616. Vanderbilt and BCBS had a hospital services agreement between them like the Cigna Agreement. The agreement provided that Vanderbilt would bill BCBS for the medical services rendered to BCBS insureds (like Benton) at discounted rates. *Id*. Benton later filed a lawsuit against the at-fault driver for the personal injuries he suffered in the accident, but Vanderbilt then sought to collect the amount of the hospital expenses that had not been paid by BCBS and filed a statutory Notice of Hospital Lien against any monetary recovery that Benton might receive from the at-fault driver (a collection practice that is known as balance billing). *Id*. As a result of Vanderbilt's collection actions, Benton filed a complaint asserting claims against Vanderbilt for abuse of process, breach of contract, and violation of the Tennessee Consumer Protection Act on the grounds that Vanderbilt had agreed to accept payment in full from BCBS based on the hospital services agreement between Vanderbilt and BCBS. *Id.* In response to the Complaint, Vanderbilt moved to compel Benton to arbitrate his claims pursuant to the arbitration provision in the contract between Vanderbilt and BCBS. *Id.* On appeal, the Tennessee Supreme Court held that Benton was a third-party beneficiary attempting to enforce the contract between Vanderbilt and BCBS and Benton was bound by all of that agreement's terms—including the arbitration provision. *Id.* at 620. Accordingly, the Tennessee Supreme Court compelled Benton to arbitrate his claims against Vanderbilt pursuant to the hospital services agreement between BCBS and Vanderbilt. *Id*.

Significantly, in that case Benton argued (as does the circuit court in its decision here) that he was not subject to the arbitration provision because it only applied to the "parties to the agreement" and he was not a party to the agreement between Vanderbilt and BCBS. *Id*. at 619. The Tennessee Supreme Court rejected this argument and agreed with the courts of Alabama,

Pennsylvania, and Maryland, all of which relied on *Williston on Contracts* as well as the Restatement (Second) of Contracts, to find that a third-party beneficiary attempting to enforce the hospital services agreement is a "party" to that agreement for the purpose of enforcing the agreement's arbitration provision against him. *Id.*

The circuit court in this case did not provide any analysis of the direct benefits estoppel framework that was laid out and applied in *Pearson* and *Benton*. Similarly, the circuit court did not provide any basis for finding that Owens was not attempting to enforce the Cigna Agreement as a third-party beneficiary. Instead, the circuit court—without any discussion or explanation as to why *Pearson* and *Benton* were not directly on point (which they are)—found under the facts and circumstances of this case were similar to the facts at issue in *Wilson v. Willis*, 426 S.C. 326, 340, 827 S.E.2d 167, 175 (2019) and *Weaver v. Brookdale Senior Living, Inc.*, 847 S.E.2d 268, 271 (S.C. Ct. App. 2020). (R. ___). However, those cases are not dispositive of the issues in this case. Those cases involve defendants who moved to compel the non-signatory plaintiffs to arbitrate claims pursuant to an agreement that the plaintiffs were not suing to enforce or from which to take direct benefit.

The court in *Wilson*, 426 S.C. at 340, 827 S.E.2d at 175, contrasted the proper application of direct benefits estoppel applied in *Pearson* with the different fact pattern present in the *Wilson* case. A fact pattern which the *Wilson* court found to only constitute indirect benefit. In analyzing the defendant insurers' motion to compel arbitration under the attending facts in that case, the court in *Wilson* distinguished between a party seeking to obtain direct benefits and a party seeking to obtain indirect benefits from a contract. *Id.* at 342-44, 827 S.E.2d at 176-77. Under the facts of the case in *Wilson*, the court found that the nonsignatory was not making a claim under or directly exploiting terms of the agreement which also contained the arbitration clause. Only the general

relationship of the parties arising from the agreement was relevant to the claims by the non-signatories in *Wilson*, not actual provisions of the agreement. In such circumstances, the *Wilson* court found that direct benefits estoppel did not apply. Those are not facts applicable to Owens' claims. Owens seeks to enforce specific provisions of the Cigna Agreement and to take benefits existing exclusively thereunder.

In *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 228, 847 S.E.2d 268, 271 (Ct. App. 2020), the court found a nursing home could not compel the plaintiff to arbitrate her claims related to the death of the plaintiff's grandmother in accordance with the arbitration provision in the residency agreement executed by the plaintiff's grandmother. Thus, the court affirmed the denial of the nursing home's motion to compel arbitration because (1) the plaintiff's claims relied on general tort duties and not any provision of the residency agreement; (2) the plaintiff had not "'exploited' or otherwise sought to enforce or benefit from the residency agreement;" and (3) the plaintiff was not attempting to procure any direct benefit specifically arising from the residency agreement while attempting to avoid its arbitration provision. *Weaver*, 431 S.C at 232-33, 847 S.E.2d at 273-74.

Like the plaintiffs in *Pearson* and *Benton*, Owens' claims are based upon the fundamental assertion that Defendants are obligated by the terms of the hospital services agreement to bill his health insurance provider (Cigna) at discounted rates, and Defendants may not seek to recover payment for the medical services rendered to Owens through his recovery from an at-fault driver's insurance carrier. Regardless of the merit or lack of merit in his claims, Owens' claims are absolutely and fundamentally dependent upon the specific alleged obligation that Defendants bill Cigna at discounted rates, and not attempt any billing to, or collection from Owens. That obligation—if it exists at all—is created by the Cigna Agreement. Unlike the plaintiffs in *Wilson*

and *Weaver*, Owens has admitted that his claims "admittedly rel[y] on the hospital services agreement." (R. ____; Plaintiffs' Memorandum in Opposition to Defendants' Motion to Alter of Amend p. 6). Owens has expressly argued that he was "harmed by [Mary Black's] failure to act in accordance with the contract." (R. ____; Plaintiffs' Memorandum in Opposition to Defendants' Motion to Alter of Amend p. 2). Those admissions alone negate the application of the holdings in *Wilson* and *Weaver*. Therefore, as an alleged third-party beneficiary seeking to enforce the Cigna Agreement, Owens is subject to all the terms and conditions of the Cigna Agreement (including the arbitration provision).

Accordingly, the Court must reverse the circuit court, stay the case, and compel Owens to arbitrate his claims against Defendants pursuant to the arbitration provision in the Cigna Agreement. Section 6.2.2 of the Cigna Agreement unequivocally provides that:

> Arbitration shall be the exclusive remedy for the resolution of disputes arising under this Agreement. . . .

(R. ___).

As discussed above, Owens' claims to enforce the billing and payment terms, and the discounted rates, set fourth only in the Cigna Agreement are unquestionably matters arising under the Cigna Agreement. Moreover, any doubt as to whether Owens' claims are within the scope of the Cigna Agreement's broad arbitration provision should be resolved in favor of arbitration. *Landers v. Fed. Deposit Ins. Co.*, 402 S.C. 100, 109, 739 S.E.2d 209, 213 (2013). Accordingly, Owens must individually arbitrate his claims against Defendants pursuant to the terms of the arbitration agreement contained within the Cigna Agreement.

B. The circuit court erred when it held the application of the arbitration provision was adversely affected by the arbitration provision being subject to either party's election to enforce the arbitration provision.

The circuit court erred in finding the arbitration agreement's language that "either party may initiate arbitration by providing written notice to the other party" renders the Cigna Agreement's arbitration provision unenforceable.

Contrary to the circuit court's erroneous conclusions, resolution of disputes in arbitration does not need to be identified as the exclusive remedy to be binding and enforceable. The arbitration provision is enforceable when any party demands it be enforced. In *MailSource, LLC v. M.A. Bailey & Associates Inc.*, 356 S.C. 370, 373, 588 S.E.2d 639, 640-41 (Ct. App. 2003), the court analyzed a similar elective arbitration provision and found the circuit court erred in failing to compel the plaintiff to arbitrate its claims against the defendant. In *MailSource*, the court stated that the principal agreement "required the parties to attempt in good faith to settle any disputes first through consultation and negotiation, and then by mediation. If those attempts failed, the agreement provided 'either party may demand that the dispute be arbitrated. . . .'" 356 S.C. 370, 373, 588 S.E.2d at 341. After the plaintiff filed an action against the defendant, the defendant moved the circuit court to compel arbitration. The court held that while the elective nature of the arbitration provision may be unique, nevertheless, the circuit court erred in refusing to compel the plaintiff to arbitrate its claims against the defendant. *Id*. at 377, 588 S.E.2d at 643.

Like the circuit court in *MailSource*, the circuit court in this case erred in denying the Motion and refusing to compel Owens to arbitrate his claims. The elective nature of the arbitration provision in the Cigna Agreement does not alter the proper analysis of the demand for arbitration pursuant to an enforceable agreement to arbitrate. The Cigna Agreement states that either party may demand arbitration and, like the defendant in *MailSource*, Defendants made a proper demand for arbitration in response to the Amended Complaint. Accordingly, the Court must reverse the

circuit court, stay the case, and compel Owens to arbitrate his claims against Defendants pursuant to the Cigna Agreement's arbitration provision.

C. The circuit court erred in finding the disclaimer of class arbitration and the bar to consolidating arbitrations with third-parties rendered the arbitration agreement unenforceable.

The Cigna Agreement's arbitration provision states:

> The parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision shall not be consolidated with an arbitration involving other hospitals or third parties, and that the arbitrator shall be without power to conduct an arbitration on a class basis.

(R. ___).

The circuit court erred in finding that this language renders the Cigna Agreement's arbitration provision unenforceable against Owens—who is seeking to act as a party to the Agreement and enforce its terms to his direct benefit.

South Carolina courts have recognized the principle that the inclusion of express language stating that an arbitration will not include class claims is permissible and proper. *See York v. Dodgeland of Columbia, Inc.*, 406 S.C. 67, 94, 749 S.E.2d 139, 153 (Ct. App. 2013). Moreover, the arbitration provision's requirement that "arbitration conducted under this provision shall not be consolidated with an arbitration involving other hospitals or third parties" is simply an express statement that the arbitration will not be consolidated with other arbitration proceedings which is also valid and enforceable under the law. *See DIRECTV, Inc. v. Imburgia*, 577 U.S. 47, 50, 136 S. Ct. 463, 466, 193 L. Ed. 2d 365 (2015) (enforcing an anti-consolidation provision that stated "[n]either you nor we shall be entitled to join or consolidate claims in arbitration.").

Therefore, the circuit court erred in concluding the waiver of class arbitration and bar to consolidating arbitrations rendered the Cigna Agreement's arbitration provision unenforceable.

Accordingly, the Court must reverse the circuit court, stay the case, and compel Owens to arbitrate his claims against Defendants pursuant to the Cigna Agreement's arbitration provision.

II. The interlocutory issues raised in the Motion are subject to immediate review by the Court.

Given that the appeal in this case is unquestionably proper at this time and necessary to address the circuit court's denial of Defendants' motion to compel arbitration, *see* S.C. CODE ANN. § 15-48-200, this is a case where it is also proper and prudent for the Court to exercise its authority to review and address other erroneous rulings by the circuit court which, although not immediately appealable on their own, present the opportunity to avoid unnecessary and unwarrantedly protracted litigation. The Court has the authority to exercise its discretion to review the other interlocutory issues raised in the Defendants' Motion—and ruled upon in the circuit court's Order—because issues raised in an interlocutory order that are not directly appealable can be considered by the Court when raised in tandem with an immediately appealable issue. *See Cox v. Woodmen of World Ins. Co.*, 347 S.C. 460,469, 556 S.E.2d 397, 402 (Ct. App. 2001) (reviewing the appellants' Rule 12(b) arguments that were raised in tandem with a motion to compel arbitration); *Ferguson v. Charleston Lincoln Mercury, Inc.*, 349 S.C. 558, 565, 564 S.E.2d 94, 98 (2002) ("This Court reviews interlocutory orders when they contain other appealable issues."); *Hite v. Thomas & Howard Co.*, 305 S.C. 358, 360, 409 S.E.2d 340, 341 (1991) *overruled on other grounds by Huntley v. Young*, 319 S.C. 559, 462 S.E.2d 860 (1995) ("[A]n order that is not directly appealable will nonetheless be considered if there is an appealable issue before the Court and a ruling on appeal will avoid unnecessary litigation.").

In deciding when to exercise discretion to review an issue that would typically not be immediately appealable, courts consider whether immediate review will "avoid another appeal in the future and potentially narrow the issues for trial (i.e. judicial economy)." *Edge*

v. State Farm Mut. Auto. Ins. Co., 366 S.C. 511, 517, 623 S.E.2d 387, 390 (2005); *see also Roberts v. Recovery Bureau, Inc.*, 316 S.C. 492, 495 n.2, 450 S.E.2d 616, 618 n.2 (Ct. App. 1994) ("The appellate courts have discretion . . . to consider an unappealable order if an appealable issue is before the court and a ruling on appeal will avoid unnecessary litigation.").

Judicial economy favors immediate review of all of the issues raised in Defendants' Motion, because such review and consideration likely will eliminate the need for further proceedings (regardless of the forum) and may resolve important issues related to the scope of claims for further litigation. In this case those concerns and needs are heightened because Plaintiffs purport to base class claims on inherently flawed claims by the named Plaintiffs as purported class representatives.

For example, if the Court finds that Owens' claims are not subject to arbitration, then the Court may consider whether he even has a legally cognizable claim. As presented in the Motion, Owens' claims are, in fact, barred by the applicable statutes of limitation because Owens was added (improperly) to this matter—years after the filing of the original complaint and his claims cannot and do not, as a matter of law, relate back to Blackwell's filing of the original complaint. The time bar of Owens' claims is apparent on the face of his own allegations. Judicial economy favors the Court's immediate consideration of this legal issue, because immediate review and dismissal of Owens' claims allows Defendants and the circuit court to avoid wasting time and money on further litigation of those claims. Additionally, resolution of Owens' claims resolves a whole set of related and dependent class claims alleged.[3]

[3] A class representative can only represent those with the same claims against the same parties. *See Bailey v. Patterson*, 369 U.S. 31, 32-33, 82 S. Ct. 549, 550, (1962); *E. Tex. Motor Freight Sys., Inc. v. Rodriguez*, 431 U.S. 395, 403 (1977); *Edisto Fleets, Inc. v. S.C. Tax Comm'n*, 256 S.C. 350, 354, 182 S.E.2d 713, 714 (1971). Thus, since each named Plaintiff is covered by separate and different insurance, that named Plaintiff can only be a representative of a class with the same

As another example, judicial economy favors an immediate review of the claims asserted by Blackwell. Blackwell has asserted a claim for unjust enrichment against Defendants; however, for such a claim to exist, Blackwell must have adequately alleged, and must be able to prove, that she conferred an actual benefit on Defendants which they have unjustly retained and must return. But, Blackwell's Amended Complaint does not allege that she conferred any benefit upon any of the Defendants. Without conferring a benefit to Defendants, Defendants have not been unjustly enriched and there is no available remedy for Blackwell. Not only is a meritless claim by Blackwell dispensed without the costs and burdens of continuing litigation, as discussed above, her dismissal further reduces the scope of any purported class whose claims only she of the three named plaintiffs can represent. Judicial economy requires that the Court consider now the legal and factual defects in the claims and avoid wasting additional time and money in further litigation.

Based on the foregoing, judicial economy favors the immediate review of all of the issues raised in Motion which are set forth below.

III. The circuit court erred in failing to dismiss Owens' claims on the grounds that they are barred by the applicable statute of limitations because Owens' claims do not relate back to the filing of the original complaint.

The circuit court erred by denying the Motion and refusing to dismiss Owens' claims on the grounds they are barred by the applicable statutes of limitation. His claims, raised for the first time upon the filing of the Amended Complaint which added him as a new plaintiff, do not relate back to the date of Blackwell's filing of the original complaint. Therefore, Owens claims are facially time barred and must be dismissed.

Rule 15(c) of the South Carolina Rules of Civil Procedure governs the relation back of a pleading. *Jackson v. Doe*, 342 S.C. 552, 558, 537 S.E.2d 567, 570 (Ct. App. 2000). Rule 15(c)

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insurance. Dismissal of a named Plaintiff in this case eliminates putative class members with that same insurer.

and its relation back provision only apply, and may only validate a relation back argument, to a substitution or change in a party. *Id*. "[T]he addition of a party is not the same as a substitution or change of party." *Id*. The addition of a new party is not contemplated by Rule 15(c), and does not relate back. *Gause v. Smithers*, 384 S.C. 130, 133, 681 S.E.2d 607, 609 (Ct. App. 2009).

Claims asserted by new parties added to a case do not relate back to the original filing of the complaint. *See Jackson*, 342 S.C. at 558, 537 S.E.2d at 570; *Gause*, 384 S.C. at 133, 681 S.E.2d at 609. Because Owens' claims do not relate back to the filing of the original complaint, his claims for tortious interference with contract and unjust enrichment must be timely on their own. The new claims by Owens are not timely and are barred by the applicable statute of limitations. According to the Amended Complaint, Owens settled his bill with Mary Black on October 14, 2016. (R. ___; Amended Complaint ¶ 52), and any claims he might assert in this case certainly accrued no later than that date. *Holly Woods Ass'n of Residence Owners v. Hiller*, 392 S.C. 172, 183, 708 S.E.2d 787, 793 (Ct. App. 2011). Owens' claims are all based on the allegation that Defendants were not permitted to collect payment from him directly; therefore, when he made a direct payment to Mary Black on October 14, 2016, he knew or should have known that Mary Black was attempting to collect payment from him directly and not from his alleged health insurance provider.

Plaintiffs filed the Motion to Amend Complaint and add Owens on October 18, 2019. Therefore, more than three (3) years passed between the time Owens knew or should have known of his alleged claims (October 14 ,2016), and any action to commence his claims (October 18, 2019). *See Burgess v. Elliott*, No. 3:16-CV-3325-RBH, 2017 WL 1505421, at *3 (D.S.C. Apr. 27, 2017), *aff'd*, 696 F. App'x 125 (4th Cir. 2017) ("The applicable statute of limitations for civil actions of breach of contract, negligence, and tortious interference with contract is likewise three

years."); *Graham v. Welch, Roberts & Amburn, LLP*, 404 S.C. 235, 239, 743 S.E.2d 860, 862 (Ct. App. 2013) (holding a claim for unjust enrichment was barred by the three year statute of limitations).

It is clear from the face of the Amended Complaint that Owens did not commence his claim within the applicable three year limitation period. Therefore, Owens' claims are barred by the applicable statutes of limitation because his claims were not commenced within three (3) years of the date his complaint established that he knew or should have known he had the claims asserted, and his complaint does not relate back to Blackwell's filing of the original Complaint. Accordingly, the Court should reverse the circuit court and dismiss Owens' claims against Defendants on the grounds that his claims are barred by the applicable statutes of limitation.

IV. The circuit court erred in failing to dismiss Blackwell's claim for unjust enrichment, because Blackwell did not, and cannot allege she conferred any benefit to Defendants.

It is not disputed that South Carolina law requires that anyone seeking recovery for unjust enrichment must plead and prove: "(1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its value." *Columbia Wholesale Co., Inc. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994).

Blackwell's claim for unjust enrichment—according to the Amended Complaint and Plaintiffs' Response in Opposition to the Motion to Alter or Amend—is based upon the allegation that Defendants "assert[ed] liens against Plaintiff Blackwell's potential third party automobile accident claim." (R. ___; Plaintiffs' Memorandum in Opposition to Defendants' Motion to Alter of Amend p. 13; Amended Complaint ¶ 40). Blackwell does not allege she paid any money or gave any value to Defendants.

A claim for unjust enrichment is a claim to have a defendant return a benefit that would be inequitable for the defendant to retain. *Columbia Wholesale*, 312 S.C. at 261, 440 S.E.2d at 130; *Campbell v. Robinson*, 398 S.C. 12, 24, 726 S.E.2d 221, 228 (Ct. App. 2012) (stating that restitution is the remedy for a claim for unjust enrichment). Blackwell cannot state a claim for unjust enrichment unless she can and does allege that she actually conferred a benefit to Defendants that can and must be returned. *Niggel Assocs., Inc. v. Polo's of N. Myrtle Beach, Inc.*, 296 S.C. 530, 532-33, 374 S.E.2d 507, 509 (Ct. App. 1988). She has utterly failed to make such an allegation. Indeed, she cannot make such an allegation because she never did confer any benefit upon Mary Black or the other Defendants. There is no factual allegation in either of Blackwell's Complaints that Defendants received or retain possession of anything of any value belonging to Blackwell. Thus, there is, and can be, no actionable unjust enrichment. *See also Harrison v. Christus St. Patrick Hosp.*, 430 F. Supp. 2d 591, 597 (W.D. La. 2006) (granting the hospital's motion to dismiss a patient's claim for unjust enrichment because "[n]one of the requirements of an unjust enrichment claim [were] satisfied" because, among other reasons, (i) the hospital received nothing from the patient and (ii) the patient paid nothing as a result of a contract with the hospital).

The only allegation by Blackwell is that Defendants asserted a lien against her potential third-party automobile accident claim. (R.___; Plaintiffs' Memorandum in Opposition to Defendants' Motion to Alter of Amend p. 13; Amended Complaint ¶ 40). However, a lien does not transfer a property interest. *See Horry Cty. v. Ray*, 382 S.C. 76, 83-84, 674 S.E.2d 519, 523-24 (Ct. App. 2009) ("An equitable lien is neither an estate or property in the thing itself, nor a right to recover the thing" (citation and internal quotation marks omitted)); *Matter of Hinson*, 20 B.R. 753, 758 (Bankr. D.S.C. 1982) (a judgment lien "does not operate to give a judgment creditor a

property interest in specific property" and "does not constitute a taking of property"). Thus, the mere assertion of a lien does not constitute the receipt or retention of a benefit.

Blackwell makes no allegations through which any court could award her restitution—the remedy for a claim of unjust enrichment. *Campbell*, 398 S.C. at 24, 726 S.E.2d at 228. Blackwell has conferred no payment, value or benefit to Defendants and Defendants do not owe and have nothing to return to Blackwell. Therefore, Blackwell's claim for unjust enrichment fails as a matter of law, and the Court should reverse the circuit court and dismiss Blackwell's claim for unjust enrichment.

V. The circuit court erred in failing to find that Blackwell lacks standing to pursue her claims because she is not an intended third-party beneficiary under the agreement between Mary Black and her health insurer (MedCost).

The circuit court erred in refusing to find that Blackwell's claims fail as a matter of law because she does not have the right to enforce the MedCost Agreement as a non-signatory third-party beneficiary due to the fact that the MedCost Agreement contains a plain and unambiguous disclaimer of third-party beneficiaries.[4]

Blackwell's claims are all premised upon her contention that she is a third-party beneficiary of the MedCost Agreement between Mary Black and her health insurer (MedCost). In fact, in the Response in Opposition to the Motions to Dismiss, Plaintiffs stated: "Plaintiffs contend they are third-party direct beneficiaries of the agreements between their insurance companies and Mary Black." (R. ___). Contrary to this assertion, Blackwell is not, and cannot be an intended third-party beneficiary who can sue to enforce that Agreement for her own benefit. Therefore, she cannot maintain any claim derived from or dependent upon the terms of that Agreement.

[4] The circuit court did not expressly rule on this issue despite Defendants raising the issue in the Motion and again requesting a ruling in the Motion to Alter or Amend.

In South Carolina, there is a presumption that a contract is not enforceable by a person who is not a party to the contract, and the expressed intent of the parties to the contract shall govern the interpretation of that contract. *See Windsor Green Owners Ass'n, Inc. v. Allied Signal, Inc.*, 362 S.C. 12, 17, 605 S.E.2d 750, 752 (Ct. App. 2004). It is well settled that the law presumes that parties contract exclusively for their own benefit. *See Ancrum v. Camden Water, Light & Ice Co.*, 82 S.C. 284, 295, 64 S.E. 151, 155 (1909). In order to overcome this presumption, a non-signatory third-party must show that the parties to a contract intended the third-party to be a direct beneficiary of the contract. *Touchberry v. City of Florence*, 295 S.C. 47, 48-49, 367 S.E.2d 149, 150 (1988). However, "[n]o third-party beneficiary status is created absent an intent by the parties to confer a substantial benefit on [a non-signatory third-party]." *Windsor Green Owners Ass'n, Inc.*, 362 S.C. at 19, 605 S.E.2d at 753 (emphasis added).

The line between a direct intended third-party beneficiary and a mere incidental or consequential third-party beneficiary is first drawn by examining the clear intent expressed by the actual parties to the contract. Absent an expression that the actual contracting parties clearly intended to directly benefit the third-party, that third-party is merely an incidental beneficiary with no right to enforce the contract. *See TC X, Inc. v. Commonwealth Land Title Ins. Co.*, 928 F. Supp. 618, 623 (D.S.C. 1995), *aff'd*, 86 F.3d 1152 (4th Cir. 1996). Therefore, the necessary first step in determining whether a party is an intended direct third-beneficiary of a contract is to ascertain and give legal effect to the language of the contract on the issue of intent. *Whitlock v. Stewart Title Guar. Co.*, 399 S.C. 610, 614, 732 S.E.2d 626, 628 (2012).

When the parties to a contract include an express third-party beneficiary disclaimer, as they did in the MedCost Agreement, a court is bound to find the parties did not intend to convey a direct benefit to third parties or to create a right for such third parties to enforce or sue upon the contract.

See Lightsey v. Toshiba Corp., No. 9:18-CV-190, 2019 WL 5872168, at *3 (D.S.C. Mar. 4, 2019) (applying New York law and finding that "[d]ismissal of a third-party-beneficiary claim is appropriate where the contract rules out any intent to benefit the claimant. . . .").

The MedCost Agreement plainly and directly expresses Mary Black's and MedCost's intent to bar third-parties from enforcing the MedCost Agreement. This intent is unequivocally stated in Section 10.9 of the MedCost Agreement, which expressly and definitively states Mary Black's and MedCost's intention that the contract was not to be construed to have any third-party beneficiaries:

> This Agreement is entered into by and between the parties hereto for their benefit. **There is no intent by either party to create or establish a third party beneficiary status** or rights in a Covered Person, Employer, subcontractor, or other third party to this Agreement, except as such rights are expressly created and as set forth herein, and **no such third party shall have any rights to enforce any right to enjoy any benefit created or established under this Agreement**.

(R. ____) (emphasis added).

Review of the plain and unambiguous language must result in a finding that Mary Black and MedCost did not express, and did not have, an intent to allow Blackwell to enforce the MedCost Agreement as a third-party beneficiary. In fact, they expressed the clear and unambiguous intent that neither she, nor others, were third-party beneficiaries with such rights. The circuit court did not find any facts allowing a conclusion to the contrary and identifies in its Orders no findings to justify a conclusion that Blackwell is an intended third-party beneficiary with rights to enforce or sue upon the terms of the Agreement. Since Blackwell is not a third-party beneficiary and lacks standing to enforce the MedCost Agreement as a third-party beneficiary, she cannot sue to enforce the terms of the MedCost Agreement or to pursue any of her alleged claims. Therefore, as a matter of law, Blackwell's claims must be dismissed and the circuit court erred in

refusing to dismiss her claims. Accordingly, the Court should reverse the circuit court and dismiss Blackwell's claims against Defendants.

VI. The circuit court erred in failing to dismiss Brooks' claims because her claims are governed by the Medicare Act and the law under that act does not support the claims alleged.

Like the other Plaintiffs, the *sine qua non*, of Brooks' claims is that Defendants were obligated to seek payment for her medical expenses from her health care coverage and not from her or another source. However, in her case the health care coverage is alleged to be through Medicare.

The circuit court erred in failing to dismiss Brooks' claims because under the controlling Medicare Act, 42 U.S.C.A. § 1395y(b)(2)(A)(ii), hospitals—like Mary Black—are required to seek payment from any applicable auto or liability policy coverage prior to seeking or obtaining any payment from Medicare. Rather than recognizing the fatal flaw in Brooks' claims, the circuit court stated that it could not dismiss her claims based on the application of the Medicare Act because it was not specifically alleged in the Amended Complaint that the at-fault driver in the automobile accident had a valid insurance policy from which to collect.

The operative allegations by Brooks are simple:

1. On February 26, 2016, Brooks was injured in an automobile accident, and two days later, she presented to the emergency room at Mary Black for treatment. (R. ___; Amended Complaint ¶ 41);

2. Brooks had valid health insurance through Medicare. (R. ___; Amended Complaint ¶ 43);

3. Mary Black did not send a bill to Medicare and, instead, asserted a lien against her third-party automobile accident claim. (R. ___; Amended Complaint ¶ 44); and

4. Mary Black agreed to accept a reduced payment for the medical services provided to Brooks after reviewing the

> settlement offer in her personal injury case. (R. ___; Amended Complaint ¶ 46).

Brooks' claims against Defendants fail, as a matter of law, because of the controlling terms of the Medicare Act, 42 U.S.C.A. § 1395y(b)(2)(A)(ii). The Medicare Act requires hospitals—like Mary Black—to seek payment from any applicable automobile or liability policy prior to seeking or obtaining any payment from Medicare. 42 U.S.C.A. § 1395y(b)(2)(A)(ii). Specifically, the Medicare Act states:

> Payment under this subchapter may not be made . . . with respect to any item or service to the extent that . . . (ii) **payment has been made or can reasonably be expected to be made** under a workmen's compensation law or plan of the United States or a State **or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance**.

Id. (emphasis added).

All of Brooks' claims are based on the allegations that she had health coverage through Medicare, and Defendants are liable because they sought collections for her medical care costs by asserting a right to payment against the insurer for the at-fault driver in her automobile accident instead of immediately and directly submitting the claim for her medical care costs to Medicare. Thus, her claims against Defendants are baseless because of the controlling provisions of the Medicare Act.

Other jurisdictions that have been confronted with this issue have concluded that 42 U.S.C. § 1395y(b)(2)(A)(ii) explicitly prohibits medical service providers from collecting payment from Medicare when payment can reasonably be expected to be made under an automobile or liability insurance policy. *See Parkview Hosp., Inc. v. Roese*, 750 N.E.2d 384, 389 (Ind. Ct. App. 2001) ("[W]e find that Congress's intent is clearly expressed in 42 U.S.C. § 1395y(b)(2)(A)(ii). It explicitly prohibits medical service providers from collecting payment from Medicare when payment can reasonably be expected to be made promptly under an automobile or liability

insurance policy."); *Joiner v. Med. Ctr. E., Inc.*, 709 So. 2d 1209, 1221 (Ala. 1998) (holding that a hospital had a right under the Medicare Act to obtain full payment of its charges from the proceeds of the plaintiff patient's settlement with an automobile liability carrier, instead of filing a claim for reimbursement with Medicare).

The circuit court declined to dismiss Brooks' claims because it rationalized that it would be required to presume that the at-fault driver in her automobile accident had a valid insurance policy from which to collect. The circuit court failed to recognize that in South Carolina drivers are required under the law to have automobile insurance and "[i]n the absence of proof to the contrary, it is presumed that a person observed the law." *See* S.C. CODE ANN. §§ 56-10-10 to -40 and 56-10-210 to -280; S.C. CODE ANN. §§ 38-77-140, -150, and -160; *see also Croft v. Old Republic Ins. Co.*, 365 S.C. 402, 416-17, 618 S.E.2d 909, 916 (2005) (reciting insurance requirement principles); *Simmons v. Atl. Coast Line R. Co.*, 250 S.C. 199, 203, 157 S.E.2d 172, 175 (1967) (stating that it is presumed a person complied with the law). Thus, the circuit court's inference that the driver may not have had a valid automobile insurance policy is error and contrary to the established law that requires a presumption that the driver did in fact have a valid automobile insurance policy. Thus, it was appropriate and proper for Defendants reasonably to expect that payment could be made from an automobile or liability policy. And it was necessary then for Defendants to pursue that avenue of collection for Brooks' bills rather than submitting those bills to Medicare. In this light, the entire premise for Brooks' claims against Defendants is false and the claims must be dismissed.

In short, Defendants cannot be liable to Brooks in this case for doing exactly what Medicare requires of them. Brooks' entire premise for liability fails and her claims must be dismissed as a matter of law. Accordingly, the Court should reverse the circuit court and dismiss Brooks' claims.

VII. The circuit court erred in failing to dismiss the claims asserted by Brooks and Owens pursuant to the voluntary payment doctrine.

The circuit court erred in failing to apply the voluntary payment doctrine as a bar to the claims asserted by Brooks and Owens.

The relevant allegations in the Amended Complaints related to the payments made by Brooks and Owens are simple:

> 1. On or about September 26, 2017, **Defendants agreed to accept** a 50% reduction on Plaintiff Brooks's account and settle for $4,991.22. Defendants agreed to this reduction only after asserting a lien against Plaintiff Brooks's third-party recovery in her personal injury case and after reviewing the settlement offer for that case. (R. ___; Amended Complaint ¶ 46 (emphasis added)); and
>
> 2. On or about October 14, 2016, **Defendants agreed to accept** a 50% reduction on Plaintiff Owens's account and settle for $4,543.38. Defendants agreed to this reduction only after asserting a lien against Plaintiff Owens's third-party recovery in her personal injury case and after reviewing the settlement offer for that case. (R. ___; Amended Complaint ¶ 52 (emphasis added)).

These allegations result in one clear interpretation, Defendants accepted offers from Owens and Brooks to pay only fifty percent of the bills for the medical services rendered to them. Based on a plain reading of the Amended Complaint, these offers to settle were made by Owens and Brooks and accepted by Defendants. Yet, after making these offers, and making payments to Mary Black following the acceptance of those offers, Owens and Brooks sued Defendants. In effect, Owens and Brooks now sue Defendants for accepting settlement offers and payments which Plaintiffs offered.

The law of South Carolina does not allow such claims to proceed. It is a long standing and elementary principle of South Carolina law that no action will lie to recover money voluntarily paid. *Hardaway v. S. Ry. Co*., 90 S.C. 475, 488-89, 73 S.E. 1020, 1025 (1912); *Moody v. Stem*,

214 S.C. 45, 60, 51 S.E.2d 163, 169 (1948). The Amended Complaint does not contain any allegation that the payments were made under coercion or duress, or were in any way not voluntary.

Recently, in *Cross v. Ciox Health, LLC*, 438 F. Supp. 3d 572 (E.D.N.C. 2020), *appeal dismissed*, No. 20-1262, 2020 WL 5203205 (4th Cir. Aug. 31, 2020), the North Carolina District Court applied the voluntary payment doctrine to bar a plaintiff's class action claim based upon allegations that the Plaintiff was overcharged for medical records. In *Cross*, the plaintiff alleged that she requested medical records from the hospital that treated her, that she was overcharged for those records, and her attorney paid those charges on her behalf. *Cross* at 583. The District Court granted the defendant's Motion to Dismiss pursuant to Rule 12(b)(6) on the grounds that the plaintiff's claims were barred by the voluntary payment doctrine. *Id.* at 590. The District Court held:

> Here, where it is alleged that defendant provided an itemized bill showing charges for the medical records, and where it is alleged that plaintiffs' attorney proceeded to pay the bills as requested, payment thus was made by plaintiffs with full knowledge of all the facts pertinent to their instant claims. Accordingly, the voluntary payment doctrine bars their claims for unjust enrichment.

Id.

Moreover, the Court found that the plaintiff did not meet the standard for avoiding the application of the voluntary payment doctrine based on "coercion or duress" because "they have alleged their attorney both requested and paid for the medical records." *Id.*

In this case, Brooks and Owens make no allegations of fraud, duress or coercion in connection with the voluntary payments. Accordingly, the Court should reverse the circuit court and dismiss the claims asserted by Brooks and Owens on the grounds that their claims are barred by the voluntary payment doctrine.

VIII. The circuit court erred in failing to dismiss Plaintiffs' claim for tortious interference with a contract.

Plaintiffs' Amended Complaint utterly fails to allege facts sufficient to constitute a cause of action for tortious interference against any Defendant.

The circuit court found the Amended Complaint could be construed to state a theory of recovery for tortious interference with a contract on the grounds that the patients' contracts with their own insurers were breached because Plaintiffs paid their premiums and did not have their hospital bills paid by their insurers. The circuit court failed to recognized that the Amended Complaint does not actually allege facts sufficient to infer that those contracts were actually breached.

In this case, Plaintiffs acknowledge that the contracts in issue are those between themselves and their respective health insurers. Without a breach by the health insurers of their insurance contracts with Plaintiffs, there can be no recovery from Defendants under a cause of action for tortious interference with a contractual relationship. *First Union Mortgage Corp. v. Thomas*, 317 S.C. 63, 73, 451 S.E.2d 907, 913 (Ct. App. 1994); *see also Camp v. Springs Mortgage Corp.*, 310 S.C. 514, 517, 426 S.E.2d 304, 305-06 (1993) (stating the elements necessary for a claim for tortious interference with a contract).

Plaintiffs' Amended Complaint does not allege an actual breach by any of the health insurers of any of the relevant health insurance contracts (policies). The Amended Complaint contains only bald and unsupported allegations that Plaintiffs did not receive the benefit of their individual health insurance contracts. However, the failure to receive a benefit of a contract is not a breach of a contract. Plaintiffs do not even assert their individual contracts with their health insurance carriers were breached. *Eldeco, Inc. v. Charleston Cty. Sch. Dist.*, 372 S.C. 470, 482, 642 S.E.2d 726, 732 (2007) ("In the absence of a breach of a contract, [the plaintiff] cannot prove

the required elements of its cause of action for tortious interference with contractual relations."). Thus, Plaintiffs' conclusory and vague pleadings with not even an allegation that the third-party contract was breached, are insufficient to state a claim for tortious interference with a contractual relationship. Accordingly, the circuit court erred in refusing to dismiss Plaintiffs' claims for tortious interference with contract.

IX. The circuit court erred in concluding that the Amended Complaint states facts sufficient to constitute any viable cause of action against CHSPSC or PASI.

The circuit court erred in finding that the Amended Complaint's bare allegations against PASI and CHSPSC are sufficient to state any viable cause of action.

Plaintiffs' conclusory lumping together of "all Defendants" is insufficient to meet their pleading burden and state a claim against PASI or CHSPSC. The entirety of the specific and individual allegations against PASI and CHSPSC are encompassed in three paragraphs of the Amended Complaint:

> 16. Defendant CHSPSC, LLC, formerly known as Community Health Systems Professional Services Corporation, is a Delaware corporation with its principal place of business in Tennessee. On information and belief, CHSPSC regularly conducts business in the State of South Carolina and other states and has responsibility for the billing of patients and liens filed within the State of South Carolina.
>
> 17. Defendant Professional Account Services, Inc. ("PASI") is a Tennessee corporation with its principal place of business in Brentwood, Tennessee. PASI is a collection firm that regularly conducts business in the State of South Carolina and elsewhere.
>
> 18. On information and belief, CHSPSC and PASI exercise control over policies and procedures enacted by and implemented by Mary Black Health System, including policies relating to billing and liens, and all of these entities committed the acts and omission complained of herein jointly and in concert.

(R. ____).

The Amended Complaint contains no other specific or individual allegations about or against PASI or CHSPSC. Rather, the remainder of the Amended Complaint contains only non-specific generalized allegations referencing PASI, CHSPSC, and Mary Black collectively as "Defendants." There are no allegations sufficient to identify what PASI or CHSPSC did, or failed to do, which would support the assertion of each (or any) of the purported causes of action against them specifically. Furthermore, there are no factual allegations which could support or form the basis for any claim to pierce the corporate veil of PASI or CHSPSC, or to establish a basis for an amalgamation or conspiracy claim. *See Juntti v. Prudential-Bache Sec., Inc.*, 993 F.2d 228 (4th Cir. 1993) (affirming the dismissal of the plaintiff's complaint that contained an "impermissible aggregation of defendants without specifically alleging which defendant was responsible for which act."); *see also Magluta v. Samples*, 256 F.3d 1282, 1284 (11th Cir. 2001) ("The complaint is a quintessential 'shotgun' pleading of the kind we have condemned repeatedly, beginning at least as early as 1991. . . . The complaint is replete with allegations that 'the defendants' engaged in certain conduct, making no distinction among the fourteen defendants charged, though geographic and temporal realities make plain that all of the defendants could not have participated in every act complained of."); *Barmapov v. Amuial*, 986 F.3d 1321, 1324-25 (11th Cir. 2021) ("Besides violating the rules, shotgun pleadings also "waste scarce judicial resources, inexorably broaden the scope of discovery, wreak havoc on appellate court dockets, and undermine the public's respect for the courts." (citation omitted)).

In *Scurmont LLC v. Firehouse Rest. Grp., Inc.*, No. 4:09-CV-00618-RBH, 2010 WL 11433199, at *16 (D.S.C. May 19, 2010), the Court found this type of group or "shotgun" pleading was insufficient to state a claim against individual defendants. In *Scurmont*, after filing the initial complaint, the plaintiff amended the complaint to assert claims not only against Firehouse

Restaurant Group, Inc., but also its alleged owners, Chris and Robin Sorensen. *Id*. The amended complaint contained only a single paragraph referencing the individual defendants and, thereafter, did not differentiate among the defendants or allege any facts establishing how the Sorensens specifically participated in, or directed any of the acts alleged. *Id.* Under those circumstances, this Court granted the Sorensens' Motion to Dismiss pursuant to Rule 12(b)(6) because the amended complaint failed to contain "any facts establishing how the Sorensens specifically participated in or directed any of the acts alleged against Firehouse." *Id.*

Similarly, in *Camel v. Cannon*, No. 6:06-3030-GRA-WMC, 2007 WL 465583 (D.S.C. Feb. 7, 2007), the court dismissed a prisoner's complaint against the individual prison guard defendants on the grounds that the complaint failed to identify facts as to how any of the individual defendants were involved in, or responsible for, the alleged misconduct. Applying even the liberal standard afforded to *pro se* litigants, the court held that the "lack of factual allegations of individual responsibility and/or vicarious liability of any of the named Defendants is fatal to his case at this stage of the litigation" and "[w]here there are no allegations of responsibility specifically naming any Defendant, there is nothing for this Court to liberally construe." *Id.* at *1 and *3.

Since, the Amended Complaint contains only group or collective conclusory allegations against PASI and CHSPSC, Plaintiffs have failed to plead ultimate facts sufficient to constitute any cause of action against PASI and CHSPSC. *See Jones v. Gilstrap*, 288 S.C. 525, 528, 343 S.E.2d 646, 648 (Ct. App. 1986) (providing that conclusory allegations in a complaint are insufficient to survive the defendant's motion to dismiss for failure to state a cause of action). Without alleging facts related to an act or omission by PASI or CHSPSC the Amended Complaint fails on its face and the claims against PASI and CHSPSC must be dismissed as a matter of law.

Accordingly, the circuit court erred in failing to dismiss the claims against PASI and CHSPSC based on the Plaintiffs' impermissible collective or "shotgun" pleadings that fail to state any facts sufficient to constitute a cause of action against CHSPSC or PASI.

CONCLUSION

Based on the foregoing, the Court must compel Owens to arbitration and stay the remaining claims, and should reverse the circuit court, and dismiss the claims asserted by each of the Plaintiffs.

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