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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas
The Honorable Steven H. John, Circuit Court Judge

Appellate Case No. 2021-001342

Jessica Bennett and Thuy N. Gasser, individually and on behalf of those similarly situated, Respondents,

v.

ACS Primary Care Physicians-Southeast P.C., Appellant.

BRIEF OF RESPONDENT JESSICA BENNETT

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Dated: June 16, 2022

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2. Did the lower court properly deny Appellant's motion to compel arbitration against a nonsignatory to the arbitration provision where the nonsignatory, Ms. Bennett, did not mislead Appellant to injury and Appellant's failed to establish the traditional elements of equitable estoppel?

3. Was the denial of Appellant's motion to compel arbitration also proper because her claims do not fall within the terms or scope of that agreement's arbitration provision?

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STATEMENT OF THE CASE

This is a class action arising out of Appellant ACS Primary Care Physicians-Southeast P.C.'s ("ACS") practice of refusing to submit bills for treatment rendered to its patients' health insurance. Respondent alleges Appellant employed a scheme by which it identified Blue Cross Blue Shield ("BCBS") patients that sustained injuries for which a recovery might be had from a third-party tort recovery. In such instances, Appellant refuses to submit such patients' bills to BCBS, opting instead to assert a lien for full reimbursement against the patients' tort recovery in an effort to collect more money than it would under the reimbursement rate Appellant agreed to in its provider agreement with BCBS. This practice is designed to increase Appellant's recovery for treatment rendered to accident victims. However, it is done at the expense of the victims who in turn face medical bills far in excess of the co-payments or deductibles they would otherwise pay had their insurance been billed for these charges.

Respondent Jessica Bennett originally filed this case in the circuit court on March 17, 2020, asserting claims for breach of contract, unjust enrichment, and equity. In addition to her individual claims, Respondent seeks to represent a proposed class including:

> All persons in South Carolina having an insurance policy with Blue Cross Blue Shield of South Carolina, who received services from [ACS] from March 17, 2017, to March 17, 2020, where [ACS] billed the persons directly at a higher price for services than the Blue Cross Blue Shield negotiated rates. (R. p. 42).

Appellant removed the case to the United States District Court for the District of South Carolina, Florence Division, on the basis of ERISA preemption. The District Court remanded the matter back to the circuit court on August 17, 2020. Appellant then filed its Motion to Compel Arbitration and Dismiss or Stay the action on August 31, 2020. Respondent filed her response in opposition on September 30, 2020. Appellant filed its Reply on October 15, 2020. In lieu of a hearing during the COVID pandemic, the circuit court requested supplemental briefs prior to issuing a ruling on the motion. Both parties submitted supplemental briefs on January 4, 2021.

The circuit court entered its order denying Appellant's motion on June 21, 2021. Appellant filed a motion to reconsider that order on July 1, 2021. Respondent filed her response in opposition on July 14, 2021. The circuit court entered its order denying Appellant's motion to reconsider on November 5, 2021. This appeal followed.

STATEMENT OF THE FACTS

This case arises out of Appellant's practice of seeking to recover its charges for emergency medical treatment directly from its patients instead of from its patients' health insurance provider, BCBS, with which Appellant has a reimbursement agreement. Respondent alleges Appellant has a scheme by which it identifies patients who are accident victims who might be entitled to third-party tort recoveries and then bills those patients directly in an amount well in excess of what

Appellant would recover under its reimbursement agreement with BCBS. (R. pp. 41-42). The effect of this practice is to increase Appellant's collections on treatment rendered to accident victims. (R. p. 46). However, this practice deprives those victims the benefit of their health insurance with BCBS, subjecting them to emergency room bills far in excess of the co-payment or deductible amounts to which they would normally be entitled. (R. pp. 45-46). Appellant does not dispute that it had an internal practice of attempting to determine whether patients' injuries were the result of a motor vehicle accident. (R. p. 441).

A. Underlying Facts

Following a car crash in which she was seriously injured, Respondent, a resident of Spartanburg, South Carolina, was taken to the emergency room at the Mary Black Memorial Hospital in Spartanburg for treatment following a car accident on December 14, 2018. (R. p. 40). At the hospital, Respondent was treated by emergency medical professionals employed by Appellant. (R. p. 40). Appellant contracts with various South Carolina hospitals, such as Mary Black Memorial Hospital, to provide medical staff in the emergency department. (R. p. 40). Appellant primarily staffs emergency room doctors for hospital systems. (R. p. 38). Instead of the hospital employing the physician, the physician is employed by Appellant, and Appellant contracts with the hospital for those physicians' services. (R. p. 199).

At the time of her injury and subsequent medical care, Respondent's health care costs were covered under an employer-provided health insurance policy with Blue Cross Blue Shield of South Carolina ("BCBS"). (R. p. 40; *see also* R. p. 153). Appellant accepts insurance provided by BCBS as an in-network provider. (R. p. 39). To become an in-network provider, Appellant has an agreement with BCBS, the Preferred Provider Agreement ("PPO Agreement"). (R. pp. 151-71). Under the PPO Agreement, Appellant agrees to accept BCBS insurance, to submit

medical bills for care provided to BCBS members directly to BCBS, and to accept a negotiated rate from BCBS for services rendered to BCBS members. (R. p. 39); (R. p. 162, § IV(A)(1)); (R. p. 163, § IV(A)(11)).

Despite Respondent being covered under a health insurance plan with BCBS at the time of her medical treatment, Appellant did not submit a claim to BCBS for the services rendered to her. (R. p. 40). Instead, Appellant billed Respondent $1,050.00 for medical services rendered to her at a cost significantly higher than what the cost of the same services would have been, had Appellant timely billed BCBS in conformity with the PPO Agreement. (R. p. 40).

Respondent also alleges that Appellant failed to submit emergency room bills to BCBS on behalf of similarly situated BCBS insureds who were accident victims in order for Appellant to recover a greater amount directly from its patients. (R. pp. 46-47). Following the initiation of her suit, Respondent discovered that at least one other victim of this scheme had filed a similar suit to vindicate the rights of similarly situated BCBS insureds being deprived the benefits of their health insurance by Appellant. *See Gasser v. ACS Primary Care Physicians-Southeast P.C.*, 2020-CP-26-03169 (Horry County Common Pleas). The circuit court similarly denied Appellant's motion to compel arbitration in that action and it too is on appeal to the Court. That action has now been consolidated with this matter.

B. The PPO Agreement and Arbitration Provision

Appellant seeks to compel arbitration of Respondent's claims and dismissal (or a stay) of Respondent's action in the circuit court. The basis of Appellant's motion is the Preferred Provider Agreement ("PPO Agreement") between Appellant and BCBS. (R. pp. 155-171). Importantly, it is undisputed that Respondent is not a party or signatory to the PPO agreement. Moreover, Respondent had no knowledge of the PPO Agreement between BCBS and Appellant. (R. p. 216).

Under the PPO Agreement, Appellant agreed to bill BCBS directly for covered medical services rendered by Appellant to patients insured by BCBS. (R. p. 162, § IV(A)(1)); (R. p. 163, § IV(A)(11)). Specifically, these services were to be billed at a negotiated rate of service to those patients insured by BCBS. (R. p. 162, § IV(A)(1)). The PPO Agreement specifies that Appellant will accept a discounted rate for services provided to BCBS members and requires Appellant to "[a]ccept payment of [BCBS's] Fee Allowance amount plus any Patient Pay Amounts as payment in full for Covered Services rendered to Members." R. p. 162, § IV(A)(1)); (R. p. 160, § (II)(K)). Appellant did not bill BCBS for the services provided to Respondent; instead, Appellant billed Respondent directly for an amount in excess of that which Appellant would, in ordinary practice, have received under its Fee Allowance with BCBS. (R. pp. 40, 46).

The PPO Agreement contains an arbitration clause. However, the arbitration provision makes clear that it applies only to BCBS and Appellant, specifically providing:

> (1) Except for decisions made pursuant to the Utilization Management Program[1], [BCBS] and [Appellant] agree to meet and confer in good faith to resolve any problems or disputes that may arise under this agreement.
>
> (2) In the event that the parties through mutual negotiation are not able to satisfactorily resolve any problem or dispute . . . [BCBS] and [Appellant] agree to arbitrate such problem or dispute. A single arbitrator shall conduct the arbitration (including conducting pre-hearing matters) under the then current commercial rules of the American Arbitration Association and such rules shall apply in lieu of state or federal rules of civil procedure. The American Arbitration Association shall appoint an arbitrator who is knowledgeable in the healthcare management field. The arbitration shall be held and any award shall be made in South Carolina. Subject to the terms of the Uniform Arbitration Act, the arbitrator's determination shall be final and binding upon the parties. By entering into this Agreement and selecting arbitration as a dispute resolution mechanism the parties waive any right to jury trial.

(R. p. 169, § IX(M)(1)-(2)).

[1] The Utilization Management Program is a separate set of procedures governing *inter alia* how BCBS determines whether a member's services are medically necessary or whether a member's care is pre-approved. It is not relevant to Respondent's claims.

The arbitration provision by its own language only governs the resolution of claims between the parties to the agreement, Appellant and BCBS.[2] Notably, the provision does not contain a blanket provision that "any and all claims arising out of or relating to" the agreement are subject to arbitration. Instead, the provision is specifically limited to disputes between Appellant and BCBS and requires a meet and confer to occur prior to arbitration proceedings.[3] Despite Respondent not signing, knowing of, or being covered under this provision, Appellant seeks to force Respondent's claims to arbitration. The circuit court properly denied Appellant's motion to compel arbitration.

STANDARD OF REVIEW

Whether an arbitration agreement may be enforced against a nonsignatory to an agreement is a matter subject to *de novo* review by an appellate court. *Wilson v. Willis*, 426 S.C. 326, 335, 827 S.E.2d 167, 172 (2019); *see also Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 286, 733 S.E.2d 597, 599 (Ct. App. 2012). "[A] presumption *against* arbitration arises where the party resisting arbitration is a nonsignatory to the written agreement to arbitrate." *Wilson*, 426 S.C. at 337, 827 S.E.2d at 173 (emphasis in original). Under *de novo* review, a circuit court's factual findings will not be reversed on appeal if any evidence reasonably supports those findings. *Hodge v. UniHealth Post-Acute Care of Bamberg, LLC*, 422 S.C. 544, 813 S.E.2d 292 (Ct. App. 2018).

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[2] *See* (R. p. 169, § IX(M)(1)-(2)) ("BCBS and Preferred Provider [Appellant] agree to meet and confer . . ."; "BCBS and Preferred Provider [Appellant] agree to arbitrate . . ."; "the arbitrator's determination shall be final and binding upon the *parties*.").

[3] *Id.*

ARGUMENT

I. The lower court correctly held that Respondent, as a nonsignatory, could not be compelled to arbitration.

"[A] party cannot be required to submit to arbitration any dispute which he has not agreed to submit." *Zabinski v. Bright Acres Assocs.*, 346 S.C. 580, 596, 553 S.E.2d 110, 118 (2001). This is because arbitration is a matter of consent, not coercion, and it "[e]xists solely by agreement of the parties." *E.E.O.C. v. Waffle House,* Inc., 534 U.S. 279, 294, 122 S.Ct. 754, 764, 151 L.Ed.2d 755, 764 (2002); *Wilson*, 426 S.C. at 337, 827 S.E.2d at 173. Where a party seeks to compel arbitration of claims of a nonsignatory to the arbitration provision "a presumption *against* arbitration arises where the party resisting arbitration is a nonsignatory to the written agreement to arbitrate." *Wilson*, 426 S.C. at 337, 827 S.E.2d at 173 (emphasis in original). And where, as here, there is no contractual provision to arbitrate binding on Respondent "[t]here is . . . no public policy—federal or state—'favoring' arbitration." *Palmetto Constr. Grp., LLC v. Restoration Specialists, LLC*, 432 S.C. 633, 639, 856 S.E.2d 150, 153 (2021). "State law controls when an arbitration agreement may be enforced against someone who has not signed it." *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 228, 847 S.E.2d 268, 271 (Ct. App. 2020).[4]

[4] Appellant continues to argue that the Federal Arbitration Act preempts state law despite the clear dictates of state and federal law. This argument is without merit and state law controls to determine whether an arbitration provision can be enforced against a nonsignatory. *See Wilson*, 426 S.C. at 338, 827 S.E.2d at 173-74 ("Whether an arbitration agreement may be enforced against nonsignatories, and under what circumstances, is an issue controlled by state law); *Arthur Andersen LLP v. Carlisle*, 556 U.S. 624, 630–31, 630 n.5 (2009) (observing state law is applicable to determine which contracts are binding under section 2 of the FAA, and traditional principles of state law may permit a contract to be enforced by or against nonparties to a contract through theories of assumption, piercing the corporate veil, and estoppel, among others).

Appellant primarily contends the lower court erred when it failed to apply direct benefits estoppel and compel Respondent, a nonsignatory to the arbitration provision, to arbitrate her claims. However, as the lower court recognized, because Appellant cannot meet the necessary elements to show entitlement to the equitable relief it seeks or show that Respondent actively exploited the PPO Agreement, estoppel is not justified in these circumstances.

A. The lower court correctly found that Appellant failed to meet the requirements of estoppel in the arbitration context.

Equitable estoppel is "a theory designed to prevent injustice, and it should be used sparingly." *Wilson*, 426 S.C. at 345, 827 S.E.2d at 177; *see also Hirsch v. Amper Fin. Servs., LLC*, 71 A.3d 849, 852 (N.J. 2013) (estoppel "is more properly viewed as a shield to prevent injustice rather than a sword to compel arbitration"). "The essence of equitable estoppel is that the party entitled to invoke the principle was misled to his injury." *S.C. Pub. Serv. Auth. v. Ocean Forest, Inc.*, 275 S.C. 552, 554 (1981). The traditional requirements of equitable estoppel apply with equal force in this context. *See Thompson v. Pruitt Corp.*, 416 S.C. 43, 59-60, 784 S.E.2d 679, 688-89 (Ct. App. 2016) (applying both the traditional and "direct benefits" test in the arbitration context); *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 233, 847 S.E.2d 268, 274 (2020) ("the heart of the theory is that the party entitled to invoke the principle was misled to his injury.") (internal quotations and citations omitted).

Under South Carolina law the elements of equitable estoppel "as to the party estopped are: (1) conduct by the party estopped which amounts to a false representation or concealment of material facts; (2) the intention that such conduct shall be acted upon by the other party; and (3) knowledge, actual or constructive, of the true facts." *Zabinski*, 346 S.C. at 589. The "[e]ssential elements of estoppel as related to the party claiming the estoppel are: (1) lack of knowledge and

of means of knowledge of truth as to facts in question; (2) reliance upon conduct of the party estopped; and (3) prejudicial change in position." *Id.*

Because of these principles, our courts will apply estoppel to enforce arbitration against a nonsignatory only where the nonsignatory's conduct is such that it would be inequitable to allow the nonsignatory to avoid arbitration. Thus, our courts will only enforce arbitration as to nonsignatories where there is evidence that the nonsignatory both "knowingly exploits the benefits of an agreement containing an arbitration clause, **and** receives benefits flowing directly from the agreement." *Wilson*, 426 S.C. at 340-41, 827 S.E.2d at 175 (internal citations and quotations omitted) (emphasis supplied).

The circuit court correctly found Appellant failed to meet that burden. Direct benefits estoppel "is not implicated simply because a claim relates to or would not have arisen 'but for' a contract's existence." *Weaver*, 431 S.C. at 230-31, 847 S.E.2d at 272 (quoting *Wilson*, 426 S.C. at 343). Nor can it be used to compel arbitration "when the benefits to a nonsignatory are merely indirect . . . ." *Wilson*, 426 S.C. at 343. "[A]ny benefit derived from an agreement is indirect where the nonsignatory exploits the contractual relationship of the parties, but does not exploit (and thereby assume) the agreement itself." *Id.* (citing *MAG Portfolio Consult, GMBH v. Merlin Biomed Grp. LLC*, 268 F.3d 58, 61 (2d Cir. 2001)).

Most, if not all, of the courts discussing direct benefits estoppel note it requires the nonsignatory's knowledge of the agreement and a knowing acceptance of benefits under the agreement. *See Deloitte Noraudit A/S v. Deloitte Haskins & Sells, U.S.*, 9 F.3d 1060, 1064 (2d Cir. 1993); *MAG Portfolio Consult, GMBH*, 268 F.3d at 61; *Int'l Paper Co. v. Schwabedissen Maschinen & Anlagen GMBH*, 206 F.3d 411, 418 (party estopped where he has "consistently maintained that other provisions of the contract should be enforced to benefit him."). The circuit

court correctly found that neither was present here. Appellant presented no evidence that Respondent actively exploited, or received any benefit under, the PPO Agreement.

And how could it? The true benefit Respondent seeks is to receive the benefits of *her* health insurance plan. That benefit to Respondent is the reduced cost of medical services under her insurance plan for which she pays. A major incentive for the purchase of health insurance is to ensure an unforeseen medical emergency does not financially overwhelm an insured. Prior to receipt of a bill from Appellant, Respondent knew nothing of Appellant or its PPO Agreement with BCBS. Respondent can hardly be said to have "knowingly exploited" or "knowingly accepted" a benefit under the PPO Agreement. Rather, Appellant is knowingly exploiting Respondent's status as an automobile crash victim in order to seek a higher rate for its services.

To be sure, Respondent seeks a benefit from the contractual relationship between BCBS and Appellant, but only to the extent that Appellant's conduct effectively denies her insurance benefits under her insurance plan with BCBS. To date, Respondent has received no benefit at all under any agreement. Any benefit to Respondent under the PPO Agreement is indirect as the ultimate benefit flows to Respondent through her health insurance contract. Under the circumstances, Respondent cannot force BCBS to pay a claim that Appellant refuses to submit to BCBS.

The estoppel Appellant seeks "is not implicated simply because a claim relates to or would not have arisen 'but for' a contract's existence." *Weaver*, 431 S.C. at 230-31, 847 S.E.2d at 272 (quoting *Wilson*, 426 S.C. at 343). The direct benefit for any BCBS insured is reduced health care costs under their health insurance plan, regardless of the medical services provider. To compel Respondent to arbitrate her claim would incentivize all BCBS preferred providers to

refuse to bill BCBS for valid health claims, despite their promise to do so and without fear of being haled into court, in the hopes the patient will pay a higher, non-discounted rate.

Even if the benefit sought were a "direct benefit," Appellant must also show that Respondent knowingly and actively exploited the PPO Agreement to Respondent's benefit. *See Wilson*, 426 S.C. at 340-41, 827 S.E.2d at 175. It is undisputed, and the circuit court recognized, that Respondent did not exploit, or even know of, the PPO Agreement. To date, she has received no benefit whatsoever because Appellant refused to submit her medical bills to BCBS for payment.

Nonetheless, Appellant relies primarily on *Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 297, 733 S.E.2d 597, 605 (Ct. App. 2012) as an analogous case on which this Court should reverse the lower court. But *Pearson* is clearly distinct. In *Pearson*, the plaintiff-physician was a nonparty to a contract between the hospital at which he worked and the staffing agency that placed him there. The *Pearson* court compelled arbitration finding the plaintiff-physician "received a benefit due to the contract, in that he was able to work at the Hospital and receive payment for his work." *Id.* at 296-97, 733 S.E.2d at 605 ("If not for that contract, then Dr. Pearson would have had to make separate arrangements with the Hospital in order to work there. He knowingly accepted benefits of the contract between the hospital and Locum. Accordingly, Dr. Pearson benefitted from that contact and should not be able to disclaim the arbitration agreement contained in it."). As noted by the Supreme Court in *Wilson*, it was persuasive to the *Pearson* court that the nonsignatories "did not embrace the [agreement] during the life of the contract" only to later seek to repudiate it. *Wilson*, 426 S.C. at 342, 827 S.E.2d at 176 (analyzing *Pearson*'s "knowing exploitation" analysis). Also, persuasive to the *Pearson* court was the fact that both contracts at issue (the one between plaintiff-physician and the staffing company, and the one between the

hospital and the placement company) contained arbitration provisions and the plaintiff-physician knew of the hospital's contract with his staffing company. 400 S.C. at 296-97, 733 S.E.2d at 605.

Respondent has neither exploited the PPO Agreement, nor received any benefit under it. To the contrary, Appellant's actions are depriving Respondent of her ability to receive health benefits under her agreement ***with BCBS***. Benefits for which she paid. Appellant cannot seriously contend Respondent exploited the PPO Agreement during its existence. Bearing in mind that estoppel should only be used in rare circumstances "to prevent injustice," *Weaver v. Brookdale Senior Living*, 431 S.C. at 231, 847 S.E.2d at 272, in the absence of exploitation by Respondent, estoppel is not warranted. The lower court should be affirmed on this basis alone.

B. The lower court correctly applied a traditional equitable estoppel analysis in addition to the direct benefits analysis.

While correctly recognizing that estoppel in this context should only be used sparingly to prevent injustice, the lower court correctly applied the traditional equitable principles of South Carolina law.

In *Thompson v. Pruitt Corp.*, 416 S.C. 43, 58 (Ct. App. 2016), our Court of Appeals found that *Pearson* and its direct benefits estoppel analysis was an application of federal substantive law – despite the U.S. Supreme Court's mandate to apply state law to such disputes. *See Arthur Andersen LLP v. Carlisle*, 556 U.S. 624, 630 (2009) (holding that a nonparty to an agreement is entitled to invoke the Federal Arbitration Act (FAA) "if the relevant state contract law allows him to enforce the agreement"). Applying state law to the defendants' argument that plaintiff should be estopped from denying the arbitration provision, the Court of Appeals analyzed the claim in *Thompson* under our traditional estoppel elements including false representation / concealment, intent, knowledge, and reliance. *See Thompson*, 416 S.C. at 60. This is the correct approach

which was followed by the lower court here – denying application of estoppel where Respondent did not have knowledge of the PPO Agreement and did not mislead Appellant in any way.

Our Supreme Court in *Wilson* agreed, holding state law governs this issue. *See Wilson*, 426 S.C. at 338 ("whether an arbitration agreement may be enforced against nonsignatories, and under what circumstances, is an issue controlled by state law."). And without adopting the federal courts' "direct benefits estoppel" as the law of South Carolina[5], the Supreme Court reviewed and reversed the Court of Appeals' analysis of the claims under that framework and found the nonsignatories did not knowingly exploit or receive a direct benefit from the underlying contract. *Id.* at 340 n.9, 344. Importantly, the Supreme Court's analysis in *Wilson* itself retains classic features of traditional estoppel principles by placing weight on the nonsignatories' lack of knowledge of the arbitration agreement. *Id.* at 342 (noting nonsignatories could not exploit an agreement of which they had no knowledge).[6]

Appellant does not attempt to meet the traditional requirements of equitable estoppel, nor could it. There is no evidence of conduct by Respondent which amounts to a false representation or concealment of material facts made with intent to deceive. Respondent did not know about the PPO Agreement. The lower court was correct to deny the Appellant's motion to compel arbitration on this basis as well.

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[5] *Wilson*, 426 S.C. at 340, n.9 (noting that it only analyzed this matter under the direct benefits test because that was the focus of the parties' arguments and the Court of Appeals' opinion, expressing no opinion regarding whether the traditional South Carolina estoppel test must also be analyzed, an alternative argument raised by plaintiffs).

[6] Note the lack of knowledge in this case is even greater, as Respondent had no knowledge that an ACS physician was even treating her, much less that Appellant could compel her to arbitrate these claims after Appellant's actions deprived her the benefit of her health insurance.

II. Additional sustaining grounds exist for the proper denial of Appellant's motion to compel arbitration.

"Under the present rules, a respondent—the "winner" in the lower court—may raise on appeal any additional reasons the appellate court should affirm the lower court's ruling, regardless of whether those reasons have been presented to or ruled on by the lower court." *I'On, L.L.C. v. Town of Mt. Pleasant*, 338 S.C. 406, 419, 526 S.E.2d 716, 723 (2000). Here, a number of additional sustaining grounds exist for which it would have been proper for the lower court to deny Appellant's motion to compel arbitration. And they were presented to the lower court. Those include: (1) the scope of the arbitration does not cover Respondent or this dispute; (2) the South Carolina Uniform Arbitration Act precludes arbitration here because the claim involves insurance benefits; and (3) the selected arbitral forum under the arbitration provision is not available, rendering the provision void.

A. Denial of the motion to compel arbitration is also proper because the arbitration provision's scope does not encompass Respondent or cover this dispute

To compel arbitration Appellant "must demonstrate (1) there is a valid arbitration agreement, and (2) the claims fall within its scope." *Weaver*, 431 S.C. at 228, 847 S.E.2d at 271. Appellant cannot make this showing.

Here, the PPO Agreement is explicitly between only Appellant and BCBS: "In the event that the parties through mutual negotiation are not able to satisfactorily resolve any problem or dispute, . . . **BCBS** and **Preferred Provider** [Appellant] agree to arbitrate such problem or dispute." (R. p. 169, § IX(M)(1)) (emphasis supplied); *see also* (R. p. 166). In sum, the provision

governs the resolution of claims solely between the parties to the agreement, Appellant and BCBS.[7]

Additionally, the arbitration provision does not cover this specific dispute. The arbitration provision does not utilize the standard language covering "any and all claims arising out of or relating to" often seen in arbitration provisions. *See, e.g., Pearson*, 400 S.C. at 286, 733 S.E.2d at 599; *Zabinski*, 346 S.C. at 597, 553 S.E.2d at 119. Instead, this provision specifically limits arbitration to disputes between Appellant and BCBS:

> (1) . . . [BCBS] and [Appellant] agree to meet and confer in good faith to resolve any problems or disputes that may arise under this agreement.
>
> (2) In the event that the parties through mutual negotiation are not able to satisfactorily resolve any problem or dispute . . . [BCBS] and [Appellant] agree to arbitrate such problem or dispute.

(R. p. 169, § IX(M)(1-2)). The provision itself specifically contemplates arbitrations between only the parties. Here, Respondent is defined in the PPO Agreement as a Member. *See* (R. p, 160, § II(M)). Yet nowhere does the arbitration provision contemplate a Members' participation in an arbitration proceeding. The inclusion of Members within the PPO Agreement itself coupled with their exclusion in the arbitration provision makes clear that the clause "is not susceptible to any interpretation which would cover the asserted dispute." *Zabinski*, 346 S.C. at 597, 553 S.E.2d at 118-19.

Moreover, the provision contemplates arbitration only after a condition precedent is met – a meet and confer and mutual negotiation. Without meeting the condition precedent, the arbitration provision fails as to Respondent. *See Perdue Farms Inc. v. Design Build Contracting*

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[7] *See* (R. p. 169, § IX(M)(1)) ("BCBS and Preferred Provider agree to meet and confer . . ."; "BCBS and Preferred Provider agree to arbitrate . . ."; "the arbitrator's determination shall be final and binding upon the *parties*.") (emphasis supplied).

Corp., 263 Fed. Appx. 380, 383 (4th Cir. 2008) ("Where a condition precedent to arbitration is not fulfilled, a party to a contract does not have a right to arbitration."); *HIM Portland LLC v. DeVito Builders Inc.*, 317 F.3d 41, 44 (1st Cir. 2003) (refusing to compel arbitration because "[u]nder the plain language of the contract, the arbitration provision of the agreement is not triggered until one of the parties requests mediation"); *Kemiron Atl. Inc. v. Aguakem Int'l Inc.*, 290 F.3d 1287, 1291 (11th Cir. 2002) (same).

Nor can the failure to meet the condition precedent be cured because the scope of the arbitration provision does not permit a Member, like Respondent, pre-arbitration dispute resolution rights. Rather, the arbitration provision is plainly limited to disputes that persist following such a conference between **only** BCBS and Appellant. It does not require the arbitration of "any and all disputes arising under or relating to the agreement."

As such, the scope of the arbitration provisions does not cover either Respondent or this claim. The motion to compel arbitration can be properly denied on this basis as well.

B. Denial of the motion to compel arbitration is also proper because Respondent's claims are not subject to arbitration under the SCUAA because they involve insurance benefits.

Appellant argues Respondent's claims are subject to arbitration under the South Carolina Uniform Arbitration Act ("SCUAA"). However, the SCUAA specifically excludes disputes involving insurance benefits from its application.

The SCUAA provides that arbitration provisions do not apply to claims by "any insured or beneficiary under any insurance policy or annuity contract." *See Cox v. Woodmen of World Ins. Co.*, 347 S.C. 460, 468 (Ct. App. 2001) (quoting S.C. Code Ann. § 15-48-10(b)(4)). Here, Appellant's refusal to bill BCBS results in Respondent losing the benefits for which she pays as an insured under her BCBS insurance policy. As a result, this is clearly a "claim . . . to any insured

or to any beneficiary under any insurance policy . . . .” and the arbitration provision is unenforceable as to her claim. S.C. Code Ann. § 15-48-10(b)(4); *see Am. Health and Life Ins. Co. v. Heyward*, 272 F. Supp. 2d 578, 582-83 (D.S.C. 2003).

One of Appellant’s core obligations under the PPO Agreement is to “[a]ccept payment of the Fee Allowance amount (plus any copay or deductible) . . . as payment in full for Covered Services rendered to Members” (like Respondent) with such payment being “subject to the terms of the Member’s Benefits Contract” (Respondent’s health insurance plan). (R. p. 162, § IV(A)(1)). The introductory recitals of the PPO agreement acknowledge that a primary objective of the agreement is to establish “cooperative healthcare cost containment programs that will assure availability and continuity of quality care to BCBS’s Members.” (R. p. 159, § I(A)).[8]

It is Appellant’s failure to bill BCBS, and failure to accept payment from BCBS, that deprives Respondent the benefits for which she pays as an insured under her BCBS insurance policy. Thus, this is clearly a claim involving “any insured or beneficiary under any insurance policy.” Because South Carolina prohibits arbitration of such claims, the arbitration provision here is unenforceable. *See Am. Health and Life Ins. Co. v. Heyward*, 272 F. Supp. 2d 578, 582-83 (D.S.C. 2003).

Should Appellant argue the Federal Arbitration Act (FAA) preempts application of S.C. Code Ann. § 15-48-10(b)(4), that argument is foreclosed. S.C. Code § 15-48-10(b)(4) “reverse preempts” the FAA through the application of the McCarran-Ferguson Act. *See Cox v. Woodmen of World Ins. Co.*, 347 S.C. 460, 468 (S.C. App. 2001); *see also Blue Ridge Emergency*

[8] “Members” is defined as “any individual who is covered under a Benefits Contract . . .” (R. p. 160, § II(M)).

Physicians, P.A. v. Emergency Physicians Ins. Co. RRG, C/A no. 6:10-cv-00428-JMC, 2011 WL 899639, at *2 (D.S.C. March 15, 2011).

Appellant will counter that the PPO agreement is not an "insurance policy." This is a closer call but still incorrect. In *Walden v. Harrelson Nissan, Inc.*, 399 S.C. 205 (S.C. App. 2012), the Court of Appeals found that the General Assembly "did not intend for the arbitration exception of section 15-48-10(b)(4) to apply to automobile lease agreements that only have a tangential relationship to an insurance policy, but was instead intended to apply directly to an insurance contract." *Walden*, 399 S.C. at 210; *see also Wilson v. Willis*, 416 S.C. 395, 426-27 (S.C. App. 2016) (finding claims under a 2010 Agency Agreement between an insurer and an insurance agency permitting the sale of insurance products did not constitute claims of a beneficiary under an insurance policy).

But the claims at issue here specifically relate to Respondent's attempt to receive benefits under her health insurance policy. Thus, an insurance policy is squarely at issue. And the PPO Agreement recognizes this by defining Members as "any individual who is covered under a [BCBS] Benefits Contract . . ." (R. p. 160, § II(M)). As such, this Court should analyze the enforceability of the arbitration provision under S.C. Code § 15-48-10(b)(4) despite the fact the arbitration provision at issue was not contained in an insurance policy because the claims clearly involve the receipt or denial of insurance benefits.

There would be no purpose in having a PPO Agreement but for Appellant's promise to accept health insurance payments by BCBS for care rendered to members like Respondent. The PPO Agreement repeatedly references BCBS's members' benefits contracts and Appellant agrees to accept payments from BCBS "subject to the terms of the Member's Benefits Contract." (R. p. 162, § IV(A)(1)).

Consider this: had Appellant submitted Respondent's medical bills to BCBS and BCBS denied them, BCBS could not compel arbitration of a claim by Respondent for wrongful denial of benefits because § 15-48-10(b)(4) would prohibit it. Why then should Appellant be exempted from the application of § 15-48-10(b)(4) when it is effectively doing the same thing: denying Respondent the benefit of her health insurance? In the absence of health insurance, there is simply no basis for the existence of the PPO Agreement. This is in stark contrast to the agreements at issue in *Walden* (automobile lease agreement) and *Wilson* (agency agreement). It can hardly be said the PPO Agreement here is merely tangential to Respondent's health insurance. Rather, it depends upon it.

As such, an additional sustaining ground for the proper denial of Appellant's motion to compel arbitration is that S.C. Code Ann. § 15-48-10(b)(4) prohibits the enforcement of the arbitration provision at issue because Respondent's claim involves a claim to "any insured or beneficiary under any insurance policy."

C. Denial of the motion to compel arbitration is also proper because the provision is void for failure of an integral term – its stated arbitral forum.

The arbitration provision is also unenforceable because the provision's exclusive forum for arbitration is unavailable to arbitrate this dispute. *See Grant v. Magnolia Manor-Greenwood, Inc.*, 383 S.C. 125 (2009) (where selection of arbitrator is integral term of an arbitration provision and arbitrator becomes unavailable, arbitration agreement is unenforceable).

Here, the provision provides not only that the rules of the American Arbitration Association ("AAA") apply, but also that "The American Arbitration Association shall appoint an arbitrator who is knowledgeable in the healthcare management field." (R. p. 169, § IX(M)). However, the AAA is not available to perform or appoint an arbitrator for this dispute.

In 2003 the AAA announced, "it would not administer *healthcare arbitrations between individual patients and healthcare service providers* that relate to medical services, such as negligence and medical malpractice disputes, *unless all parties agreed to submit the matter to arbitration after the dispute arose*." (R. p. 211, n.7). The announcement states that this is consistent with the AAA's "Due Process Protocol for the Mediation and Arbitration of Health Care Disputes." The AAA's Healthcare dispute protocol makes various recommendations including:

> ▪ Alternative dispute resolution can and should be used to resolve disputes over health care coverage and access arising out of the relationship between patients and private health plans and managed care organizations.
> . . .
> ▪ *In disputes involving patients*, binding forms of dispute resolution should be used *only where the parties agree to do so after a dispute arises*.

(R. p. 211); (R. p. 236, § II) (emphasis supplied). The protocol goes on to discuss Principle 3 which is:

> The agreement to use ADR should be knowing and voluntary. Consent to use an ADR process should not be a requirement for receiving emergency care or treatment. *In disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises.*

Id. (emphasis supplied).

In addition to the AAA rules prohibiting arbitration of disputes between patients and providers where the arbitration was not voluntarily agreed to after the dispute arose, the AAA also requires that the AAA administer the arbitration. For example:

> R-13. AAA and Delegation of Duties When the consumer and the business agree to arbitrate under these Rules or other AAA rules, or when they provide for arbitration by the AAA and an arbitration is filed under these Rules, the *parties also agree that the AAA will administer the arbitration*. The AAA's administrative duties are set forth in the parties' arbitration agreement and in these Rules. *The AAA will have the final decision on which office and which AAA staff members will administer the case*. Arbitrations administered under these Rules shall only be

> administered by the AAA or by an individual or organization authorized by the AAA to do so.

(R. p. 212) (emphasis supplied).

Not only do the AAA rules mandate that the AAA administer arbitrations that are subject to its rules, but here the arbitration provision *specifically* requires that the AAA administer the arbitration by mandating that the AAA "shall appoint an arbitrator . . . ." This is a significant fact.

In *Dean v. Heritage Healthcare of Ridgeway, LLC*, the Supreme Court held "when parties elect for a proceeding "administered by" a named forum, that forum should be viewed as integral to the arbitration agreement, absent other evidence to the contrary." 408 S.C. 371, 384 (2014). In finding the arbitration provision at issue enforceable, the *Dean* court notes that "by invoking only the AAA's rules, and not the AAA itself, the [arbitration agreement] suggests that the parties anticipated an entity *other than the AAA* might conduct the arbitration." *Id.* at 385. The arbitration provision in *Dean* only required that it be conducted under the rules of the AAA and did not require AAA administration. This was the factor that caused the Supreme Court to distinguish the arbitration provision in *Dean* from the one in *Grant v. Magnolia Manor-Greenwood, Inc*., 383 S.C. 125 (2009).

In *Grant*, the arbitration provision at issue required that the arbitration be "administered by the National Health Lawyers Association." ("NHLA") 383 S.C. at 128. Prior to the dispute in *Grant*, the NHLA changed its rules for health care liability claims to provide that it would only arbitrate such claims if the arbitration agreement was entered into after the alleged injury occurred. *See id.* Because the plaintiff did not sign the arbitration agreement post-injury, he argued the unavailability of the NHLA to administer the arbitration changed an integral part of the agreement, rendering the agreement unenforceable. The Supreme Court agreed, finding that because the parties were "bound by a panel of arbitrators selected by the service," it reflected their

intent to arbitrate exclusively in that forum. *Id.* at 131-32. In light of the unavailability of that forum due to the rule change, the court found that integral part of the agreement failed, and the arbitration clause was unenforceable. *Id.* at 132.

Grant is on all fours with this matter in that the arbitration provision at issue mandates the AAA "shall" select the arbitrator. *See* (R. p. 169, § IX(M)). It is not, as in *Dean*, a provision that merely adopts the AAA rules. The subject provision both adopts the AAA rules and explicitly requires the AAA to administer the arbitration by selecting the arbitrator. AAA protocol and policy is clear that "[i]n disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises." That clearly did not happen here as Respondent was not a party or signatory to the agreement – a factor that weighs against arbitration. AAA policy precludes the AAA from appointing an arbitrator or presiding over this dispute.

Because the AAA is unavailable as an arbitral forum, an integral part of the arbitration provision fails, and it must be deemed unenforceable. As such, this is an additional sustaining ground upon which the lower court may be affirmed in its denial of the motion to compel arbitration.

CONCLUSION

"He who seeks equity must do equity." *Provident Life & Accident Ins. Co. v. Driver*, 317 S.C. 471, 479, 451 S.E.2d 924, 929 (1994). The primary basis for the relief Appellant seeks is equity. Yet, the Appellant's scheme to deprive Respondent and others the benefit of their health insurance for its own financial gain is not deserving of equity. If there has been any exploitation here it is Appellant's exploitation of Respondent as the victim of a motor vehicle crash. Because

Respondent neither exploited nor knew of the PPO Agreement between Appellant and BCBS, the circuit court properly denied Appellant's motion to compel arbitration.

As such, the decision of the circuit court should be AFFIRMED.

Respectfully submitted,

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June 16, 2022
Columbia, South Carolina

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas
The Honorable Steven H. John, Circuit Court Judge

Appellate Case No. 2021-001342

Jessica Bennett and Thuy N. Gasser, individually and on behalf of those similarly situated, Respondents,

v.

ACS Primary Care Physicians-Southeast P.C., Appellant.

CERTIFICATE OF COUNSEL

I certify that the Brief of Respondent Jessica Bennett complies with Rule 211(b), SCACR.

Respectfully,

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