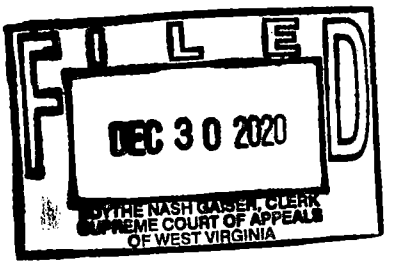
IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

No. 20-0792

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

BRIEF OF THE PETITIONER

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2. 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.

II. STATEMENT OF THE CASE

This is an appeal from an order entered by the Honorable Michael Lorensen, Judge of the Circuit Court of Berkeley County ("Circuit Court") on September 4, 2020, ordering the Petitioner, Auto Club Property & Casualty Insurance Company ("Petitioner" or "Auto Club"), to issue to the Respondent, Jessica A. Moser ("Respondent"), medical payments coverage in the amount of $1,342.09, as well as attorney fees and costs in the amount of $34,026.75 ("Order").[1]

This Order followed a June 5, 2020, Order awarding partial summary judgment to the Respondent on Counts I and II of her Complaint for declaratory judgment and breach of contract, respectively ("SJ Order")[2] and another Order also dated September 4, 2020, granting Respondent's Motion for Award of Reasonable Attorney Fees ("Attorney Fee Award").[3]

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[1] [App. at P001].

[2] [App. at P310-P316].

[3] [App. at P443-P455]. Both the Attorney Fee Award and SJ Order were incorporated into the Order which also included Rule 54 language indicating that there is no just reason for delay. It is from these rulings that the Petitioner now appeals.

The underlying case arose out of a two-car motor vehicle accident, which occurred on October 17, 2017, and involved the Respondent who, at the time of the accident, was an insured driver under an automobile policy issued by Auto Club to Joshua Jandreau.[4] The driver of the other vehicle, Jennifer Weaver, was determined to be at fault and had available liability insurance to compensate Respondent for her damages.[5]

Pursuant to the Auto Club policy, the Respondent had medical payments coverage with an available limit of five thousand dollars ($5,000.00). As such, a first-party medical payments claim was opened by Auto Club while the Respondent pursued her liability claim against the at-fault tortfeasor. At all relevant times during the Respondent's post-accident medical treatment, Respondent was a Medicaid recipient.[6]

After paying at least one bill directly to a provider, by letter dated February 22, 2018, the Petitioner received a demand for reimbursement of a Medicaid lien in the amount of $505.61 paid by Medicaid for physical therapy services rendered to the Respondent for the period of October 17, 2017, through January 29, 2018.[7] Auto Club directly reimbursed Medicaid under the available medical payments coverage, and subsequently reimbursed Medicaid an additional amount of $932.00 for subsequent physical therapy services provided to the Respondent by Rankin Physical Therapy.[8]

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[4] [App. at P002-P012, ¶¶ 3, 4; App. at P013-P028, ¶¶ 3, 4.]

[5] *See id.*

[6] [App. at P215].

[7] [App. at P222-P223].

[8] [App. at P225-P226].

On April 27, 2018, the Respondent, through counsel, requested that Auto Club issue medical payments policy proceeds directly to the Respondent in the amount of $2,165.00, which was the original invoice from Rankin Physical Therapy for services rendered to Respondent.[9] At that time, however, a portion of the Rankin Invoice had been written off in light of the Respondent's enrollment in Medicaid, and the remaining balance was reimbursed by Auto Club.[10]

Because the invoice showed that no balance was owed to the healthcare provider by the Respondent, Auto Club declined to issue medical payments benefits directly to the Respondent for the already-satisfied Rankin invoice:

> Based on the documents submitted, our investigation finds no medical expenses have been incurred by your client as the bills submitted were paid by Medicaid and Auto Club Property-Casualty Insurance Company subsequently reimbursed Medica*Id.* Additionally, the bills you submitted indicate that no balance is owed. Therefore, we must deny your client's request for reimbursement of the medical bills submitted on April 27, 2018.[11]

Dissatisfied at not being paid $2,165.00 *to whom she owed no one*, the Respondent filed her Complaint against Auto Club on May 30, 2019, seeking declaratory judgment regarding the applicability of her automobile insurance policy with Auto Club (Count I), and asserting claims of breach of contract (Count II), bad faith (Count III), and an alleged violation of the West Virginia Unfair Trade Practices Act ("UTPA") (Count IV).[12]

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[9] [App. at P235-P237].

[10] [App. at P222-P228].

[11] [App. at P230-P231].

[12] [App. at P002-P012].

As of the date of filing her Complaint on May 30, 2019, the Respondent was never charged for, and never paid, *any medical expenses related to the Rankin Invoice.*[13] Instead, the Respondent sought to "pocket" the difference between the original Rankin Invoice and the amount accepted by Rankin *as payment in full from MedicaId.* In sum, the Respondent sued claiming she was entitled to a windfall of $2,165.00 pursuant to the medical payments provisions of the Auto Club policy.

On October 23, 2019, the Respondent entered a settlement agreement with the liability carrier for the at-fault driver totaling $60,000.00 of the available $100,000 liability limits.[14] In light of the settlement proceeds received by the Respondent from her settlement with the tortfeasor, Medicaid asserted a subsequent, additional lien in the amount of $1,547.29.[15] Medicaid/Aetna[16] agreed to accept $1,078.69 as full and final payment of the additional lien which "was paid . . . out of [Respondent's] bodily injury settlement proceeds" with the liability carrier.[17] Notably, Auto Club consented to the liability carrier and agreed to waive its right of subrogation for the medical payments coverage issued on behalf of the Respondent.[18] Nonetheless, the Respondent continued to pursue additional medical payments coverage from Auto Club.

This case involved limited discovery and although the Respondent carried the burden of proof, she designated no expert witnesses. Auto Club identified expert witness Rudy Martin as an

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[13] [App. at 236-237; *see also* App. P230-P231 (advising that "the bills submitted [by Respondent] were paid by Medicaid and Auto Club Property-Casualty Insurance Company subsequently reimbursed Medicaid" and that "the bills [Respondent] submitted indicate that no balance is owed")].

[14] [App. at P239].

[15] [App. at P241-P245].

[16] Aetna Better Health of West Virginia, a Medicaid Plan, retained the services of Equian to represent Aetna in connection with its rights of subrogation and recovery regarding medical claims paid on behalf of Plaintiff. [App. at P222-223].

[17] [App. at P213-P217].

[18] [App. at P239].

expert witness.[19] Thereafter, the Respondent filed a motion in limine to strike Mr. Martin as an expert witness,[20] which motion was fully briefed but never ruled upon by the Circuit Court before the submission of the parties' cross-motions for summary judgment.

On March 13, 2020, the Respondent moved for partial summary judgment on Counts I and II of the Complaint for declaratory judgment and breach of contract, respectively.[21] On March 27, 2020, Auto Club timely moved for summary judgment on all counts in the Complaint.[22] The respective cross-motions for summary judgment were fully briefed by all parties and oral argument was held on May 13, 2020.[23]

In its Order entered June 5, 2020, the Circuit Court granted partial summary judgment in favor of the Respondent on Counts I and II of the Complaint for declaratory judgment and breach of contract, respectively, and denied the Petitioner's cross-motion for summary judgment.[24]

The Circuit Court ordered Auto Club to issue medical payments coverage to the Respondent in the amount of the $2,165.00 Rankin Invoice, less any amounts Auto Club could show that it had actually paid on the specific invoice.[25] The Order also invited the Respondent to submit a motion for attorney fees and invited the Petitioner to request Rule 54(b) language so that the Order could be reviewed before resolution of the remaining counts in the Complaint.[26]

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[19] [App. at P029-038].

[20] [App. at P039-P041].

[21] [App. at P042-P091].

[22] [App. at P092-P183].

[23] [App. at P308].

[24] [App. at P310-P316].

[25] *See id.*

[26] *See id.*

On July 7, 2020, an Agreed Order Granting Defendant Auto Club's Motion for Credit for Rankin Invoice Payments was entered, concluding that Auto Club was entitled to a credit of $822.91 to be applied to the Rankin Invoice, thereby reducing the amount to be paid by Auto Club to the Respondent to $1,342.09.[27]

Thereafter, the parties fully briefed the Respondent's motion for attorney fees, and on September 4, 2020, the Circuit Court entered its Attorney Fee Award, granting judgment to the Respondent and ordering Auto Club to pay the Respondent attorney fees and costs in the amount of $34,026.75 or almost thirty times the compensatory damages award.[28]

Also, on September 4, 2020, the Circuit Court entered its Judgment, incorporating the prior SJ and Attorney Fees Orders, and directing Auto Club to pay the Respondent the sum of $1,342.09 plus attorney fees and costs in the amount of $34,026.75 ("Circuit Court Order").[29]

III. SUMMARY OF ARGUMENT

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.

[27] [App. at P354-P355].

[28] [App. at P443-P455].

[29] [App. at P456]. The Order included Rule 54 language and concluded that there was no just reason for delay.

The Circuit Court also 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.

IV. STATEMENT REGARDING ORAL ARGUMENT AND DECISION

This case is appropriate for Rule 20 argument as one presenting issues of first impression.[30]

V. ARGUMENT

A. STANDARD OF REVIEW

Because the Circuit Court should have denied partial summary judgment to the Respondent as a matter of law, and granted summary judgment in favor of the Respondent, the appropriate standard of review in this case relative to those issues is *de novo*.[31]

Similarly, the legal issue of whether a first-party insured can pocket medical payments coverage in excess of the amount actually due and owing – particularly when the insured has settled with the tortfeasor for less than the available liability limits -- is subject to *de novo* review.[32]

Finally, review of the circuit court's decision to award attorney fees is for an abuse of discretion.[33]

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[30] R.A.P. 20(a)(1).

[31] Syl. pt. 1, *Findley v. State Farm Mutual Automobile Insurance Co.*, 213 W. Va. 80, 576 S.E.2d 807 (2002) ("This Court reviews de novo the denial of a motion for summary judgment, where such a ruling is properly reviewable by this Court.").

[32] Syl. pt. 1, *Chrystal R.M. v. Charlie A.L.*, 194 W. Va. 138, 459 S.E.2d 415 (1995) ("Where the issue on an appeal from the circuit court is clearly a question of law or involving an interpretation of a statute, we apply a *de novo* standard of review."); see also *Riggs v. West Virginia University Hospitals, Inc.*, 221 W. Va. 646, 653, 656 S.E.2d 91, 98 (2007) ("As the issue raised directly challenges the trial court's application of the MPLA's non-economic damages cap to the jury verdict, our review is *de novo*.").

[33] *Karpacs-Brown v. Murthy*, 224 W. Va. 516, 526, 686 S.E.2d 746, 756 (2009).

B. 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 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.

The Circuit Court erred in holding that the Respondent is entitled to pocket medical payments coverage for medical expenses that were paid by other entities, and for which she will never make any out-of-pocket payments, particularly where the Respondent accepted a liability settlement from the tortfeasor[34] well below the available liability limits, and Auto Club did not pursue its right of subrogation to recoup the medical payments benefits expended on behalf of the Respondent. In so holding, the Circuit Court's ruling thwarts the purpose of medical payments coverage, improperly relied upon this Court's holding in *Kenney v. Liston*,[35] and impermissibly expands the manner in which medical payments coverage is pa*Id.*

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

The medical payments coverage at issue in the underlying case has a policy limit of $5,000.00.[36] At issue were the Respondent's attempts to directly recover under her medical payments coverage the difference between the original Rankin Invoice in the amount of $2,165.00, and the amount paid by Medicaid and accepted by Rankin as payment in full. In awarding partial summary judgment to the Respondent on Counts I and Counts II of the Complaint, the Circuit Court conflated first- and third-party coverages.

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[34] [App. at P239].

[35] 167 W. Va. 779, 280 S.E.2nd 584 (1991).

[36] [App. at P002-012, ¶ 13; App. at P013-P028, ¶ 13].

West Virginia law is clear that medical payments coverage "is not an additional layer of underinsured coverage," but rather "serves a distinctly different purpose" by "permit[ting] the insured to gain speedy reimbursement for medical expenses incurred as a result of a collision without regard to the insured's fault."[37] In fact, the very purpose of medical payments coverage is to protect the insured from *having to pay out-of-pocket medical expenses.*[38]

This is precisely why medical payments coverage has been characterized as "special provision," of which its "purpose . . . is to provide prompt and adequate medical care when injury is incurred," . . . "similar to a health insurance policy covering the injured person."[39] Medical payments coverage has been described as a shield for a first-party insured, in that its "purpose . . . is essentially to 'shield the insured' from having eventually to pay out-of-pocket expenses."[40]

For example, in *Newbury v. State Farm Fire & Casualty Insurance Co.*,[41] the Supreme Court of Montana held that the insured was not entitled to medical payment benefits in excess of his medical expenses. Specifically, the court provided that the insured's expectations under the policy "were not objectively reasonable" because "while it was reasonable for [the insured] to expect that his [insurance] policies would pay his medical expenses . . . once the State Fund had paid all it was

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[37] *State Farm Mut. Auto. Ins. Co. v. Schatken*, 230 W. Va. 201, 207, 737 S.E.2d 229, 235 (2012) (internal quotation omitted) (quoting *Ferrell v. Nationwide Mut. Ins. Co.*, 217 W. Va. 243, 249, 617 S.E.2d 790, 796 (2005)).

[38] *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).

[39] *Id.*

[40] *Schmalfeldt v. N. Pointe Ins. Co.*, 252 Mich. App. 556, 564, 652 N.W.2d 683, 687 (Mich. Ct. App. 2002); *see also 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.").

[41] 343 Mont. 279, 287–90, 184 P.3d 1021, 1027–28 (2008).

required to pay, it was not reasonable for [the insured] to expect to receive funds *in excess* of his medical expenses."[42] The court concluded, "What [the insured] paid valuable consideration for in this case was to have his medical expenses paid and it is undisputed that his medical expenses were pa*Id.* To allow [the insured] to receive in excess of the total amount of his medical expenses would result in a windfall to [him]."[43]

Like the insured in *Newbury*, it is indisputable that the Respondent's medical expenses were paid such that *there was a zero balance due and owing.* The Rankin Invoice was paid adjusted and by Medicaid, and Medicaid was subsequently reimbursed by Auto Club.[44] Because her medical bills were paid, the Respondent received the benefit due under the medical payments provision of the policy. Just as the *Newbury* court explained, "[t]o allow [the insured] to receive in excess of the total amount of [her] medical expenses would result in a windfall."

Accordingly, because the Respondent's medical expenses were paid,and she thus received the benefit for which she contracted under the policy, the Circuit Court erred in holding that the Respondent was entitled to pocket the difference between the original Rankin Invoice and the amount accepted by the provider as payment in full from Medicaid.

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 Circuit Court's SJ Order concluding that the Respondent "incurred" medical expenses in an amount equal to the difference between the original Rankin Invoice and the amount

[42] *Id.* at 289-90, 184 P.3d at 1028 (emphasis added).

[43] *Id.* at 290, 184 P.3d at 1029.

[44] [App. at P228-P231].

paid by Medicaid thereby reducing the Ranking Invoice to reflect a *zero balance owed* - and of which no portion was ever paid by the Respondent - was counterintuitive and plainly in error.

The relevant portion of the policy provides:

> 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***:
>
> 1. caused by an accident; and
>
> 2. sustained by an ***insured person***.
>
> We will pay only those ***medical expenses*** necessary for services furnished within 3 years from the date of accident. ***We*** may request mental and physical exams to determine whether ***medical expenses*** incurred are reasonable or medical treatment is necessary.[45]

The word "incurred" is not defined in the policy; accordingly, it must "be given its plain, ordinary meaning."[46] As this Court has previously held, "[w]here the provisions of an insurance policy contract are clear and unambiguous they are not subject to judicial construction or interpretation, but full effect will be given to the plain meaning intended."[47] In contrast, terms in an insurance policy should not be interpreted "in a strained or philosophical sense."[48]

In Paragraph 28 of the Complaint, it was alleged that "incurred" is defined in BLACK'S LAW DICTIONARY as "[t]o become liable or subject to."[49] Although similar, the definition of "incur" provided in the most current edition of BLACK'S LAW DICTIONARY is "[t]o suffer or bring

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[45] [App. at P164 (emphasis in original)].

[46] *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).

[47] Syl. pt. 1, *Christopher v. U.S. Life Ins. Co.*, 145 W. Va. 707, 116 S.E.2d 864 (1960).

[48] *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).

[49] [App. P002-P012, ¶ 28].

on oneself (a liability or expense)."[50] Regardless of which definition is considered, the Rankin Invoice produced by the Respondent in her demand to directly pocket medical payments coverage reflected medical expenses that were either written off as a result of Respondent's Medicaid enrollment, or paid by Medicaid, and Medicaid was subsequently directly reimbursed by Auto Club[51] and therefore, not "incurred" by the Respondent.

In *Atkins v. Great Am. Ins. Co.*,[52] the court addressed the issue of what constitutes "incurred" within the meaning of the medical payments provision of an automobile liability policy. In *Atkins*, the insured sought medical payments coverage for dental services not yet performed but anticipated. Rejecting the insured's argument for coverage, the court noted:

> "As used in the policy in suit the word 'incurred' emphasizes the idea of liability and the definition of 'incur' is: 'To have liabilities (or a liability) thrust upon one by act or operation of law'; a thing for which there exists no obligation to pay, either express or implied, cannot in law constitute an 'incurred expense'; a debt or expense has been incurred only when liability attaches. ..."[53]

Because no healthcare services had been performed for which the policyholder had "incurred" an "obligation to pay," the court held she was not entitled to medical payments coverage.[54] Similarly, courts have held that where a policyholder ultimately has no liability to pay for medical services, the insured has not "incurred" medical expenses for purposes of medical payments coverage.

The court's decision in *Newbury v. State Farm Fire & Cas. Ins. Co.*,[55] is instructive.

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

[51] [App. at P130-P137].

[52] 15 N.C. App. 79, 189 S.E.2d 501 (1972).

[53] 15 N.C. App. at 83, 189 S.E.2d at 504 (citations omitted); see also *Virginia Farm Bureau Mut. Ins. Co. v. Hodges*, 238 Va. 692, 696, 385 S.E.2d 612, 614 (1989) ("[a]n expense can only be 'incurred' ... when one has paid it or become legally obligated to pay it.").

[54] *Id.*

[55] *Supra* Note 41.

In *Newbury*, the plaintiff was a snowplow driver who was injured while attempting to assist a driver stuck in a ditch.[56] The plaintiff filed a workers' compensation claim and the state fund paid all but $1,175 of his medical expenses.[57] The plaintiff submitted a claim to his automobile insurance provider, State Farm, requesting payment of the full $10,000 medical payment coverage limits.[58] As in this case, State Farm paid the remaining medical expenses of $1,175.[59] Nevertheless, as in this case, the plaintiff filed suit against State Farm, seeking additional payment under his medical payment coverage, *even though his medical bills had been fully paid.*[60]

Based on those circumstances, the *Newbury* court determined that "while it was reasonable for Newbury to expect that his State Farm policies would pay his medical expenses (up to the policy limits of $10,000.00) once the State Fund had paid all it was required to pay, it was not reasonable for Newbury to expect to receive funds in excess of his medical expenses."[61] The court noted that medical payment benefits are payable only for medical expenses, and the undisputed facts demonstrated that the plaintiff received full payment of his medical expenses and owed nothing more to his healthcare providers[62] and upheld State Farm's refusal to pay more than the medical expenses actually incurred because a windfall would result if the plaintiff were to receive additional money under his medical payments coverage in excess of his total medical expenses.[63]

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[56] 343 Mont. at 281, 184 P.3d at 1023.

[57] *Id.*

[58] *Id.*

[59] *Id.*

[60] *Id.* at 281-282, 184 P.3d at 1023-1024.

[61] *Id.* at 289, 184 P.3d at 1028.

[62] *Id.*

[63] *Id.* at 290, 184 P.3d at 1029.

Similarly, in *State Farm Mut. Auto. Ins. Co. v. Bowers*,[64] the insurer sued its policyholder after it mistakenly paid him for medical payments coverage he would never incur where, as in this case, he had no legal obligation to pay for the health services provided. Ruling in favor of the insurer, the court noted to do otherwise, as in this case, would constitute a "windfall" to the policyholder:

> The evidence in the instant case was that Bowers would never be liable for any amount greater than that which the various health-care providers accepted as full payment for their services based on the Blue Cross fee schedule. Stated differently, the health-care providers' agreements with Blue Cross prevented them from collecting more than the scheduled fee and any required co-payment. Therefore, we conclude that the medical expenses Bowers "incurred" were the amounts that the health-care providers accepted as full payment for their services rendered to him. Bowers has not paid nor is he "legally obligated to pay" the amounts written off by the providers. *Id.*; accord *Irby v. Gov't Employees Ins. Co.*, 175 So.2d 9, 10 (La. Ct. App.1965); *United Services Auto Ass'n v. Schlang*, 111 Nev. 486, 894 P.2d 967, 969 (1995); *Lefebvre v. Gov't Employees Ins. Co.*, 110 N.H. 23, 259 A.2d 133, 135 (1969); *Sanner v. Gov't Employees Ins. Co.*, 150 N.J. Super. 488, 376 A.2d 180, 182 (App.Div.1977); *Atkins v. Great Am. Ins. Co.*, 15 N.C. App. 79, 189 S.E.2d 501, 504 (1972). *To decide otherwise would be to grant Bowers a windfall because he would be receiving an amount greater than that which he would ever be legally obligated to pay.*[65]

In *Newbury*, the policyholder "incurred" no liability because the workers' compensation fund paid the medical expenses involved, and in *Bowers*, it was a health insurance provider,[66] but

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[64] 255 Va. 581, 500 S.E.2d 212 (1998).

[65] 255 Va. at 585-586, 500 S.E.2d at 214 (emphasis supplied and footnote omitted).

[66] *See also Lefebvre v. Gov't Emp. Ins. Co.*, 110 N.H. 23, 259 A.2d 133 (1969) (value of medical services rendered to wife of military serviceman at naval hospital, without charge to serviceman or wife, were not "expenses incurred" within medical payment coverage of serviceman's automobile policy); *Gordon v. Fld. & Cas. Co. of N.Y.*, 238 S.C. 438, 120 S.E.2d 509 (1961) (career soldier, who received free medical treatment in army hospital for injuries suffered while driving his insured motor scooter, did not "incur" expenses for his medical treatment within liability policy providing that insurer was to pay expenses incurred for medical services); *Irby v. Gov't Emp. Ins. Co.*, 175 So. 2d 9 (La. Ct. App. 1965) (insured, who was not charged for medical and hospital services he received as result of automobile accident and who, because of his status as member of United States Coast Guard on active duty, was under no obligation to pay for those services, was not entitled to recover under medical payments provision requiring insurer to pay expenses incurred for medical services).

the same analysis applies whenever, as here, the policyholder's medical bills are covered by Medicaid.[67]

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."

In concluding that the Respondent "incurred" medical expenses - despite the zero balance - the Circuit Court erroneously relied on this Court's decision in *Kenney v. Liston*.[68] Not only are the facts of *Kenney* distinguishable from the instant case, the issue of whether an insured "incurred" a cost, or, in other words, became liable for an expense, subject to reimbursement under the *medical payments provision* of an insurance policy, was not considered in *Kenney*.

In *Kenney*, a third-party tortfeasor attempted to diminish the amount of medical expenses the plaintiff would be permitted to recover at trial from the tortfeasor's liability insurance coverage.[69] The Court held that "the *collateral source rule* permits the [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."[70]

In stark contrast, here, the Respondent —a first-party claimant— sought to personally pocket medical payments coverage *from her own automobile insurance policy* in excess of what the

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[67] *Waters v. United Servs. Auto. Assn.*, 41 Cal. App. 4th 1063, 1081, 48 Cal. Rptr. 2d 910, 921 (1996) ("we cannot infer that medical or hospital bills were incurred when there is no reference to any such bills and when it appears distinctly probable that Mrs. Waters' medical bills were all covered by Medicare and group health insurance.").

[68] 233 W. Va. 620, 760 S.E.2d 434 (2014).

[69] *Id.* at 624–32, 760 S.E.2d at 438–46.

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

provider accepted as payment in full – even though the Respondent settled with the tortfeasor for less than the available liability limits, never presented an underinsured motorist claim, and asked her own carrier to consent to the tortfeasor settlement and waive subrogation, which it d*Id.*

Therefore, 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.[71] This is because the "[c]are of the nation's poor is an admirable social policy[,]" but "where the plaintiff pays no enrollment fee, has no wages deducted, and otherwise provides no consideration for the collateral source benefits he receives ... "the plaintiff is unable to recover the 'write-off' amount."[72]

Accordingly, *Kenney* is inapplicable to this case and has no bearing on the issue of whether the Respondent "incurred" medical expenses that are subject to the issuance of benefits under the medical payment provision of the policy. Even the Circuit Court noted, prior to entry of the Order, that it was questionable as to whether the holding in *Kenney* applied to a first party medical payments coverage claim: "I actually even thought about certified questions to see if that *Kenney* case actually cross-applied over to this matter."[73]

Other courts addressing this issue with regard to medical bill adjustments with respect to first-party coverage have reached similar conclusions.

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

[72] *Bozeman v. State*, 2003-1016 (La. 7/2/04), 879 So. 2d 692, 705; see also Syl. pt. 5, *Bates v. Hogg*, 22 Kan. App. 2d 702, 921 P.2d 249 (1996) ("Under the facts of this case, an injured plaintiff cannot apply the collateral source rule to include in a claim for economic damages amounts that have been written off by the health care provider in conjunction with a Medicaid contract. The appropriate measure of damages is the amount actually paid by Medicaid on the injured plaintiff's behalf.").

[73] [App. at P472, lines 11-13].

For example, in *Bowers*,[74] the Virginia Supreme Court held that an insured could never be "legally obligated to pay," and, therefore, could never "incur" amounts written off by healthcare providers. The court reasoned, "To decide otherwise would be to grant [the plaintiff-insured] a windfall because he would be receiving an amount greater than that which he would ever be legally obligated to pay."[75]

Likewise, in this case, the Respondent was not obligated to pay and, therefore, did not "incur" the medical expenses paid to her providers by Medicaid because those expenses were reimbursed by Auto Club. As the court explained in *Bowers*, if the Respondent is awarded medical payment benefits under the policy, she would receive a windfall, because her medical expenses were either written off, or satisfied by Medicaid and reimbursed by Auto Club.

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 by basing its holding, in part, on the conclusion that the Respondent had a reasonable expectation that her medical payments coverage was primary and the carrier would owe her the full amount of the Rankin Invoice.[76] At no point did Auto Club – through its actions or in argument - contend that the medical payments coverage under the policy was excess as opposed to primary coverage. Auto Club did not wait until all other applicable coverage was exhausted prior to issuing medical payments benefits to satisfy the Medicaid lien.[77] Instead,

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[74] 255 Va. at 585–86, 500 S.E.2d at 214.

[75] *Id.* at 586, 500 S.E.2d at 214.

[76] [App. at P314, ¶ 20].

[77] *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

Auto Club argued to the Circuit Court that in accordance with industry practice and custom, medical payments coverage is *not* "independent stand-alone coverage that pays regardless of payments made to health care providers for medical expenses related to the subject accident."[78]

In this case, 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."[79] 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. Simply because the medical payments coverage is primary does not mean that Medicaid write-offs or payments from other sources cannot be applied to lower the ultimate cost of medical expenses that will be paid through the issuance of medical payments benefits.

Other courts, including West Virginia courts,[80] have rejected reasonable expectations arguments, similar to those advanced by the Respondent in this case, where the medical payments

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is not triggered until the underlying primary limits are exhausted by way of judgment or settlements . . . ." (internal quotation and citation omitted)).

[78] [App. at P181-P183, ¶ 8].

[79] *See Schatken*, 230 W. Va. at 207, 737 S.E.2d at 235.

[80] *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.").

policy provisions are clear and unambiguous.[81] Likewise, the Circuit Court should have rejected application of the reasonable expectations doctrine in this case.

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

The Circuit Court erred in holding that Auto Club was not authorized under the policy to issue medical payments coverage to Equian, as the third-party administrator for Medicaid, upon receipt of notice of Medicaid's lien for amounts paid under the Rankin Invoice.[82] In so holding, the Circuit Court reasoned that "Equian was not a party to the contract of insurance and did not incur any reasonable medical expenses because of bodily injuries in a covered automobile."[83] The Circuit Court's holding in this regard again completely disregards the policy language, as well as the nature and purpose of medical payments coverage.

The insuring agreement for the medical payments coverage states that Auto Club "will pay reasonable **medical expenses** incurred for necessary medical and funeral services because of **bodily injury**." The policy does not state to whom the medical expenses will be paid, and there is no language in the policy precluding Auto Club from issuing the payment to the provider or to Medicaid if Medicaid adjusted and paid the bill and seeks reimbursement.

Furthermore, the Circuit Court's ruling in this regard conflicts with the statutory Medicaid requirements. State Medicaid plans "require the state Medicaid agency to 'take all reasonable

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[81] *See, e.g., Progressive N. Ins. Co. v. J & S Exch., Inc.*, 352 F. Supp. 3d 1156 (2018), aff'd sub nom. *Progressive N. Ins. Co. v. Peavler*, 789 F. App'x 84 (10th Cir. 2019) (reasonable expectations doctrine could not be utilized to reform written terms of commercial auto policy to extend medical payments coverage); *Allen v. United Servs. Auto. Ass'n*, 907 F.3d 1230 (10th Cir. 2018) (reasonable-expectations doctrine did not apply to preclude application of automobile insurance policy's one-year limitation period for medical-payments coverage).

[82] [App. at P310-316, ¶¶ 17-18].

[83] *Id.*, ¶ 18.

measures to ascertain the legal liability of third parties (including health insurers . . . or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan."[84] In fact,

> [T]o the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, *the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services.*[85]

As stated by this Court, "A state's Medicaid plan must require an individual to assign the State that individual's rights to support and to payment for medical care from any third party as a condition of eligibility for Medicaid."[86] As such, pursuant to 42 U.S.C. § 1396a(a)(25)(H), and in light of the Respondent's enrollment in Medicaid, "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."[87] W. Va. Code § 9-5-11(b) contains similar language:

> (1) Submission of an application to the department for medical assistance is, as a matter of law, an assignment of the right of the applicant or his or her legal representative to recover from third parties past medical expenses paid for by the Medicaid program.
>
> (2) At the time an application for medical assistance is made, the department shall include a statement along with the application that explains that the applicant has assigned all of his or her rights as provided in this section and the legal implications of making this assignment.[88]

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[84] 42 U.S.C. § 1396a(a)(25)(A).

[85] 42 U.S.C. § 1396a(a)(25)(H) (emphasis added); *see also* W. Va. Code § 9-5-11(b)(1)–(2).

[86] *In re E.B.*, 229 W. Va. 435, 446, 729 S.E.2d 270, 281 (2012).

[87] 42 U.S.C. § 1396a(a)(25)(H).

[88] W. Va. Code § 9-5-11(b)(1)–(2); *see also In re E.B.*, *supra* at 446, 729 S.E.2d at 281.

Therefore, Auto Club had a legal obligation to issue medical payments benefits to satisfy the Medicaid lien for expenses related to Plaintiff's medical services, and the Circuit Court erred when it held that Auto Club should not have issued reimbursement to Medicaid upon receipt of notice of its lien.[89]

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

The Circuit Court improperly disregarded the affidavit of Auto Club's expert witness who was not offered for the purpose of interpreting the policy but opining as to the industry custom and practice in handing first-party medical payments coverage claims. Auto Club timely designated Rudy Martin as an expert witness.[90] Thereafter, the Respondent filed a motion in limine seeking to strike Mr. Martin's testimony as an expert witness,[91] but never sought to take his deposition. Auto Club opposed the motion,[92] and attached an affidavit from Mr. Martin in support of its position on summary judgment.[93] The Circuit Court concluded that Mr. Martin's affidavit should be disregarded because it improperly concluded that Mr. Martin's affidavit was submitted to prove the meaning of the policy.[94]

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[89] Because the Respondent's ultimate settlement with the liability carrier was in excess of the $20,000.00 threshold established by W. Va. Code § 9-5-11(d)(4), said exemption is not applicable in this case.

[90] [App. at P029-P038].

[91] [App. at P039].

[92] [App. at P302-307].

[93] [App. at P181-P183].

[94] [App. at P310-P316, ¶ 15].

To the contrary, Mr. Martin's opinions in his affidavit,[95] as well as his anticipated testimony,[96] did not run afoul of any rule or law regarding the scope of expert testimony. In fact, Mr. Martin's affidavit and anticipated testimony were specifically confined to the appropriate parameters, 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."[97]

This anticipated testimony fully complied with *Jackson v. State Farm Mutual Automobile Insurance Company*.[98] Neither Mr. Martin's anticipated testimony nor the opinions contained in his affidavit concern any instruction on the "applicable law" of the case.[99] His opinions were confined to the "custom and practice within the insurance industry," the nature and purpose of medical payments benefits, subrogation of medical payments coverage, and the "industry standard."[100] This is precisely the kind of testimony permitted by *Jackson*.[101] In *Jackson*, this Court held:

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[95] [App. at P181-P183].

[96] [App. at P029-P038].

[97] *See id.*

[98] 215 W. Va. 634, 600 S.E.2d 346 (2004).

[99] *See Id.* at 643–44, 600 S.E.2d at 355–56.

[100] [App. at P029-P038; P181-P183].

[101] *See* 215 W. Va. at 644, 600 S.E.2d at 356 ("While [plaintiff's expert] may testify to ordinary practices of claims adjustment and settlement within the insurance industry, and whether [the insurer's]

> As a general rule, an expert witness may not give his or her opinion on the interpretation of the law as set forth in W. Va. Code, 33-11-4(9)(a)-(o) (2002), which defines unfair claim settlement practices; the legal meaning of terms within that code section; or whether a party committed an unfair claim settlement practice as defined in that code section. Rather, it is the role of the trial judge to instruct the jury on the law.[102]

Mr. Martin's affidavit consciously and correctly excludes opinion regarding the "ultimate issues" in the case; that is, whether Auto Club's issuance of medical payments benefits directly to Equian in satisfaction of the Medicaid lien and declining to provide the Respondent medical payments benefits for medical expenses that were written off in light of Medicaid's agreement with the provider, were breaches of the insurance policy, because to opine on these issues would be contrary to law and prohibited by *Jackson*. The opinions of Mr. Martin were, therefore, admissible and the Circuit Court erred in excluding the same from consideration.

C. 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.

Based upon the above arguments, the Circuit Court erred in granting partial summary judgment to the Respondent such that the entire Order - including the subsequent award of fees and costs - should be vacated. Notwithstanding, even had an award of attorney fees been proper, the Circuit Court abused its discretion by not further reducing the Responding's request for attorney fees in the amount of $35,082.50, where the underlying award to the Respondent was only

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conduct in the instant case conformed to those ordinary practices, he may not testify as to the legal consequences of that conduct.").

[102] Syl. pt. 5, 215 W. Va. 634, 600 S.E.2d 346.

$1,342.09, there was minimal litigation activity performed, and the amount of time billed was clearly excessive.

Upon issuance of the SJ Order, the Circuit Court invited the Respondent to move for recovery of attorney fees and costs consistent with *Hayseeds v. State Farm.*[103] The Respondent submitted a Motion for Reasonable Attorneys' Fees analyzing the factors presented in *Aetna Cas. & Sur. Co. v. Pitrolo,*[104] and requesting an amount of $35,082.50.

Auto Club objected to the amount of the attorney fee requested on multiple grounds, arguing that the amount requested was clearly excessive given that the time and labor required by, and expended on, the underlying matter is not as involved as other civil causes of action.[105] In fact, the underlying litigation was limited to the filing of a complaint, an answer, a brief exchange of written discovery, one motion in limine filed by Plaintiff's counsel, summary judgment briefing, and a four-hour mediation.[106] The Respondent retained no expert witness and there were no depositions. The limited docket activity in the case alone demonstrates that the purported time spent on the case is excessive.

The Circuit Court, in granting the Respondent's full request[107], wrongfully concluded that the Respondent failed to address the *Pitrolo* factors for an award of reasonable attorney fees. The *Pitrolo* factors include an analysis of "the time and labor required" and "the amount involved and

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[103] 177 W. Va. 323, 352 S.E.2d 73 (1986).

[104] 176 W. Va. 190, 342 S.E.2d 156 (1986).

[105] [App. at P385-P413].

[106] [App. at P521].

[107] In responding to the Motion for Attorney Fees, Auto Club pointed out a miscalculation by the Respondents' counsel which the Respondents' counsel subsequently acknowledged and conceded, thereby reducing their claimed fee award from $35,082.50 to $34,025.75.

the results obtained."[108] It was on these two *Pitrolo* factors that the vast majority of Auto Club's objection was based. Specifically, the Respondent's request for attorney fees included excessive time entries, duplicative entries of multiple attorneys performing the same task, and block billing entries that did not actually specify the legal task being performed.

For instance, the Respondent's fee request included multiple time entries and time spent on the case before the Complaint.[109] While *Hayseeds* allows for an award of reasonable attorney fees if "a policyholder substantially prevails,"[110] recovery is only permissible "if a policyholder must sue his or her own insurance company to enforce an insurance contract." [111] Therefore, the fees for attorney work that was performed prior to the filing of the Complaint and also unrelated to the filing of this civil action should have been excluded by the Circuit Court from the fee computation.[112]

The requested attorney fees that are based on block billing time entries should likewise have been reduced by the Circuit Court. These single-line time entries span over a considerable period

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[108] *Pitrolo*, Syl. pt 4.

[109] The nature of the records tendered suggest that they are inaccurate and may have been retroactively prepared. The following is but one example:

April 15, 2019	Preparation of complaint	1 hour
April 16, 2019	Preparation of complaint	1 hour
April 19, 2019	Preparation of complaint	1 hour
April 22, 2019	Revisions to complaint	1 hour
April 25, 2019	Revisions to complaint	1 hour

[App. at P344]. Perhaps exactly one hour was spent over five days by one of the Respondent's attorneys preparing and revising the Complaint but logic suggests otherwise.

[110] *Hayseeds*, 177 W. Va. at 329, 352 S.E.2d at 80.

[111] *Richardson v. Kentucky National Insurance Co.,* 216 W. Va. 464, 471, 607 S.E.2d 793, 800 (2004).

[112] The Respondent's counsel submitted attorney fees totaling $3,217.50, and representing time spent on the case prior to the drafting of the Complaint instituting the underlying litigation. [App. at P386-P387; P366-P375].

of time. *A single fee entry* on one of the attorney timesheets is dated between April 27, 2018, through April 26, 2019—*a span of almost one year.*[113] Another single billing entry spanned a two-week period and overlapped work on the same matter by the other attorney.[114]

It is widely acknowledged that "block billing" makes it difficult to determine whether the time spent on particular tasks was reasonable.[115] Yet despite the number block billing entries, the Circuit Court did not ask counsel to further separate the submitted time entries or otherwise reduce the amount claimed.

In addition to the block billing issue, the attorney fees submitted to the Circuit Court for consideration contained multiple duplicative entries representing the same task performed by two or more attorneys. It is generally accepted that internal meetings between counsel should not be double billed,[116] and for this reason alone the Circuit Court should have reduced the fee award.

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4/27/2018 - 4/26/2019	Meet and confered with Ron Harman on legal issues in case.	5.00

[App. at P372].

114

4/11/2019 - 4/25/2019	Work with Ron Harman to draft Complaint and review of Complaint	3.00

Id.

[115] *See, e.g., Spell v. McDaniel*, 852 F.2d 762, 768 (4th Cir. 1988) ("Because the burden is on the party seeking the fee award to establish the reasonableness of the hours spent, where it is necessary for the court to approximate because of counsel's inadequate record-keeping we consider it just so to do in favor of the party contesting the fee award." (internal citation omitted)); *Wolfe v. Green*, No. 2:08-01023, 2010 WL 3809857, at *8 (S.D. W. Va. Sept. 24, 2010) (collecting cases and reducing number of hours requested by ten percent in light of "counsel's practice from time to time of block-billing"); *CashCall, Inc. v. Morrisey*, No. 12-1274, 2014 WL 2404300, at *22 (W. Va. May 30, 2014) (affirming circuit court's discount of fifteen percent off attorney's time in light of block billing entries and the attorney's "failure to keep contemporaneous records").

[116] *See, e.g., Hensley v. Eckerhart*, 461 U.S. 424, 434 (1983) (advising that counsel "should make a good faith effort to exclude from a fee request hours that are excessive, redundant, or otherwise unnecessary, just as a lawyer in private practice ethically is obligated to exclude such hours from his fee submission," and stating that "[h]ours that are not properly billed to one's *client* also are not properly billed to one's *adversary* pursuant to statutory authority" (emphasis in original)); *Smith v. Hartmann's Moonshine Shoppe, LLC*, No. 17-4211, 2019 WL 4888996, at *4 (D. Minn. Oct. 3, 2019) (noting "two separate entries

Moreover, the entries that double billed for "internal conferences" between Respondent's two attorneys did not match up on dates or the amount of time spent - calling into question the reliability of the time entries submitted by Respondent to support her request for fees. The Circuit Court failed to address, let alone act, upon these inconsistencies in the Respondent's motion for an award of reasonable attorney fees.

The Circuit Court further abused its discretion in not reducing the amount of "double billing" for the same activity that was performed by Respondent's two attorneys. The issues presented in the underlying matter do not call for two partner-level attorneys to be consistently, actively involved in this case (as opposed to a single partner-level attorney, or a single partner-level attorney and one associate).

For example, the underlying issue was not so complex so as to require Mr. Harman and Mr. Jenkinson to *both* review *all* case filings, including, *but not limited to*, the "double" review of Auto Club's filings. Just as the internal meetings described above, the redundant review of filings results in a double billing scenario that should be reduced by the Circuit Court.[117]

Auto Club further objected to a number of time entries submitted by Respondent that were simply excessive on their face. It does not take 12 minutes (.2 hours) to review a return of service e-filed by the Secretary of State, nor does it take 42 mintues (.7 hours) to send an email attaching

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for February 25, 2019 that bill for the same internal meeting" and "reduc[ing] [those] entries to eliminate double billing"); *Rogers v. Astrue*, No. 5:12-CV-00003, 2015 WL 9239000, at *3 (W.D. N.C. Dec. 17, 2015) ("The timesheet also double bills attorney time in multiple places (such as office meetings), which is inappropriate.").

[117] *See, e.g.*, *Grayer v. Cerda*, No. 12 C 2665, 2014 WL 6713480, at *8 (N.D. Ill. Oct. 6, 2014) (reducing "unreasonably cumulative" work of two attorneys on same case).

documents to opposing counsel. The Circuit Court clearly abused its discretion by failing to address these excessive time entries.

Moreover, analyzing the remaining *Pitrolo* factors, it is clear that the Circuit Court abused its discretion not reducing the attorney fee award to the Respondent. Although the Circuit Court acknowledged that the underlying issue was a novel one, the novelty of this issue alone does not render the request for $35,082.50 in attorney fees presumptively reasonable, nor did it require an attorney with a higher level skill.

There was absolutely no basis to conclude that the nature and complexity of the underlying case would preclude counsel from other employment due to acceptance of this matter. Indeed, the Respondent's counsel typically works on a contingency fee basis, and, in light of the $2,165.00 medical bill at issue in this case (although there are additional claims of alleged UTPA violations and bad faith), counsel was aware of potential limitations on fee awards.

Counsel worked on a contingency basis, with the understanding that counsel would be paid based on identified hourly rates only if Plaintiff "substantially prevailed" and was able to secure reimbursement of attorney fees from the Defendant. There are no identifiable time limitations imposed by the client or the circumstances. There is no information that would render this case "undesirable." Counsel's relationship with the Respondent appears to have begun relatively recently in April 2018.

Taking all of the *Pitrolo* factors into consideration – but particularly those that look at the amount of time required and the underlying award – it is clear that the Circuit Court abused its discretion in awarding the Respondent attorney fees in the amount of $34,025.75.

VI. CONCLUSION

WHEREFORE, 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.

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CERTIFICATE OF SERVICE

I certify that on December 30, 2020, I served the foregoing "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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