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Court of Appeals
Division I
State of Washington

No. 744488

IN THE COURT OF APPEALS, DIVISION I,
OF THE STATE OF WASHINGTON

LEXINE OTEY, *et al.*,

Appellant,

v.

GROUP HEALTH COOPERATIVE,

Respondent.

BRIEF OF APPELLANT

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I. INTRODUCTION

This case involves Group Health Cooperative (GHC) overcharging its Members for inexpensive prescription drugs. Improperly interpreting the contract in the light most favorable to the insurer and not the insured, the trial court granted GHC's motion for summary judgment and dismissed all of Plaintiff's claims—breach of contract, bad faith, and Consumer Protection Act.

GHC's group medical insurance contract uses ambiguous terms such as "actual charge," "cost share," "portion of the cost," "copayment," and "covered services." For example, although "actual charge" is undefined, GHC does not charge its Members the "actual charge" from the supplier. Rather, when the suppliers' "actual charge" is between \$3–\$5 per monthly supply, GHC charges its Members a made-up "actual charge" ranging from \$13.30–\$14.75. This ambiguity is unfair and deceptive to average insureds.

Although GHC covers inexpensive prescription drugs, the trial court adopted GHC's self-serving interpretation, leaving GHC with no duty to provide any such coverage benefits. Rather than receiving a benefit, the Member is charged the "actual charge" (\$3–\$5 cost to obtain drugs from supplier), plus a markup of three to five times the "actual charge," which results in a final price to the Member of between \$13.30–\$14.75. The trial court erred.

This Court should reverse and remand for trial.

II. ASSIGNMENT OF ERROR

Assignment of Error 1. The trial court erred in granting defendant/respondent Group Health Cooperative's motion for summary judgment. Clerk's Papers (CP) at 82-83 (order).

III. ISSUES PERTAINING TO ASSIGNMENT OF ERROR

1. Whether the trial court erred in failing to find the undefined term "actual charge" ambiguous, and failing to interpret it in favor of Otey?

2. Whether the trial court erred in failing to find the contract terms "cost share," "portion of the cost," "copayment," and "coverage" ambiguous, and failing to interpret them in favor of Otey?

3. Whether the trial court erred in holding GHC may exclude coverage (declining to pay any portion of the costs) for inexpensive drugs that GHC admits are "covered" without any clear and unequivocal language of exclusion stated in the contract?

4. Whether the trial court erred in adopting GHC's "aggregate" theory of cost-sharing to deny cost-sharing coverage for inexpensive prescription drugs?

5. Whether the trial court erred in dismissing Plaintiff's bad faith and Consumer Protection Act claims solely on the basis of its coverage and breach of contract rulings, where these claims involve genuine issues of material fact, and Group Health submitted no evidence supporting dismissal as a matter of law?

IV. STATEMENT OF THE CASE

A. Facts regarding whether GHC overcharges Members for inexpensive prescription drugs by using ambiguous and misleading contract terms.

Plaintiff Lexine Otey (hereinafter “Otey”) has health care insurance with GHC that includes coverage for inexpensive outpatient prescription drugs. This appeal arises from GHC interpreting the ambiguous contract terms “actual charge,” “cost share,” “portion of the cost,” and “covered services” in a light most favorable to GHC, and thereby overcharging Otey for her inexpensive prescription drugs. CP 1-16, 45-70.

GHC’s contract provides coverage for outpatient prescription drugs in three tiers. GHC admits Tier 1 and 2 drugs are “covered” by the insurance. CP 108-09, 160-61; Verbatim Transcript of Proceedings (RP) (Dec. 4, 2015) at 4-5, 13-15. For all Tiers the contract states:

(a) the Member (subscriber) is liable for payment of “Cost Shares for Covered Services”;

(b) “Cost Shares” are the “portion of the cost of Covered Services for which the Member is liable”;

(c) Cost Shares “will not exceed the **actual charge** for that service”;

(d) “Cost Share” includes copayments and deductibles;

(e) there are no deductibles for prescription drugs; and

(f) “copayment” means the “specific dollar amount a Member is required to pay at the time of service,” which (for outpatient prescription drugs) varies by Tier:

- (i) for Tier 1 (preferred generic drugs) the Member pays the lesser of \$15, or the “**actual charge** for that service”;
- (ii) for Tier 2 (preferred brand-name drugs) the Member pays the lesser of \$30, or the “**actual charge** for that service”;
- (iii) for Tier 3 (non-preferred generic and brand-name drugs) the Member pays “100% of all charges.”

CP 108-09, 160-61; RP 4-5, 13-15.

The term “actual charge” is not defined in the contract.

B. Procedural History.

Otey alleged in her complaint that GHC overcharged her and other Members for various Tier 1 and 2 prescription drugs at prices ranging from \$13.60–\$14.75 that only cost GHC between \$3–\$5 each, a fact not disclosed to Members. CP 4-5. Otey alleged the contract terms “copayment” and “cost share” mean “both parties to the contract must contribute to the cost of the insureds prescription drugs.” CP 12 at ¶48. GHC’s failure to share the cost of prescription drugs, concealing the actual cost of drugs, and overcharging Members a hefty profit markup, are unfair and/or deceptive acts or practices in violation of the Consumer Protection Act. CP 10-13 at ¶¶ 37-55. Further, GHC’s failure to share in the cost of prescription drugs was a breach of contract that amounts to “overcharge[ing]” the Members. CP 14 at ¶63. Also, “any ambiguities in the contract must be construed against [Group Health].” CP 14 at ¶62.

For purposes of summary judgment, GHC did not contest the factual allegations of Otey’s complaint. GHC stipulated that “GHC’s wholesale drug expenses for Ms. Otey’s prescriptions identified in

the Complaint are less than the amounts she was charged for those prescriptions...” CP 41. GHC offered no evidence to refute Otey’s allegation that GHC charges Members 100% of the drug cost plus a profit markup of 3–5 times its cost to obtain prescription drugs. Instead, it argued its pricing is “irrelevant” because the contract clearly states a Member’s financial responsibility is to pay the copayment or “actual charge” levied by the pharmacy, whichever is less. CP 28, 30-31, 76.

To support summary judgment, the only substantive evidence put forward by GHC was its Health Coverage Agreements for 2014 and 2015, and an HMO Certificate from the Washington State Insurance Commissioner. CP 84-195.

On December 4, 2015, the Honorable Bruce Heller granted GHC’s motion and dismissed all claims. CP 83. The order stated there was “no genuine issue of material fact.” *Id.* At the hearing, the trial court explained its ruling. First, the contract language was not ambiguous. RP 32-33. The terms “copayment,” “cost share,” and “actual charge” could have “only one reasonable interpretation” to mean amounts owing by a Member. *Id.* Second, nothing in the contract language “suggest[ed] to the Court an ambiguity or at least a...reasonable possibility” that “requires Group Health to share the cost for a particular bottle of pills” or the “cost of a particular service.” RP 33-34. The “insurance” provided to Members occurs when a Member’s out-of-pocket limit is reached and the GHC pays for all services thereafter. RP 33. Third, since the contract terms were

“clear and unambiguous” and GHC “followed the terms of the contract,” Otey’s Consumer Protection Act claim also had to be dismissed. RP 34.

V. ARGUMENT

A. Standard of review is de novo.

The standard of review for an order of summary judgment is de novo—the appellate court performs the same inquiry as the trial court, and considers the facts and inferences from the facts in a light most favorable to the nonmoving party. *E.g., Powers v. W.B. Mobile Servs., Inc.*, 182 Wn.2d 159, 164, 339 P.3d 173 (2014). Judgment as a matter of law for summary judgment purposes is warranted “only if reasonable people could reach one conclusion based on the evidence when viewing the facts in the light most favorable to the nonmoving party.” *O.S.T. v. Regence BlueShield*, 181 Wn.2d 691, 703, 335 P.3d 416 (2014). Interpretation of an insurance contract is a question of law reviewed *de novo*. *Queen Anne Park Homeowners Ass’n v. State Farm Fire & Cas. Co.*, 183 Wn.2d 485, 489, 352 P.3d 790 (2015).

B. The contract term “Actual Charge” is ambiguous and must be interpreted in a light most favorable to Otey.

For Tier 1 and 2 drugs, the GHC contract provides:

Charges will be for the lesser of the Cost Shares for the Covered Service or the **actual charge** for that service. Cost Shares will not exceed **actual charge** for that service.

CP 100, 153 (III(B)) (bold added). The term “actual charge” is not defined in the contract. Undefined terms “are to be interpreted in

accord with the understanding of the average purchaser of insurance, and the terms are to be given their plain, ordinary and popular meaning.” *Queen City Farms, Inc. v. Cent. Nat’l Ins. Co. of Omaha*, 126 Wn.2d 50, 77, 882 P.2d 703 (1994).¹

“Actual charge” is ambiguous because it “is fairly susceptible to two different reasonable interpretations.” *Cf. Kitsap County v. Allstate Ins. Co.*, 136 Wn.2d 567, 576, 964 P.2d 1173 (1998) (ambiguity in insurance contract). Does it mean a Member is required to pay the actual charge of the supplier (\$3–\$5)? Or does it mean a Member is required to pay whatever GHC wants to charge its Members (\$13.30–\$14.75)?²

A majority of courts have ruled the term “actual charges” as used in health insurance contracts is ambiguous. *See Pedicini v. Life Ins. Co.*, 686 F. Supp. 2d 692, 696-97 (W.D. Ky. 2010), *aff’d in part, vacated in part on other grounds*, 682 F.3d 522, 528-29 (6th Cir. 2012); *Smith v. Life Investors Ins. Co. of Am.*, No. 2:07-cv-681, 2009 U.S. Dist. LEXIS 103536, at *13-19 (W.D. Pa. Nov. 6, 2009); *Lindley v. Life Investors Ins. Co. of Am.*, No. 08-CV-0379-CVE-PJC, 2009 U.S. Dist. LEXIS 61175, at *21-24 (N.D. Okla. July 17, 2009); *Pierce v. Cent. United Life Ins. Co.*, No. 07-1023-PHX-EHC, 2009 U.S. Dist.

¹ The average person reads at a 7th – 8th grade level. Tiffany M. Walsh & Teresa A. Volsko, *Readability Assessment of Internet-Based Consumer Health Information*, *Respir. Care*, Vol. 53 No. 10, 1310, 1311 (2008), available at <http://www.rcjournal.com/contents/10.08/10.08.1310.pdf> (accessed: Mar. 14, 2016).

² This issue is discussed at CP 58-60 (Otey Response), CP 75-76 (GHC Reply); RP 13-16 (GHC counsel), and RP 33-34 (trial court ruling).

LEXIS 61723, at *14-26 (D. Ariz. July 15, 2009); *Hodges v. Am. Fid. Assur. Co.*, No. 5:06-cv-65(DCB)(JMR), 2008 U.S. Dist. LEXIS 109334, at *3 (S.D. Miss. Mar. 17, 2008); *Guidry v. Am. Pub. Life Ins. Co.*, 512 F.3d 177, 182-84 (5th Cir. 2007); *Ward v. Dixie Nat'l Life Ins. Co.*, Nos. 06-2022 & 06-2054, 257 Fed. Appx. 620, 625-27, 2007 U.S. App. LEXIS 27699 (4th Cir. Nov. 29, 2007) (unpublished); *Conner v. Am. Pub. Life Ins. Co.*, 448 F.Supp.2d 762, 765-66 (N.D. Miss. 2006); *Metzger v. Am. Fid. Assur. Co.*, No. CIV-05-1387-M, 2006 U.S. Dist. LEXIS 70061, at *12-14 (W.D. Okla. Sept. 26, 2006).

In *Pedicini*, for example, the Sixth Circuit stated: "We hold that the term "actual charges" is ambiguous....[I]t is clear that "a reasonable person would find [the term "actual charges"] susceptible to different or inconsistent interpretations," making it ambiguous under Kentucky law. *Pedicini*, 682 F.3d at 527-28.

In *Guidry*, the Fifth Circuit concluded the Black's Law Dictionary definition of "actual" as "[r]eal, substantial; existing presently in fact" just as reasonably suggested that "actual charges" means the amount billed rather than the amount accepted as full payment. *Guidry*, 512 F.3d at 184.

In *Ward*, the Fourth Circuit examined "actual charges" as a term of art in the health insurance industry, noting that numerous health care dictionaries define "actual charges" as the amount billed. *Ward*, 257 Fed. Appx. at 626. Because the policy itself did not indicate which definition was intended by the parties, the Fourth Circuit concluded that its meaning was ambiguous. *Id.* at 626-27.

These “actual charge” cases involve supplemental health insurance policies where the term “actual charge” could mean the actual charge of the health care provider, or supplier, or a lower amount that the provider or supplier accepts as full payment. See, e.g., *Ward*, 257 Fed. Appx. at 623 (pre-negotiated, discounted fee agreement between medical providers and health care insurer required providers to accept discounted amount as payment-in-full for services rendered to insureds). Though somewhat distinct on their facts, in all material respects they address the same undefined contract term “actual charge.”

Here, the question is whether “actual charge” means (1) the actual charge the drug supplier imposes on GHC, or (2) GHC’s made-up, inflated charge to the Member, including cost plus profit. Consequently, the term “actual charge” is ambiguous because it is susceptible to more than one reasonable interpretation. The trial court itself noticed the same “charge to whom” ambiguity in the drug coverage section pertaining to brand-name drugs. See RP 9-10; CP 109, 161. A Member’s responsibility to pay the “difference in cost” (brand-name vs. generic) could reasonably be interpreted as either (1) the “charge to GHC,” *i.e.*, the cost that GHC pays the supplier (provider), or (2) the “charge to the Member,” *i.e.*, the price GHC ultimately decides to charge the Member. See RP 10. The same ambiguity inheres to the term “actual charge” as used in the Financial Responsibilities section (CP 100, 153). Though GHC argued “there is absolutely nothing in [the contract] that relates to the provider’s

cost,” RP 10, there is also nothing in the contract that dispels the ambiguity.

GHC engages in “the business of insurance” as a health maintenance organization (HMO). CP 195; see *Kruger Clinic Orth., LLC v. Regence BlueShield*, 157 Wn.2d 290, 300 & n. 6, 138 P.3d 936 (2006). GHC has a quasi-fiduciary duty to act in good faith toward its insureds, the Members. See *Cedell v. Farmers Ins. Co.*, 176 Wn.2d 686, 696, 295 P.3d 239 (2013). Good faith requires GHC to “deal fairly with an insured, giving equal consideration in all matters to the insured's interests.” *Mut. of Enumclaw Ins. Co. v. Dan Paulson Const., Inc.*, 161 Wn.2d 903, 915 n. 9, 169 P.3d 1 (2007). “When one party has discretionary authority to determine certain terms of the contract, such as...price...,” good faith “does not provide a blank check for that party to define terms however it chooses.” *Rekhter v. DSHS*, 180 Wn.2d 102, 113, 323 P.3d 1036 (2014).

Courts construe ambiguities in favor of coverage. *Moeller v. Farmers Ins. Co.*, 173 Wn.2d 264, 272-76, 267 P.3d 998 (2011). Ambiguous terms must “be interpreted as broadly as is reasonably proper in order to provide the greatest coverage possible.” *McDonald Indus., Inc. v. Rollins Leasing Corp.*, 95 Wn.2d 909, 915, 631 P.2d 947 (1981), quoting 12 Couch at § 45:125. “[T]he meaning and construction most favorable to the insured must be applied, even though the insurer may have intended another meaning.” *Queen Anne Park*, 183 Wn.2d at 491.

The reasoning set forth in *Ward, Pedicini*, and the majority of courts is persuasive: this Court should similarly hold the term "actual charge" as used in the GHC contract is ambiguous and rule in favor of Otey, the insured. *Cf. Queen Anne Park*, 183 Wn.2d at 491 ("The definition of "collapse" requested by the insured—substantial impairment of structural integrity—is a reasonable definition because it comports with the commonsense meaning of "collapse," which is evident from it having been adopted as the definition of "collapse" by many courts across the country...").

Otey should be required to pay only the "actual charge" to GHC from the drug supplier. Damages should be assessed for amounts GHC overcharged its Members. As noted in the next section, GHC also should be required to cost share on inexpensive prescription drugs.

C. The contract terms "Cost Share" and "Copayment" are ambiguous: the average person would interpret them to mean GHC will pay a portion of drug costs and not shift the entire cost to the Member and charge a profit markup of 3 - 5 times the actual cost.

Key language in the contract defines "Cost Share" as follows:

The **portion of the cost** of Covered Services for which the Member is liable. Cost share includes Copayments, coinsurances and Deductibles.

CP 138, 190 (bold added). Key language in GHC's Online Glossary of Terms defines "Prescription Drug Coverage" as follows:

Health insurance or plan **that helps pay for** prescription drugs and medications.”³

The term “Cost Share” is ambiguous because the average person would interpret it to mean GHC will pay a portion for drug costs or “help pay” for drug costs, and not shift the entire cost, plus a hefty markup, to the Member.

Construed as a whole, the contract is given “a fair, reasonable, and sensible construction as would be given to the contract by the average person purchasing insurance.” *Queen Anne Park*, 183 Wn.2d at 489 (internal quotations omitted). The “proper inquiry is not whether a learned judge or scholar can, with study, comprehend the meaning of an insurance contract”, but instead “whether the insurance policy contract would be meaningful to the layman...” *Boeing Co. v. Aetna Cas. & Sur. Co.*, 113 Wn.2d 869, 881, 784 P.2d 507, 513 (1990).

Focused on the plain meaning of the words used in the contract, the trial court had it right at the outset of the summary judgment hearing:

THE COURT:...I think one of the reasons why we're having this dispute is that we have these terms -- we have Copayment, we have Cost Share -- **those terms suggest that there's been an allocation of payment, that the Member or the Subscriber pays a certain part and Group Health pays the other...**

³ Glossary of Health Coverage and Medical Terms at 3, available at <https://www1.ghc.org/static/pdf/employer/omni-glossary.pdf> (viewed: Apr. 3, 2016) (bold added).

RP 7 (bold added). There is nothing in the contract that dispels this commonsense understanding that both parties will share in the cost of inexpensive prescription drugs, regardless of copayments or deductibles that do not apply.

The term “Cost Share” as it applies to prescription drugs is not adequately defined in the agreement, and this Court can consider dictionary definitions to ascertain its common meaning. CP 3 ¶12; see *Int’l Marine Underwriters v. ABCD Marine, LLC*, 179 Wn.2d 274, 284, 313 P.3d 395 (2013) (undefined terms given “plain, ordinary, and popular meaning” according to standard English dictionaries or specialty dictionaries); *Moeller*, 173 Wn.2d at 272 (undefined terms in insurance policy given ordinary and common meaning).

The phrase “portion of the costs” is not defined in the contract. “Portion” means “a part of any whole, either separated from or integrated with it”; or “the part of a whole allotted to or belonging to a person or group; share.” DICTIONARY.COM UNABRIDGED, Random House, Inc. <http://dictionary.reference.com>. “Cost” means “the price paid to acquire, produce, accomplish, or maintain anything.” *Id.* at <http://dictionary.reference.com/browse/cost?s=t>. As a noun, “share” means “the full or proper portion or part allotted or belonging to or contributed or owed by an individual or group”; as a verb, it means “to divide and distribute in shares; apportion”; or “to use, participate in, enjoy, receive, etc., jointly”; or “to have a share or part; take part (often followed by in)”; or “to divide, apportion, or receive equally.” *Id.* at <http://dictionary.reference.com/browse/share?s=t>. The term “cost-

share” is ordinarily defined as “to share the cost of: to cost-share a joint venture.” *Id.* at <http://dictionary.reference.com/browse/cost-share>.

Nothing in the contract contradicts these common definitions. “Cost Share” as used in the Group Medical Coverage Agreement means GHC will share the cost of prescription drugs with the insured Member.

Even the contract definition of “Cost Share” supports Otey’s interpretation because the average person would understand the words “**portion of the cost** of Covered Services” (cost share) to mean *both parties are sharing the cost of the drug*: the Member pays a portion of the cost and GHC pays a portion of the cost, *i.e.*, they are both sharing the cost of obtaining the drug for the benefit of the Member. The average person would not understand that the Member bears the entire cost. The average person would not understand that GHC is free to pay *none of the cost* of acquiring the drug and that it can secretly and without disclosure charge 3-5 times the actual cost in order to profit from the Member.

Likewise, the average person would understand the word “copayment” to mean that both parties are sharing the cost of the drug. A dictionary defines “copayment” as: “[a]n amount paid by a health insurance plan enrollee for each office or emergency department visit or purchase of prescription drugs **in addition to the amount paid by the insurance company.**” MOSBY’S MEDICAL DICTIONARY (8th ed. 2009) (bold added).

GHC's contract defines "copayment" in terms of the responsibility of the Member: "The specific dollar amount a Member is required to pay at the time of service for certain Covered Services." CP 138, 190. But this definition must be read in conjunction with the definition of "cost share," of which "copayment" is a subset. When read together, the obvious meaning is that the Member will pay a portion and GHC will pay a portion, just as the word "copayment" implies. Nothing in this *contract* dispels the common understanding that the drug cost is being shared.

"Cost share" and "copayment" are ambiguous terms because, as the lower court noted, the average person would interpret them to mean that GHC must share in the cost (pay its portion) for inexpensive prescription drugs. But GHC interprets the terms to mean that that it does not have any duty to pay its portion. Because the terms are susceptible to two or more reasonable interpretations, they are ambiguous. Where terms in an insurance policy are ambiguous, the meaning and construction most favorable to the insured must be applied, even though the insurer may have intended another meaning. *Queen Anne Park*, 183 Wn.2d at 491. Otey is thus entitled to damages for GHC's failure to cost share in an amount to be determined by the trier of fact.

D. Tier 1 and 2 prescription drugs are covered benefits.

Tier 1 and 2 prescription drug benefits are within the scope of coverage. GHC admitted on the record that these prescription drugs are "covered services." RP 4, 5, 13, 15. The contract defines "cost

share” as “[t]he **portion of the cost of Covered Services** for which the Member is liable [and] includes Copayments, coinsurances and Deductibles.” CP 138, 190 (bold added). Courts “liberally construe insurance policies to provide coverage wherever possible.” *Bordeaux, Inc. v. Am. Safety Ins. Co.*, 145 Wn. App. 687, 694, 186 P.3d 1188 (2008); see also *Patriot Gen. Ins. Co. v. Gutierrez*, 186 Wn. App. 103, 110, 344 P.3d 1277 (2015) (inclusionary clause should be liberally construed to provide coverage whenever possible).

GHC nonetheless claims that it has no duty to pay any portion of the cost for these “covered” drugs. In effect, GHC claims these drugs are implicitly “excluded”—it has no duty to pay and the Member is solely responsible for paying the cost of these drugs plus an additional amount for profit charged by GHC or its authorized pharmacy. GHC’s phantom exclusion is not supported by any specific policy language.

Moreover, its phantom exclusion is directly contradicted by its own contract language:

The cost of **non-Covered** Services and supplies is the responsibility of the Member. The Subscriber is liable for payment of any fees charged for **non-Covered** Services provided to the Subscriber and his/her Dependents at the time of service. Payment of the amount billed must be received within 30 days of the billing date.

CP 101, 154 at §3.C (“Financial Responsibilities for Non-Covered Services”) (bold added). GHC cannot have it both ways: since Tier 1 and 2 drugs are covered, the Member is not solely responsible for

the cost, and GHC must share the cost. Otherwise, these drugs are “non-Covered” and not labeled as such, and GHC unfairly and deceptively marks them up in violation of the CPA and in bad faith.

The absurd result of GHC’s interpretation is that Otey would be better off if low-cost prescription drugs were *not covered* in the insurance contract: (1) she could obtain the drugs for less from other vendors (but the contract requires her to purchase them from “a Group Health-designated pharmacy”);⁴ and (2) she would have no \$15 or \$30 copayment obligation.

1. No contract language excludes Tier 1 and 2 drugs, yet GHC treats them as though they are excluded.

Courts construe coverage exclusions strictly against the insurer “because they are contrary to the fundamental protective purpose of insurance.” *Vision One, LLC v. Phila. Indem. Ins. Co.*, 174 Wn.2d 501, 512, 276 P.3d 300 (2012) (no extending exclusions beyond clear and unequivocal meaning). Since exclusionary clauses are “narrowly construed for the purpose of providing maximum coverage” for the insured, “if insurers want exclusions upheld, they have the burden of drafting them in “clear” and “unequivocal” terms.” *Marine Underwriters*, 179 Wn.2d at 288; *Gutierrez*, 186 Wn. App. at 110 (burden on the insurer to draft exclusionary clauses with clear and unequivocal terms).

Nothing in the contracts specifically excludes coverage of inexpensive Tier 1 and 2 prescription drugs. The “exclusions” clause

⁴ CP 108, 160.

in the prescription drug benefits section does not state these drugs are “not covered” or that GHC is relieved from providing a benefit by sharing the costs with a Member. See CP 109, 162.

2. Otey and other Members are not getting the coverage benefit of cost-sharing for inexpensive prescription drugs.

Otey has no deductible in her health coverage plan. CP 102, 155. She and other Members are not getting the coverage benefit of cost sharing or even any partial benefit—the Member is paying 100 percent of the cost for inexpensive Tier 1 and 2 prescription drug costs plus a 3–5 times profit markup. GHC is only cost-sharing for “expensive drugs” that exceed the cost of the copayment (\$15/\$30) amount paid by the Member. The purpose of cost sharing is that both parties share in the cost of health care. The purpose is not that the insurer pays nothing and gains an unfair windfall profit.

Moreover, GHC’s handling of inexpensive prescription drugs is unreasonable and not supported by the contract language. GHC cannot argue prescription drugs are “covered” and then claim no duty to pay any portion of the costs. Coverage means they will pay unless specifically excluded. There is no exclusion for inexpensive Tier 1 and 2 prescription drugs.

Prescription drugs (a category of “covered services”) has its own special payment provisions. The contract makes a clear distinction as to how Tier 1 and 2 drugs are charged compared to Tier 3. Tier 3 drugs are “Not covered; Member pays 100% of all charges.” CP 108, 160. There is no cost-sharing for Tier 3 drugs—no copayment, coinsurance, or deductible—because the Member is

paying the entire “cost” plus whatever profit the pharmacy is charging the Member in the price.

But with Tier 1 drugs (preferred generic drugs - \$15 copay or actual charge if less) and Tier 2 drugs (preferred brand name drugs – Member pays \$30 copay or actual charge if less), the contract does not state, as it does for Tier 3, the Member “pays 100% of all charges.” All it states is “copayment,” although elsewhere it explains the actual charge may be less.⁵ While Tier 3 drugs are disclosed as “not covered,” no such language appears for Tier 1 or Tier 2 drugs. The contract language states, and an insured is led to believe, these drugs are “covered,” and therefore they are getting a Plan benefit from cost sharing with the insurer. However, the reality is that inexpensive Tier 1 and 2 drugs are “not covered” the same way as Tier 3 drugs are “not covered,” because the insured has to pay 100 percent of the actual charges, which includes a hidden fee to GHC. GHC’s failure to provide any benefit for this covered service (inexpensive prescription drugs) and instead charging a hefty profit, violates the very nature of insurance, which is to provide a benefit, not a monetary burden.

The trial court erred in holding that GHC may exclude coverage (declining to pay any portion of the costs) for inexpensive drugs that GHC admits are “covered” without any clear and

⁵ CP 107-108, 160-161; CP 100, 153 at III¶¶B (“Charges will be for the lesser of the Cost Shares for the Covered Service or the actual charge for that service. Cost Shares will not exceed the actual charge for that service.”).

unequivocal language of exclusion stated in the contract. This Court should reverse and remand for trial.

3. The trial court’s rationale of “aggregate” cost-sharing that excludes cost-sharing for inexpensive prescription drugs is a strained interpretation not supported by the contract.

Cost-sharing in the form of copayments and coinsurance “assure that the subscriber and the insurance company share in all annual pharmacy expenditures.” *Regence BlueShield v. Ins. Comm’r*, 131 Wn. App. 639, 650, 128 P.3d 640 (2006). As a matter of contract interpretation, the trial court ruled GHC’s cost-sharing is not for any specific category of service such as prescription drugs (any “particular bottle of pills”—as coined by the trial court), but for services in general after a Member’s out-of-pocket expense limit is reached.⁶ This interpretation, GHC argued, was the only reasonable one possible because there cannot be a “cost share obligation before the Member satisfie[s] the deductible...because no benefits are payable until the deductible is satisfied.” RP 13 (GHC counsel).

The aggregate theory of cost-sharing is not a reasonable interpretation of the contract because there is no contract language to support it. It was an entirely made up argument from GHC’s counsel at the summary judgment hearing, which is not evidence. *See Green v. A.P.C.*, 136 Wn.2d 87, 100, 960 P.2d 912 (1998)

⁶ See CP 73-74 (GHC Reply); RP 8, RP 11, RP 12, *citing* GHC 0013 [CP 100] (out-of-pocket limit); RP 13, RP 18, RP 20, RP 22, RP 26-27 (trial court framing issue as “aggregate” cost-sharing or not); RP 30, (GHC counsel); RP 33 (trial court oral decision mentioning “particular bottle of pills”).

("Argument of counsel does not constitute evidence."). Evidence must demonstrate objectively manifested mutual intent—not unilateral, subjective, or undisclosed intent—concerning the meaning of the contract. *Lynott v. Nat'l Union Fire Ins. Co.*, 123 Wn.2d 678, 683-84, 871 P.2d 146 (1994). A court "cannot import one party's unexpressed, subjective intentions into the writing." *Lietz v. Hansen Law Offices, P.S.C.*, 166 Wn. App. 571, 585, 271 P.3d 899 (2012).

No language in GHC's contracts states that GHC cost shares only on an aggregate basis and not for any "particular bottle of pills." Without clear language in the contract supporting such a theory, the trial court reasoned that an aggregate cost-sharing interpretation is determinative of the case. RP 34. The trial court erred by applying the meaning and construction most favorable to the insurer. See *Queen Anne Park*, 183 Wn.2d at 491 ("[T]he meaning and construction most favorable to the insured must be applied, even though the insurer may have intended another meaning.").

The aggregate theory of cost-sharing is flawed for three other reasons. First, deductibles do not apply to prescription drug benefits, the only coverage at issue in this case. Members like Otey pay the same copays \$15/\$30 for Tier 1 and 2 drugs regardless of whether the deductible is paid. See CP 107-108; CP 160. Drug benefits are subject to copayment, not deductibles. Second, Otey has no deductible in her Plan of any kind. CP 102, 155. So in this case we are only concerned with the Prescription Drug benefit *subject to*

copayment until the Out-of-Pocket Limit (\$2000 per year [CP 102]) is met. Third, the “aggregate” theory is inconsistent with GHC practice for *expensive* prescription drugs where it does cost share regardless of whether out-of-pocket limits or deductibles have been met.

E. The trial court erred in dismissing Otey’s bad faith and Consumer Protection Act claims.

After dismissing Otey’s breach of contract claim, the trial court dismissed Otey’s bad faith and Consumer Protection Act (CPA) claims without further analysis since “Group Health followed the terms of the contract.” RP 34. This Court should reverse on the contract coverage issue, so the bad faith and CPA claims should be reinstated as well. *See Vision One*, 174 Wn.2d at 523 (determination of coverage under insurance policy reinstates jury verdict against insurer for breach of contract, bad faith and CPA); *Pedicini*, 682 F.3d at 528-29 (issue of fact whether insurer had reasonable basis in law to deny coverage based on ambiguous term “actual charges” construed in favor of insured made summary judgment on bad faith claim improper amidst allegations of deceit in furtherance of pecuniary gain).

Alternatively, even if GHC did not breach the express terms of the contract, the bad faith and CPA claims are independent claims with unresolved issues of fact to be decided by a jury. *Cf. Schnall v. AT & T Wireless Services, Inc.*, 171 Wn.2d 260, 259 P.3d 129 (2011) (CPA and breach of contract claims asserted against wireless phone company for misleading, hidden charges mischaracterized to customers as due and owing under terms of customer agreements).

A contractual relationship between the plaintiff and defendant is not even necessary to prove a CPA violation. *Panag v. Farmers Ins. Co. of Wash.*, 166 Wn.2d 27, 39, 204 P.3d 885 (2009) (“An actionable violation can occur without any consumer or business relationship between the particular plaintiff bringing a private cause of action under the CPA and the actor because “trade or commerce” is not limited to such transactions.”).

Summary dismissal of an insured’s breach of contract claim because coverage is excluded does not necessarily require dismissal of the insured’s other claims for bad faith and CPA violation. *Coventry Assocs. v. Am. States Ins. Co.*, 136 Wn.2d 269, 279, 961 P.2d 933 (1998) (“An insured may maintain an action against its insurer for bad faith...and violation of the CPA regardless of whether the insurer was ultimately correct in determining coverage did not exist.”).

As in *Coventry*, the trial court here erred by ruling the bad faith and CPA claims “could not exist in the absence of coverage.” *Id.* at 275. Here, the trial court overlooked “the duty of good faith is separate from the duty to pay for a claim when required to do so.” See *id.* at 282. Rejecting a “no harm, no foul” approach, the Washington Supreme Court ruled:

[T]he insurance contract brings the insured a certain peace of mind that the insurer will deal with it fairly and justly when a claim is made. Conduct by the insurer which erodes the security purchased by the insured breaches the insurer's duty to act in good faith.

Coventry, 136 Wn.2d at 282-83 (footnote omitted). Thus, the insurer's liability for bad faith or CPA violation is an issue of fact not appropriate for summary judgment. See *id.* at 280; see also *St. Paul Fire & Marine Ins. Co. v. Onvia, Inc.*, 165 Wn.2d 122, 130, 196 P.3d 664 (2008) (whether insurer acted in bad faith is a question of fact).

No evidence supported dismissing Otey's bad faith and CPA claims. Other than argument and the contracts, GHC put forward *no evidence* that its interpretation of the contract was reasonable or even internally consistent. The "existence of some theoretical reasonable basis for the insurer's conduct does not end the inquiry." *Smith v. Safeco Ins. Co.*, 150 Wn.2d 478, 485-86, 78 P.3d 1274 (2003) (insurer's bad faith is question of fact—there must be no disputed facts pertaining to the "reasonableness of the insurer's action in light of all the facts and circumstances of the case").

The trial court erred in granting summary judgment because there were issues of fact regarding GHC's drug coverage practices and good faith.

VI. CONCLUSION

The trial court erred by not interpreting ambiguous terms of the contract in favor of the insured. The term "actual charge" is ambiguous. Therefore, Otey and other Members should only pay the "actual charge" of the prescription drug supplier. The terms "cost share," "portion of the cost," "copayment," and "coverage" are ambiguous. They should be given their plain meaning and GHC must "cost share" for inexpensive drugs. Since Tier 1 and 2 prescription

drugs are covered, GHC must provide a payment benefit of either 100 percent or “cost share” for these inexpensive drugs. This Court should reverse and remand for trial.

Dated May 6, 2016.

HOUCK LAW FIRM, PS

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CERTIFICATE OF SERVICE

I certify that on the date specified below I served the foregoing

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DATED: May 6, 2016, at Issaquah, Washington

s/ William Houck
William Houck

Appendix

Unpublished Opinion

Ward v. Dixie Nat'l Life Ins. Co.

United States Court of Appeals for the Fourth Circuit
May 23, 2007, Argued; November 29, 2007, Decided on Rehearing
No. 06-2022, No. 06-2054

Reporter

257 Fed. Appx. 620; 2007 U.S. App. LEXIS 27699

MARTHA WARD, on behalf of herself and all others similarly situated, Plaintiff - Appellant, versus DIXIE NATIONAL LIFE INSURANCE COMPANY; NATIONAL FOUNDATION LIFE INSURANCE COMPANY, Defendants - Appellees, and PALMETTO MARKETING ASSOCIATES, INCORPORATED; PATTI JENKINS, Defendants. SOUTH CAROLINA DEPARTMENT OF INSURANCE; AMERICA'S HEALTH INSURANCE PLANS, INCORPORATED, Amici Supporting Appellees. MARTHA WARD, on behalf of herself and all others similarly situated, Plaintiff - Appellee, versus NATIONAL FOUNDATION LIFE INSURANCE COMPANY, Defendant - Appellant, DIXIE NATIONAL LIFE INSURANCE COMPANY, Defendant - Appellee, and PALMETTO MARKETING ASSOCIATES, INCORPORATED; PATTI JENKINS, Defendants. SOUTH CAROLINA DEPARTMENT OF INSURANCE; AMERICA'S HEALTH INSURANCE PLANS, INCORPORATED, Amici Supporting Appellant.

Notice: PLEASE REFER TO FEDERAL RULES OF APPELLATE PROCEDURE RULE 32.1 GOVERNING THE CITATION TO UNPUBLISHED OPINIONS. ON REHEARING

Subsequent History: Motion denied by, Summary judgment granted by. On remand at Ward v. Dixie Nat'l Life Ins. Co., 2008 U.S. Dist. LEXIS 119107 (D.S.C., Aug. 12, 2008)

Prior History: **[**1]** Appeals from the United States District Court for the District of South Carolina, at Columbia. Joseph F. Anderson, Jr., Chief District Judge. (3:03-cv-03239-JFA).
Ward v. Dixie Nat'l Life Ins. Co., 2007 U.S. App. LEXIS 23397 (4th Cir. S.C., Oct. 5, 2007)
Ward v. Dixie Nat'l Life Ins. Co., 2006 U.S. Dist. LEXIS 38525 (D.S.C., May 10, 2006)

Disposition: VACATED IN PART. AFFIRMED IN PART, DISMISSED IN PART, AND REMANDED.

Case Summary

Procedural Posture

Plaintiff insured sought rehearing of a decision of the court which concluded that the United States District Court for the District of South Carolina, at Columbia properly limited a plaintiff class to statewide residents rather than a multistate class in an action against defendants, an assignee and an assignor. The action claimed that the assignee refused to pay the full amount of benefits owed under insurance policies.

Overview

Plaintiff sued defendants, arguing that the assignee refused to pay the full amount of benefits owed under supplemental cancer insurance policies that were issued by the assignor and later assigned to the

assignee. The district court certified a statewide plaintiff class rather than the multistate class plaintiff sought to represent, and the district court later granted summary judgment in favor of the assignee on breach of contract claims. On plaintiff's appeal, the court concluded that although the district court properly limited the plaintiff class to South Carolina residents, the district court improperly granted summary judgment on the breach of contract claims, and remanded for further proceedings. The court dismissed the assignee's cross-appeal and remanded. On rehearing, the court vacated the summary judgment for the assignee. At issue was the definition of the phrase "actual charges" under the policies. The court held that because the phrase was patently ambiguous, construction of the policy was for the court rather than a jury. However, plaintiff failed to show, as required by *Fed. R. Civ. P. 23(b)*, that common issues of law would be predominant in a multistate class.

Outcome

The court vacated the district court's grant of summary judgment to the assignee and remanded with instructions for the district court to grant summary judgment to plaintiff on the breach of contract claims. The court affirmed the district court's decision to limit class membership to South Carolina residents. The court dismissed without prejudice the cross-appeal filed by defendant challenging the certification of a statewide class.

Counsel: ARGUED: Richard Ara Harpootlian, Columbia, South Carolina, for Martha Ward, on behalf of herself and all others similarly situated.

Elliot H. Scherker, GREENBERG & TRAUIG, L.L.P., Miami, Florida, for Dixie National Life Insurance Company and National Foundation Life Insurance Company.

ON BRIEF: Tobias G. Ward, Jr., TODD & WARD, P.C., Columbia, South Carolina, for Martha Ward, on behalf of herself and all others similarly situated.

C. Allen Foster, Kevin E. Stern, GREENBERG & TRAUIG, L.L.P., Washington, D.C.; J. Calhoun Watson, SOWELL, GRAY, STEPP & LAFFITTE, L.L.C., Columbia, South Carolina, for Dixie National Life Insurance Company and National Foundation Life Insurance Company.

Jeffrey A. Jacobs, SOUTH CAROLINA DEPARTMENT OF INSURANCE, Columbia, South Carolina, for the South Carolina Department of Insurance, Amicus Curiae Supporting Dixie National Life Insurance Company and National Foundation Life Insurance Company.

Joni Hong, AMERICA'S HEALTH INSURANCE PLANS, [**2] INC., Washington, D.C.; Markham R. Leventhal, Mitchell D. Sprengelmeyer, JORDEN BURT, L.L.P., Miami, Florida, for America's Health Insurance Plans, Inc., Amicus Curiae Supporting Dixie National Life Insurance Company and National Foundation Life Insurance Company.

Judges: Before MICHAEL and TRAXLER, Circuit Judges, and WIDENER,¹

¹ Judge Widener heard oral argument in this case but died prior to the time the decision was filed. The decision is filed by a quorum of the panel. 28 U.S.C. § 46(d).

Opinion

[*622] PER CURIAM:

Plaintiff Martha Ward sued National Foundation Life Insurance Company (National) and Dixie National Life Insurance Company (Dixie), asserting that National refused to pay the full amount of benefits owed under supplemental cancer insurance policies that were issued by Dixie and later assigned to National. The district court certified a statewide (South Carolina) plaintiff class rather than the multistate class Ward sought to represent, and the court later granted summary judgment in favor of National on the breach of contract claims. Ward appealed and National cross-appealed. In a prior opinion, we concluded that although the district court properly limited the plaintiff [**3] class to South Carolina residents, the court improperly granted summary judgment on the breach of contract claims, and we remanded for further proceedings on those claims. We dismissed National's cross-appeal without prejudice. See Ward v. Dixie Nat'l Life Ins. Co., 2007 U.S. App. LEXIS 23397, 2007 WL 2914954 (4th Cir. Oct. 5, 2007).

Ward filed a petition for rehearing, and National, supported by various amici, filed a petition for rehearing and rehearing *en banc*. We granted Ward's petition for panel rehearing and denied National's petition for rehearing, thus vacating our prior opinion.² See Fourth Circuit I.O.P. 40.2. Dispensing with further briefing and argument, we now vacate the district court's decision granting summary judgment in favor of National, and we remand with instructions for the district court to instead enter judgment in favor of Ward on the breach of contract claims. In light of our remand, we conclude that it would be premature for us to consider the class certification issue. We therefore dismiss without prejudice National's cross-appeal.

I.

In August 1990 Ward purchased a cancer treatment benefit policy from Dixie covering both herself and her husband. [*623] Ward's policy is a type of supplemental insurance under which direct payments are made to the policyholder when an insured patient undergoes covered cancer treatments. Benefits under this kind of policy are paid regardless of whether the patient has other insurance sufficient to cover all medical expenses. When the patient has other insurance covering cancer treatments, the policyholder is able to retain the money received as a result of the supplemental coverage.

Benefits under Ward's policy vary as to the procedure performed. In some sections the policy provides clear caps as to the maximum benefit to be paid. For example, the policy provides a "Schedule of Operations" listing the maximum amount to be paid -- ranging from \$ 150 for skin excisions to \$ 3000 for removal of an intracardiac tumor -- for a variety of operations. In many other sections of the policy no dollar amounts are provided, and benefits are calculated in relation to the "actual charges" for the covered procedures. Section (F) of the policy, titled "X-ray Therapy, Radium Therapy, Radiation Therapy, and [**5] Chemotherapy Benefit," provides an example of this language:

We will pay the actual charges for teleradiotherapy, using either natural or artificially propagated radiation, when used for the purpose of modification or destruction of tissue invaded by cancer. We

² Because no member of the court called for a vote on National's petition for rehearing *en banc*, the petition was denied. See Fourth Circuit Local Rule 35(b). [**4]

will also pay the actual charges made for plaques or molds or the administration internally, interstitially, or intracavitarily of radium or radioisotopes in sealed sources for the purpose of modification or destruction of tissue invaded by cancer. We will also pay the actual charges for cancericidal chemical substances and the administration thereof for the purpose of the modification or destruction of tissue invaded by cancer.

J.A. 221. Although the phrase is used repeatedly throughout the policy, no definition for "actual charges" is provided.

Dixie assigned Ward's policy to National in 1994. In 2001 Ward began filing claims under the policy after her husband, James Ward (James), was diagnosed with prostate cancer and started receiving treatment. Shortly thereafter, a dispute between Ward and National arose over how benefits paid in the amount of the "actual charges" are calculated.

For a number of years after the assignment, [**6] National appears to have calculated benefits in the same manner that Dixie had previously done. Specifically, when the benefit owed was based on the "actual charges," Dixie paid the benefit based on the amounts billed to patients by their medical providers. Dixie paid such amounts even though providers often have agreements with certain insurers to accept as payment-in-full an amount less than that reflected on the patient's bill. In this case, for example, James's primary health insurance is provided through a plan administered by Blue Cross and Blue Shield of South Carolina (BCBS). Regardless of the amounts billed to James, his medical providers have an agreement with BCBS that requires them to accept a discounted amount as payment-in-full for services rendered to BCBS insureds. This agreement prohibits providers from attempting to collect an amount in excess of the pre-negotiated, discounted fee from BCBS insureds such as James.

Toward the end of the year in 2001, National changed its benefit payment practice. When Ward submitted claims for James's treatments in 2002, she was told that she would have to submit an explanation of benefits (EOB) statement. By viewing the EOB, National [**7] would be able to determine what the pre-negotiated discount rate was for James's treatments [*624] and calculate benefits in light of this reduced amount. Ward refused to provide National with the EOB statements because she contended that under the terms of her policy, the "actual charge" was reflected in the non-discounted bill that she received rather than in the EOB.

On March 7, 2003, after Ward was unable to resolve the dispute, she filed an action in the Court of Common Pleas for Richland County, South Carolina, against both Dixie and National. The defendants removed the action to federal court on October 10, 2003. On September 15, 2004, Ward moved to certify a plaintiff class consisting of

all persons insured under cancer policies from Defendant Dixie National Life Insurance Company where Dixie promised to pay to the insured the "actual charges" incurred for certain medical services, but instead paid not the actual charges but rather the (lesser) amount that the insured's primary health insurer negotiated with the healthcare provider to pay for the medical procedure[.]

S.A. 7. On May 5, 2005, the district court certified a class of South Carolina residents. The court limited the class [**8] to South Carolina residents based on its understanding of South Carolina's

door-closing statute, S.C. Code Ann. § 15-5-150. Ward, with permission of the court, filed a third amended complaint on September 27, 2005, asserting claims for (1) breach of contract against both Dixie and National; (2) bad faith refusal to pay against National; and (3) breach of contract accompanied by a fraudulent Act against National. Ward later abandoned the bad faith claim. Cross-motions for summary judgment followed. In addition, National filed a motion, joined by Dixie, to decertify the statewide class.

On May 10, 2006, the district court granted National's motion for summary judgment while denying Ward's. The court concluded that under South Carolina contract law, the phrase "actual charges" is not ambiguous and must be read to mean "the charges for which the patient is liable when medical services are rendered, not the fictional amounts indicated on the invoice that the provider does not expect the patient to pay." J.A. 1074. Because Ward did not prevail on her breach of contract claims, the joint motion to decertify the class and Dixie's motion for summary judgment were denied as moot.

Ward appeals [**9] both the grant of summary judgment to National as well as the district court's decision to limit class membership to South Carolina residents. National has filed a cross-appeal contesting the district court's decision to certify even a statewide class.

II.

We begin with Ward's argument that the district court erred in concluding that, as used in her policy, the unambiguous meaning of the phrase "actual charges" is the discounted amount that medical providers have agreed to accept as full payment pursuant to a third-party agreement with another insurer. Under South Carolina law when a term has a "plain, ordinary, and popular meaning," courts must interpret the term to give effect to that ordinary usage. Century Indem. Co. v. Golden Hills Builders, Inc., 348 S.C. 559, 561 S.E.2d 355, 358 (S.C. 2002). When a term has a plain meaning and that meaning is "clear and unambiguous, the language [of the contract] alone determines the contract's force and effect." Schulmeyer v. State Farm Fire & Cas. Co., 353 S.C. 491, 579 S.E.2d 132, 134 (S.C. 2003). Of course not all terms are susceptible to plain and ordinary definition because of the simple fact that they are not popularly used. As a result, a contract term is ambiguous [**10] when it lacks a plain [*625] definition and is "capable of more than one meaning when viewed objectively by a reasonably intelligent person who has examined the context of the entire integrated agreement and who is cognizant of the customs, practices, usages and terminology as generally understood in the particular trade or business." Hansen v. United Servs. Auto. Ass'n, 350 S.C. 62, 565 S.E.2d 114, 117-18 (S.C. 2002).

In the district court's endeavor to discern the plain meaning of "actual charges" as used in Ward's policy, it reasoned that the word "actual" should be given a separate meaning from the word "charges." Because the district court understood the word "actual" to mean something that is real or true, it concluded that "actual charges" means the amounts for which the patient is truly liable as opposed to "the fictional amounts indicated on the invoice that the provider does not expect the patient to pay." J.A. 1074. We disagree both with the district court's interpretive approach as well as the conclusion that it reached. The definition settled on by the district court is not the only one possible when the language of the policy is considered in light of its context. As we explain below, the [**11] meaning of the phrase "actual charges" as used in Ward's policy is ambiguous.

First, even under the district court's approach -- defining each word separately and then putting those definitions together -- another meaning can reasonably be found. The words "actual charges" could

also be understood to mean the amount shown on the bill sent to the patient regardless of whether this amount is the same as the amount actually owed. Viewed from within the four corners of the policy, the phrase is ambiguous as there is nothing to indicate whether "actual charges" is best understood to mean the amount actually billed or the amount actually owed. See Conner v. Am. Pub. Life Ins. Co., 448 F. Supp. 2d 762, 766 (N.D. Miss. 2006) (finding "inherent ambiguity in the undefined term 'actual charges'"); Metzger v. Am. Fid. Assur. Co., No. CIV-05-1387-M, 2006 U.S. Dist. LEXIS 70061, at *13 (W.D. Okla. Sept. 26, 2006) (same).

Second, we disagree with the assertion that the district court was correct "in considering ordinary dictionary definitions" of both "actual" and "charges." Appellees' Br. at 21. We conclude that a person "who is cognizant of the customs, practices, usages and terminology as generally [**12] understood" in the health insurance industry would regard "actual charges" as a term of art rather than two words to be separately defined. Hansen, 565 S.E.2d at 117. The words are used throughout the insurance policy together as a phrase -- a phrase that neither appears in a standard dictionary nor has an ordinary, popular usage. Contrary to the defendants' contention, South Carolina's principles of contract interpretation in no way prohibit courts from reading a phrase as a term of art if that is how it would be regarded by an objective observer well-versed in medical insurance terminology. See Frazier v. Badger, 361 S.C. 94, 603 S.E.2d 587, 591 (S.C. 2004).

Third, even when viewed as a term of art, the phrase remains ambiguous. Prior to filing this lawsuit, Ward wrote to the South Carolina Department of Insurance and asked to be provided with a legal definition of "actual charge." A representative of the Department wrote back explaining that "[t]he term 'actual charge' in industry-wide standards is the amount that you are *legally obligated to pay for a specific service*." J.A. 611 (emphasis in original). In contrast to the view taken by the Department of Insurance, numerous health care dictionaries [**13] define "actual [*626] charge" as the amount billed. See, e.g., Mosby's Medical, Nursing, and Allied Health Dictionary 26 (4th ed. 1994) ("actual charge, the amount actually charged or billed by a medical practitioner for a service. The actual charge may not be the same as that paid for the service by an insurance plan."); Lee Hyde, The McGraw-Hill Essential Dictionary of Health Care 133 (1988) ("actual charge, the amount a physician or other practitioner actually *bills* a patient or his insurance for a medical *service* or *procedure*.") (emphasis in original). Because the policy itself does not indicate which definition was intended by the parties, we conclude that its meaning is ambiguous.³

We must now determine what remedy flows from our conclusion that the insurance policy is ambiguous. In a typical contract dispute, the meaning of an ambiguous contract is a question of fact to be resolved by the jury. See, e.g., Cafe Assoc., Ltd. v. Gerngross, 305 S.C. 6, 406 S.E.2d 162, 164 (S.C. 1991) ("As a general rule, written contracts are to be construed by the Court; but where a contract is ambiguous or capable of more than one construction, the question of what the parties intended becomes one of fact, and the question should be submitted to the jury."). Although statements of that general rule appear in cases involving insurance disputes, see Waters v. S. Farm Bureau Life Ins. Co.,

³ National and its supporting amici contend that, absent compelling reasons, we must defer to the Department of Insurance's interpretation of "actual charges." We disagree. Although an agency's interpretation of a statute it is charged with enforcing is entitled to deference, see Dunton v. S.C. Bd. of Examiners in Optometry, 291 S.C. 221, 353 S.E.2d 132, 133 (S.C. 1987), the Department of Insurance has no statutory mandate to pronounce the meaning of a term in an individual insurance policy. We are of course interested [**14] in the Department's position, but South Carolina law does not in this case require us to defer to the Department's view of the matter.

365 S.C. 519, 617 S.E.2d 385, 388 (S.C. Ct. App. 2005); only *latent* ambiguities in an insurance policy are resolved by a jury; *patent* ambiguities must be resolved in favor of the insured. See Cogdill v. Equity Life & Annuity Co., 262 S.C. 248, 203 S.E.2d 674, 677 (S.C. 1974); Hann v. Carolina Cas. Ins. Co., 252 S.C. 518, 167 S.E.2d 420, 423 (S.C. 1969). Accordingly, if the ambiguity in this case is patent, the district [**15] court should have granted summary judgment in favor of Ward on the breach of contract claims. If the ambiguity is latent, the meaning of the policy must be determined by a jury on remand.

A patent ambiguity is one where the uncertainty as to meaning "arises upon the words of the will, deed, or other instrument as looked at in themselves, and before any attempt is made to apply them to the object which they describe." Hann, 167 S.E.2d at 422 (quoting Jennings v. Talbert, 77 S.C. 454, 58 S.E. 420, 421 (S.C. 1907)); cf. Stone Container Corp. v. Hartford Steam Boiler Inspection & Ins. Co., 165 F.3d 1157, 1162 (7th Cir. 1999) ("A patent ambiguity in a contract is one that is apparent from just reading the contract."). With a latent ambiguity, "the uncertainty arises, not upon the words of the will, deed, or other instrument as looked at in themselves, but upon those words when applied to the object or subject which they describe." Hann, 167 S.E.2d at 422. A latent ambiguity thus "does not appear on the face of the words used, nor is its existence known until those words are brought into contact with collateral facts." Hastings v. Union Fire Ins. Co., 130 S.C. 326, 125 S.E. 923, 924 (S.C. 1924) (internal quotation [**16] marks omitted); cf. Stone Container Corp., 165 F.3d at 1162 ("A latent ambiguity arises when, although the contract is clear 'on its face,' anyone [**627] knowing the background would know that it didn't mean what it seems to mean.").

We believe that the phrase "actual charges" is patently ambiguous. The phrase is susceptible of more than one reasonable interpretation, and the uncertainty of meaning arises thus from the phrase itself, not from the application of the phrase to collateral facts. See Cogdill, 203 S.E.2d at 677 (concluding that "lame back" as used in a policy provision limiting disability benefits could plausibly be construed in more than one way and that the phrase was patently ambiguous); Hastings, 125 S.E. at 924 (finding latent ambiguity in fire insurance policy that covered two barns because the insured's property included two traditional barns and an abandoned tenant house used by the insured as a barn).

Because the ambiguity is patent, construction of the policy is for the court rather than a jury. See Cogdill, 203 S.E.2d at 677; Hann, 167 S.E.2d at 423. South Carolina law very clearly requires us to resolve the ambiguity in favor of the insured. See Helena Chem. Co. v. Allianz Underwriters Ins. Co., 357 S.C. 631, 594 S.E.2d 455, 459 (S.C. 2004) [**17] ("Where the words of an insurance policy are capable of two reasonable interpretations, the construction most favorable to the insured should be adopted."); Hann, 167 S.E.2d at 423 ("It is settled beyond cavil in this jurisdiction that the terms of an insurance policy should be construed most liberally in favor of the insured, and that in case of conflict or ambiguity, a construction will not be adopted that defeats recovery if the policy is reasonably susceptible of a meaning that will permit recovery. We uniformly give the insured the benefit of any doubt in the construction of the terms used in an insurance policy."). Accordingly, we vacate the district court's grant of summary judgment to National and remand with instructions that the district court enter summary judgment in favor of Ward on her breach of contract claims.

III.

A.

We now turn to the question of whether the district court properly limited the class of plaintiffs to those who, like Ward, are residents of South Carolina. In her motion for class certification, Ward made clear that she sought to represent persons residing throughout the southern United States who had bought policies from Dixie that were later assigned to [**18] National. Because the proposed class included non-residents of South Carolina, the district court requested briefing from the parties on the effect of South Carolina's door closing statute, S.C. Code Ann. § 15-5-150, on the potential out-of-state class members. That statute provides:

An action against a corporation created by or under the laws of any other state government or country may be brought in the circuit court:

- (1) By any resident of this State for any cause of action; or
- (2) By a plaintiff not a resident of this State when the cause of action shall have arisen or the subject of the action shall be situated within this state.

S.C. Code Ann. § 15-5-150. As recently reinterpreted by the Supreme Court of South Carolina in Farmer v. Monsanto Corp., 353 S.C. 553, 579 S.E.2d 325 (S.C. 2003), § 15-5-150 determines the capacity of a party to sue. Furthermore, Farmer held that "§ 15-5-150 controls the eligibility of class members in a class action where the defendant is a foreign corporation." 579 S.E.2d at 559. For suits in South Carolina state court, the effect of Farmer is to limit class membership to those persons who would have had capacity to sue for themselves.

[*628] In ruling on Ward's motion for [**19] class certification, the district court concluded that § 15-5-150 prevented Ward from representing out-of-state plaintiffs. The district court reached this conclusion by relying on our prior decisions stating that "a South Carolina federal court exercising diversity jurisdiction must apply § 15-5-150 unless there are affirmative countervailing federal considerations." Proctor & Schwartz, Inc. v. Rollins, 634 F.2d 738, 739-40 (4th Cir. 1980) (quoting Szantay v. Beech Aircraft Corp., 349 F.2d 60, 64 (4th Cir. 1965)). Our decisions in Proctor & Schwartz and Szantay, however, interpreted the door-closing statute in light of the then-prevailing understanding that § 15-5-150 restricted not capacity to sue but the subject matter jurisdiction of state courts. In Farmer the Supreme Court of South Carolina overruled its prior cases stating that § 15-5-150 dealt with jurisdiction.

In this case, we do not find it necessary to decide what effect the reinterpreted door-closing statute has on class membership in suits being heard in South Carolina federal courts sitting in diversity. This is so because, as we discuss next, Ward has failed to establish that the proposed multistate class meets [**20] Rule 23(b)(3)'s requirement that common legal issues predominate.

B.

Fed. R. Civ. P. 23 sets the requirements for class certification. First, Rule 23(a) provides that certification is proper only if

- (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

Fed. R. Civ. P. 23(a). Once Rule 23(a)'s requirements of numerosity, commonality, typicality, and representational adequacy are met, the proposed class must still satisfy one of three additional requirements for certification under Rule 23(b). Because Ward sought class certification under Rule 23(b)(3), she was required to show that

questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy.

Fed. R. Civ. P. 23(b)(3). The predominance requirement under Rule 23(b)(3) "is [**21] similar to but 'more stringent' than the commonality requirement of Rule 23(a)." Thorn v. Jefferson-Pilot Life Ins. Co., 445 F.3d 311, 319 (4th Cir. 2006) (quoting Lienhart v. Dryvit Sys., 255 F.3d 138, 146 n. 4 (4th Cir. 2001)). The party seeking class certification bears the burden of establishing all Rule 23 requirements. In re A.H. Robins Co., 880 F.2d 709, 728 (4th Cir. 1989).

In her class certification memorandum, Ward stated that "members of the Class are dispersed throughout the southern United States." S.A. 12. She further noted that "Dixie marketed and sold cancer policies in at least seven states other than South Carolina, including Alabama, Florida, Georgia, Louisiana, Mississippi, Tennessee, and Texas." *Id.* Although Ward's multistate class purported to include "at a minimum, thousands of persons" across the southern United States, Ward never identified what state law would apply to the claims of absent class members who are not residents of South Carolina and whose claims have no connection to that state. *Id.* In a class action potentially governed by the laws of multiple states, identifying the applicable body or bodies of [**629] state law is critical because "variations in state [**22] law may swamp any common issues and defeat predominance." Castano v. American Tobacco Co., 84 F.3d 734, 741 (5th Cir. 1996). Ward has the burden of showing "that common questions of law predominate, and [she] cannot meet this burden when the various laws have not been identified and compared." Gariety v. Grant Thornton, LLP, 368 F.3d 356, 370 (4th Cir. 2004); see also Cole v. GMC, 484 F.3d 717, 730 (5th Cir. 2007) (decertifying a class because "[p]laintiffs have failed to adequately address, much less extensively analyze, [] variations in state law") (internal quotation marks and citation omitted).

Because the district court ruled on the effect of the door-closing statute before addressing the merits of Ward's motion for class certification, it did not decide whether the proposed multistate class meets the requirements of both Rule 23(a) and Rule 23(b)(3). Even assuming that this proposed class could satisfy the requirements of Rule 23(a), Ward has not established that the multistate class satisfies Rule 23(b)(3)'s requirement that common questions of law predominate. Specifically, Ward failed to identify and compare the applicable state laws. When a plaintiff seeking certification [**23] fails to provide this analysis, it is not possible for the district court to determine whether any variations in state law "pose 'insuperable obstacles' to certification" of a multistate class. Spence v. Glock, GES.m.b.H., 227 F.3d 308, 313 (D.C. Cir. 2000) (quoting Walsh v. Ford Motor Co., 257 U.S. App. D.C. 85, 807 F.2d 1000, 1017 (D.C. Cir. 1986)). The need in this case to identify all governing state laws and compare any variations is underscored by the decisions in two recent cases where plaintiffs in states within the proposed geographic class made claims materially similar to Ward's. In contrast to our decision today under South Carolina law, two district courts applying contract law principles of Alabama and Louisiana concluded that the meaning of "actual charges" is unambiguous as a matter of law. See Claybrook v. Cent. United Life Ins. Co., 387 F. Supp.2d 1199, 1203 (M.D. Ala. 2005); Jarreau v. Cent.

United Life Ins. Co., No. 05-83-FJP-SCR, 2006 U.S. Dist. LEXIS 51196 at *2 (M.D. La. May 16, 2006). In light of Ward's failure to show that common issues of law would be predominant in a multistate class, we affirm the decision of the district court to limit class membership to South Carolina residents [**24] regardless of the effect of the door-closing statute. See United States v. Smith, 395 F.3d 516, 519 (4th Cir. 2005) ("We are not limited to evaluation of the grounds offered by the district court to support its decision, but may affirm on any grounds apparent from the record.").

IV.

We now turn to the cross-appeal filed by National, one of the defendants. National claims that the district court abused its discretion in certifying even a statewide class because: (1) the class is not sufficiently numerous; (2) Ward is neither a typical nor adequate class representative; and (3) individual issues will predominate the determination of class members' claims. On May 19, 2005, after the statewide class had been certified but before any party had filed a motion for summary judgment, National and Dixie petitioned this court to review the district court's certification order pursuant to Fed. R. Civ. P. 23(f). This rule grants us the discretion to entertain appeals from class certification orders prior to the entry of a final judgment. See Lienhart, 255 F.3d at 145. Our court applies a five-factor test to guide our discretion in deciding whether to hear such interlocutory appeals:

- (1) whether the [**25] certification ruling is likely dispositive of the litigation;
- (2) whether the district court's certification decision contains a substantial weakness; [**630]
- (3) whether the appeal will permit the resolution of an unsettled legal question of general importance;
- (4) the nature and status of the litigation before the district court (such as the presence of outstanding dispositive motions and the status of discovery); and
- (5) the likelihood that future events will make appellate review more or less appropriate.

Id. In their Rule 23(f) petition, the defendants raised the same objections to the class certification order that National now asserts in this appeal. We denied the interlocutory petition for review on June 23, 2005.

National's cross-appeal of the class certification is before us as a result of the appeal taken by the plaintiff, Ward, from a final judgment, namely, the summary judgment awarded to defendant National. Because we have decided to vacate that judgment and remand the case for further proceedings, National's current challenge to class certification is procedurally akin to the earlier interlocutory appeal. This circumstance leads us to conclude that it would be premature for us [**26] to address the class certification issue. Earlier, when the district court certified the statewide class, it explicitly reserved its authority to decertify or modify the class at a future date. See McNamara v. Felderhof, 410 F.3d 277, 281 (5th Cir. 2005) (noting that under Rule 23(c)(1)(C) the district court on remand "is free to reconsider its class certification order as often as necessary before judgment."). The defendants went on to file motions for summary judgment and for decertification of the statewide class. After the district court granted summary judgment to National, the pending motion to decertify was denied as moot. Now, in light of the remand, the district court will be able to consider the motion to decertify. Accordingly, we dismiss without prejudice the cross-appeal filed by National. Cf. Baskin v. Hawley, 810 F.2d 370, 371 (2d Cir. 1987) ("Prudential considerations lead to our conclusion that these appeals should be dismissed as premature notwithstanding the fact that they are taken from what was, at that time, a 'final decision[.]' within the meaning of 28 U.S.C. § 1291.") (alteration in original).

V.

In sum, we conclude that the meaning of the phrase "actual charges" [**27] as used in Ward's policy is patently ambiguous. We therefore vacate the district court's grant of summary judgment to National and remand with instructions for the district court to grant summary judgment to Ward on the breach of contract claims. We affirm, albeit on alternate grounds, the district court's decision to limit class membership to South Carolina residents. Finally, we dismiss without prejudice the cross-appeal filed by National challenging the district court's certification of a statewide class.

VACATED IN PART,

AFFIRMED IN PART,

DISMISSED IN PART,

AND REMANDED