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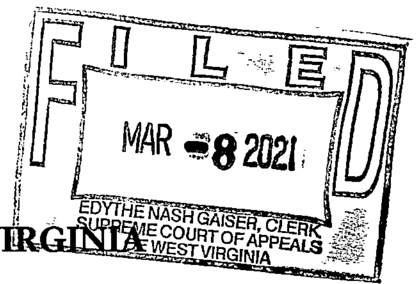

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

No. 20-0792

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AUTO CLUB PROPERTY CASUALTY INSURANCE CO.,
Defendant-Below, Petitioner

v.

JESSICA A. MOSER,
Plaintiff-Below, Respondent

Honorable Michael Lorensen, Judge
Circuit Court Berkeley County
Civil Action No. 19-C-165

REPLY BRIEF OF THE PETITIONER

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City of Fairmont v. W. Virginia Mun. League, Inc., No. 18-0873, 2020 WL 201188, at *4 (W. Va. Jan. 13, 2020) (memorandum) ("The law does not permit a double recovery for a single injury.")

Doe v. Pak, 237 W. Va. 1, 5, 784 S.E.2d 328, 332 (2016) ("Therefore, we hold that when an insurer makes an advance payment to a tort-claimant upon condition that the advance payment will be credited against a future judgment or determination of damages, the damages recovered by the claimant on a subsequent judgment shall be reduced by the amount of the advance payment.") (footnote omitted).

I. INTRODUCTION

The Brief of the Respondent, Jessica A. Moser ("Respondent"), fails to meaningfully respond to any of the errors committed by the Circuit Court, warranting a reversal and remand with directions for entry of judgment for the Petitioner, Auto Club Property & Casualty Insurance Company ("Auto Club").

The Respondent openly admits that she seeks a double recovery but argues that she is entitled to the windfall. To the contrary, the Auto Club policy and the nature and scope of medical payments coverage clearly reflect that the Circuit Court erred in ruling that a policyholder is entitled to first-party medical payments coverage where: (a) her insurer made payments to Medicare to reimburse it for the amount paid towards the insured's medical bills reducing those bills to zero, (b) the policyholder settled with the liability carrier for less than the available liability limits, (c) the insurer waived subrogation pursuant to the liability settlement, and (d) the coverage results in a windfall.

Similarly, the Respondent offers no reasonable basis upon which this Court can affirm the Circuit Court's fee award wherein it includes (a) block billing entries, (b) duplicative entries, (c) excessive time, and (d) an attorney fee award almost thirty times the compensatory damages award.

II. ARGUMENT

A. THE CIRCUIT COURT ERRED IN RULING THAT A POLICYHOLDER IS ENTITLED TO COVERAGE FOR FIRST-PARTY MEDICAL PAYMENTS COVERAGE WHERE: (A) HER INSURER MADE PAYMENTS TO MEDICAID TO REIMBURSE IT FOR THE AMOUNT PAID TOWARDS THE INSURED'S MEDICAL BILLS REDUCING THOSE BILLS TO ZERO, (B) THE POLICYHOLDER SETTLED WITH THE LIABILITY CARRIER FOR LESS THAN THE AVAILABLE LIABILITY LIMITS, (C) THE INSURER WAIVED SUBROGATION PURSUANT TO THE LIABILITY SETTLEMENT, AND (D) THE COVERAGE RESULTS IN A WINDFALL.[1]

1. The Partial Summary Judgment Order Improperly Overlooked the Purpose and Scope of First-Party Medical Payments Coverage.

The Respondent openly admits in her Brief that she is seeking a double recovery[2], but nonetheless suggests that her requested windfall is permitted under the policy. The Respondent's argument, as adopted in the Circuit Court's Order, belies the spirit and purpose behind medical payments coverage which is to protect the insured from *having to pay out-of-pocket medical expenses,*[3]

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[1] The Respondent correctly points out in her Brief that the title of the Petitioner's first assignment mistakenly states Medicare, instead of Medicaid, however, it is clearly a scrivener's error since the remainder of the Petitioner's Brief clearly discusses Medicaid.

[2] See Respondent's Brief, p. 28 ("Auto Club's . . . policy contained no specific limitation or offset language on which it may reasonably rely, thereby permitting double recovery through the plain policy language.").

[3] *See, e.g., Am. Family Ins. Grp. v. Cleveland*, 356 Ill. App. 3d 945, 949–950, 827 N.E.2d 490, 494 (Ill. App. Ct. 2005) (characterizing a "medical payments provision in an automobile liability policy" as a "special provision," advising that its "purpose . . . is to provide prompt and adequate medical care when injury is incurred," and stating that such provision "is similar to a health insurance policy covering the injured person"); *Schmalfeldt v. N. Pointe Ins. Co.*, 252 Mich. App. 556, 564, 652 N.W.2d 683, 687 (Mich. Ct. App. 2002) (providing that "the purpose of the [medical payments] provision in the instant case is essentially to 'shield the insured' from having eventually to pay out-of-pocket expenses"); *McCauley v. Farmers Ins. Co.*, No. CJ-2006-680, 2009 WL 2494755, at ¶ 10 (Okla. Dist. Ct. July 30, 2009) ("[T]he purpose of the medpay insurance contracts at issue is to pay an insured's reasonable medical expenses to protect the insured from sustaining any out-of-pocket expenses.").

not to provide a double recovery windfall as sought by the Respondent. As aptly noted by the Respondent, this Court's opinion in *Ferrell* previously acknowledged that the purpose of medical payments is to prevent out-of-pocket expenses paid directly by the insured, holding that "[medical payments coverage] permits the insured to gain speedy *reimbursement for medical expenses* incurred as a result of a collision without regard to the insured's fault."[4] Here, there is nothing for which to *reimburse* Respondent. She paid nothing, she owes nothing, and Medicaid - which adjusted and then satisfied the Rankin invoice -- *was fully reimbursed by Auto Club.*

Contrary to the incorrect factual recitation of the Respondent, Auto Club has, in fact, waived subrogation against the third-party tortfeasor for medical coverage payments made on behalf of the Respondent. It is undisputed that Auto Club had a contractual right of subrogation for the medical payment coverage paid out on behalf of Respondent.[5] It likewise cannot be disputed that the Respondent was made whole through her settlement with the tortfeasor wherein she settled on for $60,000.00 out of the available $100,000.00 liability limits.[6] It has been over four years since the motor vehicle accident occurred, and Auto Club has not sought subrogation against the tortfeasor or the Respondent's liability settlement.[7] In fact, it is uncontroverted that at no time

[4] *Ferrell v. Nationwide Mut. Ins. Co.*, 217 W. Va. 243, 249, 617 S.E.2d 790, 796 (2005).

[5] *Roberts v. State Farm Mut. Auto. Ins. Co.*, No. 13-0743, 2014 WL 2404314, at *5 (W. Va. May 30, 2014) (memorandum) ("[I]t is undisputed that State Farm had a contractual right of subrogation to recover medical payments made under petitioner's policy. It is further undisputed that this right was subject only to petitioner's right to be made whole).

[6] [App. 0002-012, ¶¶ 3, 4; App. 013-028, ¶¶ 3, 4]; *Roberts v. State Farm Mut. Auto. Ins. Co.*, No. 13-0743, 2014 WL 2404314, at *5 (W. Va. May 30, 2014) (memorandum) (noting that where "Petitioner voluntarily entered into a settlement whereby she was paid $50,000.00, the limits of liability under the Allstate policy, plus $10,000.00 from the State Farm policy of the driver (Alderson), which had limits of liability of $100,000.00. Under the limited facts of this case, we agree with the circuit court that "no reasonable fact-finder could find [Petitioner] was not made whole.").

[7] *Application; Generally—Subrogated Claims*, 17 COUCH ON INS. § 236:8 ("Since the insurer's claim by subrogation is derivative from that of the insured, it is subject to the same statute of limitations as though

did Auto Club seek to recoup through subrogation the medical payments coverage paid out on behalf of the Respondent - despite Auto Club's contractual right to do so. Nonetheless, the Respondent continues to pursue Auto Club for additional medical payments coverage - even though she never paid anything, she owes nothing, and Auto Club did not exercise its contractual right of subrogation which would have likely reduced her liability settlement.

The fallacy of the Respondent's position that she is entitled to a double recovery or windfall is further illuminated by the Respondent's admission that she "held back a sum sufficient to satisfy Auto Club's subrogation claim when [she] settled her third-party claim."[8] The Respondent's action in holding back tortfeasor settlement monies *to reimburse Auto Club* for its subrogation claim is a direct contradiction to the Respondent's argument that medical payments coverage may permissibly provide a windfall or double recovery to the first-party insured.

A thorough reading of the Montana Supreme Court case, *Winter,*[9] relied upon by Respondent reveals the case is distinguishable from the facts of this case and has no application herein. In the *Winter* opinion, there is no evidence that State Farm ever reimbursed the insured's private health carrier, Blue Cross Blue Shield, for the medical expenses that it paid on behalf of the insured. Rather, State Farm issued payment for $25.02 of the nearly $8,000.00 of medical expenses that were previously paid by Blue Cross Blue Shield and for which the *Winter* court noted

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the cause of action were sued upon by the insured ... In other words, the statute of limitations begins to run from the date of the occurrence creating the insurer's liability rather than the date of the accrual of the insurer's claim by way of subrogation, unless otherwise provided by statute. Furthermore, the insurer's subsequent subrogation to the rights of the insured does not extend the period within which suit can be brought."); *see also Roberts v. State Farm Mut. Auto. Ins. Co.*, No. 13-0743, 2014 WL 2404314, at *5 (W. Va. May 30, 2014) (memorandum) (noting that State Farm had two years from date of accident to submit medical payment subrogation claim to inter-company arbitration approximately).

[8] Respondent's Brief, p. 5.

[9] *Winter v. State Farm Mut. Auto. Ins. Co.*, 375 Mont. 351, 328 P.3d 665 (2014).

that the insured paid a significant yearly premium. Here, Medicaid paid the Respondent's Rankin Invoice, and Auto Club then reimbursed Medicaid. Nonetheless, the Respondent now wants Auto Club to also pay her additional medical payments coverage (i.e., a double recovery) even though she paid nothing, legally owes nothing, and was otherwise made whole through her liability settlement. The nature and scope of first-party medical payment coverage was intended only to reimburse the respondent for out-of-pocket medical expenses incurred as a result of the accident, not to provide an insured a windfall double recovery.

2. The Circuit Court Erred in Concluding that the Respondent "Incurred" Expenses for Medical Services Under the Medical Payment Coverage Provision of the Policy.

The Respondent spends unnecessary time briefing the law of policy interpretation and arguing that the Respondent qualifies as a first-party insured under the Auto Club policy. That issue is not in dispute. Neither is it disputed that the medical payments coverage at issue is primary *as it relates to out-of-pocket payments for medical expenses*. The Respondent's understanding and position pertaining of this kind of primary coverage is flawed. Medical payments coverage is not, as Respondent suggests, primary in the sense that it compensates an insured above and beyond the out-of-pocket medical expenses sustained because of a covered loss. As noted, *supra*, this Court has previously acknowledged that the intended purpose of medical payments coverage is for the "insured to gain speedy *reimbursement* for medical expenses incurred as a result of a collision . . ."[10] An insured never needs to be *reimbursed* for amounts that have been written off by the provider, previously paid directly to the provider, or previously paid directly to Medicaid on the insured's behalf. To find otherwise, would treat medical payments coverage as no different than

[10] *See Ferrell v. Nationwide Mut. Ins. Co.*, *supra* at 249, 617 S.E.2d at 796.

liability or underinsured motorist coverage.

For this reason, the Respondent's reliance on the "Other Insurance" provision in the policy, likewise does not support the Respondent's position that she is entitled a windfall reimbursement of medical expenses she never paid or owed. As noted by some scholars, the "'Other Insurance' clause is another vehicle used to limit coverage 'when multiple policies potentially provide coverage for the same loss.'"[11] In other words, the "Other Insurance" provision "control[s] the priority of coverage."[12] Here, the "Other Insurance" provision is not applicable, nor did Auto Club contend that it was applicable, because the Respondent was not driving a non-owned vehicle to which other layers of potential automobile insurance may have attached.

There are also no facts in this case that suggest Auto Club ever viewed the medical payments coverage as excess. Auto Club did not wait until all other applicable coverage was exhausted prior to issuing medical payments benefits to satisfy the Medicaid lien.[13] Nor did Auto Club suggest that it owed only a pro rata share in comparison to other applicable insurance, such as Medicaid. Rather, Auto Club *fully* reimbursed Medicaid after Medicaid had adjusted and

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[11] § 9:10. *Other insurance clauses*, 1 PRACTICAL TOOLS FOR HANDLING INSURANCE CASES § 9:10 (internal citations omitted).

[12] *Id.*

[13] *See, e.g.*, *Horace Mann Ins. Co. v. Gen. Star Nat'l Ins. Co.*, 514 F.3d 327, 329 (4th Cir. 2008) ("Excess liability policies . . . do not provide first-dollar coverage for insured losses, but instead provide an additional layer of coverage for losses that exceed the limits of a primary liability policy. Coverage under an excess policy thus is triggered when the liability limits of the underlying primary insurance policy have been exhausted."); *Gauze v. Reed*, 219 W. Va. 381, 387, 633 S.E.2d 326, 332 (2006) ("[E]xcess coverage generally is not triggered until the underlying primary limits are exhausted by way of judgment or settlements . . . ." (internal quotation and citation omitted)).

satisfied the Rankin invoice, reducing it to a zero-balance owed – all without the Respondent ever making any out-of-pocket payments.

At issue, is the use of the word "incur" in the medical payments coverage provision of the policy and the Respondent's attempt to shoehorn a meaning of the word as discussed in the context of a collateral source analysis.

The medical payments provision provides in relevant part that "Subject to the Definitions, Exclusions, Conditions and Limits of Liability of this policy, ***we*** will pay reasonable ***medical expenses*** incurred for necessary medical and funeral services because of ***bodily injury*** . . ."[14] The Respondent and Auto Club apparently agree that because the word "incurred" is not defined in the policy, it must be given its plain and ordinary meaning.[15] The Respondent and Auto Club further agree that the plain meaning of the word "incur" as found in the most recent edition of Black's Law Dictionary is "[t]o suffer or bring on oneself (a liability or expense)."[16]

Here, at the time the Respondent presented her claim to Auto Club for payment of the Rankin invoice, no liability or expense to the Respondent existed. In fact, the Respondent sent Auto Club the Rankin invoice reflecting zero balance owed and nevertheless demanded that payment be issued directly to the Respondent.[17]

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[14] [App. 0067] (emphasis in original).

[15] *See* Syl. pt. 1, *Soliva v. Shand, Morahan & Co.*, 176 W. Va. 430, 345 S.E.2d 33 (1986), *rejected on other grounds by Nat'l Mut. Ins. Co. v. McMahon & Sons, Inc.*, 177 W. Va. 734, 356 S.E.2d 488 (1987); *see also Cherrington v. Erie Ins. Prop. and Cas. Co.*, 231 W.Va. 470, 491, 745 S.E.2d 508, 529 (2013) (internal quotation and citation omitted); Syl. pt. 1, *Christopher v. U.S. Life Ins. Co.*, 145 W. Va. 707, 116 S.E.2d 864 (1960).

[16] "Incur," BLACK'S LAW DICTIONARY 15c (11th ed. 2019).

[17] [App. 0083-85].

There were no medical expenses incurred by the Respondent for which Respondent was entitled to reimbursement under the medical payments coverage provision. The Rankin invoice had been immediately adjusted and paid by Medicaid, and Medicaid was, in turn, reimbursed by Auto Club under the medical payments coverage. The Rankin invoice was reduced to zero dollars due and owing. As such, the Respondent had no liability or expense, the medical expenses having previously been paid by Auto Club.

The cases relied upon by the Respondent are all easily distinguishable. None of the cases have facts akin to this case wherein the insured's bill was adjusted and paid by Medicaid - bringing the total balanced due to zero - after which the automobile carrier issued medical payments coverage directly to Medicaid as full reimbursement.

In *Stout*, the Minnesota Supreme Court's holding was based entirely on the court's interpretation of the Minnesota No-Fault Automobile Insurance Act, Minn. Stat. §§ 65B.41-.71 (2000), which legislatively defined loss as "'economic detriment resulting from the accident causing the injury consisting only of,' among other things, 'medical expense,'" and further explained that " '[l]oss accrues not when injury occurs, but as ... medical ... expense is *incurred*.' ".[18] West Virginia has no legislation specially defining any of the policy provisions at issue, as relied upon by the Minnesota Supreme Court in rendering the decision in *Stout*.

In *Holmes*, the court addressed a situation wherein the insured assigned her Medicare benefits to the hospital. There is nothing in the opinion to indicate that the automobile carrier reimbursed Medicare for the expenses it paid out on behalf of the insured.[19]

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[18] *Stout v. AMCO Ins. Co.,* 645 N.W.2d 108, 108, 112 (Minn. 2002).

[19] *Holmes v. California State Auto. Ass'n*, 185 Cal. Rptr. 521, 135 Cal.App.3d 635 (1982).

The *Hollister* case did not involve a medical payments provision coverage, but rather a suit by a United States serviceman against his medical and hospitalization insurer.[20]

In *Samsel*, the insured's HMO paid all of the medical expenses, except for approximately $300 dollars. The carrier paid the remaining balance, but refused to pay any more, because the other carrier had been obligated to, and did, pay the expenses. Again, there is nothing in the opinion to indicate that the carrier reimbursed the HMO.[21]

Unlike the cases relied upon by the Respondent, Auto Club adjusted and paid the Rankin invoice in this case, bringing the balance owed to zero. Auto Club then fully reimbursed Medicaid for the amounts that it paid on behalf of the insured, and thereafter, did not pursue its contractual right of subrogation.

In sum, the Medicaid write-offs were not "incurred" by the Respondent, and therefore did not require reimbursement to the Respondent.[22] The Circuit Court's holding that the Respondent "incurred" medical expenses based on an invoice submitted by Respondent to Auto Club for payment that reflected on its face *zero balance owed*, and based on an invoice of which no portion was ever paid by Respondent is counterintuitive.[23]

The Respondent was not charged for any of the medical services itemized on the Rankin invoice.[24] Those medical expenses were either written off as a result of the Respondent's Medicaid

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[20] *Hollister v. Government Employees Ins. Co.*, 192 Neb. 687, 224 N.W.2d 164 (1974).

[21] *Samsel v. Allstate Ins. Co.*, 204 Ariz.1, 59 P.3d 281 (2002).

[22] *See State Farm Mut. Auto. Insur. Co. v. Bowers*, 255 Va. 581, 585-86, 500 S.E.2d 212, 214 (1998) (holding that an insured could never be "legally obligated to pay," and, therefore, could never "incur" amounts written off by healthcare providers).

[23] [App. 0083-85] (Rankin Invoice submitted to Auto Club by Respondent for payment, reflecting zero balance due and owing).

[24] *See id.*

enrollment, or paid by Medicaid, and Medicaid was subsequently directly reimbursed by Auto Club. It is not reasonable to conclude that this provision within the medical payments portion of the policy provides benefits for medical expenses for which the insured will never pay. The Respondent, therefore, by the word's plain and ordinary meaning, did not personally "incur" any medical expenses as applicable to triggering payment under the medical payments coverage benefits.

3. The Circuit Court Erred in Relying Upon this Court's Opinion in *Kenney v. Liston* to Interpret the Word "Incurred" Because it is a "Collateral Source" Case, not a Contract Case, and Medicaid, for Which a Beneficiary Pays No Premiums, is Therefore Not a "Collateral Source."

The Respondent noticeably glosses over the Circuit Court's clear error in basing its holding on *Kenny v. Liston*. *Kenney*, which stands for the proposition that the collateral source rule operates to "exclude[ ] payments from other sources to plaintiffs from being used to reduce damage awards imposed upon culpable defendants," is simply not applicable to this case.[25] Even the Circuit Court recognized the stark difference between *Kenny* and this first party medical payments case during the hearing held on June 8, 2020, when he noted "I actually even thought about certified questions to see if that *Kenny* case actually cross-applied over to this matter."[26] *Kenny* does not, and should not, cross-apply to this case.

Kenny involved a third-party tortfeasor attempting to diminish the amount of medical bills the plaintiff would be permitted to "board" or otherwise seek at trial in association with the plaintiff's third-party liability claim.[27] This Court held that "the collateral source rule permits the

[25] *See* Syl. Pt. 1, 233 W. Va. 620, 760 S.E.2d 434 (2014) (internal quotation and citation omitted).

[26] [App. 0472, lines 11-13].

[27] *See* 233 W. Va. at 624–32, 760 S.E.2d at 438–46.

[injured] person to recover the entire reasonable value of the medical services necessarily required by the injury. The tortfeasor is not entitled to receive the benefit of the reduced, discounted or written-off amount."[28] The collateral source rule, which operates to "exclude[ ] payments from other sources to plaintiffs from being used to reduce damage awards imposed upon culpable defendants," is simply not in issue.[29] The holding in *Kenny* was therefore limited to a third party collateral rule context, and at no time did this Court define the word "incur", let alone hold that a first-party claimant may recover a windfall of medical payments coverage for medical bills she never paid, never owed, and will never be legally obligated to pay.

4. The Circuit Court Erred in Basing its Partial Summary Judgment Award to the Respondent on the Doctrine of Reasonable Expectations.

The Circuit Court erred in relying upon the doctrine of reasonable expectations to support its holding. Under West Virginia case law, a court should not resort to the doctrine of reasonable expectations unless the policy language, such as the medical payments provision here, is clear and unambiguous.[30] West Virginia law is clear that "[b]efore the doctrine of reasonable expectations is applicable to an insurance contract, there must be an ambiguity regarding the terms of that contract."[31] Here, no ambiguity exists. The Respondent did not incur medical expenses for which

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[28] *Id.* at Syl. pt. 7.

[29] *See Id.* at Syl. pt. 1 (emphasis added) (internal quotation and citation omitted).

[30] *Ferrell v. Brooks*, No. CIV.A. 5:05CV115, 2007 WL 2893000, at *7 (N.D. W. Va. Sept. 28, 2007) ("The transcript sections of Melissa Ferrell's deposition provided by the plaintiffs to support their claim of reasonable expectations neither assert nor imply that Hughes made any representations about auto medical payments coverage or underinsured motorists coverage that could have created a reasonable expectation by the plaintiffs that Arch's policy covered bodily injuries to the MRVFD firemen when they used their own vehicles to provide emergency services to the public.").

[31] *Erie Ins. Prop. & Cas. Co. v. Chaber*, 239 W. Va. 329, 336, 801 S.E.2d 207, 214 (2017).

she should have been directly reimbursed where the expenses were adjusted and reduced to a zero balance by Medicaid, and Auto Club then reimbursed Medicaid.

Even had the Circuit Court appropriately determined that an ambiguity existed, there was no basis upon which to conclude that the Respondent should have reasonably expected to pocket money as reimbursement for medical expenses she never paid.[32] The benefit due to the Respondent under the medical payments provision of the policy is that she be "permit[ted] . . . to gain speedy reimbursement for medical expenses incurred as a result of a collision without regard to the insured's fault."[33] As such, the medical payments coverage is primary as it relates to *out-of-pocket payments* for medical expenses. Medical payments coverage is not, as the Circuit Court held, primary in the sense that it compensates an insured above and beyond the out-of-pocket medical expenses sustained as a result of a covered loss.

5. The Circuit Court Erred in Holding that Auto Club Should Not Have Made Any Payments to Directly Reimburse Medicaid.

The Circuit Court clearly erred in concluding that Auto Club should not have made payments to Medicaid where a valid statutory medical lien existed requiring reimbursement of Medicaid pursuant to 42 U.S.C. § 1396a(a)(25)(H) and West Virginia Code § 9-5-11(b). The Circuit Court's holding in this regard clearly contravenes the statutory provisions designed to ensure reimbursement to Medicaid. The ruling further misinterprets the Auto Club policy which

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[32] *See id.* ("[T]he reasonable expectations doctrine is not a mandate for courts to rewrite insurance policies and reallocate their assignment of risks between insurer and insured.").

[33] *See State Farm Mut. Auto. Ins. Co. v. Schatken*, 230 W. Va. 201, 207, 737 S.E.2d 229, 235 (2012).

does not specify *to whom* Auto Club will issue payment.[34] The policy does not preclude payment to Medicaid (or providers) on the Respondent's behalf.

It is telling that the Respondent fails to even address the Medicaid statutory provisions in her Brief. That is because the federal and state Medicaid provisions clearly require insurance carriers to satisfy Medicaid liens/payments. Pursuant to 42 U.S.C. § 1396a(a)(25)(H) "to the extent that payment [was] made under the [Medicaid] plan for medical assistance for health care items or services furnished to [Plaintiff]," Medicaid "acquired the rights of [Plaintiff] to payment by any other party for such health care items or services."[35] West Virginia has a similar statutory provision.[36] There can be no question that upon Auto Club's notice of the Medicaid payments and liens, through its third-party administrator Equian - Auto Club had an obligation to comply with the Federal and State statutes requiring reimbursement to Medicaid.

The Respondent's argument that the ultimate settlement with the tortfeasor "could have" been less than $20,000.00, thereby invoking the exemption pursuant to W. Va. Code § 9-5-11(d)(4), is superfluous and an improper attempt to introduce evidence into the record that simply does not exist. The Respondent settled with the tortfeasor for $60,000.00 of the available $100,000.00 policy limits; no exemption applied. As such, the Circuit Court clearly erred in concluding that Auto Club was prohibited from issuing payment directly to Medicaid.

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[34] The policy merely states that Auto Club "will pay reasonable **medical expenses** incurred for necessary medical and funeral services because of **bodily injury**." *See* App. at P0067 (emphasis in original).

[35] 42 U.S.C. § 1396a(a)(25)(H).

[36] *See* W. Va. Code § 9-5-11(b).

6. The Circuit Court Erred in Rejecting the Opinions of Auto Club's Insurance Industry Standards Expert.

The Respondent's Brief fails to meet the substance of the assigned err relative to the Circuit Court's treatment of Auto Club's expert witness. Regardless of whether the Circuit Court "rejected" or "disregarded" Mr. Rudy Martin's expert affidavit, the practical effect is that the Circuit Court erred by improperly concluding that the affidavit was submitted to prove the meaning of the policy.[37] As set forth in Auto Club's Brief, Mr. Martin's affidavit and anticipated testimony were specifically confined to the appropriate parameters in full compliance with *Jackson v. State Farm Mutual Automobile Insurance Company*[38], including "the standards and practices for conducting good faith handling of a claim for medical payments coverage," the "duties of an insurance carrier relative to claims seeking medical payments coverage," "the purpose and rationale behind the medical payments coverage section provided in automobile insurance policies," and his opinion that "Auto Club's handling of Plaintiff's claim for medical payments coverage was conducted in adherence with insurance industry customs and practices."[39]

The opinions of Mr. Martin were, therefore, admissible and the Circuit Court erred in excluding the same from consideration.

[37] [App. 310-316, ¶ 15].

[38] 215 W. Va. 634, 600 S.E.2d 346 (2004).

[39] *See id.*

B. THE CIRCUIT COURT ERRED IN AWARDING ATTORNEY FEES IN THE AMOUNT OF $34,026.75 WHERE THE FEE AWARD INCLUDES (A) BLOCK BILLING ENTRIES, (B) DUPLICATIVE ENTRIES, (C) EXCESSIVE TIME, AND (D) AN ATTORNEY FEE AWARD ALMOST THIRTY TIMES THE COMPENSATORY DAMAGES AWARD.

The Circuit Court's abuse of discretion in the award of attorney fees is apparent on the Order where the fees awarded to counsel were *well over 25 times* the damages counsel obtained for their client. Respondent was awarded $1,342.09 in damages; her counsel was awarded $34,026.75 by the Circuit Court.[40]

The Respondent mistakenly argues that the amount of the fee award was justified because Auto Club itself "hired multiple lawyers from two (2) of the best law firms in the entire State."[41] In fact, a review of the underlying pleadings clearly demonstrates that at the Circuit Court level, there was a single associate level attorney and of counsel attorney – both from the same law firm – who worked on this case.

At issue is the Circuit Court's complete failure to thoroughly address the specific objections and examples of unreasonableness raised by Auto Club in response to the request for attorney fees, and as set forth in the Petitioner's Brief. Instead, the Circuit Court's Order primarily focused on the law and *Pitrolo* factors, and then summarily glossed over Auto Club's objections to multiple factors of the *Pitrolo* case, including, but not limited to the "time and labor" alleged to have been involved and "the amount involved and results obtained." An award of said amount in a case wherein there was not a single deposition taken, limited written discovery procured, and resolution upon cross-motions for summary judgment is on its face an abuse of discretion because

[40] [App. 354-355; P456].

[41] Respondent's Brief, p. 35.

the Circuit Court clearly did not properly analyze the time and labor, nor the amount involved. The attorney fee award is simply unsupported by the record and should be reversed.

III. CONCLUSION

WHEREFORE, the Petitioner, Auto Club Property and Casualty Insurance Company, respectfully requests that this Court reverse the Order of the Circuit Court of Berkeley County entering judgment in favor of the Respondent, Jessica Moser, and remand with directions to enter judgment for Auto Club Property and Casualty Insurance Company.

AUTO CLUB PROPERTY CASUALTY INSURANCE COMPANY

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CERTIFICATE OF SERVICE

I certify that on March 8, 2021, I served the foregoing "REPLY BRIEF OF THE PETITIONER" on Respondent's counsel by having a true copy thereof deposited in the United States mail, postage prepaid, as follows:

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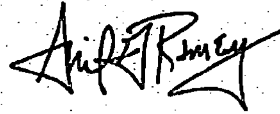

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