

RECEIVED

Jun 21 2022

SC Court of Appeals

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

---

APPEAL FROM HORRY COUNTY  
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.

---

**RECORD ON APPEAL VOLUME I OF II**

---

A. Victor Rawl, Jr. (9261)  
E-mail: vrawl@grsm.com  
40 Calhoun Street, Suite 350  
Charleston, SC 29401  
Telephone: (843) 278-5900  
*Attorneys for Appellant ACS Primary Care  
Physicians-Southeast, P.C.*

Other Counsel of Record:  
Chris Moore, Esq.  
Will Lewis, Esq.  
RICHARDSON, THOMAS,  
HALTIWANGER  
MOORE & LEWIS, LLC  
1513 Hampton Street  
Columbia, SC 29201  
Telephone: (803) 281-8150  
cmoore@richardsonthomas.com  
wlewis@richardsonthomas.com  
*Attorneys for Respondent Jessica Bennett*  
William E. Hopkins, Jr., Esq.  
J. Clay Hopkins, Esq.

HOPKINS LAW FIRM, LLC  
12019 Ocean Highway  
Post Office Box 1885  
Pawleys Island, SC 29585  
Telephone: (843) 314-4202  
bill@hopkinsfirm.com  
clay@hopkinsfirm.com

Jeffrey D. Morris, Esq.  
Ian Andrew Taylor, Esq.  
MORRIS LAW FIRM  
PO Box 14724  
Surfside Beach, SC 29587  
Telephone: (843) 232-0944  
jm@jeffmorrislawfirm.com  
ian@jeffmorrislawfirm.com

Robert Morris Hadden, Esq.  
HADDEN LAW FIRM, LLC  
1501 Belle Isle Ave, Ste. 110-30  
Mt. Pleasant, SC 29464  
Telephone: (843) 388-6883  
rhadden@haddenlawfirm.com  
*Attorneys for Respondent Thuy N. Gasser*

## INDEX

|                                                                                                                                                                            |     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| Bennett Order remanding case to state court, filed on August 13, 2020 .....                                                                                                | 3   |
| Gasser Order remanding case to state court, filed on August 13, 2020.....                                                                                                  | 15  |
| Bennett Order Denying Motion to Stay / Dismiss and Compel Arbitration of Plaintiff's Claims,<br>filed on June 21, 2021 .....                                               | 26  |
| Bennett Order Denying ACS's Motion to Reconsider, filed on November 5, 2021 .....                                                                                          | 30  |
| Gasser Order Denying Motion to Stay / Dismiss and Compel Arbitration of Plaintiff's Claims,<br>filed on November 23, 2021 .....                                            | 31  |
| Bennett Plaintiff's Summons and Complaint, filed on March 17, 2020.....                                                                                                    | 36  |
| Bennett Defendant's Notice of Removal to the United States District Court for the District of<br>South Carolina, Florence Division, filed on April 20, 2020.....           | 50  |
| Bennett Plaintiff's Motion to Remand, filed on May 18, 2020 .....                                                                                                          | 53  |
| Gasser Plaintiff's Summons and Complaint, filed on May 21, 2020 .....                                                                                                      | 64  |
| Gasser Defendant's Notice of Removal to the United States District Court for the District of<br>South Carolina, Florence Division, filed on June 26, 2020.....             | 74  |
| Gasser Plaintiff's Motion to Remand to State Court and Memorandum of Law in Support, filed<br>on July 27, 2020.....                                                        | 77  |
| Gasser Defendant's Response in Opposition to Motion to Remand to State Court, filed on<br>August 10, 2020 .....                                                            | 99  |
| Gasser Plaintiff's Reply to Response in Opposition to Motion to Remand to State Court and<br>Memorandum of Law in Support, filed on August 27, 2020.....                   | 125 |
| Bennett Defendant's Motion to Compel Arbitration and Dismiss or Stay and all Exhibits thereto,<br>filed on August 31, 2020.....                                            | 142 |
| Gasser Defendant's Motion to Compel Arbitration and Dismiss or Stay and all Exhibits thereto,<br>filed on August 31, 2020.....                                             | 172 |
| Bennett Plaintiff's Memorandum in Opposition to Defendant's Motion to Compel Arbitration<br>and Dismiss or Stay and all Exhibits thereto, filed on September 30, 2020..... | 198 |
| Gasser Plaintiff's Memorandum in Opposition to Defendant's Motion to Compel Arbitration and<br>Dismiss or Stay and all Exhibits thereto, filed on October 7, 2020.....     | 285 |
| Bennett Defendant's Reply in Support of Defendant's Motion to Dismiss and all Exhibits<br>thereto, filed on October 15, 2020 .....                                         | 307 |
| Gasser Defendant's Reply in Support of Defendant's Motion to Dismiss and all Exhibits thereto,<br>filed on October 26, 2020 .....                                          | 357 |

|                                                                                                                                                                       |     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| Bennett Defendant's Supplemental Brief in Support of Motion to Compel Arbitration and Dismiss and all Exhibits thereto, filed on January 4, 2021.....                 | 418 |
| Bennett Plaintiff's Supplemental Brief in Opposition to Defendant's Motion to Compel Arbitration and Dismiss and all Exhibits thereto, filed on January 4, 2021 ..... | 431 |
| Bennett Defendant's Rule 59(e) Motion for Reconsideration of Denial of Motion to Compel Arbitration and Dismiss or Stay, filed on July 1, 2021.....                   | 442 |
| Plaintiff's Memorandum in Opposition to Defendant's Rule 59(e) Motion for Reconsideration and all Exhibits thereto, filed on July 14, 2021 .....                      | 518 |
| Bennett Defendant's Notice of Appeal, filed on November 14, 2021.....                                                                                                 | 522 |
| Gasser Defendant's Notice of Appeal, filed on December 3, 2021.....                                                                                                   | 524 |
| Certificate of Appellant.....                                                                                                                                         | 527 |

UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF SOUTH CAROLINA  
FLORENCE DIVISION

|                                               |   |                                    |
|-----------------------------------------------|---|------------------------------------|
| Jessica Bennett, individually and on behalf ) |   |                                    |
| of those similarly situated, )                |   | Civil Action No.: 4:20-cv-1501-RBH |
|                                               | ) |                                    |
| Plaintiff, )                                  |   |                                    |
|                                               | ) |                                    |
| v. )                                          |   | <b>ORDER</b>                       |
|                                               | ) |                                    |
| ACS Primary Care Physicians-South, P.C., )    |   |                                    |
|                                               | ) |                                    |
| Defendant. )                                  |   |                                    |
| _____ )                                       |   |                                    |

This matter is before the Court on Plaintiff Jessica Bennett’s (“Plaintiff”) motion to remand this case to state court. *See* ECF No. 7. The Court grants the motion for the reasons herein.<sup>1</sup>

**Background**

Plaintiff originally filed this action in the Horry County Court of Common Pleas on March 17, 2020 after she received medical care following a car accident in which she was injured. *See* Summons & Complaint [ECF No. 1-1]. In her complaint, Plaintiff alleges Defendant ACS Primary Care Physicians-South, P.C. (“Defendant”), a third-party healthcare provider, failed to submit Plaintiff’s medical bills to her insurer, Blue Cross Blue Shield (“BCBS”). Compl. ¶ 4. Plaintiff avers Defendant entered into a contract with BCBS to be an in-network provider (“Provider Agreement”). Compl. ¶ 2. Plaintiff is suing as a third-party beneficiary of the Provider Agreement asserting a breach of contract claim. Instead of billing BCBS for services rendered to Plaintiff, Defendant billed Plaintiff directly at rates higher than those negotiated in the Provider Agreement, resulting in an increase in healthcare costs to Plaintiff and other insureds. Compl. ¶ 4-5. Plaintiff

---

<sup>1</sup> The Court decides the motion without a hearing pursuant to Local Civil Rule 7.08 (D.S.C.).

asserts causes of action for breach of contract, unjust enrichment, and equity.

Defendant removed the action to this Court asserting federal question jurisdiction was available under 28 U.S.C. § 1331.<sup>2</sup> See ECF No. 1. Specifically, Defendant alleges this Court has original jurisdiction of this action under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), 29 U.S.C. § 1001, *et seq.*, because Plaintiff’s allegations relate to her employer-sponsored health insurance plans. Plaintiff then filed the instant motion to remand, ECF No. 7, Defendant responded in opposition, ECF No. 10, Plaintiff replied, ECF No. 11, and Defendant filed a sur reply, ECF No. 14. Accordingly, Plaintiff’s motion is ripe for decision before this Court.

### **Standard of Review**

The party seeking to remove a case to federal court bears the burden of establishing federal subject matter jurisdiction. *Mulcahey v. Columbia Organic Chemicals Co.*, 29 F.3d 148, 151 (4th Cir. 1994). Thus, Defendant bears the burden to establish federal jurisdiction is proper in this case. “Because removal jurisdiction raises significant federalism concerns, [the Court] must strictly construe removal jurisdiction. If federal jurisdiction is doubtful, a remand is necessary.” *Id.* (internal citation omitted).

A state court defendant may remove a civil action to a federal district court having original jurisdiction over the action. 28 U.S.C. § 1441(a). Federal district courts have original jurisdiction over all civil actions arising under federal law. 28 U.S.C. § 1331 (federal-question jurisdiction). Ordinarily, “[t]he presence or absence of federal-question jurisdiction is governed by the

---

<sup>2</sup> Defendant's notice of removal also references 28 U.S.C. § 1332(d); however, Defendant has abandoned any argument that this Court has subject matter jurisdiction under 28 U.S.C. § 1332.

‘well-pleaded complaint rule,’ which provides that federal jurisdiction exists only when a federal question is presented on the face of the plaintiff’s properly pleaded complaint.” *Caterpillar Inc. v. Williams*, 482 U.S. 386, 392 (1987). However, in certain situations Congress has “so completely preempt[ed] a particular area [of the law] that any civil complaint raising this select group of claims is necessarily federal in character. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987). In this situation, a claim that “comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law.” *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (internal quotations omitted). ERISA is one such situation. *Taylor*, 481 U.S. at 67.

In *Davila*, the seminal ERISA preemption case, the Supreme Court laid out a two-part test for determining whether a claim is completely preempted by ERISA’s civil enforcement provision. “[I]f an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant’s actions, then the individual’s cause of action is completely preempted by ERISA § 502(a)(1)(B).” *Davila*, 542 U.S. at 211; *see also Prince v. Sears Holdings Corp.*, 848 F.3d 173, 178 (4th Cir. 2017) (“‘It follows that if an individual brings suit complaining of a denial of coverage...where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls “within the scope of ERISA § 502(a)(1)(B)”’”) (quoting *Davila*, 542 U.S. at 210). The test set out in *Davila* is conjunctive; a state-law claim is completely preempted by ERISA only if both prongs of the test are satisfied.<sup>3</sup> *See Montefiore Med. Ctr. v. Teamsters Local*,

---

<sup>3</sup> The Fourth Circuit has set forth a three-prong test for when § 502(a)’s civil enforcement provision completely preempts a plaintiff’s state law claim: “(1) the plaintiff must have standing under § 502(a) to pursue its claim; (2) the claim must come within the scope of an ERISA provision that can be enforced via § 502(a); and (3) the claim must

642 F.3d 321, 328 (2d Cir. 2011).

### **Discussion**

Plaintiff argues remand to state court is required because the Court lacks subject matter jurisdiction. Defendant contends federal question jurisdiction exists under § 1331 because Plaintiff's claims are completely preempted by ERISA § 502(a)(1)(B), or alternatively, because Plaintiff's claims are completely preempted by ERISA §§ 502(a)(2) and 502(a)(3). The Court will address each of Defendant's arguments in turn.

#### **(a) Whether Plaintiff's claims are completely preempted by § 502(a)(1)(B)**

Defendant first argues remand is improper because Plaintiff's claims are completely preempted by § 502(a)(1)(B). Section 502(a)(1)(B) provides "[a] civil action may be brought (1) by a participant or beneficiary...to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). In order for this case to remain before this Court, Defendant must prove (1) plaintiff's suit complains "of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan" and (2) the plaintiff does not allege the violation of a "legal duty (state or federal) independent of ERISA or the plan terms." *Davila*, 542 U.S. at 210. If Defendant proves both prongs of the *Davila* test, Plaintiff's claims are completely preempted by ERISA and this case was properly removed to

---

not be capable of resolution without an interpretation of the contract governed by federal law, i.e., an ERISA-governed employee benefit plan." *Prince v. Sears Holding Corp.*, 848 F.3d 173, 177 (4th Cir. 2017) (quoting *Sonoco Products Co. v. Physicians Health Plan, Inc.*, 338 F.3d 366, 372 (4th Cir. 2003)). Although the Supreme Court and the Fourth Circuit have phrased their respective tests differently, the crux of both tests is (1) whether the claim could be brought under § 502(a) and (2) whether there is an independent legal duty outside of ERISA implicated by a defendant's actions.

this Court.

The first prong of *Davila* requires Plaintiff to complain she was denied coverage for medical care and she was only entitled to such coverage because of the terms of an ERISA-regulated employee benefit plan. Plaintiff asserts the first prong of *Davila* cannot be met in this case because she is not suing her ERISA plan or the plan administrator to enforce her rights under the terms of her ERISA plan, she is not suing to recover benefits, and she is not asking for a clarification of her rights to future benefits. *See* 29 U.S.C. § 1132(a)(1)(B). Instead, Plaintiff is suing Defendant, a healthcare provider, in a state common law breach of contract action based upon Defendant's violation of the Provider Agreement with BCBS because Defendant failed to bill BCBS and instead billed Plaintiff directly and overcharged her for the services Defendant provided, in violation of the Provider Agreement.

In response, Defendant alleges that, although couched in terms of a state law breach of contract claim, Plaintiff is essentially claiming Defendant's actions resulted in the denial of benefits that she was due under her ERISA plan, including the benefit of being charged a lower fee for services rendered under the plan. Defendant further argues that in order for the Court to determine if Plaintiff should have been billed at a lower rate, the Court will be required to interpret Plaintiff's ERISA plan. Both parties rely heavily on *Salzer v. SSM Health Care of Okla., Inc.*, 762 F.3d 1130 (10th Cir. 2014), although they predictably disagree on the impact *Salzer* has on the present case.

In *Salzer*, the Tenth Circuit addressed the issue of ERISA preemption where a plaintiff brought six claims, including breach of contract and tortious interference with contract, in Oklahoma state court against a healthcare provider who billed the plaintiff directly rather than billing his insurance company. The defendant removed the suit in reliance upon ERISA preemption,

and the plaintiff moved to remand the case to state court. The district court denied the plaintiff's motion, holding his claims were completely preempted by ERISA, and the plaintiff appealed.

The Tenth Circuit held five of the plaintiff's six claims, including claims for breach of contract, violation of the Oklahoma Consumer Protection Act, deceit, specific performance, and punitive damages, did not fall under § 502(a)(1)(B) because "they [did] not seek to vindicate rights set forth in the 'terms of the plan,' as required by the provision" and therefore the first prong of *Davila* was not met. *Salzer*, 762 F.3d at 1135. Specifically, the Tenth Circuit held:

[the plaintiff] does not assert claims for benefits under his Plan, nor does he seek to enforce or clarify rights under the Plan. Instead, he complains that [the defendant] did not fulfill its obligation to submit charges for his care to the insurer, but instead billed him directly. The contracts under which these claims arise are the Provider Agreement and the Hospital Services Agreement, not the [ERISA] Plan. *See Anderson v. Ochsner Health Sys.*, No. 11-2236, 2012 WL 2116173, at \*4 (E.D.La. June 11, 2012) (unpublished) (patient's claim against health care provider as third-party beneficiary to provider agreement was not preempted by ERISA because the claim "does not involve a denial of benefits" and thus could not be brought under § 502(a)).

*Id.*

The Court went on to hold these claims also failed the second prong of *Davila*, which requires no "independent legal duty" other than ERISA be implicated. *Id.* (citing *Davila*, 542 U.S. at 210).

Because the plaintiff claimed he was a third-party beneficiary to the Provider Agreement, the Court concluded his claims were based on statutory and common law duties that existed independently of ERISA. *Id.*

The Tenth Circuit did find, however, that the plaintiff's claim for tortious interference with contract was completely preempted by ERISA because "this claim depends entirely upon the existence of a benefit contained in an ERISA plan." *Id.* at 1137. The Court found this claim was "highly analogous" to the claims asserted in *Davila*, because the plaintiff could succeed on the

tortious interference claim “only if his ERISA plan actually entitled him to a discount for the services provided by [the defendant].” *Id.* at 1138. Because federal jurisdiction over any one claim is sufficient to support to removal, the Tenth Circuit ultimately affirmed and concluded the case was properly in federal court. *See* 28 U.S.C. § 1441(a) (permitting removal of any case over which the district court could have exercised original jurisdiction).

Despite the clear reasoning of the Tenth Circuit, Defendant relies upon this case for the proposition that Plaintiff’s claims are preempted because she is alleging she was denied coverage for medical care under her ERISA plan and thus, her claims are attempts to recover benefits due under § 502(a)(1)(B). In attempting to distinguish between the *Salzer* Court’s holding with respect to the tortious interference claim versus the remaining five claims, Defendant states “the fact that Plaintiff does not expressly allege a claim for tortious interference is of no moment.” ECF No. 10 at 8. Not only does Plaintiff not expressly make a tortious interference claim in this case, there is no suggestion anywhere in the Complaint of any tortious interference with the Provider Agreement, her ERISA plan, or any other contract. Thus, Plaintiff’s claims in this case are far more similar to the five claims the *Salzer* Court said were not completely preempted by ERISA than they are to the tortious interference claim.

The Court is further persuaded Plaintiff’s claims are not completely preempted by the reasoning of the Sixth Circuit in *K.B. by and through Qassis v. Methodist Healthcare-Memphis Hospitals*, 929 F.3d 795 (6th Cir. 2019). In *K.B.*, the plaintiff was injured in a car accident, sought treatment for her injuries, and then was billed by her healthcare provider. She sued in state court alleging breach of contract and claiming that the healthcare provider should have billed her insurance company instead and further, that the healthcare provider charged her more than the

negotiated rate set forth in the Provider Agreement. *Id.* at 798. The defendant removed the case to federal district court, the district court denied the plaintiff's motion to remand, and the plaintiff appealed, arguing the district court never had subject matter jurisdiction because her claims were not completely preempted by ERISA. *Id.* at 799.

The Sixth Circuit agreed with the plaintiff. The Court noted that "[i]n cases where ERISA does completely preempt a state claim, the plaintiff usually alleges that a medical provider denied coverage because an insurer refused to pay." *Id.* at 801. (citing *Davila*, 542 U.S. at 211). The *K.B.* Court explained this case was different:

Since [the plaintiff] has not alleged a denial of benefits under her husband's ERISA plan, ERISA does not completely preempt her claim. Indeed, she makes no claim at all against her ERISA plan. Instead, she claims that the hospital overcharged her for her care. She is suing the hospital, and only the hospital, for its billing practices. This is far afield from the "heart" of what ERISA governs: "the rights of beneficiaries...against plan administrators."

*Id.* at 801 (quoting *Hutchison v. Fifth Third Bancorp.*, 469 F.3d 583, 588 (6th Cir. 2006)).

Defendant attempts to distinguish *K.B.* on the basis that the plaintiff in *K.B.* had three insurance plans making payments for the services rendered, only one of those three plans was governed by ERISA, and the ERISA-governed plan only paid \$100 of the approximately \$8,000 total bill. ECF No.10 at 11. Defendant also argues that the *K.B.* Court did not consider the link between the provider agreement at issue there and the plaintiff's ERISA plan. The Court is unpersuaded by these distinctions. The facts giving rise to the *K.B.* plaintiff's claim are very similar to the facts here, and the reasoning for her claims are not completely preempted is just as applicable regardless of the number of insurance plans, the amount of money paid by the ERISA governed plan, or whether the Court discussed the link between the provider agreement and the plaintiff's

ERISA plan.

Here, just as in *Salzer* and *K.B.*, Plaintiff is not alleging Defendant “should have given her treatment that it did not or that doctors should have given her different medication.” *Id.* Plaintiff does not contest her coverage or raise any issue with it. “Rather, she says that given her coverage, given her benefit determinations, and given the care she received, [Defendant] overcharged her.” *Id.* Defendant’s reliance on *Salzer* is misplaced; this case is not alleging a denial of benefits, but rather asserts a claim as a third-party beneficiary of a contract Plaintiff alleges Defendant breached. Like *K.B.*, Plaintiff is suing the healthcare provider and only the healthcare provider for its billing practices. Defendant cannot satisfy the first prong of *Davila*, and therefore the doctrine of complete preemption is inapplicable and remand is proper.<sup>4</sup>

**(b) Whether Plaintiff’s claims are completely preempted by §§ 502(a)(2) and 502(a)(3)**

Defendant also asserts remand is improper and this case is properly before this Court because the Complaint is completely preempted by ERISA §§ 502(a)(2) and 502(a)(3). Section 502(a)(2) creates a right of action by a participant or beneficiary, among others, for “appropriate relief” based on a breach of fiduciary duty as set forth in 29 U.S.C. § 1109. 29 U.S.C. § 1132(a)(2). Section 502(a)(3) creates a right of action by a participant or beneficiary, among others, “(A) to enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan, or (B) to

---

<sup>4</sup> Even if Defendant was able to satisfy the first prong of *Davila*, complete preemption would still be inapplicable because the test is conjunctive and the second prong cannot be satisfied. The second prong of *Davila* requires Defendant to prove “there is no other independent legal duty that is implicated by a defendant’s actions.” *Davila*, 542 U.S. at 211. In this case, Plaintiff is suing as a third-party beneficiary of the Provider Agreement asserting a breach of contract claim. The Provider Agreement creates a legal duty for Defendant independent of any ERISA plan, and therefore, Plaintiff’s claims are not preempted by ERISA. *See id.* at 210 (explaining that actions that implicate an independent legal duty separate from § 502(a) are not preempted by ERISA); *see also K.B.*, 929 F.3d at 802 (holding “[s]ince a determination of [the defendant’s] liability stems from a different agreement and ‘not the terms of the [ERISA plan] itself,’ [the plaintiff’s] claim is based upon a ‘duty that is ‘independent of ERISA and the plan terms.’” (citations omitted); *Salzer*, 762 F.3d at 1135 (“Because [the plaintiff] seeks to enforce contracts other than the [ERISA plan] in these five claims, the claims also fail the second prong of the *Davila* preemption test...)).

obtain other appropriate equitable relief (I) to redress such violations or (ii) to enforce any provisions of [ERISA] or the terms of the plan.” 29 U.S.C. § 1132(a)(3). Again, the Fourth Circuit has held a claim is completely preempted under any of the provisions of ERISA § 502(a) where: (1) the plaintiff has standing to bring the claim under § 502(a); (2) the claim falls “within the scope of an ERISA provision that [the plaintiff] can enforce via § 502(a)”;

and (3) resolution of the claim must require interpretation of the ERISA plan. *Prince*, 848 F.3d at 177.<sup>5</sup>

Defendant is correct that §§ 502(a)(2) and 502 (a)(3) can completely preempt state law claims and create federal jurisdiction. *See Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278, 291 (4th Cir. 2003). The problem with Defendant’s theory is that § 502(a)(2) is not implicated by Plaintiff’s claims. Plaintiff has asserted claims for breach of contract, unjust enrichment, and equity; she has not asserted a claim for breach of fiduciary duty. As Plaintiff explained in her reply, the reason why she did not assert a breach of fiduciary duty claim in this lawsuit is because South Carolina law does not recognize a fiduciary duty under these circumstances. *See Beverly v. Grand Strand Regional Medical Center, LLC*, 429 S.C. 502, 515 (Ct. App. 2020) (“The circuit court properly found that South Carolina does not recognize a fiduciary duty related to a hospital’s billing practices.”). Because Plaintiff has not made a claim for breach of fiduciary claim, § 502(a)(2) has no applicability to the present litigation and cannot serve as a basis for this Court to hold that Plaintiff’s claims are completely preempted by ERISA’s civil enforcement provision.

The Court is also unpersuaded by Defendant’s argument that § 502(a)(3) completely

---

<sup>5</sup> In *Davila*, the petitioners only invoked § 502(a)(1)(B), and thus, the Supreme Court did not address any of the other provisions of § 502(a). *Davila*, 542 U.S. at 206, n.1 (“In this Court, petitioners do not claim or argue that respondents’ causes of action fall under ERISA § 502(a)(2). Because petitioners do not argue this point, and since we can resolve these cases entirely by reference to ERISA § 502(a)(1)(B), we do not address ERISA § 502(a)(2).”)

preempts Plaintiff's claims. In support of this argument, Defendant relies heavily on *Southern v. Wakemed*, No. 5-15-CV-35-FL, 2015 WL 13714472 (E.D.N.C. Apr. 21, 2015). In *Southern*, the plaintiff filed suit against a hospital system in North Carolina, asserting claims for breach of contract, violation of the North Carolina Unfair and Deceptive Trade Practices Act, breach of fiduciary duty, constructive fraud, and unjust enrichment. *Id.* at \*1. The plaintiff also sought injunctive relief. *Id.* While the case was still in state court, the plaintiff filed a motion to amend his first amended complaint, which was granted. *Id.* at \*2. In his second amended complaint, the plaintiff added two additional breach of contract claims, a claim for conversion, and a claim for violation of the North Carolina Debt Collection Act. *Id.* One of the additional breach of contract claims added by the plaintiff was against Blue Cross Blue Shield of North Carolina ("BCBSNC"), in which the plaintiff alleged BCBSNC violated the terms of the plaintiff's employer-provided BCBSNC healthcare plan ("Breach of Plan claim"). *Id.*

As relevant here, the district court found the case was properly removed because the Breach of Plan claim was completely preempted by § 502(a)(3). In fact, the defendant in *Southern* did not even attempt to remove the case until the plaintiff added the Breach of Plan claim. *Id.* The plaintiff in *Southern* alleged "he ha[d] been wrongfully denied benefits under his ERISA-governed plan and that [the] defendant was contractually obligated to provide those benefits...[m]oreover, [the] plaintiff [sought] injunctive relief to prevent future denial of benefits allegedly owed to him." *Id.* at \*8. As Defendant succinctly stated in its sur-reply, the issue in this case is whether Plaintiff's allegations state a claim under §§ 502(a)(2) and 502(a)(3). The Court concludes they do not.

### **Conclusion**

For the foregoing reasons, the Court **GRANTS** Plaintiff's motion to remand [ECF No. 7]

and **REMANDS** this case to the Court of Common Pleas for Horry County, South Carolina. The Court **DIRECTS** the Clerk to mail a certified copy of this Order to the clerk of the Horry County Court of Common Pleas.

**IT IS SO ORDERED.**

August 13, 2020  
Florence, South Carolina

s/ R. Bryan Harwell  
R. Bryan Harwell  
Chief United States District Judge

UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF SOUTH CAROLINA  
FLORENCE DIVISION

|                                              |   |                                    |
|----------------------------------------------|---|------------------------------------|
| Thuy N. Gasser, individually and on behalf ) |   |                                    |
| of other similarly situated, )               |   | Civil Action No.: 4:20-cv-2419-RBH |
|                                              | ) |                                    |
| Plaintiff, )                                 |   |                                    |
|                                              | ) |                                    |
| v. )                                         |   | <b>ORDER</b>                       |
|                                              | ) |                                    |
| ACS Primary Care Physicians-South, P.C., )   |   |                                    |
|                                              | ) |                                    |
| Defendant. )                                 |   |                                    |
| _____ )                                      |   |                                    |

This matter is before the Court on Plaintiff Thuy N. Gasser's ("Plaintiff") motion to remand this case to state court. *See* ECF No. 6. The Court grants the motion for the reasons herein.<sup>1</sup>

**Background**

Plaintiff originally filed this action in the Horry County Court of Common Pleas on May 21, 2020 after she received medical care following a car accident in which she was injured. *See* Summons & Complaint [ECF No. 1-1]. In her complaint, Plaintiff alleges Defendant ACS Primary Care Physicians-South, P.C. ("Defendant"), a third-party healthcare provider, refused to process or submit bills to Plaintiffs' health insurance provider and instead demanded that Plaintiff pay medical bills out of pocket. Compl. ¶ 1. Plaintiff is suing for breach of contract and unjust enrichment as a third-party beneficiary of the Provider Agreement between Defendant and Blue Cross Blue Shield. Compl. ¶¶ 4, 35-45.

Defendant removed the action to this Court asserting federal question jurisdiction was

---

<sup>1</sup> The Court decides the motion without a hearing pursuant to Local Civil Rule 7.08 (D.S.C.).

available under 28 U.S.C. § 1331.<sup>2</sup> See ECF No. 1. Defendant alleges this Court has original jurisdiction of this action under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), 29 U.S.C. § 1001, *et seq.*, because Plaintiff’s allegations relate to her employer-sponsored health insurance plans. Plaintiff then filed the instant motion to remand, ECF No. 6, Defendant responded in opposition, ECF No. 9, Plaintiff replied, ECF No. 10. Accordingly, Plaintiff’s motion is ripe for decision before this Court.

### **Standard of Review**

The party seeking to remove a case to federal court bears the burden of establishing federal subject matter jurisdiction. *Mulcahey v. Columbia Organic Chemicals Co.*, 29 F.3d 148, 151 (4th Cir. 1994). Thus, Defendant bears the burden to establish federal jurisdiction is proper in this case. “Because removal jurisdiction raises significant federalism concerns, [the Court] must strictly construe removal jurisdiction. If federal jurisdiction is doubtful, a remand is necessary.” *Id.* (internal citation omitted).

A state court defendant may remove a civil action to a federal district court having original jurisdiction over the action. 28 U.S.C. § 1441(a). Federal district courts have original jurisdiction over all civil actions arising under federal law. 28 U.S.C. § 1331 (federal-question jurisdiction). Ordinarily, “[t]he presence or absence of federal-question jurisdiction is governed by the ‘well-pleaded complaint rule,’ which provides that federal jurisdiction exists only when a federal question is presented on the face of the plaintiff’s properly pleaded complaint.” *Caterpillar Inc. v. Williams*, 482 U.S. 386, 392 (1987). However, in certain situations Congress has “so completely

---

<sup>2</sup> Defendant’s notice of removal also references 28 U.S.C. § 1332(d); however, Defendant has abandoned any argument that this Court has subject matter jurisdiction under 28 U.S.C. § 1332.

preempt[ed] a particular area [of the law] that any civil complaint raising this select group of claims is necessarily federal in character. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987). In this situation, a claim that “comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law.” *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004) (internal quotations omitted). ERISA is one such situation. *Taylor*, 481 U.S. at 67.

In *Davila*, the seminal ERISA preemption case, the Supreme Court laid out a two-part test for determining whether a claim is completely preempted by ERISA’s civil enforcement provision. “[I]f an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant’s actions, then the individual’s cause of action is completely preempted by ERISA § 502(a)(1)(B).” *Davila*, 542 U.S. at 211; *see also Prince v. Sears Holdings Corp.*, 848 F.3d 173, 178 (4th Cir. 2017) (“It follows that if an individual brings suit complaining of a denial of coverage...where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls “within the scope of ERISA § 502(a)(1)(B)””) (quoting *Davila*, 542 U.S. at 210). The test set out in *Davila* is conjunctive; a state-law claim is completely preempted by ERISA only if both prongs of the test are satisfied.<sup>3</sup> *See Montefiore Med. Ctr. v. Teamsters Local*,

---

<sup>3</sup> The Fourth Circuit has set forth a three-prong test for when § 502(a)’s civil enforcement provision completely preempts a plaintiff’s state law claim: “(1) the plaintiff must have standing under § 502(a) to pursue its claim; (2) the claim must come within the scope of an ERISA provision that can be enforced via § 502(a); and (3) the claim must not be capable of resolution without an interpretation of the contract governed by federal law, i.e., an ERISA-governed employee benefit plan.” *Prince v. Sears Holding Corp.*, 848 F.3d 173, 177 (4th Cir. 2017) (quoting *Sonoco Products Co. v. Physicians Health Plan, Inc.*, 338 F.3d 366, 372 (4th Cir. 2003)). Although the Supreme Court and the Fourth Circuit have phrased their respective tests differently, the crux of both tests is (1) whether the claim could be brought under § 502(a) and (2) whether there is an independent legal duty outside of ERISA implicated by a defendant’s actions.

642 F.3d 321, 328 (2d Cir. 2011).

### **Discussion**

Plaintiff argues remand to state court is required because the Court lacks subject matter jurisdiction. Defendant contends federal question jurisdiction exists under § 1331 because Plaintiff's claims are completely preempted by ERISA § 502(a)(1)(B), or alternatively, because Plaintiff's claims are completely preempted by ERISA §§ 502(a)(2) and 502(a)(3). The Court will address each of Defendant's arguments in turn.

#### **(a) Whether Plaintiff's claims are completely preempted by § 502(a)(1)(B)**

Defendant first argues remand is improper because Plaintiff's claims are completely preempted by § 502(a)(1)(B). Section 502(a)(1)(B) provides "[a] civil action may be brought (1) by a participant or beneficiary...to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). In order for this case to remain before this Court, Defendant must prove (1) plaintiff's suit complains "of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan" and (2) the plaintiff does not allege the violation of a "legal duty (state or federal) independent of ERISA or the plan terms." *Davila*, 542 U.S. at 210. If Defendant proves both prongs of the *Davila* test, Plaintiff's claims are completely preempted by ERISA and this case was properly removed to this Court.

The first prong of *Davila* requires Plaintiff to complain she was denied coverage for medical care and she was only entitled to such coverage because of the terms of an ERISA-regulated employee benefit plan. In this case, Plaintiff is not alleging that Blue Cross Blue Shield erroneously

denied benefits under the terms of an ERISA plan. Rather, as Plaintiff notes, her claims are predicated solely on Defendant's unilateral refusal to bill her insurance provider. This is not a suit "by a beneficiary to recover benefits from a covered plan." [Plaintiff's motion to remand, ECF No. 6-1 at 5].

In response, Defendant alleges that, although couched in terms of a state law breach of contract claim, Plaintiff is essentially claiming Defendant's actions resulted in the denial of benefits that she was due under her ERISA plan, including the benefit of being charged a lower fee for services rendered under the plan. Defendant further argues that in order for the Court to determine if Plaintiff should have been billed at a lower rate, the Court will be required to interpret Plaintiff's ERISA plan.

In *Salzer v. SSM Health Care of Okla., Inc.*, 762 F.3d 1130 (10th Cir. 2014), the Tenth Circuit addressed the issue of ERISA preemption where a plaintiff brought six claims, including breach of contract and tortious interference with contract, in Oklahoma state court against a healthcare provider who billed the plaintiff directly rather than billing his insurance company. The defendant removed the suit in reliance upon ERISA preemption, and the plaintiff moved to remand the case to state court. The district court denied the plaintiff's motion, holding his claims were completely preempted by ERISA, and the plaintiff appealed.

The Tenth Circuit held five of the plaintiff's six claims, including claims for breach of contract, violation of the Oklahoma Consumer Protection Act, deceit, specific performance, and punitive damages, did not fall under § 502(a)(1)(B) because "they [did] not seek to vindicate rights set forth in the 'terms of the plan,' as required by the provision" and therefore the first prong of *Davila* was not met. *Salzer*, 762 F.3d at 1135. Specifically, the Tenth Circuit held:

[the plaintiff] does not assert claims for benefits under his Plan, nor does he seek to enforce or clarify rights under the Plan. Instead, he complains that [the defendant] did not fulfill its obligation to submit charges for his care to the insurer, but instead billed him directly. The contracts under which these claims arise are the Provider Agreement and the Hospital Services Agreement, not the [ERISA] Plan. *See Anderson v. Ochsner Health Sys.*, No. 11-2236, 2012 WL 2116173, at \*4 (E.D.La. June 11, 2012) (unpublished) (patient’s claim against health care provider as third-party beneficiary to provider agreement was not preempted by ERISA because the claim “does not involve a denial of benefits” and thus could not be brought under § 502(a)).  
*Id.*

The Court went on to hold these claims also failed the second prong of *Davila*, which requires no “independent legal duty” other than ERISA be implicated. *Id.* (citing *Davila*, 542 U.S. at 210).

Because the plaintiff claimed he was a third-party beneficiary to the Provider Agreement, the Court concluded his claims were based on statutory and common law duties that existed independently of ERISA. *Id.*

The Tenth Circuit did find, however, that the plaintiff’s claim for tortious interference with contract was completely preempted by ERISA because “this claim depends entirely upon the existence of a benefit contained in an ERISA plan.” *Id.* at 1137. The Court found this claim was “highly analogous” to the claims asserted in *Davila*, because the plaintiff could succeed on the tortious interference claim “only if his ERISA plan actually entitled him to a discount for the services provided by [the defendant].” *Id.* at 1138. Because federal jurisdiction over any one claim is sufficient to support to removal, the Tenth Circuit ultimately affirmed and concluded the case was properly in federal court. *See* 28 U.S.C. § 1441(a) (permitting removal of any case over which the district court could have exercised original jurisdiction).

Despite the clear reasoning of the Tenth Circuit, Defendant relies upon this case for the proposition that Plaintiff’s claims are preempted because she is alleging she was denied coverage

for medical care under her ERISA plan and thus, her claims are attempts to recover benefits due under § 502(a)(1)(B). In attempting to distinguish between the *Salzer* Court's holding with respect to the tortious interference claim versus the remaining five claims, Defendant states "the fact that Plaintiff does not expressly allege a claim for tortious interference is of no moment." ECF No. 9 at 8. Not only does Plaintiff not expressly make a tortious interference claim in this case, there is no suggestion anywhere in the Complaint of any tortious interference with the Provider Agreement, her ERISA plan, or any other contract. Thus, Plaintiff's claims in this case are far more similar to the five claims the *Salzer* Court said were not completely preempted by ERISA than they are to the tortious interference claim.

The Court is further persuaded Plaintiff's claims are not completely preempted by the reasoning of the Sixth Circuit in *K.B. by and through Qassis v. Methodist Healthcare-Memphis Hospitals*, 929 F.3d 795 (6th Cir. 2019). In *K.B.*, the plaintiff was injured in a car accident, sought treatment for her injuries, and then was billed by her healthcare provider. She sued in state court alleging breach of contract and claiming that the healthcare provider should have billed her insurance company instead and further, that the healthcare provider charged her more than the negotiated rate set forth in the Provider Agreement. *Id.* at 798. The defendant removed the case to federal district court, the district court denied the plaintiff's motion to remand, and the plaintiff appealed, arguing the district court never had subject matter jurisdiction because her claims were not completely preempted by ERISA. *Id.* at 799.

The Sixth Circuit agreed with the plaintiff. The Court noted that "[i]n cases where ERISA does completely preempt a state claim, the plaintiff usually alleges that a medical provider denied coverage because an insurer refused to pay." *Id.* at 801. (citing *Davila*, 542 U.S. at 211). The *K.B.*

Court explained this case was different:

Since [the plaintiff] has not alleged a denial of benefits under her husband’s ERISA plan, ERISA does not completely preempt her claim. Indeed, she makes no claim at all against her ERISA plan. Instead, she claims that the hospital overcharged her for her care. She is suing the hospital, and only the hospital, for its billing practices. This is far afield from the “heart” of what ERISA governs: “the rights of beneficiaries...against plan administrators.”

*Id.* at 801 (quoting *Hutchison v. Fifth Third Bancorp.*, 469 F.3d 583, 588 (6th Cir. 2006)).

Here, just as in *Salzer* and *K.B.*, Plaintiff is not alleging Defendant “should have given her treatment that it did not or that doctors should have given her different medication.” *Id.* Plaintiff does not contest her coverage or raise any issue with it. Defendant’s reliance on *Salzer* is misplaced; this case is not alleging a denial of benefits, but rather asserts a claim as a third-party beneficiary of a contract Plaintiff alleges Defendant breached. Like *K.B.*, Plaintiff is suing the healthcare provider and only the healthcare provider for its billing practices. Defendant cannot satisfy the first prong of *Davila*, and therefore the doctrine of complete preemption is inapplicable and remand is proper.<sup>4</sup>

**(b) Whether Plaintiff’s claims are completely preempted by §§ 502(a)(2) and 502(a)(3)**

Defendant also asserts remand is improper and this case is properly before this Court because the Complaint is completely preempted by ERISA §§ 502(a)(2) and 502(a)(3). Section

---

<sup>4</sup> Even if Defendant was able to satisfy the first prong of *Davila*, complete preemption would still be inapplicable because the test is conjunctive and the second prong cannot be satisfied. The second prong of *Davila* requires Defendant to prove “there is no other independent legal duty that is implicated by a defendant’s actions.” *Davila*, 542 U.S. at 211. In this case, Plaintiff is suing as a third-party beneficiary of the Provider Agreement asserting a breach of contract claim. The Provider Agreement creates a legal duty for Defendant independent of any ERISA plan, and therefore, Plaintiff’s claims are not preempted by ERISA. *See id.* at 210 (explaining that actions that implicate an independent legal duty separate from § 502(a) are not preempted by ERISA); *see also K.B.*, 929 F.3d at 802 (holding “[s]ince a determination of [the defendant’s] liability stems from a different agreement and ‘not the terms of the [ERISA plan] itself,’ [the plaintiff’s] claim is based upon a ‘duty that is “independent of ERISA and the plan terms.”’”) (citations omitted); *Salzer*, 762 F.3d at 1135 (“Because [the plaintiff] seeks to enforce contracts other than the [ERISA plan] in these five claims, the claims also fail the second prong of the *Davila* preemption test...).

502(a)(2) creates a right of action by a participant or beneficiary, among others, for “appropriate relief” based on a breach of fiduciary duty as set forth in 29 U.S.C. § 1109. 29 U.S.C. § 1132(a)(2). Section 502(a)(3) creates a right of action by a participant or beneficiary, among others, “(A) to enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan, or (B) to obtain other appropriate equitable relief (I) to redress such violations or (ii) to enforce any provisions of [ERISA] or the terms of the plan.” 29 U.S.C. § 1132(a)(3). Again, the Fourth Circuit has held a claim is completely preempted under any of the provisions of ERISA § 502(a) where: (1) the plaintiff has standing to bring the claim under § 502(a); (2) the claim falls “within the scope of an ERISA provision that [the plaintiff] can enforce via § 502(a)”; and (3) resolution of the claim must require interpretation of the ERISA plan. *Prince*, 848 F.3d at 177.<sup>5</sup>

Defendant is correct that §§ 502(a)(2) and 502 (a)(3) can completely preempt state law claims and create federal jurisdiction. *See Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278, 291 (4th Cir. 2003). The problem with Defendant’s theory is that § 502(a)(2) is not implicated by Plaintiff’s claims. Plaintiff has asserted claims for breach of contract and unjust enrichment; she has not asserted a claim for breach of fiduciary duty. As Plaintiff explained in her reply, the reason why she did not assert a breach of fiduciary duty claim in this lawsuit is because South Carolina law does not recognize a fiduciary duty under these circumstances. *See Beverly v. Grand Strand Regional Medical Center, LLC*, 429 S.C. 502, 515 (Ct. App. 2020) (“The circuit court properly found that South Carolina does not recognize a fiduciary duty related to a hospital’s billing practices.”).

---

<sup>5</sup> In *Davila*, the petitioners only invoked § 502(a)(1)(B), and thus, the Supreme Court did not address any of the other provisions of § 502(a). *Davila*, 542 U.S. at 206, n.1 (“In this Court, petitioners do not claim or argue that respondents’ causes of action fall under ERISA § 502(a)(2). Because petitioners do not argue this point, and since we can resolve these cases entirely by reference to ERISA § 502(a)(1)(B), we do not address ERISA § 502(a)(2).”)

Because Plaintiff has not made a claim for breach of fiduciary duty claim, § 502(a)(2) has no applicability to the present litigation and cannot serve as a basis for this Court to hold that Plaintiff's claims are completely preempted by ERISA's civil enforcement provision.

The Court is also unpersuaded by Defendant's argument that § 502(a)(3) completely preempts Plaintiff's claims. In support of this argument, Defendant relies heavily on *Southern v. Wakemed*, No. 5-15-CV-35-FL, 2015 WL 13714472 (E.D.N.C. Apr. 21, 2015). In *Southern*, the plaintiff filed suit against a hospital system in North Carolina, asserting claims for breach of contract, violation of the North Carolina Unfair and Deceptive Trade Practices Act, breach of fiduciary duty, constructive fraud, and unjust enrichment. *Id.* at \*1. The plaintiff also sought injunctive relief. *Id.* While the case was still in state court, the plaintiff filed a motion to amend his first amended complaint, which was granted. *Id.* at \*2. In his second amended complaint, the plaintiff added two additional breach of contract claims, a claim for conversion, and a claim for violation of the North Carolina Debt Collection Act. *Id.* One of the additional breach of contract claims added by the plaintiff was against Blue Cross Blue Shield of North Carolina ("BCBSNC"), in which the plaintiff alleged BCBSNC violated the terms of the plaintiff's employer-provided BCBSNC healthcare plan ("Breach of Plan claim"). *Id.*

As relevant here, the district court found the case was properly removed because the Breach of Plan claim was completely preempted by § 502(a)(3). In fact, the defendant in *Southern* did not even attempt to remove the case until the plaintiff added the Breach of Plan claim. *Id.* The plaintiff in *Southern* alleged "he ha[d] been wrongfully denied benefits under his ERISA-governed plan and that [the] defendant was contractually obligated to provide those benefits...[m]oreover, [the] plaintiff [sought] injunctive relief to prevent future denial of benefits allegedly owed to him." *Id.* at

\*8. The issue in this case is whether Plaintiff's allegations state a claim under §§ 502(a)(2) and 502(a)(3). The Court concludes they do not.

**Conclusion**

For the foregoing reasons, the Court **GRANTS** Plaintiff's motion to remand [ECF No. 6] and **REMANDS** this case to the Court of Common Pleas for Horry County, South Carolina. The Court **DIRECTS** the Clerk to mail a certified copy of this Order to the clerk of the Horry County Court of Common Pleas.

**IT IS SO ORDERED.**

August 13, 2020  
Florence, South Carolina

s/ R. Bryan Harwell  
R. Bryan Harwell  
Chief United States District Judge

STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

COUNTY OF HORRY

C/A no. 2020-CP-26-01982

Jessica Bennett, individually and on  
behalf of those similarly situated,

Plaintiff,

**ORDER**

v.

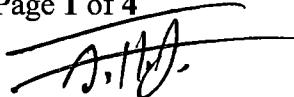
ACS Primary Care Physicians-Southeast  
P.C.,

Defendant.

Defendant, ACS Primary Care Physicians-Southeast P.C. (ACS), filed a Motion to Stay / Dismiss and Compel Arbitration of Plaintiff's Claims. Plaintiff opposes the motion. The parties submitted initial briefs. The court then granted leave for the filing of supplemental briefs in lieu of a hearing. The parties submitted those briefs as well. Having fully reviewed the parties' positions, the court denies ACS's motion.

**I. Introduction.**

Plaintiff alleges the following facts: Plaintiff was injured in a car crash. Plaintiff alleges that she went to the emergency department at a Spartanburg hospital, staffed with ACS physicians, to receive treatment for those injuries. Plaintiff alleges that she informed ACS that she was an insured member and beneficiary under a Blue Cross Blue Shield of South Carolina (BCBS) health insurance plan. ACS, a Georgia corporation, is an in-network provider for BCBS under the terms of a preferred provider organization (PPO) agreement. Under that agreement, ACS is held out as an in-network or preferred provider for BCBS patients. The Plaintiff alleges that the agreement requires ACS to bill BCBS directly for covered medical services ACS provides to BCBS health plan



members.<sup>1</sup> The Plaintiff alleges that the agreement also provides that ACS will accept a discounted rate (the Fee Allowance amount) for services provided to BCBS's members.<sup>2</sup> Last, the agreement requires ACS 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."<sup>3</sup>

Plaintiff alleges ACS did not bill BCBS for the services that ACS provided her, but instead billed her directly for an amount in excess of the BCBS fee allowance. Plaintiff further alleges that ACS has a common practice of identifying car crash victims and not submitting their bills to insurance in order to get a higher rate directly from the patients. As a result, plaintiff filed this action on behalf of herself and all others similarly situated.

Plaintiff alleges two causes of action. First, she alleges ACS is in breach of its agreement with BCBS to accept her health insurance benefits for services provided to her. Second, plaintiff alleges unjust enrichment and equity as a result of ACS's alleged scheme to circumvent her health insurance. After being served, ACS filed their Motion to Compel Arbitration of Plaintiff's Claims. Plaintiff opposes the motion, arguing that she is not bound by the arbitration provision.

## **II. Legal analysis.**

The PPO agreement between ACS and BCBS provides the framework for how ACS is to administer billing to BCBS's insured members. The PPO agreement between ACS and BCBS contains an arbitration agreement. It provides:

---

<sup>1</sup> See PPO agreement at p.5, § IV(A)(11) [Ex. A to plaintiff's opposition (Aug. 31, 2020)].

<sup>2</sup> *Id.* at p.4, § IV(A)(1).

<sup>3</sup> *Id.*

(1) Except for decisions made pursuant to the Utilization Management Program, [BCBS] and Preferred Provider [ACS] 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 Preferred Provider [ACS] 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.<sup>4</sup>

Although Bennet was not a signatory to the agreement at issue, ACS argues that the mandatory arbitration agreement governs this dispute under the doctrine of equitable estoppel. Defendant claims that "a nonsignatory is estopped from refusing to comply with an arbitration clause 'when it receives a direct benefit from a contract containing an arbitration clause.'" *Pearson v. Hilton Head Hops*, 400 S.C. 281 at 290, 733 S.E. 2d 597 at 601 (Ct. App. 2012). According to Defendant, a nonsignatory seeks a direct-benefit when they assert a claim based upon the contract at issue. As a result, Defendant asserts that "because Plaintiff is relying on [the contract] as the foundation for her breach of contract claim, she is estopped from denying she is not a signatory to that agreement" *Def. Motion to Compel Arbitration and Dismiss or Stay*, at 6.

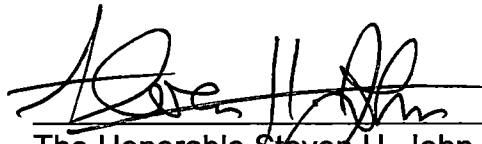
---

<sup>4</sup> PPO agreement at p.11, § IX(M) (emphasis added).

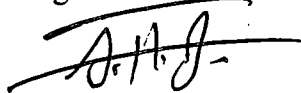
However, South Carolina Courts have repeatedly held that "direct benefits estoppel is not implicated simply because a claim relates to or would not have arisen 'but for' a contract's existence". Weaver v. Brookdale Senior Living, 431 S.C. 223 at 231, 847 S.E. 2d 268 at 272 (Ct. App. 2020) (Citing Wilson v. Willis, 426 S.C. 326 at 343, 827 S.E.2d 167 at 176 (Supreme Court 2019)). Instead, equitable estoppel is "a theory designed to prevent injustice, and it should be used sparingly". *Id.* at 233, 274. The doctrine of equitable estoppel is reserved for instances where a beneficiary of a contract "actively exploits" the agreement or "mislead[s] [the other party] to his injury". *Id.*

In this case, the Plaintiff was completely unaware that the PPO contract existed when she received her medical treatment. Plaintiff underwent medical treatment with the understanding that she would not bear the full responsibility of paying her medical bills given her valid health insurance. Plaintiff was not aware of, nor did she actively exploit, the PPO agreement between ACS and BCBS. Therefore, Defendant's Motion to Stay / Dismiss and Compel Arbitration of Plaintiff's Claims is DENIED.

**IT IS ORDERED.**

  
The Honorable Steven H. John  
Resident Judge  
Fifteenth Judicial Circuit

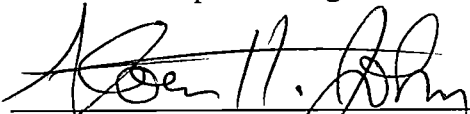
Dated: 6/18/21  
Conway, South Carolina.



|                                        |   |                                    |
|----------------------------------------|---|------------------------------------|
| STATE OF SOUTH CAROLINA                | ) | IN THE COURT OF COMMON PLEAS       |
|                                        | ) |                                    |
| COUNTY OF HORRY                        | ) | FIFTEENTH JUDICIAL CIRCUIT         |
|                                        | ) |                                    |
|                                        | ) | Civil Action No.: 2020-CP-26-01982 |
| Jessica Bennett, individually and on   | ) |                                    |
| behalf of those similarly situated,    | ) |                                    |
|                                        | ) |                                    |
| PLAINTIFF                              | ) |                                    |
|                                        | ) |                                    |
| V.                                     | ) | <b>ORDER DENYING DEFENDANT'S</b>   |
|                                        | ) | <b>MOTION TO RECONSIDER</b>        |
|                                        | ) |                                    |
| ACS Primary Care Physicians-South P.C. | ) |                                    |
|                                        | ) |                                    |
| DEFENDANT.                             | ) |                                    |
|                                        | ) |                                    |

This matter came before the Court on Defendant's Rule 59(e) Motion for Reconsideration of Denial of Motion to Compel Arbitration and Dismiss or Stay. The Court has considered Plaintiff's Motion, the written response of the Defendant, both filed with the Horry County Clerk of Court, and all other matters in the Clerk of Court's file. The Court finds that oral arguments would not assist it in this matter and that any additional arguments would be redundant and unnecessary. It is therefore

ORDERED that Defendant's Rule 59(e) Motion for Reconsideration of Denial of Motion to Compel Arbitration and Dismiss or Stay, is denied and the Court's prior ruling is reaffirmed in toto.

  
 The Honorable Steven H. John  
 Chief Administrative Judge  
 Fifteenth Judicial Circuit

November 5, 2021  
 Conway, South Carolina

STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

COUNTY OF HORRY

C/A no. 2020-CP-26-03169

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

Plaintiff,

**ORDER**

v.

ACS Primary Care Physicians-Southeast  
P.C.,

Defendant.

Defendant, ACS Primary Care Physicians-Southeast P.C. (ACS), filed a Motion to Stay / Dismiss and Compel Arbitration of Plaintiff's Claims. Plaintiff opposes the motion. The parties submitted briefs and agreed to a ruling on the briefs without a hearing. Having fully reviewed the parties' positions, the court denies ACS's motion.

#### **I. Introduction.**

Plaintiff alleges the following facts: Plaintiff was injured in a car crash. Plaintiff went to the emergency department at Grand Strand Regional Medical Center, a hospital staffed with ACS physicians, to receive treatment for those injuries. Plaintiff alleges that she informed ACS that she was an insured member and beneficiary under a Blue Cross Blue Shield of South Carolina (BCBS) health insurance plan. ACS, a Georgia corporation, is an in-network provider for BCBS under the terms of a preferred provider organization ("PPO") agreement. Under that agreement, ACS is held out as an in-network or preferred provider for BCBS patients. The plaintiff alleges that the agreement requires ACS to bill BCBS directly for covered medical services ACS

provides to BCBS health plan members.<sup>1</sup> The Plaintiff alleges that the agreement also provides that ACS will accept a discounted rate (the Fee Allowance amount) for services provided to BCBS's members.<sup>2</sup> Last, the agreement requires ACS 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."<sup>3</sup>

Plaintiff alleges ACS did not bill BCBS for the services that ACS provided her, but instead billed her directly for an amount in excess of the BCBS fee allowance. Plaintiff further alleges that ACS has a common practice of identifying car crash victims and not submitting their bills to insurance in order to get a higher rate directly from the patients. As a result, plaintiff filed this action on behalf of herself and all others similarly situated.

Plaintiff alleges two causes of action. First, she alleges ACS is in breach of its agreement with BCBS to accept her health insurance benefits for services provided to her. Second, plaintiff alleges unjust enrichment and equity as a result of ACS's alleged scheme to circumvent her health insurance. After being served, ACS filed their motion to Compel Arbitration of Plaintiff's Claims. Plaintiff opposes the motion, arguing that she is not bound by the arbitration provision.

## **II. Legal Analysis.**

The PPO agreement between ACS and BCBS provides the framework for how ACS is to administer billing to BCBS's insured members. The PPO agreement between ACS and BCBS contains an arbitration agreement. It provides:

---

<sup>1</sup> See PPO agreement at p.5, § IV(A)(11) [Ex. 1 to Defendant's Motion to Stay/Dismiss and Compel Arbitration of Plaintiff's claims (Aug. 31, 2020)].

<sup>2</sup> *Id.* at p.4, § IV(A)(1).

<sup>3</sup> *Id.*

- (1) Except for decisions made pursuant to the Utilization Management Program, [BCBS] and Preferred Provider [ACS] 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 Preferred Provider [ACS] 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.<sup>4</sup>

Although Gasser was not a signatory to the agreement at issue, ACS argues that the mandatory arbitration agreement governs this dispute under the doctrine of equitable estoppel. ACS claims, that a “nonsignatory is estopped from refusing to comply with an arbitration clause ‘when it receives a direct benefit from a contract containing an arbitration clause.’” Pearson v. Hilton Head Hops, 400 S.C. 281 at 290, 733 S.E. 2d 597 at 601 (Ct. App. 2012). According to Defendant, a nonsignatory seeks a direct-benefit when they assert a claim based upon the contract at issue. As a result, Defendant asserts that “because Plaintiff is relying on the [contract] as the foundation for her breach of contract claim, she is estopped from denying she is not a signatory to the agreement.” *Def. Motion to Compel Arbitration and Dismiss or Stay*, at 6.

However, South Carolina Courts have repeatedly held that “direct benefits estoppel is not implicated simply because a claim relates to or would not have arisen

---

<sup>4</sup> PPO agreement at p.10, § IX(M) (emphasis added)

'but for' a contract's existence". Weaver v. Brookdale Senior Living, 431 S.C. 223 at 231, 847 S.E. 2d 268 at 272 (Ct. App. 2020) (Citing Wilson v. Willis, 426 S.C. 326 at 343, 827 S.E. 2d 167 at 176 (Supreme Court 2019)). Instead, equitable estoppel is "a theory designed to prevent injustice, and it should be used sparingly." *Id.* at 233, 274. The doctrine of equitable estoppel is reserved for instances where a beneficiary of a contract "actively exploits" the agreement or "mislead[s] [the other party] to his injury." *Id.*

In this case, the Plaintiff was completely unaware that the PPO contract existed when she received her medical treatment. Plaintiff underwent medical treatment with the understanding that she would not bear the full responsibility of paying her medical bills given her valid health insurance. Plaintiff was not aware of, nor did she actively exploit the PPO agreement between ACS and BCBS. Therefore, Defendant's motion to Stay/Dismiss and Compel Arbitration of Plaintiff's Claims is DENIED.

**IT IS ORDERED.**

Dated: \_\_\_\_\_  
Conway, South Carolina

---

The Honorable Steven H. John  
Resident Judge  
Fifteenth Judicial Circuit



### Horry Common Pleas

**Case Caption:** Thuy N Gasser VS ACS Primary Care Physicians Southeast PC

**Case Number:** 2020CP2603169

**Type:** Order/Other

So Ordered

s/ Steven H. John, Resident Circuit Judge, #129

|                         |   |                              |
|-------------------------|---|------------------------------|
| STATE OF SOUTH CAROLINA | ) | IN THE COURT OF COMMON PLEAS |
|                         | ) | FIFTEENTH JUDICIAL CIRCUIT   |
| COUNTY OF HORRY         | ) |                              |

Case No.: 2019-CP-26- \_\_\_\_\_

|                                        |   |
|----------------------------------------|---|
| Jessica Bennett, individually and on   | ) |
| behalf of all those similarly situated | ) |
|                                        | ) |
| Plaintiff,                             | ) |

**SUMMONS**

v.

**JURY TRIAL DEMANDED**

|                           |   |
|---------------------------|---|
| ACS Primary Care          | ) |
| Physicians-Southeast P.C. | ) |
|                           | ) |
| Defendant.                | ) |

To: ACS Primary Care Physicians-Southeast P.C.:

YOU ARE SUMMONED and required to answer the complaint, a copy of which is being served on you, and to serve a copy of your answer to the complaint on the attorneys for plaintiff at their office at 1513 Hampton Street, First Floor, Columbia, South Carolina 29201, within thirty (30) days after service of the complaint, exclusive of the day of such service. If you fail to answer the complaint within the thirty (30) days, plaintiff will apply to the Court for a judgment by default as to the relief requested in the complaint.

Respectfully submitted,

RICHARDSON, PATRICK, WESTBROOK  
& BRICKMAN, LLC

BY: s/ William C. Lewis  
 William C. Lewis (SCB 101287)  
 Chris Moore (SCB 77934)  
 1513 Hampton Street, First Floor  
 Columbia, SC 29201  
 T: 803.541.7850  
 F: 803.541.9625  
[wlewis@rpwb.com](mailto:wlewis@rpwb.com)  
[cmoore@rpwb.com](mailto:cmoore@rpwb.com)

Dated: March 17, 2020

**ATTORNEYS FOR PLAINTIFF**

|                         |   |                              |
|-------------------------|---|------------------------------|
| STATE OF SOUTH CAROLINA | ) | IN THE COURT OF COMMON PLEAS |
|                         | ) | FIFTEENTH JUDICIAL CIRCUIT   |
| COUNTY OF HORRY         | ) |                              |

Case No.: 2019-CP-26-\_\_\_\_\_

|                                        |   |
|----------------------------------------|---|
| Jessica Bennett, individually and on   | ) |
| behalf of all those similarly situated | ) |

|            |   |
|------------|---|
| Plaintiff, | ) |
|------------|---|

|    |   |
|----|---|
| v. | ) |
|----|---|

|                           |   |
|---------------------------|---|
| ACS Primary Care          | ) |
| Physicians-Southeast P.C. | ) |

|            |   |
|------------|---|
| Defendant. | ) |
|------------|---|

**COMPLAINT****JURY TRIAL DEMANDED**

Plaintiff, Jessica Bennett, (hereinafter "Plaintiff"), individually and on behalf of all others similarly situated, files this Class Action Complaint against ACS Primary Care Physicians-Southeast P.C. ("Defendant"), and respectfully shows the following:

**INTRODUCTION**

1. Plaintiff and those similarly situated received healthcare services provided by Defendant, while insured through Blue Cross Blue Shield (hereinafter "BCBS").

2. Upon information and belief, Defendant entered into a contract with BCBS to be an in-network provider (agreement referred to herein as "Provider Agreement"). Under the Provider Agreement, Defendant agreed to bill BCBS directly for services rendered to patients insured through BCBS ("Insureds").

3. Upon information and belief, under the Provider Agreement, Defendant agreed to accept payment from BCBS at a negotiated rate for services rendered to Insureds.

4. Despite this obligation, upon information and belief, Defendant refused to bill BCBS for services rendered to Insureds. Instead, Defendant would bill Insureds directly at a rate higher than the negotiated BCBS rate, resulting in an increase in healthcare costs to Insureds.

5. Plaintiff and those similarly situated paid premiums to BCBS in order to receive certain benefits, including but not limited to, lower costs of healthcare obtained through BCBS's negotiated rates with providers. Plaintiff and those similarly situated were directly deprived of this benefit through Defendant's unlawful actions in breach of the Provider Agreement.

### **THE PARTIES**

6. Plaintiff, Jessica Bennett, was at all times relevant a resident of Spartanburg County and insured by BCBS.

7. Defendant, ACS Primary Care Physicians-Southeast, is a professional corporation incorporated in the State of Georgia. Defendant operates throughout the State of South Carolina, with a principal place of business in Horry County, South Carolina. Defendant maintains a registered agent at 1703 Laurel Street, Columbia SC 29201.

8. As part of Defendant's business, Defendant contracts with certain hospitals throughout South Carolina to staff hospitals' emergency rooms with doctors and other staff in order to provide emergency medicine services.

### **JURISDICTION AND VENUE**

9. This Court has jurisdiction under S.C. Const. art. V § 11, granting circuit court jurisdiction over civil actions.

10. Venue is proper as Defendant's principal place of business is Horry County.

**FACTUAL ALLEGATIONS SPECIFIC TO THE NAMED PLAINTIFF**

11. Plaintiff incorporates the foregoing allegations as if fully set forth herein.
12. At all times relevant hereto, Plaintiff was covered under a health insurance policy issued by BCBS through her employer.
13. Plaintiff timely paid her premiums for the coverage provided by her BCBS policy.
14. In consideration for Plaintiff's payment of premiums, Plaintiff received certain benefits under her policy, including lower costs of health care through BCBS's negotiated rates with Providers who are in BCBS's provider network.
15. Upon information and belief, at all times relevant hereto, Defendant, acting as an in-network provider, accepted insurance provided through BCBS.
16. Upon information and belief, to become an in-network provider, Defendant entered into the Provider Agreement with BCBS.
17. Upon information and belief, under the Provider Agreement, Defendant agreed to bill BCBS directly for services rendered by Defendant to a BCBS Insured, like Plaintiff.
18. Upon information and belief, under the Provider Agreement, Defendant agreed to not bill a BCBS insured directly for services rendered to a BCBS Insured, like Plaintiff.
19. Upon information and belief, under the Provider Agreement, Defendant agreed to accept a negotiated rate for services rendered to an Insured, like Plaintiff, as full payment for those services.
20. Upon information and belief, Insureds, like Plaintiff, receive direct benefits from the Provider Agreement, including but not limited to: not receiving bills directly from an in-network provider, and the costs of the services by an in-network provider being limited to BCBS's negotiated rates.

21. On December 14, 2018, Plaintiff was in a car wreck resulting in injuries to her person.

22. On December 16, 2018, Plaintiff went to the emergency room at the Mary Black Memorial Hospital, 1700 Skylyn Drive, Spartanburg SC.

23. Upon information and belief, Mary Black Memorial Hospital contracts with Defendant to provide emergency medicine services at Mary Black.

24. On December 16, 2018, Plaintiff received treatment for her injuries from medical professionals working for Defendant.

25. At the time of the treatment, Plaintiff was insured through BCBS.

26. Despite this fact, Defendant did not submit any claim to BCBS for services rendered to Plaintiff.

27. Instead, Defendant billed Plaintiff directly for her emergency room visit.

28. Defendant has charged Plaintiff \$1,050.00 for her emergency room visit.

29. Upon information and belief, this charge is significantly higher than what Defendant is required to accept from BCBS, for the type of services rendered to Plaintiff under the Provider Agreement.

30. At all times relevant hereto, Defendant had a duty to place the interests of Plaintiff above its own financial interests.

31. At all times relevant hereto, Defendant had a duty of care to accurately bill Plaintiff for the services rendered.

32. Through its bills to Plaintiff, Defendant misrepresented that it was entitled to the \$1050.00 for these services, despite Defendant's contractual obligations and duties under the Provider Agreement.

33. Upon information and belief, Defendant ignored, breached, and violated the Provider Agreement, in an attempt to increase revenue.

34. Defendant's breach of the Provider Agreement directly harmed Plaintiff.

**CLASS ALLEGATIONS**

35. Plaintiff incorporates the foregoing allegations as if fully set forth herein.

36. Plaintiff brings this action on behalf of herself and other similarly situated persons who were covered by BCBS and received services from Defendant.

37. Defendant has provided services to Insureds throughout South Carolina.

38. Upon information and belief, Defendant has repeatedly refused to bill BCBS for services rendered to Insureds, in violation of the Provider Agreement.

39. At all times relevant hereto, Defendant was a fiduciary to Insureds through the provider-patient relationship. This duty and Defendant's ethical obligations required Defendant to place its patients' interests above its own financial interests.

40. Defendant's failure to consistently honor the terms of the Provider Agreement has resulted in systematic breaches and acts of bad faith by Defendant.

41. By billing Insureds directly, at a rate higher than the BCBS negotiated rate, Defendant's conduct has been, and continues to be, in violation of South Carolina law and contrary to the terms, conditions, and obligations of the Provider Agreement.

42. Defendant's actions, in violation of South Carolina law and Defendant's express contractual obligations, have directly and proximately resulted in damages to Plaintiff and other similarly situated persons.

43. Specifically, pursuant to Rule 23 of the South Carolina Rules of Civil Procedure, Plaintiff brings this action on behalf of herself and all others similarly situated, as a representative of the following class (the “Class”):

All persons in South Carolina having an insurance policy with Blue Cross Blue Shield of South Carolina, who received services from Defendant from March 17, 2017 to March 17, 2020, where Defendant billed the persons directly at a higher price for services than the Blue Cross Blue Shield negotiated rates.

44. Excluded from the Class are Defendant, the officers and directors of Defendant, members of their immediate families and their legal representatives, heirs, successors or assigns, and any entity in which Defendant has or had a controlling interest.

45. Defendant had a pecuniary interest in billing Class members directly at a rate higher than the Blue Cross Blue Shield negotiated rate.

46. Defendant’s continued and systematic breaches of the Provider agreement shows that Defendant placed its pecuniary interests over the interests of Class members. These breaches deprived Class members of the benefits conferred them through the Provider Agreement.

47. Defendant’s breaches of the Provider Agreement directly and proximately resulted in damages to Class members.

**THE CLASS MEETS THE REQUIREMENTS OF SOUTH CAROLINA RULE OF CIVIL PROCEDURE 23**

48. Plaintiff incorporates the foregoing allegations as if fully set forth herein.

49. The Class is properly brought and should be maintained as a class action under Rule 23(a) of the South Carolina Rules of Civil Procedure because it satisfies the prerequisites of numerosity, commonality, typicality, and adequacy.

50. On information and belief, the members of the Class are so numerous that joinder of all members is impracticable. The exact number of Class members is unknown to Plaintiff at this time and can only be ascertained through appropriate discovery.

51. The claims of Plaintiff and the members of the Class involve common questions of law and fact, which predominate over questions affecting only individual members of the Class and which can be answered with common proof, including, *inter alia*, the following: (1) whether members were third-party beneficiaries of the Provider Agreement; (2) whether Defendant, in failing to bill BCBS directly, violated South Carolina law and/or breached the terms of the Provider Agreement; (3); whether Defendant acted in good faith in billing members directly at a higher rate than what it would receive from BCBS for the same service; and (4) whether Plaintiff and Class members are entitled to damages as a result of Defendant's breaches of its contractual obligations and acts of bad faith.

52. Plaintiff's claim is typical of those of the members of the Class because her claim has the same essential characteristics as the claims of the Class members, and their claims arise from the same course of conduct by Defendant. Plaintiff and all of the members of the Class maintain, or have maintained, health insurance coverage through BCBS. Plaintiff's action arises out of a standard form Provider Agreement that has not been followed due to the policies, practices, and procedures of Defendant that omit or conceal Defendant's obligation to bill BCBS directly and accept reimbursement at the pre-negotiated rate for services. Upon information and belief, Defendant applies these policies, practices, and procedures in a similar fashion to Plaintiff and all other Class members. Plaintiff and Class members were all direct beneficiaries of the Provider Agreement's provision requiring Defendant to bill BCBS and accept a negotiated rate for services rendered to Plaintiff and Class members. The Provider Agreement directly confers these and other

benefits to Plaintiff and Class members, and as third-party beneficiaries, Plaintiff and Class Members have standing to enforce the Provider Agreement. As to Plaintiff and all Class members, Defendant breached the Provider Agreement in a substantially similar manner, *i.e.*, by Defendant billing Class members directly for services at a higher rate, contrary to the terms of the Provider Agreement requiring Provider to bill BCBS directly and accept payment at lower negotiated rate.

53. Moreover, a class action is superior to other available methods for the fair and efficient adjudication of this controversy in that, among other factors:

(a) The interests of the Plaintiff and Class Members in individually controlling the prosecution of separate actions are outweighed by the advantages of adjudicating the common issues of fact and law by means of a class action;

(b) The expense of prosecuting Plaintiff's and Class Members' claims individually would significantly exceed any economic benefit Plaintiff or Class members could realize individually, and individual litigation would overload court dockets and magnify the delay and expense to all parties, making individual litigation of liability and damages economically impractical and infeasible;

(c) It is desirable that litigation of the claims occur for the Class in this forum to preserve the resources of both the courts and the litigants, and to reduce the risk of varying and inconsistent adjudications that could occur in individual adjudications; and

(d) Little, if any, difficulty is likely to be encountered in management of this class action because applicable law and contract terms will uniformly apply to the claims of the Class.

54. Plaintiff will fairly and adequately represent the interests of all members of the Class. Plaintiff's claims are common to all members of the Class, and Plaintiff has strong interests in vindicating their rights. Plaintiff is represented by counsel experienced in complex, class action

litigation. Neither Plaintiff nor Plaintiff's counsel has any interests adverse to, or in conflict with, any absent class member.

55. The amount in controversy for all Class members exceeds one hundred dollars.

**FOR A FIRST CAUSE OF ACTION**  
**Breach of Contract or Breach of Implied Contract**

56. Plaintiff incorporates the foregoing allegations as if fully set forth herein.

57. During the relevant class period, Plaintiff and all Class members entered into a contractual agreement with BCBS. Under this contractual agreement, Plaintiff and Class members agreed to pay monthly premiums to BCBS.

58. BCBS contracted with Defendant through the Provider Agreement. Under the Provider Agreement, Defendant agreed to certain conditions to be an in-network provider. Under this agreement and as an in-network provider, Defendant agreed to bill BCBS for services rendered to individuals insured by BCBS. Additionally, Defendant agreed to accept a lower pre-negotiated rate as full payment for the services rendered to individuals insured by BCBS.

59. During the relevant class period, Plaintiff and Class members received services from Defendant.

60. Defendant failed to bill these services to BCBS.

61. Despite the contractual terms to the contrary, Defendant billed Plaintiff and Class members directly, demanding a price higher than what it would have received from BCBS for the same services.

62. By failing to bill Blue Cross Blue Shield directly, Defendant breached its Provider Agreement with BCBS, including the covenant of good faith and fair dealing.

63. Plaintiff and members of the class are third-party beneficiaries of the breached Provider Agreement.

64. This breach allowed Defendant to receive more money that it would have been entitled to had it complied with the Provider Agreement.

65. Defendant's breaches have proximately caused Plaintiff and Class members to incur damages, which include all payments collected by Defendant from Plaintiff and/or Class members and all damages which may be shown through discovery.

66. Defendant's breaches have deprived Plaintiff and Class members of benefits they paid for through their health insurance with BCBS.

67. Plaintiff and the Class members are entitled to recover damages from Defendant for breach of contract arising from Defendant's breaches.

68. Alternatively, Plaintiff seeks specific performance and/or a declaration and an order enjoining Defendant's nonperformance to prevent irreparable harm to Plaintiff and the Class Members which requires Defendant to comply with its contractual obligations.

**FOR A SECOND CAUSE OF ACTION**  
**Unjust Enrichment**

69. Plaintiff incorporates the foregoing allegations as if fully set forth herein.

70. Plaintiff and Class Members conferred a non-gratuitous benefit by paying for health care services administered by Defendant.

71. These benefits were realized by Defendant through the billing of Class members directly at a rate for services that was higher than the agreed upon BCBS rate.

72. Defendant realized the value of payments from Class members through this improper billing.

73. Had Defendant followed the terms of the Provider Agreement, it would have received less money for these services.

74. Defendant has retained these improperly obtained benefits from the Class members, none of which has been disgorged.

75. Plaintiff and Class members are entitled, as a matter of equity, to recover the increased rates associated with the Project and other relief deemed reasonable and appropriate by the Court.

**FOR A THIRD CAUSE OF ACTION**

**Equity**

76. Plaintiff incorporates the foregoing allegations as if fully set forth herein.

77. “Courts have the inherent power to do all things reasonably necessary to insure that just results are reached to the fullest extent possible.” *Ex Parte Dibble*, 279 S.C. 592, 595–96, 310 S.E.2d 440, 442 (Ct. App. 1983).

78. Defendant thwarted contractual obligations to take advantage of individuals coming to them for medical emergencies. In doing so, Defendant chose its financial interest over that of its patients, resulting in financial harm to Plaintiff and the Class.

79. Given the foregoing, this Court should employ its inherent equitable powers to right past wrongs and fashion a just and appropriate remedy for Plaintiffs and the Class.

**JURY TRIAL DEMANDED AND PRAYER FOR RELIEF**

80. **WHEREFORE**, Plaintiff demands a jury trial and pray for judgment against the Defendant and that:

- a. that summons and process issue to the Defendant as required by law;
- b. that Plaintiff, individually, recover compensatory damages for the injuries and damages she has incurred in an amount proven at trial;
- c. that the Court certify the Class requested herein and find that that Plaintiff is an appropriate representative of the Class;

- d. that the Court find that the undersigned counsel fairly and adequately represents and protects the interests of the Class, and certify the undersigned counsel to act as counsel for the Class;
- e. that judgment be entered against Defendant finding that it breached the Provider Agreement by billing Plaintiff and Class members directly;
- f. that judgement be entered against Defendant finding that it breached the Provider Agreement by requesting Plaintiff and Class members pay more than the BCBS negotiated rate for services rendered by Defendant;
- g. that judgment be entered against Defendant in such amount as will fully and adequately compensate Plaintiff and the other Class members;
- h. that the Court issue an order requiring that Defendant specifically perform its obligations under the Provider Agreement in effect and/or enjoining any non-performance by Defendant;
- i. that Plaintiff and the class be awarded the just and proper equitable relief requested;
- j. that the Court award Plaintiff and members of the Class their costs;
- k. that Plaintiff have a trial by jury with respect to her legal claims; and
- l. that the Court grant such other and further relief as it deems just and proper under the premises.

Respectfully submitted,

RICHARDSON, PATRICK, WESTBROOK  
& BRICKMAN, LLC

By: s/ William C. Lewis  
William C. Lewis (SCB 101287)  
Chris Moore (SCB 77934)  
1513 Hampton Street, First Floor  
Columbia, SC 29201  
T: 803.541.7850  
F: 803.541.9625  
[wlewis@rpwb.com](mailto:wlewis@rpwb.com)  
[cmoore@rpwb.com](mailto:cmoore@rpwb.com)

Dated: March 17, 2020

**ATTORNEYS FOR PLAINTIFF**

) Civil Action No.:   4:20-cv-1501-RBH  
)  
)  
)  
)                 **NOTICE OF REMOVAL**  
)  
)  
)  
)  
)  
)  
)  
)  
)  
)

Jessica Bennett, individually and on  
behalf of those similarly situated,  
  
                                Plaintiff,  
  
            v.  
  
ACS Primary Care Physicians-South P.C.,  
  
                                Defendant

### A. Timeliness of Removal

2. On March 19, 2020, Plaintiff served the Summons and Complaint on Defendant.

## B. Federal Question Jurisdiction

3. This Court has original jurisdiction over this action by virtue of 28 U.S.C. § 1331 because it involves claims arising under the laws of the United States. Specifically, this Court has

original jurisdiction of this action under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), 29 U.S.C. § 1001, *et seq.*, because Plaintiff’s allegations relate to her employer-sponsored health insurance plans (the “Plans”).

4. Specifically, the Complaint alleges claims for breach of contract, unjust enrichment, and equity, asserting that Defendant erroneously billed Plaintiff for services Plaintiff’s Plans should have been billed for directly and in amounts that were greater than should have been billed. These claims fall within, and are completely preempted by, ERISA § 502(a)(2) such that the assertion of these state law claims are, in actuality, the assertion of ERISA claims. *See Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 65-66 (1987) (noting that state-law claims that fall within the scope of ERISA § 502(a)(2) are “necessarily federal in character”); *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278, 283 (4th Cir. 2003).

5. Consequently, this Court has federal question jurisdiction under 28 U.S.C. §§ 1331 and 1367, and this action may be removed to this Court by Defendant pursuant to 28 U.S.C. § 1441.

6. Accordingly, the case set forth above, Case No. 2020-CP-26-01982, filed in the Court of Common Pleas for Horry County, South Carolina could have been brought before this Court pursuant to 28 U.S.C. §§ 1331, 1332(d) and 1367, and may be removed by Defendants pursuant to 28 U.S.C. § 1441.

7. Under 28 U.S.C. § 1441(a), venue of the removed action is proper in this Court as the district and division embracing the place where the state action was pending.

8. Pursuant to 28 U.S.C. § 1446(a), Defendant has attached herewith, and incorporated by reference, a copy of the Summons and Complaint filed in this action. (*See Exhibit A.*)

9. Written notice of the filing of this Notice of Removal will be given to Plaintiff as required by law.

10. A true copy of this Notice of Removal is being filed with the Court of Common Pleas for Horry County, South Carolina as required by law.

WHEREFORE, Defendant respectfully requests that the action now pending in the State of South Carolina, Horry County, Court of Common Pleas, as Case No. 2020-CP-26-01982, proceed before this Court as an action properly removed.

Dated: April 20, 2020

GORDON & REES LLP

By s/Josh Dixon

Josh Dixon (Fed. 10036)

E-mail: [jdixon@grsm.com](mailto:jdixon@grsm.com)

Victoria T. Kepes (Fed. 13000)

E-mail: [vkepes@grsm.com](mailto:vkepes@grsm.com)

40 Calhoun Street, Suite 350

Charleston, SC 29401

Telephone: (843) 278-5900

*Attorneys for ACS Primary Care  
Physicians-South P.C.*

IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF SOUTH CAROLINA  
FLORENCE DIVISION

|                                             |   |                           |
|---------------------------------------------|---|---------------------------|
| Jessica Bennett, individually and on behalf | ) |                           |
| of those similarly situated,                | ) |                           |
|                                             | ) | C/A No.: 4:20-cv-1501-RBH |
| Plaintiff,                                  | ) |                           |
|                                             | ) |                           |
| vs.                                         | ) |                           |
|                                             |   |                           |
| ACS Primary Care Physicians-South P.C.,     |   |                           |
| Defendant.                                  |   |                           |

**MOTION TO REMAND**

Pursuant to 28 U.S.C § 1447, Plaintiff respectfully moves this Court to remand this action to state court based on its lack of federal question jurisdiction. Defendant has based removal upon ERISA<sup>1</sup> preemption. However, this is not an ERISA case. Plaintiff is not suing for ERISA benefits. She is not alleging a denial of benefits under her ERISA plan. Indeed, she makes no claim whatsoever under her ERISA plan or against its administrator, Blue Cross Blue Shield (“BCBS”). Instead, Plaintiff claims that Defendant, ACS Primary Care Physicians-South P.C., a third party healthcare provider, failed to submit Plaintiff’s medical bills to BCBS and then overcharged her for her care. She is suing Defendant for its billing practices and alleges those practices violate the

---

<sup>1</sup> Employee Retirement Income Security Act of 1974, as amended (“ERISA”), 29 U.S.C. § 1001 *et. seq.*

contractual duties contained in the Provider Agreement between Defendant and BCBS.<sup>2</sup> This case simply does not involve any duty or right under an ERISA plan.

Plaintiff's case is not based upon a novel theory. Indeed, many similar cases have been brought in other state and federal courts,<sup>3</sup> and both the Sixth and Tenth Circuit Courts of Appeals have directly addressed the precise remand issue before the Court. In each of those cases, the Circuit Courts found that ERISA preemption **does not** apply to putative class actions involving breach of contract claims for the overcharging of patients in violation of provider agreements. *K.B. by & through Qassis v. Methodist Healthcare - Memphis Hosps.*, 929 F.3d 795, 802 (6th Cir. 2019); *Salzer v. SSM Health Care of Oklahoma Inc.*, 762 F.3d 1130, 1135 (10th Cir. 2014).<sup>4</sup>

---

<sup>2</sup> Plaintiff alleges that in order to accept Blue Cross Blue Shield Insurance, a provider, in this case Defendant, must enter into a contract with BCBS, referred to herein as the Provider Agreement. While Plaintiff intends to obtain the Provider Agreement in discovery, from information obtained and review of similar cases, this Provider Agreement requires Defendant to bill BCBS and accept a predetermined rate for services rendered to an insured, like Plaintiff. The *gravamen* of Plaintiff's complaint is Defendant's violation of this Provider Agreement of which Plaintiff is a third-party beneficiary. See *Beverly v. Grand Strand Reg'l Med. Ctr. LLC*, 839 S.E2d 468, 471-473 (S.C. Ct. App. 2020) (holding that insured patient is a third-party beneficiary of a provider agreement).

<sup>3</sup> In fact a similar class action involving a hospital in Myrtle Beach is currently being litigated in the South Carolina courts. *Beverly v. Grand Strand Reg'l Med. Ctr., LLC*, 839 S.E.2d 468 (S.C. Ct. App. 2020), reh'g denied (Mar. 31, 2020).

<sup>4</sup> From the undersigned's review, every Court to address ERISA preemption in provider overcharging class actions has held that ERISA preemption **does not** apply to the type of claims raised in this case. See also *Cates v. Integrus Health, Inc.*, 2018 OK 9, ¶ 19, 412 P.3d 98, 106 (2018) (Supreme Court of Oklahoma holding ERISA does not apply); *Anderson v. Ochsner Health System*, 2012 WL 2116173 at \*4 (E.D.LA. 2012) (ERISA does not apply to overcharging in violation of provider agreement).

Because this is not an ERISA case, and the federal courts have consistently rejected Defendant's argument for removal in identical cases, the Court should remand this action back to state court.

### **I. FACTUAL BACKGROUND AND TIMELINESS OF REMAND**

This action involves Defendant failing to submit its bills to Plaintiff's insurer, BCBS, pursuant to a Provider Agreement between BCBS and Defendant. This Provider Agreement required Defendant to bill BCBS and accept a certain pre-determined price for the services rendered to Plaintiff. Comp. ¶ 4.<sup>5</sup> Despite this contractual obligation, Defendant billed Plaintiff directly at a rate greater than the agreed-upon rate contained in the Provider Agreement. *Id.* As a result, Plaintiff was overcharged for her care. Comp. ¶ 5.

Based upon information obtained and communications between Plaintiff and Defendant, Plaintiff alleges that this is a routine practice of Defendant, wherein Defendant will not bill BCBS for service rendered to an insured, but instead improperly bill the patient directly and charge a price higher than what Defendant agreed to accept from BCBS. Comp. ¶ 35-47. All of this is done in direct violation of Defendant's contractual duties under the Provider Agreement. *Id.*

Consequently, on March 17, 2020, Plaintiff brought this action on behalf of herself and those similarly situated. On April 20, 2020, Defendant filed a timely notice of removal. ECF No. 1. Pursuant to 28 U.S.C. § 1447, Plaintiff must file a motion to remand within thirty days of the notice of removal. Thus, this motion to remand is timely.

---

<sup>5</sup> Plaintiff's Complaint is filed at ECF No 1-1.

## II. APPLICABLE LAW

The burden of demonstrating jurisdiction resides with “the party seeking removal.” *Dixon v. Coburg Dairy, Inc.*, 369 F.3d 811, 816 (4th Cir. 2004) (citing *Mulcahey v. Columbia Organic Chems. Co.*, 29 F.3d 148, 151 (4th Cir.1994)). The court is obliged to construe removal jurisdiction strictly because of the “significant federalism concerns” implicated. *Id.* Therefore, “[i]f federal jurisdiction is doubtful, a remand [to state court] is necessary.” *Id.*

Ordinarily, determining whether a particular case arises under federal law turns on the “well-pleaded complaint” rule. *Franchise Tax Bd. of Cal. v. Construction Laborers Vacation Trust for Southern Cal.*, 463 U.S. 1, 9–10, 103 (1983). There is, however, a “narrow exception” to the well-pleaded complaint rule—the doctrine of “complete preemption.” *Lontz v. Tharp*, 413 F.3d 435, 439 (4th Cir. 2005). Complete preemption under ERISA<sup>6</sup>— a proper basis for removal—only arises if a state-law claim can be re-characterized as a claim under ERISA's civil enforcement provision, § 502(a). *Sonoco Products Co. v. Physicians Health Plan, Inc.* 338 F.3d 366, 371 (4th Cir. 2003); *see also Darcangelo v. Verizon Commc'ns, Inc.*, 292 F.3d 181, 187 (4th Cir. 2002) (observing that § 502(a) converts all claims coming within its scope into federal claims).

In the seminal ERISA preemption case of *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), the Supreme Court laid out a two-part test for determining whether a claim falls within the scope

---

<sup>6</sup> There are two types of ERISA preemption, conflict preemption and complete preemption. *Rollins v. Kjellstrom & Lee, Inc.*, 109 F. Supp. 3d 869, 876 (E.D. Va. 2015). Defendant does not state which type of preemption it relies on in support removal; however, both cases cited in its notice, *Metro Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278 (4th Cir. 2003), rely on complete preemption. Thus, Plaintiff will only address complete preemption in this motion.

of the civil enforcement provision<sup>7</sup>: “[I]f an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant’s actions, then the individual’s cause of action is completely pre-empted by ERISA § 502(a)(1)(B).” *Davila*, 542 U.S. at 211; *see also Prince v. Sears Holdings Corporation*, 848 F.3d 173, 178 (4th Cir. 2017) (“It follows that if an individual brings suit complaining of a denial of coverage ..., where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls ‘within the scope of ERISA.’”) (quoting *Davila*, 542 U.S. at 210).<sup>8</sup> The *Davila* test is conjunctive. Therefore, a state-law claim is completely preempted by ERISA only if both prongs of the test are satisfied. *See Montefiore Med. Ctr. v. Teamsters Local* 642 F.3d 321, 328 (2d Cir. 2011).

---

<sup>7</sup> The civil enforcement provision in § 502(a) allows a plan participant or beneficiary to bring a civil action “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

<sup>8</sup> In interpreting ERISA’s civil enforcement provision § 502(a), the Fourth Circuit Court of Appeals has outlined a three-prong test for complete preemption: “(1) the plaintiff must have standing under § 502(a) to pursue its claim; (2) the claim must come within the scope of an ERISA provision that can be enforced via § 502(a); and (3) the claim must not be capable of resolution without an interpretation of the contract governed by federal law, i.e., an ERISA-governed employee benefit plan.” *Prince v. Sears Holdings Corp.*, 848 F.3d 173, 177 (4th Cir. 2017) (quoting *Sonoco*, 338 F.3d at 372).

Whether considered a two or three part test, the critical inquiry is whether the claim could be brought under §502(a), and whether there is an independent legal duty defeating preemption. *Prince*, 848 F.3d at 178 (citing *Davila*). As such, Plaintiff will apply the Supreme Court’s two-part test in this motion.

### III. ARGUMENT

Plaintiff is not suing her Plan or its administrator to enforce her rights under the terms of an ERISA plan. She is not suing to recover benefits, nor is she asking for clarification of her rights to future benefits. To be clear, Plaintiff alleges no issue with the administration, application, or delivery of rights under her ERISA plan. Plaintiff is suing Defendant, a healthcare provider, in a state common law breach of contract action<sup>9</sup> based upon Defendant's violation of its contract (the Provider Agreement) with BCBS by failing to bill BCBS and overcharging her for services. Bottom line, this is not an ERISA action, nor could it be.

#### A. *Davila's First Prong*: Plaintiff Could Not Bring this Action Under § 502(a)

Plaintiff was not denied benefits under any ERISA plan. Consequently § 502(a) is not applicable. No remedy provided by § 502(a) addresses the wrong alleged. Plaintiff is suing for damages resulting from Defendant charging her more than what Defendant agreed to charge under its Provider Agreement with BCBS. This is not an action that can be brought under § 502(a).

This exact scenario was recently addressed by the Sixth Circuit in *K.B. by and through Qassis v. Methodist Healthcare- Memphis Hospitals*. In *Methodist*, the Sixth Circuit addressed ERISA preemption involving a putative class action, wherein a Memphis hospital routinely overcharged patients in violation of a provider agreement with the patients' insurers.<sup>10</sup> The Court addressed the first prong of *Davila*, noting:

---

<sup>9</sup> She also alleges related equitable remedies. Comp ¶¶ 69-79.

<sup>10</sup> *K.B. by and through Qassis v. Methodist Healthcare- Memphis Hospitals*, 929 F.3d. 795, 798 (6th Cir. 2019) (“[Plaintiff] says that the insurance plans had already agreed with Methodist on the price of her care. She claims that, despite this agreement, Methodist overcharged her. And she alleges that this was common practice for Methodist.”)

Since Knox-Bender has not alleged a denial of benefits under her husband's ERISA plan, ERISA does not completely preempt her claim. Indeed, she makes no claim at all against her ERISA plan. Instead, she claims that the hospital overcharged her for her care. She is suing the hospital, and only the hospital, for its billing practices, and only its billing practices. This is far afield from the "heart" of what ERISA governs: "the rights of beneficiaries ... against plan administrators."

*K.B. by & through Qassis v. Methodist Healthcare - Memphis Hosps.*, 929 F.3d 795, 802 (6th Cir. 2019) (citation omitted) (emphasis supplied).

The Tenth Circuit addressed the same issue in *Salzer v. SSM Health Care of Oklahoma, Inc.*

In *Salzer*, the Court reached the same conclusion in a class action with almost identical "overcharging" allegations:<sup>11</sup>

We conclude that five of Salzer's six original claims do not fall under ERISA § 502(a)(1)(B) because they do not seek to vindicate rights set forth in the "terms of the plan," as required by that provision. A claim meets the first prong of the *Davila* test if it asserts rights to which the plaintiff is entitled "*only* because of the *terms of an ERISA-regulated employee benefit plan.*" *Davila*, 542 U.S. at 210, 124 S.Ct. 2488 (emphases added). In his claims for breach of contract, violation of the Oklahoma Consumer Protection Act, deceit, specific performance, and punitive damages, Salzer does not assert claims for benefits under his Plan, nor does he seek to enforce or clarify rights under the Plan. Instead, he complains that SSM did not fulfill its obligation to submit charges for his care to the insurer, but instead billed him directly. **The contracts under which these claims arise are the Provider Agreement and the Hospital Services Agreement, not the Plan.**

*Salzer v. SSM Health Care of Oklahoma Inc.*, 762 F.3d 1130, 1135 (10th Cir. 2014) (emphasis supplied).<sup>12</sup>

---

<sup>11</sup> *Salzer v. SSM Health Care of Oklahoma Inc.*, 762 F.3d 1130, 1133 (10th Cir. 2014) ("SSM had an existing contract with Salzer's health insurance company (the "Provider Agreement") which required SSM to submit covered medical charges to Salzer's insurance company and accept discounted payment from the insurer. Although the Provider Agreement prohibited SSM from seeking payment for a covered charge from Salzer, SSM sought the non-discounted amount directly from him.") (footnote omitted).

<sup>12</sup> In *Salzer*, the Court did find that Plaintiff's tortious interference with contract claim was preempted, as the contract allegedly interfered with was the ERISA plan. *Id.* at 1138-1139. However, in this case, Plaintiffs have not alleged tortious interference with any contract. Most importantly, Plaintiffs here have not alleged any breach of the ERISA plan. Thus, we have no such concern here.

In addition to these circuits,<sup>13</sup> at least one district court has also addressed this exact issue, finding that preemption does not apply. In *Anderson v. Ochsner Health System*, the Court examined ERISA preemption of a class action third-party breach of contract claim, again involving a provider failing to bill a patient's insurance, and instead overbilling the patient in violation of a provider agreement.<sup>14</sup> There, the court rejected the same preemption challenge lodged here, stating:

United has not denied Anderson any benefits due to her pursuant to her ERISA plan. As the dispute between Anderson and Ochsner is not a relationship governed by ERISA and this case does not involve a denial of benefits, Anderson could not sue Ochsner pursuant to ERISA § 502(a). Anderson's claims do not satisfy the *Davila* test. Accordingly, ERISA does not completely preempt her contract claims and her right to sue as a third party beneficiary for breach of that contract and this Court does not have subject-matter jurisdiction.

*Anderson v. Ochsner Health System*, 2012 WL 2116173 at \*4 (E.D. La. 2012)

These three cases address the exact issue before this Court and all reach the identical conclusion. Where the claims do not allege a denial of benefits, but are based on a separate

---

<sup>13</sup> The Supreme Court of Oklahoma, interpreting federal law, also found that ERISA preemption did not apply to a class action involving the overbilling of patients in violation of a provider agreement. See *Cates v. Integrus Health, Inc.*, 2018 OK 9, ¶ 19, 412 P.3d 98, 106 (2018) (“Plaintiff claims that such a third-party contract exists (the PPO agreement) and that it prohibits Integrus from billing her unless it first submits the charges to her insurer for review. She further alleges that Integrus billed her without first submitting the charges to her insurer for review, thus breaching both the PPO agreement and the admission form. . . . Assuming each of these allegations to be true, Cates has stated a colorable claim for relief—and has done so without reference to the ERISA plan.”).

<sup>14</sup> *Anderson v. Ochsner Health System*, 2012 WL 2116173 at \*1 (E.D.L.A. 2012) (“She alleges that, pursuant to the terms of the hospital participation agreement (the “contract”) between Ochsner and United, Ochsner is required to submit medical bills for United-covered patients to United. Anderson contends that Ochsner may not charge her any costs other than her applicable deductible, co-insurance, or other amounts allowed as under the policy or the contract. Nevertheless, Anderson claims that Ochsner improperly directly billed her \$2,824.99 for the medical services rendered, rather than submitting the claim to United.”) (footnotes omitted).

agreement, the claim is not within the scope of § 502(a). This Court need go no further and should remand the case.

*B. Davilla's Second Prong: There is an Independent Legal Duty Created by the Provider Agreement, Thereby Defeating Preemption.*

The Provider Agreement creates a legal duty for Defendant independent of any ERISA plan. Thus, complete preemption does not apply. *Davila*, 542 U.S. at 210 (explaining that actions that implicate an “independent legal duty” separate from 502(a) are not preempted by ERISA); *Prince v. Sears Holdings Corporation*, 848 F.3d 173, 178 (4th Cir. 2017) (same).

Unsurprisingly, *Methodist* and *Salazar* held that the provider agreements created an independent legal duty, defeating application of complete preemption under the second prong of *Davila*.

In *Methodist*, the Sixth Circuit explained its reasoning as follows:

Even if Methodist had shown that Knox-Bender alleged a denial of benefits, it must also show that Knox-Bender complains only of duties breached under ERISA, not any independent legal duty. Because it has not, Methodist does not meet its burden to prove the need for federal jurisdiction.

Knox-Bender raises a single claim that is completely independent of ERISA. She claims that Methodist reneged on its agreements with insurance providers by overcharging her and patients like her. She alleges that Methodist breached a duty that stems from those insurance contracts, not from her ERISA plan. Since a determination of Methodist's liability stems from a different agreement and “not the terms of the [ERISA plan] itself,” Knox-Bender's claim is based upon a “duty that is ‘independent of ERISA and the plan terms.’”

*K.B. by & through Qassis v. Methodist Healthcare - Memphis Hosps.*, 929 F.3d 795, 802 (6th Cir. 2019) (citations omitted).

In *Salzer*, the Tenth Circuit stated:

Because Salzer seeks to enforce contracts other than the Plan in these five claims, the claims also fail the second prong of the *Davila* preemption test, which requires that no “independent legal duty” other than ERISA be implicated. The district court concluded

that Salzer, “as a patient, is not a party to the provider agreement [between SSM and Aetna] and, therefore, does not have independent rights that do not derive from the ERISA benefit plan.” But Salzer alleges that SSM violated duties it owed to him under the Hospital Services Agreement—to which he is a party—and that he is a third-party beneficiary to the Provider Agreement. Salzer also alleges in these claims that by improperly billing him in violation of the above-cited agreements, SSM violated state statutory duties and common law tort duties.

*Salzer v. SSM Health Care of Oklahoma Inc.*, 762 F.3d 1130, 1135 (10th Cir. 2014) (citation and quotation omitted).

Not only are these cases factually “on all fours” with the pending matter, but their holdings are consistent with the larger body of case law holding that enforcement of separate contracts independent of an ERISA plan does not provide for preemption. *See e.g., Greenbrier Hotel Corp. v. UNITE HERE HEALTH*, 719 F. App'x 168, 179–80 (4th Cir. 2018) (“The agreement between the Greenbrier, an employer and ERISA plan sponsor, and the Fund, an ERISA plan, formed an ordinary contractual relationship. Enforcing the terms of their agreement does not implicate the regulation of, administration of, or benefits provided under ERISA plans more generally.”); *Lone Star OB/GYN Associates v. Aetna Health Inc.*, 579 F.3d 525, 531 (5th Cir. 2009) (“[Plaintiff’s] claims are entirely separate from coverage and arise out of the independent legal duty contained in the contract and [Texas law].”); *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1051–52 (9th Cir. 1999) (holding that a dispute regarding “provider agreements” was not preempted because it was based on “state law claims arising out of separate agreements for the provision of goods and services”); *Sheridan Healthcorp, Inc. v. Aetna Health Inc.*, 161 F.Supp.3d 1238 (S.D.Fla. 2016) (“Sheridan’s action is predicated on the existence of independent contracts with Defendants and the alleged breaches of those contracts. Clearly, ERISA was not enacted to ‘enforce the general principle that [contractual] promises ought to be kept.’”) (internal citations omitted)); *Boca Raton Community Hospital, Inc. v. Great–West Healthcare of Fla.*, 2008 WL 728538 \*6–7 (S.D. Fla. 2008) (holding that ERISA did not preempt hospital’s state law claims

against insurer for underpayment of claims where resolution of dispute turned on insurer's right to apply discounted rates under a separate agreement between hospital and insurer).

This case is brought to address the breach of Defendant's legal duty created though the Provider Agreement. This Agreement is separate and apart from any ERISA plan and creates an independent legal duty. As such, under *Davila*, preemption would be inappropriate in this case.

#### **IV. CONCLUSION**

Every Court to address this precise scenario has rejected Defendant's preemption argument and found remand appropriate. Defendant gives no reason for this Court to find differently.

Accordingly, Defendant's motion should be denied and the matter remanded to state court.

Respectfully submitted,

RICHARDSON, PATRICK, WESTBROOK  
& BRICKMAN, LLC

BY: s/ William C. Lewis  
William C. Lewis (#12076)  
Email: [wlewis@rpwb.com](mailto:wlewis@rpwb.com)  
Christopher Moore (#10445)  
Email: [cmoore@rpwb.com](mailto:cmoore@rpwb.com)  
1513 Hampton Street, 1<sup>st</sup> floor  
Columbia, SC 29201  
T: 803.541.7838  
F: 803.541.9625

**ATTORNEYS FOR THE PLAINTIFF**

Dated: May 18, 2020

STATE OF SOUTH CAROLINA )  
 )  
 COUNTY OF HORRY )  
 )

Thuy N. Gasser, individually and )  
 on behalf of other similarly )  
 situated, )  
 )

Plaintiffs, )

v. )  
 )

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

Defendant. )  
 )  
 \_\_\_\_\_ )

**SUMMONS**  
 (Jury Trial Demanded)

TO THE DEFENDANT ABOVE NAMED:

YOU ARE HEREBY SUMMONED AND REQUIRED to answer the Complaint in this action. A copy of the Complaint is attached to this Summons and is herewith served upon you. Your answer must be in writing and signed by you or by your attorney and must state your address or the address of your attorney if signed by your attorney. Your answer must be served upon the undersigned attorneys for the Plaintiff within thirty (30) days after the service hereof, exclusive of the day of service at 12019 Ocean Highway, Post Office Box 1885, Pawleys Island, South Carolina 29585.

YOU ARE HEREBY GIVEN NOTICE FURTHER that, if you fail to appear and defend and fail to answer the Complaint as required by this Summons within thirty (30) days after the service hereof, judgment by default will be rendered against you for the relief demanded in the Complaint.

**MORRIS LAW LLC**

s/ Ian A. Taylor

Ian A. Taylor (SC Bar #81410)

[ian@jeffmorrislawfirm.com](mailto:ian@jeffmorrislawfirm.com)

Jeffrey D. Morris (SC Bar #102081)

[jm@jeffmorrislawfirm.com](mailto:jm@jeffmorrislawfirm.com)

783 Sandy Lane

Surfside Beach, SC 29575

(843) 232-0944 – Telephone

(843) 353-2440 – Facsimile

**HOPKINS LAW FIRM, LLC**

s/ William E. Hopkins, Jr.

William E. Hopkins, Jr. (SC Bar #66474)

[bill@hopkinsfirm.com](mailto:bill@hopkinsfirm.com)

J. Clay Hopkins (SC Bar #102053)

[clay@hopkinsfirm.com](mailto:clay@hopkinsfirm.com)

12019 Ocean Highway

Post Office Box 1885

Pawleys Island, South Carolina 29585

(843) 314-4202 – Telephone

(843) 314-9365 – Facsimile

*Attorneys for Plaintiff*

Surfside Beach, South Carolina  
May 21, 2020

|                         |   |                                    |
|-------------------------|---|------------------------------------|
| STATE OF SOUTH CAROLINA | ) | IN THE COURT OF COMMON PLEAS       |
|                         | ) | FOR THE FIFTEENTH JUDICIAL CIRCUIT |
| COUNTY OF HORRY         | ) |                                    |

Thuy N. Gasser, individually and )  
on behalf of other similarly )  
situated, )

Plaintiffs, )

v. )

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

Defendant. )

**CLASS ACTION COMPLAINT**  
(Jury Trial Demanded)

Plaintiff Thuy N. Gasser, individually and on behalf of others similarly situated, alleges and states the following claims for relief against Defendant ACS Primary Care Physicians – Southeast, P.C.

**NATURE OF THE ACTION**

1. Plaintiff Thuy N. Gasser, and those similarly situated, were patients who received medical services from Defendant arising from motor vehicle accidents. At the time of treatment, Defendant refused to process or submit bills to Plaintiffs' health insurance provider and rather required or demanded Plaintiffs to pay medical bills out of pocket.

2. Ms. Gasser and the class she seeks to represent were named "insureds" or "Members" under existing insurance policies with Blue Cross Blue Shield Insurance Company (hereinafter "BCBS").

3. Defendant is a preferred provider in the BCBS network and previously agreed, pursuant to a contract, to accept scheduled rates of payment for BCBS's insureds

or Members as a condition of being a preferred provider.

4. Ms. Gasser and the class she seeks to represent are third-party beneficiaries to the preferred provider contract between Defendant and BCBS, and therefore have a right to enforce the contract between Defendant and BCBS.

5. Defendant's decision to refuse to submit claims to BCBS was based on monetary gain. By not submitting claims through BCBS, Defendant was able to increase its cash flow by charging insureds the full price of services instead of the contracted price previously negotiated with BCBS for BCBS's insureds and Members. Defendant's actions ignored its contractual obligations to both BCBS, Plaintiff, and other class members.

6. Defendant's conduct deprived Ms. Gasser and other class members of the benefit of their insurance coverage and premiums.

#### **PARTIES AND JURISDICTION**

7. Plaintiff Thuy N. Gasser is a citizen and resident of Myrtle Beach, South Carolina. Plaintiff was a patient of Defendant ACS Primary Care Physicians – Southeast, P.C. who, like the class members she seeks to represent, was denied the right to have her medical claims processed and submitted to her insurance carrier for payment at the agreed upon rate by Defendant.

8. Defendant ACS Primary Care Physicians-Southeast, P.C. is a professional corporation organized under the laws of the state of Georgia that provides medical services in South Carolina, maintains a registered agent in Richland County, South Carolina, and transacts significant business in South Carolina.

9. The jurisdiction of this Court is founded upon S.C. Const. Art. V § 11, which grants the circuit court general jurisdiction over civil actions.

10. This Court has personal jurisdiction over Defendant because Defendant conducts business in South Carolina and/or has the requisite minimum contacts with South Carolina necessary to constitutionally permit the Court to exercise jurisdiction, with such jurisdiction also being within the contemplation of the South Carolina "long arm" statute, S.C. Code Ann. § 36-2-803 as amended.

11. Venue in this Court is proper pursuant to the Rules of the South Carolina Supreme Court and the South Carolina Code.

12. Plaintiff and all class members have suffered damages in an amount of at least \$100.

**GENERAL FACTUAL ALLEGATIONS APPLICABLE TO ALL CLAIMS**

13. Upon information and belief, Ms. Gasser was involved in a motor vehicle collision on December 9, 2019, in which she sustained serious injuries.

14. Ms. Gasser received treatment at Grand Strand Regional Medical Center where a physician employee of Defendant provided medical services for her injuries.

15. At the time of the collision and treatment, Ms. Gasser was covered by a health insurance policy issued by BCBS. Ms. Gasser obtained this health insurance coverage for the purpose of defraying medical expenses.

16. Ms. Gasser's insurance information was provided to Defendant at the time of her admission and treatment.

17. At all relevant times, Defendant was a preferred provider in the BCBS network.

18. As a preferred provider, Defendant agreed to accept BCBS insurance and provide services for BCBS's insureds at reduced cost.

19. Despite these contractual relationships and Ms. Gasser's presentment of her insurance coverage, Defendant and its representatives refused to submit Ms. Gasser's bills related to the vehicle collision to BCBS for payment.

20. Medical claims of motor vehicle collision victims in a hospital's emergency room represent the worst performing revenue streams for a hospital.

21. By refusing to accept insurance coverage for motor vehicle accidents, Defendant can generate a significant increase in cash flow by receiving payment immediately and in an amount that far exceeds the negotiated rate with BCBS.

22. Defendant demanded payment in full from Ms. Gasser despite her insurance coverage.

23. Defendant claimed an amount due of \$1,622.00 for medical treatment.

24. Ms. Gasser was not aware at the time of treatment of Defendant's systematic refusal to honor its contractual obligations regarding emergency room physician bills for insured patients and did not learn of this information until a later date.

25. Defendant ignored its contractual arrangement with BCBS in an attempt to avoid the discounts it voluntarily negotiated and agreed to in order to become a preferred provider for BCBS. By not submitting Ms. Gasser's bills, BCBS unfairly profited from Ms. Gasser and others similarly situated.

26. Ms. Gasser is a third-party beneficiary of the agreements between Defendant and BCBS.

### **CLASS ACTION ALLEGATIONS**

27. All above allegations are incorporated herein as if realleged and restated in full verbatim.

28. Pursuant to Rule 23, SCRCP, Plaintiff brings this action on behalf of herself and all other similarly situated persons. Plaintiff seeks to represent the class defined as follows:

All persons (or estates of persons) in South Carolina or persons (or estates of person) who have jurisdiction with a South Carolina Court under the Door Closing Statute) insured by BCBS receiving services from Defendant in any medical facility from **December 9, 2016 to present** for whom Defendant failed to submit the bill for medical services to BCBS and instead obtained recovery from the person.

29. Upon information and belief, the class includes a substantial number of Defendant's patients and is so numerous that joinder of all members is impractical.

30. There are questions of fact or law common to the class predominating over questions affecting only individual class members, including without limitation:

- a. Whether Defendant's contract with BCBS requires submission of emergency room claims for payment by the insurer rather than the patient;
- b. Whether Defendant's pursuit of payment from class members rather than from class members' insurer was permitted by law; and
- c. Whether Defendant's retention of money for medical expenses paid by class members is just.

31. Plaintiff's claims are typical of the absent class members in that all allege financial losses and other damages attributable to Defendant's process of charging and collecting medical expenses from insured emergency room patients.

32. Plaintiff will fairly and adequately protect the interests of the other class members.

33. Plaintiff's counsel is experienced in handling class action claims. Neither Plaintiff nor Plaintiff's counsel has any interests adverse to or in conflict with the absent class members.

34. The amount in controversy for all class members exceeds one hundred dollars.

**FOR A FIRST CAUSE OF ACTION**  
(Breach of Contract)

35. All above allegations are incorporated herein as if realleged and restated in full verbatim.

36. Plaintiff and the other class members entered into a contractual agreement with BCBS, whereby Plaintiff and the other class members agreed to pay monthly premiums to BCBS for the benefit of health insurance.

37. BCBS as a part of its service to Plaintiff and other class members, contracted with Defendant to provide payments for their insureds' services. Specifically, Defendant bargained and contracted with BCBS for discounted payments as satisfaction of patient's accounts. This arrangement entitled Defendant to a preferred provider status within the BCBS network and generated business for Defendant.

38. Defendant breached its contract with BCBS, Plaintiff, and the other class members, as third-party beneficiaries, by refusing to submit claims to BCBS. Defendant deprived Ms. Gasser of the benefits of the discounts and other provisions negotiated between BCBS and Defendant.

39. As a direct and proximate result of Defendant's breach, Plaintiff and the other class members have suffered damages, which include all payments collected by Defendant from Plaintiff and the other class members together with prejudgment interest.

**FOR A SECOND CAUSE OF ACTION**  
(Unjust Enrichment)

40. All above allegations are incorporated herein as if realleged and restated in

full verbatim.

41. Defendant was unjustly enriched through the collection of additional payments from Plaintiff and the other class members for payment of services at a higher value than contracted for with BCBS.

42. This conduct constitutes an unjust retention of a benefit to the detriment of Plaintiff and class members, and Defendant's retention of money is against the fundamental principles of justice and good conscience and is patently unfair.

43. It would be unconscionable for Defendant to retain the payments made by Plaintiff and other class members because those funds were received with complete disregard of available insurance coverage and in contradiction to the agreed upon price for services bargained for between Defendant and BCBS.

44. Equity demands that Defendant be compelled to return its ill-gotten gains.

45. As a direct and proximate result of Defendant's conduct, Plaintiff and other class members have suffered damages, and request an order be entered creating a constructive trust for any sums illegally collected by Defendant, for counsel fees and costs of suit, and any other relief this Court deems necessary or proper.

WHEREFORE, having fully stated her claims against the Defendant, Plaintiff respectfully prays that the Court certify a South Carolina class, award the relief as set forth above for actual damages, special and consequential damages, attorney's fees and costs, and for such other and further relief as the Court deems necessary and proper. Plaintiff demands a jury trial on all actions so triable.

**MORRIS LAW LLC**

s/ Ian A. Taylor

Ian A. Taylor (SC Bar #81410)

[ian@jeffmorrislawfirm.com](mailto:ian@jeffmorrislawfirm.com)

Jeffrey D. Morris (SC Bar #102081)

[jm@jeffmorrislawfirm.com](mailto:jm@jeffmorrislawfirm.com)

783 Sandy Lane

Surfside Beach, SC 29575

(843) 232-0944 – Telephone

(843) 353-2440 – Facsimile

**HOPKINS LAW FIRM, LLC**

s/ William E. Hopkins, Jr.

William E. Hopkins, Jr. (SC Bar #66474)

[bill@hopkinsfirm.com](mailto:bill@hopkinsfirm.com)

J. Clay Hopkins (SC Bar #102053)

[clay@hopkinsfirm.com](mailto:clay@hopkinsfirm.com)

12019 Ocean Highway

Post Office Box 1885

Pawleys Island, South Carolina 29585

(843) 314-4202 – Telephone

(843) 314-9365 – Facsimile

*Attorneys for Plaintiff*

Surfside Beach, South Carolina  
May 21, 2020

Thuy N. Gasser, individually and on behalf of other  
similarly situated,  
  
Plaintiffs,  
  
v.  
  
ACS Primary Care Physicians-Southeast, P.C.,  
  
Defendant.

### A. Timeliness of Removal

2. On May 26, 2020, Plaintiff served the Summons and Complaint on ACS. Removal is timely as it was effected within 30 days of the service of the Summons and Complaint on Defendant. 28 U.S.C. § 1446(b)(2)(B).

**B. Federal Question Jurisdiction**

3. This Court has original jurisdiction over this action by virtue of 28 U.S.C. § 1331 because it involves claims arising under the laws of the United States; namely, the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), 29 U.S.C. § 1001, *et seq.*, due to the fact that Plaintiff’s allegations relate to putative class members’ employer-sponsored health insurance plans.

4. Specifically, the Complaint asserts claims, on behalf of a class of all persons in South Carolina insured by Blue Cross Blue Shield (BCBSSC”), for breach of contract and unjust enrichment, alleging that ACS unlawfully billed class members for services that should have been billed to BCBSSC directly and in amounts that were greater than should have been billed. The putative class includes individuals whose BCBSSC plan is an employer-sponsored health insurance plan that is governed by ERISA (the “Plans”). Thus, Plaintiff’s state law claims fall within, and are completely preempted by, ERISA § 502(a), including but not limited to §§ 502(a)(1)(B), 502(a)(2), and 503(a)(3), such that the assertion of these state law claims are, in actuality, the assertion of ERISA claims. *See Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 65-66 (1987) (noting that state-law claims that fall within the scope of ERISA § 502(a)(2) are “necessarily federal in character”); *Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278, 283 (4th Cir. 2003).

5. Consequently, this Court has federal question jurisdiction under 28 U.S.C. §§ 1331 and 1367, and this action may be removed to this Court by Defendant pursuant to 28 U.S.C. § 1441.

6. Accordingly, the case set forth above, Case No. 2020-CP-26-03169, filed in the Court of Common Pleas for Horry County, South Carolina could have been brought before this

Court pursuant to 28 U.S.C. §§ 1331, 1332(d) and 1367, and may be removed by ACS pursuant to 28 U.S.C. § 1441.

7. Under 28 U.S.C. § 1441(a), venue of the removed action is proper in this Court as the district and division embracing the place where the state action was pending.

8. Pursuant to 28 U.S.C. § 1446(a), ACS has attached herewith, and incorporated by reference, a copy of the Summons and Complaint filed in this action. (*See Exhibit A.*)

9. Written notice of the filing of this Notice of Removal will be given to Plaintiff as required by law.

10. A true copy of this Notice of Removal is being filed with the Court of Common Pleas for Horry County, South Carolina as required by law.

WHEREFORE, ACS respectfully requests that the action now pending in the State of South Carolina, Horry County, Court of Common Pleas, as Case No. 2020-CP-26-03169, proceed before this Court as an action properly removed.

Dated: June 25, 2020

GORDON & REES LLP

By s/Josh Dixon

Josh Dixon (Fed. 10036)

E-mail: jdixon@grsm.com

Victoria T. Kepes (Fed. 13000)

E-mail: vkepes@grsm.com

40 Calhoun Street, Suite 350

Charleston, SC 29401

Telephone: (843) 278-5900

*Attorneys for ACS Primary Care  
Physicians-Southeast, P.C.*

**IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF SOUTH CAROLINA  
FLORENCE DIVISION**

|                                  |   |                                    |
|----------------------------------|---|------------------------------------|
| Thuy N. Gasser, individually and | ) | Civil Action No. 4:20-cv-02419-RBH |
| on behalf of others similarly    | ) |                                    |
| situated,                        | ) |                                    |
|                                  | ) |                                    |
| Plaintiffs,                      | ) | <b>PLAINTIFF'S MOTION TO</b>       |
| v.                               | ) | <b>REMAND</b>                      |
|                                  | ) |                                    |
| ACS Primary Care Physicians -    | ) |                                    |
| Southeast, P.C.,                 | ) |                                    |
|                                  | ) |                                    |
| Defendant.                       | ) |                                    |
| _____                            | ) |                                    |

Plaintiff, individually and on behalf of others similarly situated, by and through undersigned counsel, hereby petitions the Court pursuant to 28 U.S.C. § 1447(c) for an Order remanding this case to the Horry County Court of Common Pleas based upon the facts and law establishing the absence of jurisdiction.

This motion will be further based upon the Memorandum of Law in Support of the Motion filed contemporaneously herewith, the pleadings, the Federal Rules of Civil Procedure, applicable federal and South Carolina statutory and case law, and upon such affidavits, exhibits and testimony as may be attached hereto or presented at the hearing of this motion and upon request of the Court.

**MORRIS LAW LLC**

Ian A. Taylor (Fed ID #12798)  
Jeffrey D. Morris (Fed ID #12838)  
783 Sandy Lane  
Post Office Box 14724  
Surfside Beach, South Carolina 29575  
(843) 232-0944 - Telephone  
(843) 353-2440 - Facsimile  
[ian@jeffmorrislawfirm.com](mailto:ian@jeffmorrislawfirm.com)  
[jm@jeffmorrislawfirm.com](mailto:jm@jeffmorrislawfirm.com)

**HOPKINS LAW FIRM, LLC**

s/ William E. Hopkins, Jr.  
William E. Hopkins, Jr. (Fed Id #6075)  
J. Clay Hopkins (Fed ID #12147)  
12019 Ocean Highway  
Post Office Box 1885  
Pawleys Island, South Carolina 29585  
(843) 314-4202 – Telephone  
(843) 314-9365 – Facsimile  
[bill@hopkinsfirm.com](mailto:bill@hopkinsfirm.com)  
[clay@hopkinsfirm.com](mailto:clay@hopkinsfirm.com)

*Attorneys for Plaintiff*

July 27, 2020



a health insurance policy issued by BlueCross BlueShield of South Carolina (hereinafter “BCBSSC”). Gasser's insurance information was provided to Defendant, which, at the time of Gasser's medical treatment, was a preferred provider in the BCBSSC network. Defendant refused, and continues to refuse, to submit Gasser's medical bill related to the vehicle collision to BCBSSC for consideration and payment. According to its preferred provider status with BCBSSC, Defendant would have to accept the negotiated amount determined by its agreement with BCBSSC. For that reason, Defendant demanded and sought payment of its entire bill from Gasser, and the class members, directly despite her insurance coverage in an attempt to circumvent its negotiated and agreed upon preferred provider contract amount, and extract and collect from Gasser and the proposed class more money. Defendant engaged, and continues to engage, in this conduct despite the clear language in its preferred provider contract that prohibits it from seeking money directly from the subscriber (“insured”) other than, or in addition to, the negotiated amount.

## **DISCUSSION**

### **I. Presumption Against Removal**

“The removing party bears the burden of establishing federal jurisdiction.” Strawn v. AT&T Mobility, LLC, 530 F.3d 293, 298 (4th Cir. 2008); Clipper Air Cargo, Inc. v. Aviation Prod. Intern., Inc., 981 F. Supp. 956, 958 (D.S.C. 1997). A defendant may remove a case only if the claim could have been brought in federal court on the basis of federal question jurisdiction or diversity jurisdiction. 28 U.S.C. § 1441(b); Caterpillar, Inc. v. Williams, 482 U.S. 386, 392 (1987). “[C]ourts should resolve all doubts about the propriety of removal in favor of retained state court

jurisdiction.” Hartley v. CSX Transp., Inc., 187 F.3d 422, 425 (4th Cir. 1999) (internal citation omitted); Besse v. Gen. Motors Corp., 317 F. Supp. 2d 646, 648 (D.S.C. 2004). This is because the plaintiff’s right to select the forum for her claim is stronger than the defendant’s right to remove. Griffin v. Holmes, 843 F. Supp. 81, 84 (E.D.N.C. 1993). “Removal is a statutory privilege, rather than a right, and the removing party must comply with the procedural requirements mandated in the statute when desirous of availing the privilege.” Id.

The removal jurisdiction of the federal courts is to be “scrupulously confined.” Shamrock Gas & Oil Corp. v. Sheets, 313 U.S. 100, 102, 61 S. Ct. 868, 85 L. Ed. 1214 (1941). This strict policy against removal and for remand protects the sovereignty of state governments and state judicial power. Id. at 108-09.

## **II. Federal Question Jurisdiction**

Initially, Defendant argues this Court has original jurisdiction over this action under 28 U.S.C. § 1331, and specifically asserts that Gasser’s state law claims fall within, and are completely preempted by, the Employee Retirement Income Security Act of 1974 (“ERISA”) § 502(a). Gasser vehemently disagrees that her purely state law claims fall under the strict scrutiny of ERISA. “For better or worse, under the present statutory scheme as it has existed since 1887, a defendant may not remove a case to federal court unless the plaintiff’s complaint establishes that the case “arises under” federal law.” “[A] right or immunity created by the Constitution or laws of the United States must be an element, and an essential one, of the plaintiff’s cause of action.” Franchise Tax Bd. v. Constr. Laborers Vacation Trust, 463 U.S. 1, 103 S. Ct. 2841, 77 L. Ed. 2d 420

(1983), *citing* Gully v. First National Bank, 299 U.S. 109, 112, 57 S. Ct. 96, 97, 81 L. Ed. 70 (1936).

This Court must first determine “whether federal or state law creates the cause of action.” Pinney v. Nokia, Inc., 402 F.3d 430, 442 (4th Cir. 2005). To determine whether a claim “arises under” federal law, any analysis must begin with the “well-pleaded complaint rule”. Dykema v. King, Pendleton Medical Clinic, et. al., 959 F. Supp. 736, 739 (D.S.C. 1997). Causes of action only arise under federal law when plaintiff’s well-pleaded complaint raises issues of federal law. Metro. Life Ins. Co. v. Taylor, 481 U.S. 58, 107 S. Ct. 1542, 95 L. Ed. 2d 55 (1987).

Defendant’s only argument for removal is that the “[t]he putative class includes individuals whose BCBSSC plan is an employer-sponsored health insurance plan that is governed by ERISA (the “Plans”).” Notice of Removal at ¶4. The existence of an employer-sponsored plan does not necessarily invoke ERISA. The putative class may include individuals with employer-sponsored health insurance plans, but Gasser is not alleging that BCBSSC erroneously denied benefits under the terms of a plan or did any other wrongdoing. Rather, Gasser merely alleges Defendant, an in-network preferred physician group, simply refused to bill BCBSSC in breach of its contractual obligation. The court in Franchise Tax Board addressed the issue of pre-emption under ERISA with similar causes of action and found that causes of action similar to Plaintiff’s here “[are] not of central concern to the federal statute.” Franchise Tax Board, 463 U.S. at 2. Whether the BCBSSC plan is governed by ERISA has no bearing on Defendant’s failure to comply with its contractual obligation as an in-network provider.

Gasser is not alleging that her insurer did not administer its plan according to its contract with her or Defendant, as the Plaintiff claimed in Metro. Life. It is not a suit, “by a beneficiary to recover benefits from a covered plan,” Metro. Life at 63. Gasser’s claims are predicated solely on Defendant’s unilateral refusal to bill her insurance provider and in no way connects any action, inaction, or responsibility of BCBSSC. Therefore, Gasser’s claims cannot be encompassed by ERISA. “If a plaintiff can establish, without the resolution of an issue of federal law, all of the essential elements of her state law claim, the claim does not necessarily depend on a question of federal law.” Pinney, 402 F.3d at 442.

### **III. CAFA**

In 2005, Congress passed into law the Class Action Fairness Act (“CAFA”), which altered the scenarios where a defendant in a class action lawsuit could remove the matter to federal court. Under CAFA, a defendant may now remove a class action suit to federal court when (1) the aggregate amount of all claims of all class members exceeds \$5,000,000.00; (2) any member of the class is a citizen of a different state than any defendant; and (3) the action is removed within 30 days of the amendment which gave rise to the grounds for removal. 28 U.S.C. § 1332(d). Neither factor 1 nor factor 2 are met and the court should remand the case.<sup>1</sup>

#### **A. AMOUNT IN CONTROVERSY**

The district court should remand this case to the state court because there is not \$5,000,000 in controversy as evidenced by the Complaint. “In determining the amount in controversy for federal diversity jurisdiction, the court must examine the complaint at the

---

<sup>1</sup> Defendant notice of removal does not cite or refer to CAFA as a basis for jurisdiction.

time of removal.” Chavis v. Fid. Warranty Servs., Inc., 415 F. Supp. 2d 620, 626 (D.S.C. 2006). “The status of the case as disclosed by the plaintiff’s complaint is controlling in the case of a removal . . .” Brooks v. GAF Materials Corp., 532 F. Supp. 2d. 779, 8781 (D.S.C. 2008) (quoting St. Paul Mercury Indem. Co. v. Red Cab Co., 303 U.S. 283, 291, 58 S. Ct. 586, 591 (1938)).

The rule that “[d]efendants seeking removal bear the burden of demonstrating that jurisdiction is proper” is true even in the context of removals pursuant to CAFA. Bartnikowski v.NVR, Inc., 307 Fed, App’x 730, 734 (4th Cir. 2009). When the complaint leaves damages unspecified and the defendant attempts to show that the amount in controversy has been met, the defendant is successful only if the amount is proved by a preponderance of the evidence. Id. If the defendant’s allegations regarding the amount in controversy are too speculative, the court should find that the defendant has failed to prove the jurisdictional amount has been met and remand to the state court. Bartnikowski, 307 Fed. App’x at 738-39. In Bartnikowski, an employment law case, the Fourth Circuit found that the jurisdictional amount had not been met because the defendant estimated the number of overtime hours using “pure guesswork” leaving “significant uncertainty about the actual amount in controversy. Id. at 738.

In Miedema v. Maytag Corp., 450 F.3d 1322, 1329-30 (11th Cir. 2006), the Eleventh Circuit affirmed the district court’s grant of a motion to remand because the defendant failed to establish the amount in controversy by a preponderance of the evidence. 450 F.3d at 1331. The defendant’s notice of removal included an affidavit from an employee stating how many of the potentially defective items were sold in Florida and the items’ total value, which exceeded \$5,000,000. Id. at 1325. However, the number of

sold items was not based on actual sales data but was simply a guess extrapolated from the number of product registrations the defendant received. Id. at 1332. The Eleventh Circuit found “great uncertainty” in the method chosen by the defendants to calculate the amount in controversy and held that such uncertainty should be resolved in favor of remand. Id.

In Strawn v. AT&T Mobility, LLC, the Fourth Circuit found that the defendant had proven the amount in controversy to be over the \$5,000,000 requirement. 530 F.3d at 299. There, the defendant was able to state with specificity the number of members making up the class. Id. Also, the Court stated that if the plaintiffs succeeded on the merits, there was a minimum damages figure they would be entitled to recover pursuant to statute. Id. at 298. For that reason, the Court determined that multiplying the statutory damages by the number of class members left little doubt that the jurisdictional amount in controversy had been met. Id.

In this case, however, Gasser’s complaint does not specify damages. Therefore, Defendant bears the burden of proving, by a preponderance of the evidence, that the amount in controversy is met based on the pleadings in the complaint.

Here, Defendant has failed to demonstrate by a preponderance of the evidence that the amount in controversy has been met. In fact, the notice of removal utterly fails to address or even refer to the amount in controversy. Defendant does not even speculate as to the amount of damages sustained by the class members. Defendant has offered no evidence that tends to prove the amount of damages attributable to any of Plaintiff’s causes of action. Defendant does not even aver, much less argue or present evidence, that the \$5,000,000 threshold amount would be met by a preponderance of the evidence.

Furthermore, unlike in Strawn, Plaintiff's causes of action do not have specific statutory damages, and the exact number of class members is unknown. Therefore, Defendant is incapable of proving, by a preponderance of the evidence, the amount in controversy (even had it made an attempt).

In this case, the facts resemble Bartnikowski and Miedema. In fact, though, this case involves even more guessing and speculation as to the amount in controversy. In Bartnikowski and Miedema, the defendants provided the court with some evidence regarding the potential amount in controversy. There exists no non-speculative method to properly estimate damages for Gasser's (and the class's) claims since all of the medical bills (that Defendant failed to submit to BCBSSC) would be unique to each class member. The Federal Appellate Courts have condemned guesswork and speculation when determining the amount in controversy and have remanded similar cases to Gasser's back to state court. See Bartnikowski, 370 Fed. App'x 730; Miedema, 450 F.3d 1322. Because Defendant has offered no argument or evidence as to the amount in controversy stated in Gasser's complaint or prayer for relief, the Court should remand this case to state court, where it was originally filed.

#### **B. DIVERSITY**

In one solitary sentence, which appears to be a boilerplate statement that cites to all three (3) statutory bases for removal, Defendant makes a lone reference to 1332(d). Defendant does not provide any factual or legal basis necessary to carry its strict burden necessary to prove diversity jurisdiction. In fact, other than the bald assertion itself, Defendant offers no basis whatsoever to support its conclusory statement. The pleading does not in any way lay a proper foundation for such a conclusion. The notice

of removal is devoid of any basis for this Court to find diversity and should therefore be dispositive of the issue. Out of an abundance of caution, however, and without waiving any argument or position, Gasser will address the issue.

The Fourth Circuit has joined six of its sister circuits, holding, “the party seeking to invoke federal jurisdiction must allege it in his notice of removal and, when challenged, demonstrate the basis for federal jurisdiction” in cases where a defendant attempts to remove a class action based on diversity jurisdiction. Strawn, 530 F.3d at 298 (citing Smith v. Nationwide Prop. & Cas. Ins. Co., 505 F.3d 401, 405-06 (6th Cir. 2007); Morgan v. Gay, 471 F.3d 469, 473 (3d Cir. 2006); DiTolla v. Doral Dental IPA of N.Y., L.L.C., 469 F.3d 271, 275 (2d Cir. 2006); Miedema v. Maytag Corp., 450 F.3d 1322, 1329-30 (11th Cir. 2006); Abrego Abrego v. Dow Chem. Co., 443 F.3d 676, 685-86 (9th Cir. 2006); Brill v. Countrywide Home Loans, Inc., 427 F.3d 446, 447-48 (7th Cir. 2005)).

While the Defendant here is incorporated in Georgia, its principal place of business is in Horry County, South Carolina. This is easily established by Defendant’s own representation to the Centers for Medicare & Medicaid Services (“CMS”) in applying for its National Provider Identifier (“NPI”) number.

The NPI Number is a unique 10-digit numerical identifier used to identify a provider to its health care partners, and the provider must share its NPI number with other providers, health plans, payers, and entities that require it for billing and claims purposes. The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) mandated the adoption of a standard, unique health identifier for each health care provider. Health care providers and all health plans must use the NPIs in the

administrative and financial transactions adopted under HIPAA. The National Plan and Provider Enumeration System (“NPES”) is where a provider must submit an application in order to obtain their NPI and is administered through a contractor selected by the United States Department of Health and Human Services. Attached as **Exhibit 1** hereto is Defendant’s listing from the National Provider Identifier Registry maintained by CMS. As can be seen therein, Defendant has identified as its primary business location 809 82<sup>nd</sup> Avenue, Myrtle Beach, South Carolina. The instructions specifically state that for any entity with more than one (1) physical business location, it should list its “**primary**” location. Defendant’s website notes that it has 25 locations in 23 cities in the states of Georgia and South Carolina, with 17 in South Carolina and 6 in Georgia. ([www.healthcare4ppl.com](http://www.healthcare4ppl.com), accessed last on July 24, 2020).

Since Defendant has designated South Carolina as its principal place of business, there is no diversity, despite its incorporation in Georgia. This Court has already decided this identical issue. In Johnson v. Advance America, 596 F. Supp. 2d 922 (D.S.C. 2008), a class action suit was brought regarding loans made by the defendant. The defendant was incorporated in Delaware but maintained its principal place of business in South Carolina. Relying upon the Fourth Circuit’s decision in Croxtan v. King’s Dep’t Store of Newport News, Inc., 449 F.2d 777 (4th Cir. 1971), this Court held that there is *not* diversity jurisdiction if the plaintiff is a citizen of the state of the corporate defendant’s principal place of business. 596 F. Supp. 2d at 927 (emphasis in original).

Thus, because Gasser is a citizen and resident of South Carolina, which Defendant has represented to the federal government is its primary and principal place of business,

there can be no diversity jurisdiction. Even if the amount in controversy is satisfied, which Gasser submits is not, jurisdiction under CAFA fails due to lack of diversity.

### **CONCLUSION**

For the foregoing reasons, Plaintiff respectfully requests the Court grant her motion and remand the case to the Horry County Court of Common Pleas.

#### **MORRIS LAW LLC**

Ian A. Taylor (Fed ID #12798)  
Jeffrey D. Morris (Fed ID #12838)  
783 Sandy Lane  
Post Office Box 14724  
Surfside Beach, South Carolina 29575  
(843) 232-0944 – Telephone  
(843) 353-2440 – Facsimile  
[ian@jeffmorrislawfirm.com](mailto:ian@jeffmorrislawfirm.com)  
[jm@jeffmorrislawfirm.com](mailto:jm@jeffmorrislawfirm.com)

#### **HOPKINS LAW FIRM, LLC**

s/ William E. Hopkins, Jr.  
William E. Hopkins, Jr. (Fed ID #6075)  
J. Clay Hopkins (Fed ID #12147)  
12019 Ocean Highway  
Post Office Box 1885  
Pawleys Island, South Carolina 29585  
(843) 314-4202 – Telephone  
(843) 314-9365 – Facsimile  
[bill@hopkinsfirm.com](mailto:bill@hopkinsfirm.com)  
[clay@hopkinsfirm.com](mailto:clay@hopkinsfirm.com)

*Attorneys for Plaintiff*

July 27, 2020

# EXHIBIT 1

**1861430555**

**ACS PRIMARY CARE PHYSICIANS - SOUTHEAST PC  
National Provider Identifiers Registry**

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers.

**1861430555 ACS PRIMARY CARE PHYSICIANS - SOUTHEAST PC**

|                                |              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>NPI</i>                     | 1861430555   | 10-position all-numeric identification number assigned by the NPS to uniquely identify a health care provider.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <i>Entity Type</i>             | Organization | Code describing the type of health care provider that is being assigned an NPI. Codes are:<br><ul><br><li>1 = (Person): individual human being who furnishes health care;</li><br><li>2 = (Non-person): entity other than an individual human being that furnishes health care (for example, hospital, SNF, hospital subunit, pharmacy, or HMO).</li><br></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <i>Is Organization Subpart</i> | N            | <p>The "Is the organization a subpart?" question must be answered. If the organization is a subpart, the Parent Organization Legal Business Name (LBN) and Parent Organization Taxpayer Identification Number (TIN) fields must be completed. The Parent Organization LBN and TIN fields can only be completed if the answer to the subpart question is Yes.</p> <p>Many organization health care providers who apply for NPIs are not legal entities themselves but are parts of other organization health care providers that are legal entities (the "parents").</p> <p>Here are three examples of organization health care providers that may be considered subparts and may apply for NPIs if so directed by their "parents":</p> <p>(1) The psychiatric unit in a hospital is not a legal entity but is part of the hospital (the "parent"), which is a legal entity. The legal entity must obtain an NPI. The psychiatric unit is an example of a subpart that could have its own NPI if the hospital determines that it should.</p> <p>(2) A group practice that is not a sole proprietorship has a main location and could have other offices in different locations, but each office is not a separate legal entity; instead, each office is part of the corporation (the "parent") which is a legal entity. The offices are examples of subparts that could have their own NPIs if the main location determines that they should.</p> <p>(3) A pharmacy fills prescriptions for patients whose physicians have prescribed medications for them and may also rent or sell durable medical equipment to patients whose physicians have ordered such equipment for them. Neither the pharmacy line of business nor the DME line of business represent legal entities; instead, both lines of business are part of an organization (the "parent") that is a legal entity. Each line of business represents a different Healthcare Provider Taxonomy or area of specialization that often submits its own electronic claims to health plans.</p> <p>The "parent"-we don't know who the parent is in this example-must ensure that each subpart that submits its own claims to health plans has its own NPI.</p> |

National Provider Identifiers Registry

www.hipaaspace.com

|                                                                 |                                            |                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>Provider Organization Name (Legal Business Name)</i>         | ACS PRIMARY CARE PHYSICIANS - SOUTHEAST PC | Provide organization name (legal business name used to file tax returns with the IRS). The Organization Name field allows the following special characters: ampersand, apostrophe, "at" sign, colon, comma, forward slash, hyphen, left and right parentheses, period, pound sign, quotation mark, and semi-colon. A field cannot contain all special characters. |
| <i>Provider First Line Business Mailing Address</i>             | PO BOX 635003                              | The first line mailing address of the provider being identified. This data element may contain the same information as "Provider first line location address".                                                                                                                                                                                                    |
| <i>Provider Business Mailing Address City Name</i>              | CINCINNATI                                 | The City name in the mailing address of the provider being identified. This data element may contain the same information as "Provider location address City name".                                                                                                                                                                                               |
| <i>Provider Business Mailing Address State Name</i>             | OH                                         | The State or Province name in the mailing address of the provider being identified. This data element may contain the same information as "Provider location address State name".                                                                                                                                                                                 |
| <i>Provider Business Mailing Address Postal Code</i>            | 45263-0001                                 | The postal ZIP or zone code in the mailing address of the provider being identified. NOTE: ZIP code plus 4-digit extension, if available. This data element may contain the same information as "Provider location address postal code".                                                                                                                          |
| <i>Provider Business Mailing Address Country Code</i>           | US                                         | The country code in the mailing address of the provider being identified. This data element may contain the same information as "Provider location address country code".                                                                                                                                                                                         |
| <i>Provider Business Mailing Address Telephone Number</i>       | 800-424-3672                               | The telephone number associated with mailing address of the provider being identified. This data element may contain the same information as "Provider location address telephone number".                                                                                                                                                                        |
| <i>Provider First Line Business Practice Location Address</i>   | 809 82ND PKWY                              | The first line location address of the provider being identified. For providers with more than one physical location, this is the primary location. This address cannot include a Post Office box.                                                                                                                                                                |
| <i>Provider Business Practice Location Address City Name</i>    | MYRTLE BEACH                               | The city name in the location address of the provider being identified.                                                                                                                                                                                                                                                                                           |
| <i>Provider Business Practice Location Address State Name</i>   | SC                                         | The State or Province name in the location address of the provider being identified.                                                                                                                                                                                                                                                                              |
| <i>Provider Business Practice Location Address Postal Code</i>  | 29572-4607                                 | The postal ZIP or zone code in the location address of the provider being identified. NOTE: ZIP code plus 4-digit extension, if available.                                                                                                                                                                                                                        |
| <i>Provider Business Practice Location Address Country Code</i> | US                                         | The country code in the location address of the provider being identified.                                                                                                                                                                                                                                                                                        |

National Provider Identifiers Registry

www.hipaaspace.com

|                                                                     |                     |                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>Provider Business Practice Location Address Telephone Number</i> | 843-692-1000        | The telephone number associated with the location address of the provider being identified.                                                                                                                                                            |
| <i>Provider Enumeration Date</i>                                    | 06/03/2006          | The date the provider was assigned a unique identifier (assigned an NPI).                                                                                                                                                                              |
| <i>Last Update Date</i>                                             | 09/16/2019          | The date that a record was last updated or changed.                                                                                                                                                                                                    |
| <i>Authorized Official Last Name</i>                                | DABBS               | The last name of the person authorized to submit the NPI application or to change NPS data for a health care provider.                                                                                                                                 |
| <i>Authorized Official First Name</i>                               | RANDAL              | The first name of the authorized official                                                                                                                                                                                                              |
| <i>Authorized Official Middle Name</i>                              | L.                  | The middle name of the authorized official                                                                                                                                                                                                             |
| <i>Authorized Official Title or Position</i>                        | PRESIDENT           | The title or position of the authorized official                                                                                                                                                                                                       |
| <i>Authorized Official Name Prefix Text</i>                         | DR.                 | Authorized Official Name Prefix Text                                                                                                                                                                                                                   |
| <i>Authorized Official Credential Text</i>                          | M.D.                | Authorized Official Credential Text                                                                                                                                                                                                                    |
| <i>Authorized Official Telephone Number</i>                         | 865-293-5210        | The 10-position telephone number of the authorized official.                                                                                                                                                                                           |
| <i>Healthcare Provider Taxonomy Code #1</i>                         | 363A00000X          | The Health Care Provider Taxonomy code is a unique alphanumeric code, ten characters in length. The code set is structured into three distinct "Levels" including Provider Type, Classification, and Area of Specialization.                           |
| <i>Healthcare Provider Taxonomy 1</i>                               | Physician Assistant | Healthcare Provider Taxonomy #1                                                                                                                                                                                                                        |
| <i>Healthcare Provider Primary Taxonomy Switch 1</i>                | N                   | Primary Taxonomy:<br><ul><br><li>X - The primary taxonomy switch is Not Answered;</li><br><li>Y - The taxonomy is the primary taxonomy (there can be only one per NPI record);</li><br><li>N - The taxonomy is not the primary taxonomy.</li><br></ul> |
| <i>Healthcare Provider Taxonomy Code 2</i>                          | 363L00000X          | Healthcare Provider Taxonomy Code #2                                                                                                                                                                                                                   |
| <i>Healthcare Provider Taxonomy 2</i>                               | Nurse Practitioner  | Healthcare Provider Taxonomy #2                                                                                                                                                                                                                        |

National Provider Identifiers Registry

www.hipaaspace.com

|                                                     |                                      |                                                                                                                                                                                                                                                        |
|-----------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Healthcare Provider<br>Primary Taxonomy<br>Switch 2 | N                                    | Primary Taxonomy:<br><ul><br><li>X - The primary taxonomy switch is Not Answered;</li><br><li>Y - The taxonomy is the primary taxonomy (there can be only one per NPI record);</li><br><li>N - The taxonomy is not the primary taxonomy.</li><br></ul> |
| Healthcare Provider<br>Taxonomy Code 3              | 207P00000X                           | Healthcare Provider Taxonomy Code #3                                                                                                                                                                                                                   |
| Healthcare Provider<br>Taxonomy 3                   | Emergency Medicine                   | Healthcare Provider Taxonomy #3                                                                                                                                                                                                                        |
| Healthcare Provider<br>Primary Taxonomy<br>Switch 3 | Y                                    | Primary Taxonomy:<br><ul><br><li>X - The primary taxonomy switch is Not Answered;</li><br><li>Y - The taxonomy is the primary taxonomy (there can be only one per NPI record);</li><br><li>N - The taxonomy is not the primary taxonomy.</li><br></ul> |
| Other Provider<br>Identifier 1                      | DC4477                               | Other Provider Identifier #1                                                                                                                                                                                                                           |
| Other Provider<br>Identifier Type 1                 | OTHER                                | Other Provider Identifier Type #1                                                                                                                                                                                                                      |
| Other Provider<br>Identifier State 1                | GA                                   | Other Provider Identifier State #1                                                                                                                                                                                                                     |
| Other Provider<br>Identifier Issuer 1               | MEDICARE<br>TRAVELERS RR - G         | Other Provider Identifier Issuer #1                                                                                                                                                                                                                    |
| Other Provider<br>Identifier 2                      | DO7575                               | Other Provider Identifier #2                                                                                                                                                                                                                           |
| Other Provider<br>Identifier Type 2                 | OTHER                                | Other Provider Identifier Type #2                                                                                                                                                                                                                      |
| Other Provider<br>Identifier State 2                | SC                                   | Other Provider Identifier State #2                                                                                                                                                                                                                     |
| Other Provider<br>Identifier Issuer 2               | RAILROAD MEDICARE                    | Other Provider Identifier Issuer #2                                                                                                                                                                                                                    |
| Other Provider<br>Identifier 3                      | 300041934A                           | Other Provider Identifier #3                                                                                                                                                                                                                           |
| Other Provider<br>Identifier Type 3                 | MEDICAID                             | Other Provider Identifier Type #3                                                                                                                                                                                                                      |
| Other Provider<br>Identifier State 3                | GA                                   | Other Provider Identifier State #3                                                                                                                                                                                                                     |
| Healthcare Provider<br>Taxonomy Group 1             | 193200000X MULTI-<br>SPECIALTY GROUP | Healthcare Provider Taxonomy Group 1                                                                                                                                                                                                                   |

National Provider Identifiers Registry

www.hipaaspace.com

|                                                         |                                                                                                                                        |                                                  |
|---------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| <i>Healthcare Provider Taxonomy Group Description 1</i> | Multi-Specialty Group - A business group of one or more individual practitioners, who practice with different areas of specialization. | Healthcare Provider Taxonomy Group Description 1 |
| <i>Healthcare Provider Taxonomy Group 2</i>             | 193200000X MULTI-SPECIALTY GROUP                                                                                                       | Healthcare Provider Taxonomy Group 2             |
| <i>Healthcare Provider Taxonomy Group Description 2</i> | Multi-Specialty Group - A business group of one or more individual practitioners, who practice with different areas of specialization. | Healthcare Provider Taxonomy Group Description 2 |
| <i>Healthcare Provider Taxonomy Group 3</i>             | 193200000X MULTI-SPECIALTY GROUP                                                                                                       | Healthcare Provider Taxonomy Group 3             |
| <i>Healthcare Provider Taxonomy Group Description 3</i> | Multi-Specialty Group - A business group of one or more individual practitioners, who practice with different areas of specialization. | Healthcare Provider Taxonomy Group Description 3 |

National Provider Identifiers Registry

[www.hipaaspace.com](http://www.hipaaspace.com)

NPPES National Plan & Enumeration System  
1-800-465-3203 (NPI Toll-Free)  
1-800-692-2326 (NPI TTY)  
NPI Enumerator  
PO Box 6059  
Fargo, ND 58108-6059  
Email: [customerservice@npienumerator.com](mailto:customerservice@npienumerator.com)

National Provider Identifiers Registry

[www.hipaaspace.com](http://www.hipaaspace.com)

For all questions regarding this bundle please contact [Support@HIPAASpace.com](mailto:Support@HIPAASpace.com). Also feel free to let us know about any suggestions or concerns. All additional information as well as customer support is available at <http://www.hipaaspace.com>.

IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF SOUTH CAROLINA  
FLORENCE DIVISION

Thuy N. Gasser, individually and on  
behalf of those similarly situated,  
  
Plaintiffs,  
  
v.  
  
ACS Primary Care Physicians-Southeast P.C.,  
  
Defendant

) Civil Action No.: 4:20-cv-02419-RBH  
)  
)  
) **ACS PRIMARY CARE PHYSICIANS-  
SOUTHEAST P.C.'S RESPONSE IN  
OPPOSITION TO PLAINTIFF'S  
MOTION TO REMAND**  
)  
)  
)  
)  
)  
)

Defendant ACS Primary Care Physicians-Southeast P.C. (“ACS”) hereby submits this Response in Opposition to Plaintiff’s Motion to Remand (ECF No. 6). For the following reasons, the Court should deny the Motion to Remand and retain jurisdiction over this case.

## INTRODUCTION

The Court should deny Plaintiff's Motion to Remand because Plaintiff's claims are completely preempted by ERISA. Despite Plaintiff's attempt to plead her claims to avoid federal question jurisdiction, the allegations in the Complaint are, at root, claims for benefits and equitable relief allegedly due under ERISA. As such, the Complaint is completely preempted by two provisions of ERISA. First, the Complaint is completely preempted by ERISA § 502(a)(1)(B) because it is an attempt to recover benefits due the members of the putative class. Second, the Complaint is completely preempted by ERISA § 502(a)(2) and 502(a)(3) because it alleges that ACS breached its fiduciary duties to the members of the putative class. For these reasons, the Court has subject matter jurisdiction over the Complaint, and, accordingly, the Motion to Remand should be denied.

### **FACTUAL BACKGROUND AND PROCEDURAL HISTORY**

Plaintiff alleges that she had health insurance through a group health plan with Blue Cross Blue Shield of South Carolina (“BCBSSC”). (Compl. ¶ 2-3.) Plaintiff acknowledges that at least some of the members of the putative class are covered by employer-sponsored health insurance plans. (Pl. Memo in Supp. of Mot. to Remand (“Memorandum”) at 4 (ECF No. 6-1).)<sup>1</sup> Therefore, at least some of the health plans at issue in this case are subject to the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, *et seq.* (“ERISA”).

Plaintiff alleges that ACS, a healthcare provider, is a “preferred provider” and is in-network for BCBSSC. (Compl. ¶ 3 and 7.) Plaintiff further alleges that, as a preferred provider, BCBSSC agreed to pay ACS for certain medical services covered under Plaintiff’s plan in exchange for ACS’s agreement to reduce its fees for those services. (*Id.* ¶ 18.) A true and correct copy of the Provider Agreement between ACS and BCBSSC at issue is attached hereto as Exhibit A.

As relevant here, the Provider Agreement states that BCBSSC will pay ACS for “Covered Services in accordance with the benefit allowance of the Member’s Benefits Contract.” (Provider Agreement at 3). “Covered Services” are defined as “the services a Member is entitled to under the terms and conditions of such Member’s Benefits Contract.” (Provider Agreement at 2.) Under the Provider Agreement, ACS must accept certain fees for Covered Services, subject to the Member’s Benefits Contracts. (Provider Agreement at 4.) Notably, the Provider Agreement does not create any obligation related to fees charged for services that are not Covered Services.

---

<sup>1</sup> Indeed, the plaintiff in a similar action pending before this Court, Jessica Bennett, falls within the class definition in this Complaint, and admits that her BCBSSC plan is an ERISA plan. *See Jessica Bennett, individually and on behalf of those similarly situated v. ACS Primary Care Physicians-Southeast P.C.*, Case No. 4:20-cv-01501-RBH.

Plaintiff alleges that, on or about December 9, 2019, she was in an automobile accident. (Compl. ¶ 13.) She went to Grand Strand Regional Medical Center, where ACS physicians rendered medical services to her. (*Id.* ¶ 14.) According to the Complaint, ACS did not submit the claim for its services to BCBSSC, but instead billed Plaintiff directly. (*Id.* ¶ 22.) Further, Plaintiff alleges that ACS charged her more than the amount specified for her treatment in the Provider Agreement. (*Id.* ¶¶ 21-22.)

Based on these allegations, on May 21, 2020, Plaintiff filed her Complaint in the Court of Common Pleas in Horry County, South Carolina. The Complaint is a putative class action brought on behalf of Plaintiff and “[a]ll persons . . . in South Carolina . . . insured by BCBS[SC] receiving services from Defendant in any medical facility from December 9, 2016 to present for whom Defendant failed to submit the bill for medical services to BCBS[SC].” (Compl. ¶28.) Plaintiff alleges two causes of action: breach of contract and unjust enrichment. In Plaintiff’s breach of contract claim, she alleges that she is a third-party beneficiary of the Provider Agreement and that ACS breached that agreement by “refusing to submit claims to BCBS[SC].” (*Id.* ¶¶ 36-38.) In Plaintiff’s unjust enrichment claim, she alleges that ACS “was unjustly enriched through the collection of additional payments from Plaintiff and other class members for payment of services at a higher value than contracted for with BCBS[SC].” (*Id.* ¶¶ 41-44.) Among other remedies, Plaintiff asks the Court to establish a constructive trust for the sums collected in excess of the sums allegedly permitted under the Provider Agreement, specific performance, actual damages, special and consequential damages, attorneys’ fees and costs, and “such other and further relief as the Court deems necessary and proper. (Compl. ¶¶ 45 and “WHEREFORE” Clause.)

On or about June 26, 2020, ACS timely removed the case to this Court on the basis of federal question jurisdiction because the Complaint asserts claims that are completely preempted by ERISA. Plaintiff's Motion to Remand followed.<sup>2</sup>

### **LEGAL STANDARD**

The Court should deny Plaintiff's Motion to Remand because ERISA completely preempts the Complaint, and, accordingly, the Court has subject matter jurisdiction over it.

A defendant may remove a case from state court to federal court if the federal court would have had subject matter jurisdiction had it been filed there originally. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 207 (2004) (citing 28 U.S.C. § 1441(a)). As relevant here, federal courts have original jurisdiction over "civil actions arising under the Constitution, laws, or treaties of the United States." *Id.* (quoting 28 U.S.C. § 1331). "[A] cause of action arises under federal law . . . when the plaintiff's well-pleaded complaint raises issues of federal law." *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987).

Ordinarily, federal preemption is a defense to a state-law claim, and, thus, does not give rise to federal question jurisdiction under the well-pleaded complaint rule. *Davila*, 542 U.S. at 207. In certain situations, however, Congress has "so completely pre-empt[ed] a particular area [of law] that any civil complaint raising this select group of claims is necessarily federal in character. *Taylor*, 481 U.S. 63-64. In such a situation, a claim that "comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law." *Davila*, 542 U.S. at 208 (2004) (internal quotations and alterations omitted).

---

<sup>2</sup> Plaintiff devotes more than half of her Memorandum addressing diversity jurisdiction and jurisdiction under CAFA. ACS, however, did not invoke those grounds of subject matter jurisdiction in its Notice of Removal. Thus, ACS does not address them here.

ERISA is one such situation. *Taylor*, 481 U.S. at 67. ERISA is a “comprehensive legislative scheme,” with “an integrated system of procedures for enforcement.” *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985). Thus, “any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive” and is completely preempted. *Davila*, 542 U.S. at 209. Accordingly, all state law claims that assert claims that a plaintiff could have brought under ERISA are removable to federal court. *Id.*

In considering a motion to remand involving ERISA, a Court should not “elevate form over substance and allow parties to evade the pre-emptive scope of ERISA.” *Davila*, 542 U.S. at 2011 (internal quotation marks omitted). “Because complete preemption often applies to complaints drawn to evade federal jurisdiction, a federal court may look beyond the face of the complaint to determine whether the claims alleged as state law causes of action in fact are necessarily federal claims.” *Parrino v. FFIP, Inc.*, 146 F.3d 699, 704 (9th Cir. 1998), *superseded by statute on other grounds in Abrego v. The Dow Chem. Co.*, 443 F.3d 676, 681-82 (9th Cir. 2006).

### **DISCUSSION**

Here, the Complaint states two ERISA claims under the complete preemption doctrine. First, the Complaint alleges a claim for denial of coverage under § 502(a)(1)(B). Second, the Complaint alleges a claim for equitable relief under §§ 502(a)(2) and 502(a)(3).

#### **I. The Complaint is completely preempted by § 502(a)(1)(B)**

The Complaint is completely preempted by § 502(a)(1)(B). Section 502(a)(1)(B) provides that “[a] civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” 29 U.S.C. § 1132(a)(1)(B). Under Fourth

Circuit law, a claim is completely preempted under any of the provisions of § 502(a) where: (1) the plaintiff has standing to bring the claim under § 502(a); (2) the claim falls “within the scope of an ERISA provision that [the plaintiff] can enforce via § 502(a)”; and (3) resolution of the claim requires interpretation of the ERISA plan. *Prince v. Sears Holding Corp.*, 848 F.3d 173, 177 (4th Cir. 2017). In *Davila*, the Supreme Court phrased the second and third elements of this test slightly differently for purposes of § 502(a)(1)(B), concluding that a state law claim is preempted by ERISA where: (1) the plaintiff’s suit complains “of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan” and (2) the plaintiff does not allege the violation of a “legal duty (state or federal) independent of ERISA or the plan terms.” 542 U.S. at 210. If this test is satisfied, ERISA completely preempts the state-law claim. *Id.*

This test is satisfied here. As an initial matter, it is beyond dispute that members of the putative class have standing under § 502(a)(1)(B). Indeed, as discussed Plaintiff admits that at least some members of the class claim benefits under ERISA plans. (Memorandum at 4.) Moreover, as discussed in more detail below, the Complaint satisfies both prongs of the *Davila* test. First, Plaintiff alleges that members of the putative class were denied coverage for medical care under ERISA plans. Second, Plaintiff does not allege the violation of a legal duty that is independent of the ERISA plans. Accordingly, Plaintiff’s state-law claims are completely preempted.

A. Plaintiff is complaining of a denial of coverage

The first prong of the *Davila* test is met here because Plaintiff is making a claim for “denial of coverage for medical care” to which she and the putative class members are allegedly entitled “only because of the terms of an ERISA-regulated employee benefit plan.” *Id.* at 210. At root,

Plaintiff alleges that ACS failed to provide her and the putative class members benefits that they were owed due to their status as a beneficiary of health plans, at least some of which were ERISA plans. Specifically, Plaintiff alleges that she and other putative class members “entered into a contractual agreement with BCBS[SC], whereby Plaintiff and other class members agreed to pay monthly premiums to BCBS for the benefit of health insurance” (Compl. ¶ 36.) The Complaint also alleges that ACS’s alleged breach of the Provider Agreement “deprived [her and the putative class members] of the benefits of the discounts and other provisions negotiated between BCBS[SC] and [ACS].” (*Id.* ¶ 38.) The focus of these allegations is clear: Plaintiff is alleging that ACS’s actions resulted in the denial of benefits that she or putative class members were due under their respective health plans (some of which are ERISA plans), including the benefit of being charged a lower fee for services rendered under the plan.

Further, in order to adjudicate Plaintiff’s allegations, the Court will be required to interpret the ERISA plans at issue here. As noted, the Provider Agreement defines “Covered Services” by reference to the “Member’s Benefits Contract,” (Provider Agreement at 2), which, here, will include Plaintiff or other putative class members’ ERISA plans. Thus, in order to determine whether the services at issue here should have been billed at a lower fee, the Court will be required to interpret those ERISA plans. In other words, the Court cannot determine whether the services at issue were subject to a reduced fee without first determining whether they were covered under the terms of the ERISA plans at issue here. Accordingly, under the first prong of *Davila*, Plaintiff’s Complaint alleges a “denial of coverage for medical care” that she is only entitled to “because of the terms of an ERISA-regulated employee benefit plan.” 542 U.S. at 210; *see also Lone Star OB/GYN Assocs. v. Aetna Health, Inc.*, 579 F.3d 525, 531 (5th Cir. 2009) (“[A]ny determination of benefits under the terms of a plan – i.e., what is “medically necessary” or a “Covered Service”

– does fall within ERISA...”); *Garrison v. Northeast Ga. Med. Ctr., Inc.*, 66 F. Supp. 2d 1336, 1343 (N.D. Ga. 1999) (holding that a claim against provider was completely preempted because the claim alleged that the provider said the procedure was not medically necessary under an ERISA plan).

This case is on all fours with the holding in a very similar case from the Tenth Circuit, *Salzer v. SSM Health Care of Okla., Inc.*, 762 F. 3d 1130, 1137 (10th Cir. 2014). In *Salzer*, the plaintiff received care from SSM, a medical provider, under an ERISA plan for injuries sustained in an accident. *Id.* at 1133. Like here, SSM had a provider agreement with the plaintiff’s health insurance company, which the plaintiff alleged required SSM to bill the insurance company directly and for a lower fee than it would otherwise charge for the services. *Id.* Also like here, the plaintiff alleged SSM violated the terms of the provider agreement by billing him directly and for a higher fee than called for under the agreement. *Id.* The plaintiff alleged various state law claims against SSM, including a claim for tortious interference, alleging that SSM’s actions interfered with his rights under his ERISA plan. *Id.* at 1138. The Court held that this claim was completely preempted because the plaintiff alleged that SSM had “deprived [him] of the benefit of [his ERISA] health insurance.” *Id.* at 1137. The Court reasoned that the “claim for tortious interference can succeed only if [plaintiff’s] ERISA plan actually entitled him to a discount for the services provided by SSM.” *Id.* at 1138. For this reason, the Court held that first prong of the *Davila* case was met. *Id.*

Here, as in *Salzer*, Plaintiff’s claims “can succeed only if [Plaintiff’s or the putative class members’] ERISA plan[s] actually entitled [them] to a discount for the services provided by [ACS].” *Id.* at 1138. Moreover, the fact that Plaintiff does not expressly allege a claim for tortious interference is of no moment. The Court must “look beyond the face of the complaint” to

determine the actual reality of what is being alleged. *Parrino*, 146 F.3d at 704. Here, no less than in *Salzer*, Plaintiff alleges that she and other putative class members were denied coverage for medical care under health plans, at least some of which were ERISA plans. Thus, these claims are attempts to recover benefits due under § 502(a)(1)(B). To hold otherwise would be to “elevate form over substance” and allow Plaintiff to “evade the pre-emptive scope of ERISA.” *Davila*, 542 U.S. at 2011. Accordingly, the first prong of *Davila* is met here.

B. Plaintiff has not alleged the violation of a legal duty independent of ERISA or the terms of her plan

The second prong of the *Davila* test is satisfied here because Plaintiff does not allege the violation of a “legal duty . . . independent of ERISA or the plan terms.” *Davila*, 542 U.S. at 210. To give rise to an “independent” legal duty, the claim must be “*entirely independent* of the federally regulated [plan] itself.” *Id.* at 213 (emphasis added). Where “interpretation of the terms of [the plaintiffs’] benefit plans forms an essential part of their [state law] claim,” no independent legal duty exists. *Davila*, 542 U.S. at 213.

As with the first prong of the *Davila* test, *Salzer* is also instructive on the second prong. In *Salzer*, the Tenth Circuit held that there was no independent legal duty as to the plaintiff’s tortious interference claim because it could “succeed only if [plaintiff’s] ERISA plan actually entitled him to a discount for the services provided by [defendant].” 762 F. 3d at 1138. “Accordingly, interpretation of the [plaintiff’s ERISA plan] is a *necessary component* of the claim made and thus the legal duty at issue cannot be described as ‘independent of ERISA.’” *Id.* (emphasis added) (quoting *Davila*, 542 U.S. at 214).

Here, just as in *Salzer*, interpretation of at least one ERISA plan is a “necessary component” of the claims. As discussed, Plaintiff and members of the putative class are only entitled to the benefit of ACS’s discounted fee if the services at issue were covered under their health plans, some

of which were ERISA plans. (See Provider Agreement at 4.) Plaintiff has not alleged any “independent” legal duty, because recovery is entirely dependent on the terms of at least one ERISA plan. Accordingly, the second prong of the *Davila* test is satisfied, and Plaintiff’s claims are completely preempted.

## **II. The Complaint is completely preempted by §§ 502(a)(2) and 502(a)(3)**

In the alternative, the Complaint is completely preempted by §§ 502(a)(2) and 502(a)(3). ERISA § 502(a)(2) creates a right of action by a participant or beneficiary, among others, for “appropriate relief” based on the breach of fiduciary duty under 29 U.S.C. § 1109. 29 U.S.C. § 1132(a)(2). ERISA § 502(a)(3) creates a right of action by a participant or beneficiary, among others, “(A) to enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provision of this subchapter or the terms of the plan.” 29 U.S.C. § 1132(a)(3). Again, under Fourth Circuit law, a claim is completely preempted under any of the provisions of § 502(a) where: (1) the plaintiff has standing to bring the claim under § 502(a); (2) the claim falls “within the scope of an ERISA provision that [the plaintiff] can enforce via § 502(a)”; and (3) resolution of the claim must require interpretation of the ERISA plan. *Prince*, 848 F.3d at 177.<sup>3</sup>

In *Southern v. Wakemed*, the court held that a state law claim for “improper billing practices” against a healthcare provider was completely preempted under § 502(a)(3). No. 5:15-CV-35-FL, 2015 U.S. Dist. LEXIS 149180, at \*16-17 (E.D.N.C. Apr. 21, 2015). In that case, the plaintiff was a patient who claimed that the provider improperly sent him and other putative class

---

<sup>3</sup> *Davila* was specifically limited to the question of whether § 502(a)(1)(B) preempted the state law in question. 542, U.S. at 221 n.7. Thus, *Davila* does not apply to claims implicating the other enforcement mechanisms under § 502(a), including §§ 502(a)(2) and 502(a)(3). See *Southern v. Wakemed*, No. 5:15-CV-35-FL, 2015 U.S. Dist. LEXIS 149180, at \*21 (E.D.N.C. Apr. 21, 2015) (noting that *Davila* applies only to claims involving § 502(a)(1)(B)).

members bills for services that should have been covered under an ERISA plan. *Id.* at \*2-3. The court held that the claim was completely preempted by § 502(a)(3). First, the court held that the plaintiff would have standing under § 502(a) because he was a participant in the plan. *Id.* at \*16. Second, the court held that the plaintiff's claim fell within the scope of § 502(a)(3) because the plaintiff alleged that the provider "was bound by plaintiff's ERISA-governed plan and that defendant's failure to act in accordance with the plan constitutes a breach of contract." *Id.* at \*17. Third, the court noted that the plaintiff sought equitable relief in the form of injunctive relief, "enjoining [defendant] from continuing to undertake collection efforts . . . in amounts that exceed the rates and fees set forth in" the ERISA plan. *Id.* at \*18. Further, in response to the plaintiff's argument that he was not alleging a claim based on his ERISA plan but, rather, a separate contract between the plaintiff and his insurer, the court held that, even if that allegation were true, the plaintiff's rights to services at specified rates "are derived from rights and obligations established by plaintiff's ERISA governed healthcare plan." *Id.* at 18.

The reasoning in *Southern* applies here. First, just as in the context of § 502(a)(1)(B), Plaintiff has standing under §§ 502(a)(2) and 502(a)(3) because she and / or putative class members were insured under ERISA plans.

Second, Plaintiff's claim falls within the scope of §§ 502(a)(2) and 502(a)(3) because the Complaint alleges that ACS "breached its contract with BCBS[SC], Plaintiff, and the other class members, as third-party beneficiaries, by refusing to submit claims to BCBS[BC] depriv[ing them] of the benefits of the discounts and other provisions negotiated between BCBS[BS] and [ACS]." (Compl. ¶ 38.) Notably, based on her own allegations, Plaintiff and the putative class members are only entitled to such "benefits" by virtue of their participation in ERISA health plans. These allegations state a claim for breach of fiduciary duty pursuant to §§ 502(a)(2) and 502(a)(3). *Ehlen*

*Floor Covering, Inc. v. Lamb*, 660 F.3d 1283, 1287 (11th Cir. 2011) (holding that state law causes of action were preempted by § 502(a)(2) where a fiduciary allegedly breached duties imposed by ERISA); *Southern*, 2015 U.S. Dist. LEXIS 149180, at \* 16-17 (same with respect to § 502(a)(3)).

Third, the Complaint prays for equitable relief, including but not limited to constructive trust, specific performance, and “other relief deemed reasonable and appropriate by the Court.” (*Id.* ¶¶ 45 and “WHEREFORE” clause.) These allegations round out the requisite elements for pleading claims under §§ 502(a)(2) and 502(a)(3). *See Ehlen Floor Covering, Inc.*, 660 F.3d at 1287; *Southern*, 2015 U.S. Dist. LEXIS 149180, at \*18.

Further, although Plaintiff does not directly allege that ACS violated an ERISA plan, the rights she is seeking to vindicate are manifestly “derived from rights and obligations established by ERISA . . . plan[s].” *Southern*, 2015 U.S. Dist. LEXIS 149180, at \*18. As discussed in the context of Plaintiff’s § 502(a)(1)(B) claim, in order to determine if Plaintiff and / or other putative class members are entitled to reap the benefits of the Provider Agreement, the Court must first determine that the services were “Covered Services” under the ERISA plan. Plaintiff’s claims, therefore, are not capable of resolution without an interpretation of the ERISA plan(s). Accordingly, under *Prince* and *Southern*, Plaintiff’s claims are completely preempted by ERISA, and the Motion to Remand should be denied.<sup>4</sup>

---

<sup>4</sup> In support of her argument that federal jurisdiction is lacking, Plaintiff primarily relies on a thirty-seven year-old Supreme Court case—*Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983). That case, however, which was decided before the Supreme Court held that the complete preemption doctrine applies in the ERISA context, has no application here. In *Franchise Tax Board*, the Board, a California tax enforcement agency, filed a complaint in state court against a trust that administered provisions of an ERISA plan providing paid vacation for construction workers. *Id.* at 4. The trust removed the case to federal court, contending that the complaint was completely preempted by ERISA. *Id.* at 6-7, 23. The Supreme Court disagreed, holding that, even if the complete preemption doctrine applied in the ERISA context, the complaint was not completely preempted because the claim was brought by a tax authority, not an ERISA

**CONCLUSION**

For the foregoing reasons, ACS respectfully requests that the Court DENY Plaintiff's Motion to Remand.

Dated: August 10, 2020

GORDON & REES LLP

By s/Josh Dixon

Josh Dixon (Fed. 10036)

E-mail: jdixon@grsm.com

Victoria T. Kepes (Fed 13000)

E-mail: vkepes@grsm.com

40 Calhoun Street, Suite 350

Charleston, SC 29401

Telephone: (843) 278-5900

*Attorneys for ACS Primary Care*

*Physicians-Southeast P.C.*

---

plan, beneficiary, participant, fiduciary, or the Secretary of Labor, as is required to state a claim under ERISA § 502(a). *Id.* at 25-27.

To state the facts and holding of *Franchise Tax Board* is to state the obvious—that case simply has no application here. Plaintiff and / or putative class members are participants or beneficiaries of ERISA plans, not state tax authorities. Thus, *Franchise Tax Board* is entirely inapposite.

# EXHIBIT A

**BLUECROSS BLUESHIELD OF SOUTH CAROLINA INDIVIDUAL HEALTH INSURANCE  
EXCHANGE (“HIX”) PREFERRED PROVIDER AGREEMENT**

**WITH THE EXCEPTION OF DISPUTES RELATED TO THE UTILIZATION MANAGEMENT  
PROGRAM, WHICH SHALL BE GOVERNED PURSUANT TO THE PROVISIONS OF APPENDIX A OF  
THIS AGREEMENT, THE TERMS OF THIS AGREEMENT SHALL BE SUBJECT TO ARBITRATION.**

This Group Preferred Provider Agreement (“Agreement”) is between BlueCross BlueShield of South Carolina (“BCBSSC”), a South Carolina mutual corporation, and the undersigned herein referred to as “Preferred Provider”. Any reference to Preferred Provider in this Agreement applies to individual employed physicians or professional providers of the group as well as the group as a whole.

**I. INTRODUCTION.**

- A. WHEREAS, BCBSSC desires to establish effective, cooperative healthcare cost containment programs for the Individual Health Insurance Exchange (“HIX”; as further defined herein) market that will assure the availability and continuity of quality care to BCBSSC’s Members (as defined below); and,
- B. WHEREAS, Preferred Provider wants to participate as a (HIX) Network Provider (as defined below) in the cooperative health care cost containment programs established by BCBSSC.
- C. NOW THEREFORE, in consideration of the premises and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, BCBSSC and the (HIX) Preferred Provider hereby agree as follows:

**II. DEFINITIONS.**

Capitalized terms used in this Agreement shall have the following meanings.

- A. “Agreement” means this Individual Health Insurance Exchange (“HIX”) Preferred Provider Agreement.
- B. “Associate Plan” means a company, organization or other entity that is entitled to the benefit of the terms of this Agreement as a result of such Associate Plan’s entry into an agreement with BCBSSC. The term “Associate Plan” also includes BCBSSC subsidiaries and other members of the Blue Cross Blue Shield Association.
- C. “Association” means an association of independent Blue Cross and Blue Shield Plans known as the Blue Cross and Blue Shield Association.
- D. “BCBSSC” means Blue Cross and Blue Shield of South Carolina.
- E. “Benefits Contract” means the contract between BCBSSC and a Member or an Associate Plan and its Member entitling the Member to receive Covered Services as designated in the contract. Benefits Contract as defined in this Agreement includes only Benefits Contracts purchased by individuals through an individual (i) State-Based Exchange (SBE), (ii) Federally-Facilitated Exchange (FFE) or (iii) Private Health Insurance Exchange in accordance with the Patient Protection and Affordable Care Act (PPACA).
- F. “Claim” means a paper or electronic billing instrument with the required fields completed as required by BCBSSC and in compliance with HIPAA, which has been properly and accurately completed by Preferred Provider.
- G. “Continued Stay Review” means the mandatory review conducted under the Utilization Management Program, to determine whether a continued admission is Medically Necessary.

- H. “Covered Services” means the services a Member is entitled to and which are reimbursable under the terms and conditions of the applicable Member Benefits Contract.
- I. “Effective Date” means the date that BCBSSC accepts Preferred Provider as a (HIX) Network Provider
- J. “Emergency” is defined as a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain, such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in:
- (1) placing the health of the individual, or with respect to a pregnant woman the health of a woman or her unborn child, in serious jeopardy,
  - (2) serious impairment of bodily functions, or
  - (3) serious dysfunction of any bodily organ or part.
- K. “Emergency Admission Review” means the mandatory review conducted pursuant to the Utilization Management Program to determine whether an Emergency admission is Medically Necessary
- L. “Fee Allowance” means the lower of: (1) Preferred Provider’s normal charge for a procedure, or (2) 100% of the State Health Plan Schedule of Allowances in place on the effective date of this Agreement.
- M. Health Insurance Exchange or “HIX” means an individual (i) State-Based, (ii) Federally-Facilitated or (iii) Private Health Insurance Exchange in which individual consumers may purchase health insurance in accordance with the PPACA.
- N. “Medically Necessary” shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
- (1) in accordance with generally accepted standards of medical practice
  - (2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease
  - (3) not primarily for the convenience of the patient, physician, or other health care provider
  - (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.
- O. “Member” means any individual who is eligible for Covered Services under the terms of a Benefits Contract.
- P. “Membership Card” means the card BCBSSC issues to Members to allow Preferred Provider to identify a Member
- Q. “Outpatient Review” is the mandatory review conducted pursuant to the Utilization Management Program, to determine whether certain elective outpatient procedures are Medically Necessary

- R. "Patient Pay Amounts" means, with respect to Covered Services, all deductibles, coinsurance, co-payments and other sums that are payable by the Member directly to Preferred Provider and which are not payable by BCBSSC or Associate Plan.
- S. "Pre-Admission Review" means the mandatory review conducted pursuant to the Utilization Management Program to determine whether a non-Emergency admission is Medically Necessary.
- T. "HIX Network Provider" includes the following types of persons or facilities which
- (1) provide Covered Services to a Member; and
  - (2) such persons or facilities have a written agreement with BCBSSC to participate as a HIX Network Provider:
    - a. hospitals;
    - b. skilled nursing facilities;
    - c. home health agencies;
    - d. hospices;
    - e. independent laboratories;
    - f. contracting national laboratories;
    - g. physicians;
    - h. drug stores and pharmacies;
    - i. vendors of durable medical equipment; and
    - j. other eligible providers as specified under a Benefits Contract.

Upon acceptance by BCBSSC, Preferred Provider will be a HIX Network Provider.

- U. "Utilization Management Program" means a function performed by BCBSSC or by an organization or entity selected by BCBSSC to review and determine whether the services provided, or to be provided, are Medically Necessary, including but not limited to, whether services are appropriate. This Program is established to evaluate, approve and monitor whether Covered Services are Medically Necessary, and includes case management services. The Utilization Management Program is administered pursuant to the terms of Appendix A.

### **III. BCBSSC RESPONSIBILITIES.**

- A. BCBSSC or Associate Plan shall:
- (1) Pay Preferred Provider for Covered Services in accordance with the benefit allowance of the Member's Benefits Contract. Payment will be based upon the Fee Allowance amount.
  - (2) Directly reimburse Preferred Provider for Covered Services provided to Members without requiring that Preferred Provider obtain the Member's prior authorization.
  - (3) Establish procedures and methods whereby Members can be appropriately identified by HIX Network Providers.

- (4) Provide Preferred Provider with a list of all HIX Network Providers via the BCBSSC website ([www.southcarolinablues.com](http://www.southcarolinablues.com) at the time of this writing).

#### **IV. PREFERRED PROVIDER'S RESPONSIBILITIES.**

A. Preferred Provider shall:

- (1) Accept payment of the Fee Allowance amount as payment in full for Covered Services rendered to Members. All payments are subject to the terms of the Member's Benefits Contract. Member shall be solely responsible for any required Patient Pay Amounts and Preferred Provider shall not bill the Member any amount in excess of such Patient Pay Amounts for Covered Services. Payment will be adjusted for payments made to Preferred Provider pursuant to any coordination of benefits provisions in any health plan other than the Benefits Contract.
- (2) While performing services, maintain a physician-patient relationship with enrolled Members. Any and all medical service decisions, treatment decisions or exercises of medical judgment are Preferred Provider's responsibility.
- (3) Not discriminate against any Member on the basis of race, color, sex, age, religion, national origin, handicap or insurance plan in providing services under this Agreement. Preferred Provider may choose to be closed to new Members as a group but only if Preferred Provider is closed to new patients from all payor sources.
- (4) Cooperate and comply with the Provider Office Administrative Manual (located at [www.southcarolinablues.com](http://www.southcarolinablues.com) at the time of this writing).
- (5) Use only HIX Network Providers in the delivery of Covered Services unless Covered Services, supplies or equipment are not available from any HIX Network Provider, or in the case of an Emergency.
- (6) Provide Covered Services in an appropriate outpatient setting whenever safe, quality care can be provided in such a setting.
- (7) Cooperate fully with the Utilization Management Program.
- (8) Agree to provide a second opinion to Members who have already consulted with another HIX Network Provider.
- (9) Cooperate and participate with BCBSSC and any Associate Plan in any utilization control procedures, quality assurance activities, analysis of Member's risk status, external audit systems and grievance procedures, as may be established pursuant to the terms of the Benefits Contract, and comply with all final determinations rendered through the grievance process.
- (10) Prepare, with respect to each Member for whom Covered Services are provided under this Agreement, standard medical records in such form, containing such information, and meeting such record keeping requirements as might be required by applicable federal and state law. Preferred Provider will keep confidential, and take all reasonable precautions to prevent the unauthorized disclosure of any and all records prepared and/or maintained by this Agreement. BCBSSC or the Associate Plan will have the right to inspect, review and obtain copies of such records upon request at no charge.
- (11) File a claim for all Covered Services rendered to Members within the time frame set forth in the Benefits Contract (typically 180 days). Preferred Provider will not bill BCBSSC, Associate Plan or

the Member for claims filed outside of the timely filing limit unless the party responsible for payment approves an exception. Preferred Provider will file the claims in a manner acceptable to BCBSSC. Preferred Provider may not charge the Member, BCBSSC or Associate Plan for filing a claim.

- (12) While an appeal of a decision by BCBSSC that a Covered Service was not Medically Necessary is pending, Preferred Provider will not bill BCBSSC, Associate Plan or the Member for any charges for such Covered Services that are the subject of the appeal.
- (13) Not file a claim with BCBSSC or Associate Plan or bill a Member for any charges for services rendered when it has been determined such services are not Medically Necessary. Preferred Provider may seek compensation from the Member for services determined to be not Medically Necessary only if the Member, or lawfully authorized representative thereof, consents in writing to be responsible for the payment of the specific medical services prior to the rendition of the services.
- (14) Not bill BCBSSC, Associate Plan or the Member separately for an item or Covered Service that is considered by BCBSSC to be an integral part of another item or Covered Service.
- (15) Not bill BCBSSC, Associate Plan or the Member for Serious Reportable Adverse Event(s) ("Never Event") which have been identified by the National Quality Forum and for which CMS has issued a final specific National Coverage Determination policy to not cover services related to the Never Event. BCBSSC has the right to recover any payment made in error related to Never Events.
- (16) Reimburse BCBSSC or the Associate Plan for any payment made for services determined not to be payable hereunder. Provided, however, to the extent Preferred Provider is required to reimburse the Member and does reimburse the Member under a coordination of benefits provision of a Member's health plan other than the Benefits Contract, Preferred Provider is not required to reimburse BCBSSC or Associate Plan. If Preferred Provider does not reimburse BCBSSC or Associate Plan for any payment made for services determined not to be payable, then BCBSSC may offset future payments to Preferred Provider (whether resulting from claims related to the same Member or other Members) by the amount of the refund due.
- (17) Maintain active state licensure in the state in which Preferred Provider practices.
- (18) Certify to BCBSSC that Preferred Provider is fully covered by a medical malpractice policy in accordance with BCBSSC's relevant credentialing requirements.
- (19) Allow BCBSSC to use Preferred Provider's name to inform HIX Members and potential Members that Preferred Provider is a HIX Network Provider.
- (20) Upon written request of the United States Secretary of Health and Human Services or Comptroller General or any other governing bodies or any of their duly authorized representatives, make available those contracts, books, documents and records necessary to verify the nature and extent of the cost of providing services. Such inspection shall be available up to four years after the rendering of such services. If Preferred Provider carries out any of the duties of this Agreement through a subcontract with a value of \$10,000.00 or more over a 12 month period with a related individual or organization Preferred Provider will include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of Section 1861 (v)(1) of the Social Security Act and the regulations relating to it
- (21) Use BCBSSC HIX network laboratories for reference lab work for Members.

#### **V. RELATIONSHIP BETWEEN THE PARTIES.**

- A. Nothing in this Agreement should be construed as an attempt by BCBSSC to abridge, alter or interfere with any HIX Network Provider's physician-patient relationship. Any and all medical service decisions, treatment decisions

or exercises of medical judgment are Preferred Provider's responsibility, and BCBSSC shall not be deemed liable for any such decisions or exercise of judgment in any manner.

- B. Preferred Provider is an independent contractor. This Agreement shall not be construed or deemed to create an employer-employee relationship, a joint venture, or a principal-agent relationship between BCBSSC and Preferred Provider or any Network Provider.
- C. BCBSSC may in its discretion, establish, develop, manage and market other provider networks in which Preferred Provider may not be selected to participate.

## **VI. TERM, TERMINATION AND AMENDMENT.**

- A. TERM. This Agreement shall be effective on the Effective Date and shall continue for an Initial Term expiring on December 31, 2015 ("Initial Term"). Thereafter, the Agreement shall be automatically renewed for successive one-year terms (each, a "Renewal Term") on the day immediately following the expiration date of such Initial Term and on each anniversary of such date thereafter, unless sooner terminated as hereinafter provided.
- B. TERMINATION
  - (1) Either BCBSSC or Preferred Provider may terminate this Agreement, with or without cause, by giving written notice at least one hundred twenty (120) days prior to the expiration of any term as described in Article VI (A) with termination to be effective at the end of the term.
  - (2) BCBSSC may terminate this Agreement for cause upon thirty (30) days prior written notice, for the following reason:
    - (a) Failure to abide by the terms specified in this Agreement (e.g. Preferred Provider fails to use other HIX Network Providers when available).
  - (3) BCBSSC shall have the right to terminate this Agreement for cause, immediately and without prior notice, upon actual notice to BCBSSC of significant deficiencies in licensing or qualification matters, including but not limited to the following reasons (in the event the deficiency applies to individual practitioners of Preferred Provider as opposed Preferred Provider as a whole then termination shall be limited to the applicable individual practitioner):
    - (a) Loss of license required for professional practice;
    - (b) Preferred Provider is convicted of a felony;
    - (c) Preferred Provider loses or otherwise fails to maintain all certificates(s), registration(s), or additional licensure(s) required for professional practice;
    - (d) Preferred Provider misrepresents Preferred Provider's competence or professional capabilities; or
    - (e) Preferred Provider misrepresents or fails to disclose any requested credential information or otherwise fails to meet ongoing credentialing or re-credentialing criteria; or
    - (f) Preferred Provider changes affiliation from a HIX Network Provider to a professional association that does not participate in the HIX Network. It is Preferred Provider's

responsibility to notify BCBSSC's Provider Contracting and Reimbursement Department at least thirty (30) days in advance of such a change; or

- (g) Preferred Provider files for the protection of the Bankruptcy Court or is involuntarily placed in bankruptcy or has a receiver appointed to manage Preferred Provider's affairs.
- (4) Nothing contained in this Article VI (B) shall impose on BCBSSC any duty to monitor Preferred Provider's performance under this Agreement, the quality of care provided by Preferred Provider or Preferred Provider's physical or mental condition or Preferred Provider's behavior. BCBSSC expressly disclaims any such duty. BCBSSC may monitor or may decline to monitor such performance in its sole discretion.
- (5) As of the date of termination, this Agreement shall be of no further force or effect whatsoever for services rendered thereafter and each of the parties shall be relieved and discharged from the requirements of this Agreement, except that:
  - (a) The parties shall complete any arbitration proceedings initiated pursuant to this Agreement, including requests for arbitration of disputes arising between the parties after the effective date of termination.
  - (b) Notwithstanding termination, and without cost to BCBSSC, BCBSSC shall continue to have access to Preferred Provider's records for three (3) years, to the extent permitted by law and as necessary to fulfill the terms of this Agreement and legal requirements.
  - (c) Preferred Provider agrees to complete the course of treatment for all Members that have begun a course of treatment by the date of termination notice, even if the course of treatment is completed after the date of termination. Both parties agree to honor the terms of this Agreement for the completion of such courses of treatment.
  - (d) The requirements of Article IX (K) shall remain in full force and effect.

- C. AMENDMENT. This Agreement may be amended by BCBSSC following ninety (90) days prior written notice, effective at the end of such ninety (90) day period. If Preferred Provider does not accept the terms of the amendment, Preferred Provider may terminate this Agreement by providing written notice within thirty (30) days of the receipt of such proposed amendment. Termination shall be effective at the end of the ninety (90) day period provided by BCBSSC. Notwithstanding the foregoing, any changes to applicable federal and state laws or regulations that may be enacted during the term of this Agreement shall be automatically incorporated into this Agreement as they become effective.

## **VII. ASSIGNMENT.**

- A. ASSIGNMENT OF AGREEMENT. Neither party may assign their rights or duties under this Agreement without the prior written consent of the other party, which consent shall not be unreasonably withheld.
- B. ASSIGNMENT OF COVERED SERVICES. BCBSSC may, from time to time, contract with Associate Plans for the purpose of allowing such Associate Plans to avail themselves of the same access to the benefits of this Agreement and related rights as BCBSSC and binding such persons to the payment responsibilities under this Agreement. Preferred Provider agrees to provide Covered Services to Associate Plans Members under the terms of this Agreement and to look to each Associate Plan for reimbursement for Covered Services rendered to that Associate Plan's Members. Such Associate Plans shall not be required to provide for electronic claims transmission for the use of Preferred Provider in filing claims, however, BCBSSC will encourage the use of electronic claims transmission systems by Associate Plans. The duties and obligations of Associate Plans under this Agreement are several and distinct from BCBSSC's duties and obligations under this Agreement and

BCBSSC does not guarantee any Associate Plan's performance under this Agreement and BCBSSC will not be responsible for any Associate Plan's actions. Except for references to BCBSSC under Articles V, IV, VIII, and IX, references to BCBSSC shall be deemed to refer to Associate Plans with respect to such Associate Plans duties and obligations under this Agreement and with respect solely to such Associate Plan's Members.

### **VIII. LIABILITY AND INDEMNITY.**

- A. Preferred Provider agrees to indemnify, defend and hold BCBSSC harmless from any and all liability, loss, damage, claim or expense of any kind (including all costs and reasonable attorneys' fees), which results from any breach of this Agreement by Preferred Provider or which results from the negligent or willful acts or omissions by Preferred Provider, its agents or employees regarding the duties and obligations of Preferred Provider under this Agreement, including the duty to maintain the legal standard of care applicable to Preferred Provider. Such obligation to indemnify, defend and hold harmless shall not apply to any matters resulting from negligent or willful acts or omissions of BCBSSC or its agents or employees.
- B. BCBSSC agrees to indemnify, defend and hold Preferred Provider harmless from any and all liability, loss, damage, claim or expenses of any kind (including all costs and reasonable attorneys' fees), which results from any breach of this Agreement by BCBSSC or results from the negligent or willful acts or omissions by BCBSSC, its agents or employees regarding the duties and obligations of BCBSSC under this Agreement. Such indemnification and hold harmless shall not apply to any matters resulting from negligent or willful acts or omissions of Preferred Provider or its agents or employees.

### **IX. MISCELLANEOUS.**

#### **A. PARTIES TO THE AGREEMENT.**

- (1) Preferred Provider expressly acknowledges its understanding that this Agreement constitutes a contract between Preferred Provider and BCBSSC, and that BCBSSC is an independent corporation operating under a license with the Association, permitting BCBSSC to use the Blue Cross and Blue Shield Service Mark in the State of South Carolina, and that BCBSSC is not contracting as the agent of the Association.
- (2) Preferred Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than BCBSSC and that no person, entity, or organization other than BCBSSC (and other than Associate Plans by virtue of Article VII) shall be held accountable or liable to Preferred Provider for any of BCBSSC's obligations to Preferred Provider created under this Agreement. This Article IX (A) shall not create any additional obligations whatsoever on the part of BCBSSC other than those obligations created under other provisions of this Agreement.

- B. **ORIGINALS/COPIES OF THE AGREEMENT.** BCBSSC may image this Agreement, related documents and credentials. An imaged copy of this Agreement, related documents and credentials shall be as effective and valid as the original.
- C. **USE OF DOCUMENTS.** Preferred Provider agrees that BCBSC may allow the documents and credentials referenced in this Agreement to be used by any and all subsidiary networks managed by BCBSSC.
- D. **NON-EXCLUSIVITY.** Preferred Provider and BCBSSC agree and acknowledge that this is a non-exclusive contract and that either party is free to contract with other parties to provide the services contemplated under this Agreement.
- E. **WAIVER OF BREACH.** Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision.

- F. SEVERABILITY. In the event any provision of this Agreement is rendered invalid or unenforceable by any federal statute or state law, or by any regulation duly promulgated by officers of the United States or the State of South Carolina in accordance with law, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of this Agreement shall remain in full force and effect.
- G. EFFECT OF SEVERABLE PROVISION. In the event that a provision of this Agreement is rendered invalid or unenforceable or declared null and void as provided in Article IX (F) and its removal has the effect of materially altering the obligations of either party in such manner as in the judgment of the party affected: (1) will cause serious financial hardship to such party; or (2) will cause such party to act in violation of its corporate Articles or Bylaws, the party so affected shall have the right to terminate this Agreement upon thirty (30) days prior written notice to the other party. The applicable provisions of Article VI shall apply to such termination.
- H. PROHIBITION AGAINST PAYMENT OF MEMBERS HEALTH PLAN PREMIUMS. Preferred Provider shall not pay any amount toward health plan premiums or health insurance premiums of any Members, except for its eligible employees and retirees under its own employee welfare benefit plan.
- I. HEADINGS. The headings of Articles and Sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.
- J. GOVERNING LAW. This Agreement shall be construed and enforced in accordance with the laws of the State of South Carolina.
- K. CONFIDENTIALITY.
- (1) Preferred Provider acknowledges and agrees that in the course of obtaining this Agreement it has received, and may continue to receive, BCBSSC's valuable trade secrets, confidential, and proprietary information (collectively referred to as "Confidential Information"), including the reimbursement terms and the terms of this Agreement and any and all records required to be produced or kept under the terms of this Agreement. Preferred Provider further acknowledges that the use of Confidential Information would give Preferred Provider an unfair competitive advantage were Preferred Provider to directly or indirectly compete with BCBSSC for BCBSSC's existing customers, and disclosure of Confidential Information would cause harm to BCBSSC.
  - (2) In consideration of the disclosure by BCBSSC to Preferred Provider of Confidential Information, Preferred Provider agrees to treat the Confidential Information supplied to it by BCBSSC in strict confidence, and to undertake the following additional obligations with respect thereto:
    - (a) to use Confidential Information for the sole purpose of performing its obligations under this Agreement;
    - (b) not to disclose Confidential Information to any person outside of its organization except as needed to comply with Preferred Provider's obligations under this Agreement;
    - (c) to limit dissemination of Confidential Information to only those of its employees who have a need to know to perform the limited tasks set forth in this Agreement;
    - (d) ensure that any pricing disclosed to its billing company, attorneys, CPAs, etc. is not disclosed to any other provider or other organization. Any violation of Confidentiality by such person or entity will be considered the same as if Preferred Provider committed such violation; and
    - (e) to return Confidential Information and all documents, notes or physical evidence thereof to BCBSSC upon termination of this Agreement.

- (3) The restrictions and obligations of this Article IX (K) shall survive any expiration, termination or cancellation of this Agreement and shall continue to bind Preferred Provider, its successors and assigns.
- (4) Preferred Provider acknowledges that if Preferred Provider breaches the terms of this Article IX (K), BCBSSC shall be entitled to seek monetary damages against Preferred Provider. Additionally, Preferred Provider acknowledges that if Preferred Provider breaches this Article IX (K), such monetary damages may not be a sufficient remedy for such breach and that BCBSSC shall be entitled, without waiving any other rights or remedies, to injunctive or equitable relief as may be deemed proper by a court of competent jurisdiction.

L. ENTIRE AGREEMENT. This Agreement, including all written supplements, exhibits, and amendments hereto constitutes the entire agreement of the parties hereto with respect to HIX-related services. No verbal agreement or conversation of the parties hereto shall affect or in any way modify any of the terms and conditions herein contained. Notwithstanding the foregoing, any existing agreements between the parties which are not related to HIX-related services shall remain in full force and effect.

M. DISPUTE RESOLUTION.

- (1) Except for decisions made pursuant to the Utilization Management Program, BCBSSC and Preferred Provider 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, other than a Utilization Management Program decision (which resolution shall be governed by the terms of Appendix A), BCBSSC and Preferred Provider 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 Columbia, South Carolina. The Arbitrator shall not have authority to re-write this Agreement between the parties, but rather, is bound to follow legal contract construction rules to render any decision. The arbitrator is prohibited for awarding any punitive, special or consequential damages. The arbitrator's determination shall be final and binding upon the parties. The parties agree to bear their own costs and fees relating to the arbitration and agree to equally share the arbitrator's fees and costs. By entering into this Agreement and selecting arbitration as a dispute resolution mechanism the parties waive any right to jury trial.

**IN WITNESS WHEREOF**, each of the undersigned parties to this Group Preferred Provider Agreement has caused this Group Preferred Provider Agreement to be duly executed.

BLUECROSS BLUESHIELD  
OF SOUTH CAROLINA

ACS Emergency Physicians of SC, PC  
ACS Primary Care Physicians SE, PC

 9/10/14  
By: J. Lance Lockman Date  
Its: Assistant Vice President,  
Professional Network Management

 9/10/14  
Authorized Signatory of Preferred Provider / Date

Effective Date  
(Established by BCBSSC)

**APPENDIX A****UTILIZATION MANAGEMENT PROGRAM**

The Utilization Management Program is a series of activities carried out by BCBSSC to ensure that the Covered Services that are provided to Members are Medically Necessary. These activities consist of pre-certification of admissions and length of stay and pre-certification of selected medical and surgical procedures. The Utilization Management Program also involves a review of ongoing admissions and may involve the retrospective review of admissions for appropriateness and Medical Necessity. The Utilization Management Program may also involve case management of all Covered Services provided to Members who are severely ill with long-term chronic conditions. In the event that the Preferred Provider fails to follow the requirements of the Utilization Management Program or any authorization requirements listed in the Provider Office Administrative Manual, BCBSSC reserves the right to withhold all or a portion of the payment for otherwise Covered Services which may not be billed to Member.

- A. Preferred Provider and BCBSSC hereby agree:
- (1) To avoid unnecessary or unduly costly Covered Services for Members;
  - (2) To ensure that all Members receive the appropriate and necessary level of Covered Services in accordance with community standards for care and such Members Benefits Contract;
  - (3) To maintain professional standards in the delivery of health care within the meaning of Section 40-71-10 Code of Laws of South Carolina, 1976 as amended.
- B. The Utilization Management Program will be conducted by BCBSSC. Payment to Preferred Provider may be denied when it is determined that such Covered Services were not Medically Necessary or where Preferred Provider fails to follow the Utilization Management Program's procedures. Preferred Provider will not bill a Member for charges for Covered Services where Preferred Provider fails to follow the Utilization Management Program procedures.
- C. When service evaluation is requested by BCBSSC or Associate Plan, Preferred Provider will use its best efforts to ensure that all Preferred Provider's relevant records and those of Preferred Provider's facility, if applicable, be made available to BCBSSC upon reasonable notice.
- D. The requirements of the Utilization Management Program must be followed for all Covered Services rendered to Members. The Utilization Management Program includes: Pre-Admission Reviews, Emergency Admission Reviews, Outpatient Reviews and Continued Stay Reviews. Preferred Provider or the admitting HIX Network Provider must request each type of review. Each specific type of review is subject to the following additional requirements:
- (1) Pre-Admission Review. A Pre-Admission Review and authorization is required prior to all non-Emergency admissions. Preferred Provider will cooperate with other HIX Network Providers in connection with a Pre-Admission Review, including providing any necessary clinical information relating to a Member's proposed admission.
  - (2) Emergency Admission Reviews. An Emergency Admission Review and authorization is required for all Emergency admissions. BCBSSC or Associate Plan must be notified within twenty-four (24) hours of the Emergency admission, or by noon of the next working day if the

admission is on Friday, Saturday, Sunday or a holiday. Preferred Provider will cooperate with other HIX Network Providers in connection with an Emergency Admission Review, including providing any necessary clinical information relating to a Member's proposed admission.

- (3) Continued Stay Review. Each approved admission of a Member is contemplated to last a particular number of days. Accordingly, each admission will be assigned a specific number of days at the time of approval of the admission. Additional days are subject to a Continued Stay Review and approval by BCBSSC. Preferred Provider will cooperate with other HIX Network Providers in connection with a Continued Stay Review, including providing any necessary clinical information relating to a Member's proposed continued stay.
  - (4) Outpatient Review. Elective outpatient surgical procedures may be subject to an Outpatient Review and authorization that must be obtained at least three (3) days prior to applicable procedures.
- E. BCBSSC or Associate Plan shall not pay for services that are determined through the Utilization Management Program to be not Medically Necessary or which are not Covered Services. Unless a Member has agreed, in writing, to be personally responsible for such specified Covered Services, Preferred Provider agrees not to bill any Member for services determined through the Utilization Management Program to be not Medically Necessary. In the event Preferred Provider successfully appeals a Utilization Management Program decision in accordance with this Appendix, BCBSSC or Associate Plan shall accept Preferred Provider's bill and make payment pursuant to the terms of the Agreement.
- F. Preferred Provider may appeal a Utilization Management Program decision by requesting consideration by the BCBSSC Medical Director. Any request for appeal shall be made to the BCBSSC Medical Director in writing within sixty (60) days following receipt of the Utilization Management Program's written decision. A complete medical record should accompany any request for an appeal. The decisions of the BCBSSC Medical Director shall be final and binding on the parties except for the following:
- Upon request of Preferred Provider, the BCBSSC Medical Director may (at his/her discretion) agree to submit the appeal to an external review party. The external review shall be conducted by a physician of the same or similar specialty of the requested service. For appeals that are submitted for external review Preferred Provider and BCBSSC agree that the decision of the external review shall be final and binding on the parties.
- G. Preferred Provider and BCBSSC agree that each shall be responsible for their own costs incurred in the appeal of any Utilization Management Program determination.



In Beverly v. Grand Strand Regional Medical Center, LLC, Opinion No. 5708 (Ct.App. January 15, 2020), Beverly brought an action, both individually and on behalf of others similarly situated, against the hospital because it failed to submit her medical bills to Beverly's health insurer, Blue Cross Blue Shield of South Carolina, despite entering into a preferred provider contract with the insurer. (A copy of the opinion is attached hereto as **Exhibit A**). Rather, the hospital attempted to collect the entire amount of its bill directly from the member Beverly. Beverly asserted claims for breach of contract, unjust enrichment and bad faith. The circuit court dismissed the action in its entirety. The South Carolina Court of Appeals reversed and remanded the case as to Beverly's claims for breach of contract and unjust enrichment. As to the bad faith claim, however, the Court of Appeals affirmed the dismissal and held that the "circuit court properly found South Carolina does not recognize a fiduciary duty related to a hospital's billing practices." Moreover, the Court of Appeals stated, "there is no authority to support the proposition that a fiduciary relationship exists between a hospital and patient with respect to a hospital's contractual duty to submit an insurance claim." The Court cited a number of cases from other jurisdictions which have held likewise and noted the relationship is essentially one of creditor-debtor and not a fiduciary relationship.

Thus, since South Carolina law does not recognize the relationship between the medical provider and the patient, with regard to submitting claims for payment to insurers, to be fiduciary in nature, there can be no breach of fiduciary claim and Defendant's argument to the contrary must fail. Since there can be no breach of fiduciary claim Plaintiff's claims are not preempted by §§ 502(a)(2) and 502(a)(3).

## II. Recovery of Benefits Argument

Defendant argues this is an action to recover benefits under an ERISA plan and is therefore preempted by § 502(a)(1)(B). Controlling law says otherwise. The Fourth Circuit has held that a claim is preempted under § 502(a) where (1) the plaintiff has standing to bring the claim under § 502(a); (2) the claim falls “within the scope of an ERISA provision that [the plaintiff] can enforce via § 502(a)”; and (3) resolution of the claim requires interpretation of the ERISA plan.” Prince v. Sears Holding Corp., 848 F.3d 173, 177 (4<sup>th</sup> Cir. 2017). Without even addressing the second element, which is highly doubtful, there should be no question the third element fails. The resolution of Gasser’s breach of contract claim and unjust enrichment claim will in no way require interpretation, or even reference to, any ERISA plan or group insurance plan.

As Defendant correctly notes, this test is somewhat different than the test enunciated by the Supreme Court in Aetna Health, Inc. v. Davila, 542 U.S. 200 (2004). The Supreme Court’s test, however, provides even clearer direction that Gasser’s claims are not preempted. The Supreme Court held that a claim is preempted by ERISA where (1) the plaintiff’s suit complains “of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan: and (2) the plaintiff does not allege the violation of a “legal duty (state or federal) independent of ERISA or the plan terms.” 542 U.S. at 210.

The sole duty alleged by Gasser which was breached by Defendant (to submit the bill for payment to BCBS) arose not from ERISA or any plan, but from the preferred provider contract entered by Defendant with Blue Cross Blue Shield. No group plan or statute mandates the submission of the medical bill for payment by BCBS, only the

contract to which the Defendant entered. Furthermore, there is no evidence in the record that Gasser's insurance policy is part of an employee benefit plan rather than an individual policy.

Moreover, the resolution of Gasser's claim will not require interpretation of any ERISA plan, only the interpretation of the preferred provider contract. Therefore, in accord with well settled law from the Fourth Circuit and Supreme Court, Gasser's claims are not preempted.

Additionally, the second element stated by the Supreme Court is the "denial of coverage for medical care". Gasser has not been denied coverage for any medical care. Gasser has received the medical care and the issue of coverage (or payment) has not been resolved and cannot unless and until Defendant submits the claim to BCBS. Then, and only then, could Gasser sue under ERISA for denial of coverage and even then, only if BCBS denies the claim. There cannot be a denial of coverage when the Defendant refuses to submit the claim so a coverage determination can actually be made. Gasser cannot sue for denial of coverage when no claim has been denied.

Thus, Defendant cannot establish either of the two necessary elements set forth by the Supreme Court in its test for ERISA preemption and fails to establish at least one of the elements enunciated by the Fourth Circuit to prevail in its argument that Gasser's claims are preempted by § 501(a)(1)(B).

### **III. Diversity Jurisdiction**

It appears Defendant has abandoned, or at least fails to present any argument in support of, its assertion of diversity jurisdiction and has instead placed all of its eggs in

the ERISA basket. Gasser will therefore not repeat or rehash her arguments as to why diversity jurisdiction does not exist.

### **CONCLUSION**

For the foregoing reasons, as well as those set out in the memorandum of law in support of the motion to remand, Plaintiff respectfully requests the Court grant her motion and remand the case to the Horry County Court of Common Pleas.

### **MORRIS LAW LLC**

Ian A. Taylor (Fed ID #12798)  
Jeffrey D. Morris (Fed ID #12838)  
783 Sandy Lane  
P.O. Box 14724  
Surfside Beach, SC 29575  
(843) 232-0944 – Telephone  
(843) 353-2440 – Facsimile  
[ian@jeffmorrislawfirm.com](mailto:ian@jeffmorrislawfirm.com)  
[jm@jeffmorrislawfirm.com](mailto:jm@jeffmorrislawfirm.com)

### **HOPKINS LAW FIRM, LLC**

s/ William E. Hopkins, Jr.  
William E. Hopkins, Jr. (Fed ID #6075)  
J. Clay Hopkins (Fed ID #12147)  
12019 Ocean Highway  
Post Office Box 1885  
Pawleys Island, South Carolina 29585  
(843) 314-4202 – Telephone  
(843) 314-9365 – Facsimile  
[bill@hopkinsfirm.com](mailto:bill@hopkinsfirm.com)  
[clay@hopkinsfirm.com](mailto:clay@hopkinsfirm.com)

*Attorneys for Plaintiff*

August 12, 2020

# EXHIBIT A

**THE STATE OF SOUTH CAROLINA  
In The Court of Appeals**

Jeanne Beverly, individually and on behalf of others  
similarly situated, Appellant.

v.

Grand Strand Regional Medical Center, LLC,  
Respondent.

Appellate Case No. 2016-001499

---

Appeal From Horry County  
Benjamin H. Culbertson, Circuit Court Judge

---

Opinion No. 5708  
Heard November 8, 2018 – Filed January 15, 2020

---

**AFFIRMED IN PART, REVERSED IN PART, AND  
REMANDED**

---

Sidney L. Major, Jr. and Roy F. Harmon, III, of Harmon  
& Major, PA, of Greenville; John Gressette Felder, Jr., of  
McGowan, Hood & Felder, LLC, of Columbia; Chad  
Alan McGowan and Jordan Christopher Calloway, both  
of McGowan, Hood & Felder, LLC, of Rock Hill; and  
Jeffrey Christopher Chandler, of Chandler Law Firm, of  
Myrtle Beach, for Appellant.

James Lynn Werner, William R. Thomas, and Katon  
Edwards Dawson, Jr., all of Parker, Poe, Adams &  
Bernstein, LLP, of Columbia, for Respondent.

---

**MCDONALD, J.:** Jeanne Beverly appeals the circuit court's order granting Grand Strand Medical Center, LLC's (Grand Strand's) motion to dismiss Beverly's claims for breach of contract, bad faith, and unjust enrichment. Beverly argues the circuit court erred in: (1) finding Beverly is not an intended third-party beneficiary of the preferred provider contract between Blue Cross Blue Shield (BCBS) of South Carolina and Grand Strand and (2) dismissing Beverly's claim for unjust enrichment, despite her complaint's allegation that Grand Strand impermissibly collected payments from Beverly and others "at a higher value than contracted for with BCBS." We affirm in part, reverse in part, and remand to the circuit court for further proceedings.

### **Facts and Procedural History**

On April 29, 2005, Grand Strand contracted with BCBS of South Carolina to become a preferred provider within the BCBS preferred provider organization (PPO)<sup>1</sup>. In exchange for this status and access to BCBS members (Members), Grand Strand promised to bill BCBS directly for certain medical services delivered to Members<sup>2</sup> and to accept a discounted reimbursement rate from BCBS for such services. Specifically, the Institutional Agreement (the Agreement) prohibits Grand Strand from "solicit[ing] any payment from Members"<sup>3</sup> and requires Grand Strand to "accept the reimbursement terms and rates" BCBS established for the PPO. After executing the Agreement, Grand Strand began marketing itself to Members as a BCBS preferred provider.

---

<sup>1</sup> The PPO is a network of hospitals and medical practices marketed to Members as "preferred providers."

<sup>2</sup> The contract defines "Member" as "anyone who is covered for health care services under the terms of a Benefits Contract or who is eligible for Covered Services as a result of an agreement between Plan and an Associate Plan." A "Benefits Contract" is defined, in pertinent part, as "any PPO contract between Plan and Member entitling the Member to receive Covered Services or other services as designated in the Benefits Contract."

<sup>3</sup> Exceptions to this provision include: co-payments, deductibles, coinsurance, non-covered services rendered, covered services deemed to be not medically necessary, or covered services provided to Members who are unable to provide sufficient information regarding eligibility and coverage either prior to receiving service or following services rendered.

On September 6, 2012, Beverly was injured in an automobile accident. That same day, she went to Grand Strand's emergency room, where she was evaluated and treated by an emergency room physician. Thereafter, Grand Strand sent Beverly a bill for \$8,000.00.<sup>4</sup> Because Beverly had previously purchased a health insurance policy from BCBS—and thus became a Member with access to the PPO network—Beverly did not expect to receive such a bill.

Beverly filed suit against Grand Strand, asserting claims for breach of contract, bad faith, and unjust enrichment. Beverly claimed Grand Strand breached its contract with BCBS and violated its contractual and fiduciary duties to her (and other Members who contracted for access to the PPO network) by billing her directly and charging her an amount exceeding the contractual reimbursement rate.

Grand Strand moved to dismiss and, following a hearing, the circuit court dismissed Beverly's complaint. The circuit court denied Beverly's subsequent Rule 59(e), SCRCF, motion to alter or amend.

### **Standard of Review**

"On appeal from the dismissal of a case pursuant to Rule 12(b)(6), an appellate court applies the same standard of review as the trial court." *Rydde v. Morris*, 381 S.C. 643, 646, 675 S.E.2d 431, 433 (2009). "In considering such a motion, the trial court must base its ruling solely on allegations set forth in the complaint." *Spence v. Spence*, 368 S.C. 106, 116, 628 S.E.2d 869, 874 (2006). "If the facts and inferences drawn from the facts alleged in the complaint, viewed in the light most favorable to the plaintiff, would entitle the plaintiff to relief on any theory, then the grant of a motion to dismiss for failure to state a claim is improper." *Id.* "At the Rule 12 stage, therefore, the first decision for the trial court is to decide only whether the pleading states a claim." *Skydive Myrtle Beach, Inc. vs. Horry Cty.*, 426 S.C. 175, 180, 826 S.E.2d 585, 588 (2019).

### **Law and Analysis**

#### **I. Third-Party Beneficiary**

Beverly argues the circuit court erred in finding a Member is not an intended third-

---

<sup>4</sup> Grand Strand billed Beverly \$7,031.25 for the initial medical treatment and \$968.75 for removal of staples.

party beneficiary of the Institutional Agreement between BCBS and Grand Strand because the Agreement adds Grand Strand to a PPO network structured to provide direct benefits to Members. She further asserts the Agreement's purported "beneficiary disclaimer" does not bar her claims because the disclaimer's own language renders it inapplicable to "a Member's right to receive Covered Services." We agree.

Under South Carolina law, it is well settled that a nonparty may enforce contractual terms that intentionally provide her direct benefits. *See, e.g., Kingman v. Nationwide Mut. Ins. Co.*, 243 S.C. 405, 412, 134 S.E.2d 217, 221 (1964) ("We have held in numerous cases that a contract between two persons, for the benefit of a third, even though such third party be not named therein, can be enforced by such third party."); *Jennings v. First of Ga. Underwriters Co.*, 283 S.C. 455, 457, 322 S.E.2d 694, 695 (Ct. App. 1984) (explaining contracts between two persons for the benefit of a third can be enforced by the third person even though she is not named therein). "The presumption that [a] contract is not enforceable by [a nonparty] may be overcome by showing he was intended to be the direct beneficiary of the contract." *Touchberry v. City of Florence*, 295 S.C. 47, 48–49, 367 S.E.2d 149, 150 (1988).

"The cardinal rule of contract interpretation is to ascertain and give legal effect to the parties' intentions as determined by the contract language." *Whitlock v. Stewart Title Guar. Co.*, 399 S.C. 610, 614, 732 S.E.2d 626, 628 (2012) (quoting *McGill v. Moore*, 381 S.C. 179, 185, 672 S.E.2d 571, 574 (2009)). "Courts must enforce, not write, contracts of insurance, and their language must be given its plain, ordinary and popular meaning." *Id.* (quoting *USAA Prop. & Cas. Ins. Co. v. Clegg*, 377 S.C. 643, 655, 661 S.E.2d 791, 797 (2008)). "A contract is read as a whole document so that one may not create an ambiguity by pointing out a single sentence or clause." *Williams v. Gov't Emps. Ins. Co. (GEICO)*, 409 S.C. 586, 595, 762 S.E.2d 705, 710 (2014) (quoting *McGill*, 381 S.C. at 185, 672 S.E.2d at 574). "Whether a contract is ambiguous is to be determined from examining the entire contract, not by reviewing isolated portions of the contract." *Id.*

The circuit court excluded Beverly as a third-party beneficiary based upon its examination of Section 16.16 of the Agreement, titled "No Third Party Beneficiaries," which states:

This Agreement is not intended to, and shall not be construed to, make any person or entity a third party beneficiary. Notwithstanding the preceding, nothing in

this section shall affect Plans rights under Article XV, or a Member's right to receive Covered Services<sup>5</sup> pursuant to the terms of this Agreement.

Construing Section 16.16's first sentence in isolation, the circuit court concluded BCBS and Grand Strand disclaimed the possibility of any third-party beneficiary claim by Members. However, the provision's second sentence clarifies that despite this provision "nothing in this section shall affect . . . a Member's right to receive Covered Services pursuant to the terms of this Agreement." A similar phrase is found in the Agreement's recitals: "Whereas, [Grand Strand] desires to become a PPO provider to allow it to provide Covered Services under the terms of this Agreement." Grand Strand's refusal to submit Beverly's bill directly to BCBS is arguably actionable because the language of the Agreement requires Grand Strand to do just that. Likewise, Beverly's allegation that Grand Strand's billing her and demanding an undiscounted sum for covered services states a claim because, pursuant to the terms of the Agreement, Grand Strand agreed to bill BCBS and to accept a discounted reimbursement for Member Beverly's benefit.

Moreover, the remaining twenty pages of the Agreement impose requirements on Grand Strand specifically intended to benefit Beverly and other Members. South Carolina courts have recognized that the parties' intent must be derived from the Agreement's language taken as a whole. This isolated sentence—when considered within the context of the entire Institutional Agreement—does not retract the benefits the Agreement repeatedly bestows upon BCBS PPO Members. Significantly, Section 16.16's second sentence recognizes a "Member's right to receive Covered Services pursuant to the Agreement," thus carving out related claims from any purported third-party beneficiary exclusion.

Further, interpreting Section 16.16's language as a bar to Beverly's claims disregards expressions of the parties' intent set forth elsewhere in the contract.

---

<sup>5</sup> The Agreement defines "Covered Services" as "those inpatient and outpatient hospital services, supplies, equipment, and/or items to be delivered by or through Institution to Members that are reimbursable under the applicable Member Benefits Contract. Certain services, supplies, equipment and/or items are not included under this Agreement as Covered Services, including but not limited to services provided by skilled nursing facilities, durable medical equipment suppliers, outpatient retail pharmacies, and physician services other than radiology, pathology, anesthesiology, and emergency room that are combined billed on [a certain form]." Article XV addresses Associate Plans and is inapplicable here.

BCBS established its PPO "for the benefit of Members." The very first responsibility Grand Strand undertook in the "Institution Services and Responsibilities" section of the Agreement was to "provide Covered Services to any Member." Members are also direct beneficiaries of Grand Strand's promise to accept the negotiated reimbursement rate from BCBS as well as its promise to bill BCBS, not the Member, for covered services.

Other jurisdictions have found a third-party beneficiary disclaimer may not apply when substantive provisions in the contract contradict the purported disclaimer. In a case similar to Beverly's, the Wisconsin Court of Appeals found an insured covered by a health maintenance organization (HMO) was a third-party beneficiary of her insurer's HMO provider contract with the hospital where she was treated following an automobile accident. *Dorr v. Sacred Heart Hospital*, 597 N.W.2d 462, 475 (Wis. App. 1999). The contract's language expressing a general intent to disclaim third-party beneficiaries was ineffective as to the insured because it was inconsistent with other portions of the same contract protecting subscribers' rights. *Id.* (finding "hold harmless" provision's terms were "designed specifically for the purpose of protecting HMO subscribers"). Likewise, a federal district court in Pennsylvania applied similar principles to reject a third-party beneficiary exclusion offered to prevent a medical provider from enforcing a PPO contract between an insurer and a health insurance network. *See Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr.*, Civil Action No. 13-03101, 2015 WL 1954287 (E.D. Pa. Apr. 30, 2015). Because the contract in question purported to exclude third-party beneficiaries while also granting specific benefits to nonparties, the contract was patently ambiguous and the third-party beneficiary claim could not be dismissed on a pre-answer motion. *Id.* at \*10. Like the defendant in *Huntingdon Valley*, Grand Strand cannot selectively enjoy certain benefits of the Agreement while disregarding terms beneficial to Members. *Id.*

The Tennessee Supreme Court addressed whether a patient was a third-party beneficiary entitled to enforce a similar institutional agreement between a Tennessee hospital and BCBS of Tennessee in *Benton v. Vanderbilt University*, 137 S.W.3d 614 (Tenn. 2004). *Benton* involved an arbitration dispute, but the dispute arose in part because the court had recognized a BCBS insured was a third-party beneficiary of the hospital's agreement with BCBS of Tennessee. *Id.* at 620. The court explained:

Applying these principles, we conclude that the Court of Appeals correctly held that Benton was bound by the arbitration provision contained in the contract between

Vanderbilt and [BCBS]. Benton was a third-party beneficiary to the contract who filed an action seeking to enforce rights under the contract. Benton's claim was dependent on his status as a third-party beneficiary to the contract and Vanderbilt's alleged obligations under section 6.1 of the agreement. Accordingly, based on the general principle that a third-party beneficiary cannot enforce favorable terms of a contract while avoiding unfavorable terms, we conclude that Benton's claim seeking to enforce the contract is subject to the arbitration provision.

*Id.*; see also *West v. Shelby Cty. Healthcare Corp.*, 459 S.W.3d 33, 45 (Tenn. 2014) (citing *Benton* and noting the court had "already held that persons insured by an insurance company are intended third-party beneficiaries of the contract between their insurance company and a hospital. Thus, with regard to an insurance company's customers, 'reasonable charges' are the charges agreed to by the insurance company and the hospital.").

In another billing dispute between a Blue Cross insured and a hospital contracting with the insurer, an Arizona court found a provision requiring the hospital to accept a discounted reimbursement rate was "clearly a benefit to the subscriber; that benefit is both intentional and direct." *Nahom v. Blue Cross & Blue Shield of Arizona, Inc.*, 885 P.2d 1113, 1117 (Ariz. App. 1994). As further evidence that the insured was an intended third-party beneficiary, *Nahom* noted the numerous times the class of Blue Cross subscribers was named in the contract. *Id.* at 1118. The South Dakota Supreme Court reached the same conclusion when construing a hospital's contract with a self-insured health plan. *Jennings v. Rapid City Reg'l Hosp. Inc.*, 802 N.W.2d 918 (S.D. 2011). The health plan's members were third-party beneficiaries to the contract because "the contract language clearly expresses intent to benefit" the members. *Id.* at 922. The *Jennings* court made special note of the contract's recitals which, as in this case, identified the benefits to members the insurance plan expressly intended to provide. *Id.* *Jennings* rejected the notion that the members could not be third-party beneficiaries because the contract provided direct benefits to its parties, i.e. the hospital and insurer. Notwithstanding its benefits to the contracting parties, the contract also benefited the members, and as such, the members were permitted to protect those benefits by enforcing the contract's terms. *Id.* at 923 ("We look only at who was directly and primarily benefited. In this case, it is [the health plan's insured employees].").

Here, the Agreement's language, structure, and purpose directly benefit Members like Beverly. From its opening provision, the Agreement acknowledges its core objective is to support a PPO created "for the benefit of its Members." The Agreement defines a PPO as "a network of providers under contract with the Plan whereby Benefit Contracts contain financial incentives for Members to seek Covered Services from such providers." These financial incentives are made explicit later in the contract where Grand Strand agreed to accept reimbursement for its services for BCBS Members at a discounted rate. Beyond co-pays and deductibles, Grand Strand was prohibited from directly charging Members for covered services, even at the reduced rate. In clear terms, Grand Strand agreed it would not solicit any payment from Members. Indeed, the Agreement conferred an additional practical benefit on Members by placing on preferred providers such as Grand Strand the obligation to submit the Members' bills to BCBS.

Beverly's third-party beneficiary status is also evident from the PPO's structure, which is established by the Agreement. As a South Carolina district court has explained:

A PPO is a means of health insurance whereby the insurance company contracts with a network of health care providers, including hospitals. The insurer attempts to negotiate favorable rates of reimbursement for the cost of health care that reflects the volume of patients the insurer expects to deliver to the preferred health care provider. The insurer then passes through some of this cost saving to subscribers in the form of lower co-payments and reduced deductibles, which creates the incentive for the patient to use the preferred providers and, in turn, creates the volume to support the "discount."

*Drs. Steuer & Latham, P.A. v. Nat'l Med. Enters., Inc.*, 672 F. Supp. 1489, 1513 (D.S.C. 1987).

Beverly argues and we agree the PPO here is intended to benefit its participants. Grand Strand gained access to BCBS's expansive membership along with guaranteed reimbursements from BCBS in exchange for accepting both reduced payments as well as the responsibility of submitting Members' claims to BCBS. BCBS gained greater cost control in exchange for promising prompt payment for Grand Strand's services and touting Grand Strand's PPO provider status to Members. Beverly's allegations that Grand Strand's failure to submit Beverly's bill

to BCBS and refusal to bill her at the reduced reimbursement rate state a claim that Grand Strand breached its contract in denying Beverly benefits arising from the Agreement. Therefore, the circuit court erred in dismissing Beverly's breach of contract claim.

## **II. Fiduciary Relationship**

The circuit court dismissed Beverly's breach of fiduciary duty claims against Grand Strand as based on duties arising from a contract Beverly lacked standing to enforce. However, as discussed above, a nonparty may enforce a contract that intentionally provides her direct benefits.

Although Beverly's complaint alleges certain required elements of a breach of fiduciary duty claim, the circuit court concluded Beverly and Grand Strand did not have a relationship from which a fiduciary duty arose. Beverly claims Grand Strand and Beverly created a relationship of trust when Grand Strand became a PPO preferred provider and accepted the Agreement's terms, and Beverly sought out Grand Strand for medical services because it was a part of the BCBS PPO. By providing Grand Strand with her BCBS PPO insurance identification card, Beverly contends she met the requirements for Grand Strand to fulfill the duties arising from its relationship with BCBS. Thus, Beverly claims Grand Strand breached its duty of trust.

While South Carolina courts have recognized fiduciary relationships between agents and principals, attorneys and clients, the administrator and beneficiaries of an estate, business partners, officers and shareholders of a corporation, and doctors and their patients, there is no authority to support the proposition that a fiduciary relationship exists between a hospital and patient with respect to a hospital's contractual duty to submit an insurance claim. *See Wogan v. Kunze*, 366 S.C. 583, 605, 623 S.E.2d 107, 119 (Ct. App. 2005), *affd as modified*, 379 S.C. 581, 666 S.E.2d 901 (2008) ("[T]his state has not found that medical negligence or malpractice will support a cause of action for breach of fiduciary duty. Nor have our courts found the failure of a doctor to offer assistance in filing a Medicare claim or other claim is a breach of fiduciary duty."); *see also Burton v. William Beaumont Hosp.*, 373 F. Supp. 2d 707, 723-24 (E.D. Mich. 2005) (finding Michigan law does not authorize the imposition of a fiduciary duty related to a hospital's billing practices); *DiCarlo v. St. Mary Hosp.*, 530 F.3d 255, 269 (3d Cir. 2008) ("It is clear, however, that in general New Jersey does not find fiduciary duty in the debtor-creditor context, and, given that the cases cited by both sides relate only to the provision of care and not the payment therefor, it is unlikely that

the New Jersey courts would expand a hospital's fiduciary duty to its billing practices. In the absence of a fiduciary duty, no cause of action exists for its alleged breach, and [the breach of fiduciary duty claim] will therefore be dismissed.").

Here, Beverly does not challenge the quality of the medical care she received. Rather, she complains only of Grand Strand's billing practices and its breach of the BCBS Agreement. Beverly attempts to expand the fiduciary relationship that may in certain circumstances exist between a doctor and patient to encompass a hospital's billing practices for medical services rendered. In essence, Beverly is asking the court to impose a fiduciary duty on a creditor-debtor relationship; South Carolina law does not impose such a duty in the absence of some special trust reposed in the creditor. *See Regions Bank v. Schmauch*, 354 S.C. 648, 671, 582 S.E.2d 432, 444 (Ct. App. 2003) ("South Carolina holds the normal relationship between a bank and its customer is one of creditor-debtor and not fiduciary in nature." (citing *Burwell v. South Carolina Nat'l Bank*, 288 S.C. 34, 40, 340 S.E.2d 786, 790 (1986))). The circuit court properly found South Carolina does not recognize a fiduciary duty related to a hospital's billing practices. Accordingly, we affirm the circuit court's dismissal of Beverly's claim for breach of fiduciary duty.

### **III. Unjust Enrichment/Quantum Meruit**

Beverly argues the circuit court essentially found it equitable for Grand Strand to charge a Member in violation of its agreement with BCBS. While we disagree the circuit court's order so finds, we agree with Beverly's contention that the court erred in dismissing her quantum meruit claim. *See Columbia Wholesale Co. v. Scudder May N.V.*, 312 S.C. 259, 261, 440 S.E.2d 129, 130 (1994) ("Absent an express contract, recovery under quantum meruit is based on quasi-contract, the elements of which are: (1) a benefit conferred upon the defendant by the plaintiff; (2) realization of that benefit by the defendant; and (3) retention by the defendant of the benefit under conditions that make it unjust for him to retain it without paying its value."); *Barnes v. Johnson*, 402 S.C. 458, 466, 742 S.E.2d 6, 10 (Ct. App. 2013) (explaining quantum meruit is a remedy for unjust enrichment); *Williams Carpet Contractors, Inc. v. Skelly*, 400 S.C. 320, 327–28, 734 S.E.2d 177, 181 (Ct. App. 2012) (allowing a party to allege an unjust enrichment cause of action as an alternative claim for breach of contract).

Grand Strand argues *Pitts v. Jackson National Life Insurance Co.*, 352 S.C. 319, 574 S.E.2d 502 (Ct. App. 2002), supports the circuit court's dismissal. We disagree. The asserted wrong in *Pitts* was a breach of an alleged "duty of insurer to

inform an applicant of the availability of an allegedly superior product." *Id.* at 338, 574 S.E.2d at 512. However, the court found it was not inequitable for an insurer to retain the price of an insurance policy where the insurer could have offered a policy with similar coverage at a lesser price. There simply was no duty to provide such a notification. *Id.* at 339, 574 S.E.2d at 512. *Pitts* also relied on the fact that the alleged wrongdoing was performed when the plaintiff was a mere insurance applicant. *Id.* at 331, 574 S.E.2d at 508. At that point, there was no existing relationship on which to build a fiduciary duty or to impose liability for unjust enrichment. *Id.*

But Beverly is not a mere insurance applicant; she is a defined Member in a PPO Agreement under which Grand Strand contracted to provide Covered Services. Additionally, Beverly's complaint does not allege a failure to inform; it alleges affirmative inequitable conduct seeking to deprive her of the benefit of her funds. While the *Pitts* defendant was permitted to refuse to offer a gratuitous discount, Grand Strand is not permitted to bill a Member for its services at a higher payment rate than it contractually agreed to accept. The complaint does not allege a mere matter of erroneous billing. When Grand Strand billed Beverly for covered services, it declined to bill her at the contracted for, discounted rate, and it sent her the bill in violation of its contract with BCBS. Accordingly, it was error for the circuit court to dismiss the quantum meruit claim at the 12(b)(6) stage.

### **Conclusion**

We reverse the circuit court's dismissal of Beverly's breach of contract and quantum meruit claims. We affirm as to the dismissal of the claim for breach of fiduciary duty and remand this matter for further proceedings.

**AFFIRMED IN PART, REVERSED IN PART, AND REMANDED.**

**KONDUROS and HILL, JJ., concur.**

**STATE OF SOUTH CAROLINA****) IN THE COURT OF COMMON PLEAS****COUNTY OF HORRY****) CASE NO.: 2020-CP-26-01982**Jessica Bennett, individually and on  
behalf of those similarly situated,)  
)

Plaintiff,

)  
)

v.

)  
)

ACS Primary Care Physicians-Southeast P.C.,

)  
)

Defendant

)  
)

.

)

**MOTION TO COMPEL ARBITRATION  
AND DISMISS OR STAY**

Pursuant to Rules 12(b)(1), 12(b)(3) and 12(b)(6), SCRCF, the Federal Arbitration Act, 9 U.S.C. § 4 (the “FAA”), and the South Carolina Uniform Arbitration Act, S.C. Code Ann. § 14-48-10 *et seq.* (the “SCUAA”), Defendant ACS Primary Care Physicians-Southeast P.C. (“ACS”) hereby moves to compel bilateral arbitration (*i.e.*, arbitration on a non-classwide basis) and to dismiss. In the alternative, as opposed to dismissal, ACS requests that the case be stayed pending the bilateral arbitration.

**INTRODUCTION**

The Court should enter an order compelling Plaintiff’s claims to bilateral arbitration (*i.e.*, arbitration on a non-classwide basis) and dismissing this lawsuit under the FAA. The dispute at issue here traverses state lines and, therefore involves interstate commerce, and the broad arbitration clause at issue covers the dispute. Moreover, the fact that Plaintiff herself was not a signatory to the contract containing the arbitration clause is of no moment; because Plaintiff has

alleged that she is a third-party beneficiary of that contract, she is estopped from denying that she is a signatory to it.

In the alternative, and for the same reasons as discussed in connection with the FAA, the Court should enter an order compelling Plaintiff's claims to bilateral arbitration and dismissing this lawsuit under the SCUAA. The contract at issue here contains the requisite disclaimer and, as with the FAA, the broad arbitration clause covers this dispute.

In sum, under either the FAA or the SCUAA, the court should enter an order compelling Plaintiff's claims to bilateral arbitration and dismissing this lawsuit. In the alternative, as opposed to dismissal, the Court's order should stay this matter pending the bilateral arbitration.

### **BACKGROUND**

Plaintiff, a South Carolina citizen and resident, had health insurance under an employer-sponsored health plan with Blue Cross Blue Shield of South Carolina ("BCBSSC"). (Compl. ¶ 12.) ACS, a Georgia professional corporation, is an in-network provider for BCBSSC pursuant to a Provider Agreement with BCBSC. (*Id.* ¶ 16.) A true and correct copy of the applicable Provider Agreement is attached hereto as Exhibit 1 to the Declaration of Paula Dearolf, attached hereto as Exhibit A.

The Provider Agreement contains a mandatory arbitration clause, stating that BCBSSC and ACS "agree to arbitrate [any] problem or dispute" that "arises under the agreement." (Provider Agreement at 12.) Further, the Provider Agreement states, in bold, capitalized, and underlined text at the top of the first page: "**THIS . . . AGREEMENT IS SUBJECT TO ARBITRATION PURSUANT TO THE SOUTH CAROLINA UNIFORM ARBITRATION ACT.**" (*Id.* at 1.)

Plaintiff alleges that, on or about December 14, 2018, she was in car wreck, which required her to go to Mary Black Memorial Hospital where ACS providers rendered services to her.

(Compl. ¶¶ 23-24.) According to the Complaint, ACS did not submit the claim for services to BCBSSC, but instead billed Plaintiff directly for these services. (*Id.* ¶¶ 26-27.) Further, Plaintiff alleges that ACS billed her at a rate higher than specified in the Provider Agreement. (*Id.* ¶ 29.)

The Complaint alleges three causes of action: breach of contract, unjust enrichment and a claim for damages in equity. In Plaintiff's breach of contract claim, she alleges that ACS breached the Provider Agreement, that she is a third-party beneficiary to that agreement, and that she was damaged by the alleged breach in the form of any payments made based on the allegedly incorrect bills. (*Id.* ¶¶ 34, 62-67.) In Plaintiff's unjust enrichment claim, she alleges that ACS was unjustly enriched by violating the Provider Agreement. (*Id.* ¶¶ 69-75.) Finally, in Plaintiff's equity claim, she alleges that ACS "thwarted contractual obligations." (*Id.* ¶¶ 77-79.)

### **DISCUSSION**

"The FAA reflects a liberal federal policy favoring arbitration agreements." *Adkins v. Labor Ready, Inc.*, 303 F.3d 496, 500-01 (4th Cir. 2012) (quoting *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24 (1983)). "Underlying this policy is Congress's view that arbitration constitutes a more efficient dispute resolution process than litigation." *Id.* "Accordingly, 'due regard must be given to the federal policy favoring arbitration, and ambiguities as to the scope of the arbitration clause itself resolved in favor of arbitration.'" *Id.* (quoting *Volt Info. Sciences, Inc. v. Bd. of Tr. of Leland Stanford Jr. Univ.*, 489 U.S. 468, 475-76 (1989)).

South Carolina law is similar. As with the FAA, "[t]he policy of [] South Carolina is to favor arbitration of disputes ... Arbitration is a matter of contract law and general contract principles of state law apply to a court's evaluation of the enforceability of an arbitration clause." *Parsons v. John Wieland Homes & Neighborhoods of the Carolinas*, 418 S.C. 1, 6, 791 S.E.2d 128 (2016); see also *Damico v. Lennar Carolinas, LLC*, 884 S.E.2d 66, 430 S.C. 188 (Ct. App.

2020) (“Due to the strong South Carolina and federal policy favoring arbitration, arbitration agreements are presumed valid.”).

**A. Plaintiff’s claims are subject to bilateral arbitration under the FAA**

This case is subject to bilateral arbitration under the FAA because all of Plaintiff’s causes of action are covered by the broad arbitration clause at issue here. To determine whether to compel arbitration under the FAA, the Court should consider whether: (1) there is a dispute between the parties, (2) there is a written agreement to arbitrate that covers the dispute, (3) the transaction evidenced by the dispute involves interstate commerce, and (4) one party has failed, neglected or refused to arbitrate. *Damico v. Lennar Carolinas, LLC*, 430 S.C. 188, 844 S.E.2d 66, 70 (S.C. Ct. App. 2020); *see also Adkins v. Labor Ready, Inc.*, 303 F.3d 496, 500-01 (4th Cir. 2012). In light of the liberal policy favoring arbitration, the party opposing arbitration bears the burden of proving that the dispute should not be arbitrated. *Green Tree Fin. Corp.-Ala. v. Randolph*, 531 U.S. 79, 91 (2000).

Here, arbitration should be compelled because all four of these factors are present:

**First.** There is plainly a dispute between the parties insofar as Plaintiff has filed a Complaint against ACS.

**Second.** The Provider Agreement contains an arbitration clause that covers the dispute. The arbitration clause provides that the parties “agree to arbitrate [any] problem or dispute” that “arises under the agreement,” (Provider Agreement at 11), and the claim for breach of contract is plainly a claim under the terms of the agreement. *See S.C. Pub. Serv. Auth. v. Great W. Coal*, 312 S.C. 559, 563, 437 S.E.2d 22 (1993) (“Arbitration is a matter of contract and controlled by contract law.”). Further, Plaintiff’s claims for unjust enrichment and equity also “arise under” the Provider Agreement. *See American Recovery Corp. v. Computerized Thermal Imaging*, 96 F.3d 88, 93 (4th

Cir. 1996) (holding that the FAA applies to any claims “having a significant relationship to the contract regardless of the label attached to the dispute”); *see also Great W. Coal*, 312 S.C. at 563 (“Any doubts concerning the scope of arbitration should be resolved in favor of arbitration”).

ACS anticipates that Plaintiff will argue she should not be bound by the arbitration agreement in the Provider Agreement because she is not a signatory to that agreement, but this argument is foreclosed under the doctrine of equitable estoppel. “Equitable estoppel precludes a party from asserting rights he otherwise would have had against another when his own conduct renders assertion of those rights contrary to equity.” *Pearson v. Hilton Head Hops.*, 400 S.C. 281, 295, 733 S.E.2d 597, 604 (Ct. App. 2012); *see also Wachovia Bank N.A. v. Schmidt*, 445 F.3d 762, 769 (4th Cir. 2006) (The “legal principle [of equitable estoppel] rests on a simple proposition: it is unfair for a party to rely on a contract when it works to its advantage, and repudiate it when it works to its disadvantage.”) (internal quotation marks and alterations omitted). Applying this principle to the arbitration context, “[a] nonsignatory is estopped from refusing to comply with an arbitration clause ‘when it receives a direct benefit from a contract containing an arbitration clause.’” *Pearson*, 400 S.C. at 290; *see also Am. Bankers Ins. Group*, 453 F.3d at 628 (4th Cir. 2006) (quoting *International Paper Co. v. Schwabedissen Maschinen & Analgen GMBH*, 206 F.3d 411, 418 (4th Cir. 2000)). A nonsignatory seeks a “direct benefit” under a contract when she asserts a claim based on her alleged status as a third-party beneficiary of the contract. *Am. Bankers Ins. Group*, 453 F.3d at 629 (The “direct benefit” test “examine[s] whether the plaintiff has asserted claims in the underlying suit that, either literally or obliquely, assert a breach of duty created by the contract containing the arbitration clause.”). In such a situation, the nonsignatory, who is relying on the contract as the basis for her claim, is estopped from denying she is a party to it. *Id.*

Here, Plaintiff seeks a “direct benefit” from the Provider Agreement because she has alleged she is a third party beneficiary of that agreement and she has sued ACS for breach of the Provider Agreement. (Compl. ¶ 63) Thus, because Plaintiff is relying on the Provider Agreement as the foundation for her breach of contract claim, she is estopped from denying she is not a signatory to that agreement. Because the Provider Agreement contains an arbitration clause that applies to this dispute, the court should compel Plaintiff to submit her claims to arbitration pursuant to that clause.

**Third.** The transaction at issue involves interstate commerce. The FAA defines “commerce” as “commerce among the several States or with Foreign nations . . .” 9 U.S.C. § 1. The Supreme Court has held that the meaning of this provision of the FAA is as broad as the Commerce Clause itself. *Allied-Bruce Terminix Cos. v. Dobson*, 513 U.S. 265, 274 (1994). Courts regularly hold that the fact that the contract containing the arbitration provision is entered into between parties of different states alone demonstrates that the contract “involve[s] interstate commerce under the Supreme Court’s expansive interpretation of the FAA.” *Low Country Rural Health Educ. Consortium Inc. v. Greenway Med.*, No. 9:14-cv-00874-DCN, 2014 U.S. Dist. LEXIS 157418, at \*15-16 (D.S.C. Nov. 5, 2014) (citing *Allied-Bruce*, 513 U.S. at 281).

Here, Plaintiff’s claims involve citizens of different states, involve a contract made between citizens of different states, and therefore involve interstate commerce. Specifically, Plaintiff is a South Carolina citizen, ACS is a Georgia professional corporation licensed to do business in Georgia, South Carolina, and Florida, and currently does business in Georgia and South Carolina, (See Exhibit A ¶ 5,) and BCBSSC is based in South Carolina. Moreover, the Provider Agreement applicable to Plaintiff was negotiated on behalf of ACS from a location other than

South Carolina. (*Id.* ¶ 13.) Because the transaction at issue here involves agreements between people and entities that crosses state lines, the transaction involves interstate commerce.

Moreover, the facts of the transaction clearly demonstrates that interstate commerce is present. Here, ACS contracted with a facility in South Carolina, Mary Black Memorial Hospital, to provide professional medical services. (Exhibit A ¶ 6.) After an ACS clinician treats a patient in that facility, the part of the record documenting treatment rendered on that date is transmitted to a third party billing provider, HCFS Healthcare Financial Services, LLC (“HCFS”), located in Alcoa, Tennessee, where it employs coders to interpret the records and produce CPT codes and charges. (*Id.* ¶ 8.) A bill is then generated and sent to the payer from billing operations in Florida. (*Id.*) Thus, the conduct involved in the billing of Plaintiff and / or BCBSSC on behalf of Plaintiff clearly involves interstate commerce throughout various southeastern states.

***Fourth.*** Plaintiff’s act of filing of the Complaint plainly demonstrates a failure, neglect, or refusal to arbitrate.

For these reasons, the Court should compel arbitration under the FAA.

**B. Plaintiff’s claims are subject to arbitration under the SCUAA**

Even if the Provider Agreement did not involve interstate commerce (and it plainly does), arbitration would still be required under the SCUAA. The SCUAA provides that “[a] written agreement . . . in a written contract to submit to arbitration any controversy thereafter arising between the parties is valid, enforceable and irrevocable.” S.C. Code. § 15-48-10(a). For the same reasons as already discussed in connection with the FAA, Plaintiff’s claims are subject to arbitration under the SCUAA as well.

Further, under the SCUAA, “a contract is subject to arbitration pursuant to this chapter shall be typed in underlined capital letters . . . on the first page of the contract ” S.C. Code. § 15-

48-10(a). Here, the agreement to arbitrate appears on the first page of the agreement in bold and underlined capital letters. *See* Provider Agreement at 1.

For the foregoing reasons, the Court should also compel arbitration under the SCUAA.

**C. The arbitration must be on a bilateral basis**

Moreover, although Plaintiff has attempted to plead a class action, the arbitration here should be on a bilateral basis only because the Provider Agreement does not authorize class arbitration. (*See* Provider Agreement at 12.) Instead, the arbitration clause in the Provider Agreement is written on a bilateral basis only. “[A] party may not be compelled . . . to submit to class arbitration unless there is a contractual basis for concluding that the party *agreed* to do so.” *Stolt-Nielsen S.A. v. AnimalFeeds Int’l Corp.*, 559 U.S. 662, 684 (2010); *see also Del Webb Cmtys., Inc. v. Carlson*, 817 F.3d 867, 873 (4th Cir. 2016) (*Carlson I*) (“[A] party may not be compelled to submit to class arbitration absent express agreement.”); *Del Webb Cmtys., Inc. v. Carlson*, No. 9-14-cv-1877-PMD, 2017 U.S. Dist. LEXIS 84291, at \*3-4 (D.S.C. Feb. 1, 2017) *aff’d* No. 17-1347, 2017 U.S. App. LEXIS 20016 (4th Cir. Oct. 13, 2017) (*Carlson II*) (“The principal reason to conclude that [an] arbitration clause does not authorize classwide arbitration is that the clause nowhere mentions it.”); *Grant v. Chevrolet*, No. 5757, 2020 S.C. App. LEXIS 79, at \*5 (S.C. Ct. App. filed Aug. 12, 2020) (quotations omitted) (“[A] party *may not be compelled* under the FAA to submit to class arbitration *unless* there is a contractual basis for concluding that the party *agreed* to do so.”). Because the Provider Agreement does not authorize arbitration on a class basis, the Court should enforce the arbitration agreement according to its terms and compel Plaintiff to pursue her claims in bilateral arbitration.

**D. Plaintiff's claims should be dismissed**

Finally, Plaintiff's claims should be dismissed, rather than stayed, because all of her claims are subject to arbitration.

Under the FAA, dismissal is the "proper remedy when all of the issues presented in a lawsuit are arbitrable." *Choice Hotels Int'l, Inc. v. BSR Tropicana Resort, Inc.*, 252 F.3d 707, 709-10 (4th Cir. 2001). Because all of Plaintiff's claims are subject to bilateral arbitration, the Court should compel them to arbitration and dismiss the Complaint. In the alternative to dismissal, the Court should stay any claims that it concludes are not subject to arbitration during the pendency of the arbitration.

**CONCLUSION**

For the foregoing reasons, the Court should enter an order compelling bilateral arbitration and dismissing the case. In the alternative to dismissal, the Court's order should stay this matter pending the arbitration.

Dated: August 31, 2020

GORDON & REES LLP

By s/Josh Dixon

Josh Dixon (SC 75815)

E-mail: jdixon@grsm.com

Victoria T. Kepes (SC 102536)

E-mail: vkepes@grsm.com

40 Calhoun Street, Suite 350

Charleston, SC 29401

Telephone: (843) 278-5900

*Attorneys for ACS Primary Care*

*Physicians-Southeast P.C.*

# EXHIBIT A

**) IN THE COURT OF COMMON PLEAS**

**) CASE NO.: 2020-CP-26-01982**

)

)

)

)

)

5

**AFFIDAVIT OF  
PAULA DEAROLF**

1. My name is Paula Dearolf. I am over 18 years of age. I have personal knowledge of the facts set forth below.
2. I work for HCFS Healthcare Financial Services, LLC (“HCFS”). My job title is Executive Vice President, Revenue Cycle Operations. In that role, I am responsible for the day to day oversight of revenue cycle operations to include emergency department billing centers and support departments in their role of providing coding and billing services.
3. HCFS is a limited liability company that is organized under the laws of Florida.
4. ACS Primary Care Physicians-Southeast P.C. (“ACS”) is a Georgia professional corporation.
5. ACS is licensed to do business in Georgia, South Carolina, and Florida and currently does business in Georgia and South Carolina.
6. ACS contracts to provide professional medical services for many medical facilities located in Georgia and South Carolina. One such facility was the Mary Black Memorial Hospital, although ACS no longer provides professional medical services for Mary Black Memorial Hospital.

7. When ACS clinicians treat patients in the medical facilities, they document the treatment within the facility's medical record.

8. ACS has a contract with HCFS for HCFS to code and bill for the services rendered by ACS. Pursuant to this contract, a portion of the facility's medical record that includes the clinician's documentation for the particular date of services is transmitted from the facility where the medical services were rendered to HCFS's office located in Alcoa, Tennessee. HCFS employs coders working from its office in Alcoa, Tennessee who are trained to interpret the billing record to produce a CPT code and corresponding charge. Once the CPT code and corresponding charge are determined at HCFS's office in Alcoa, Tennessee, a bill is generated and sent to the payer from billing operations in Florida.

9. The payer can be any number of people / entities, including the patient, the patient's health plan, or, in the case of a motor vehicle accident, the patient's automobile insurer.

10. ACS physicians treat many patients whose health plan is with Blue Cross Blue Shield South Carolina ("BCBSSC").

11. ACS has various Preferred Provider Agreements with Blue Cross Blue Shield South Carolina that govern the relationship with ACS and BCBSSC, including the provider agreement attached here to as Exhibit A.

12. The Preferred Provider Agreement attached as Exhibit A is the agreement that applied to Plaintiff's BCBSSC health plan.

13. The Preferred Provider Agreement attached as Exhibit A was negotiated on behalf of ACS from a location other than South Carolina.

I, Paula Dearolf, certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment by contempt.

Dated: 8/31/20

Paula R. Dearolf

(Signature)

# EXHIBIT 1

**THIS INDIVIDUAL PROFESSIONAL AGREEMENT IS SUBJECT TO ARBITRATION PURSUANT TO THE SOUTH CAROLINA UNIFORM ARBITRATION ACT. HOWEVER, THE ARBITRATION PROCEDURES FOR DISPUTES REGARDING UTILIZATION MANAGEMENT ARE GOVERNED BY THE ARBITRATION PROVISIONS CONTAINED IN APPENDIX A OF THIS AGREEMENT AND NOT BY THE UNIFORM ARBITRATION ACT.**



# **INDIVIDUAL PREFERRED PROVIDER AGREEMENT**

**®Registered mark of the Blue Cross and Blue Shield Association**

1/15/08  
PREFERRED BLUE (INDIVIDUAL)

**INSTRUCTIONS:**

**EACH PROVIDER IN A PRACTICE GROUP, PARTNERSHIP OR CORPORATION MUST INDIVIDUALLY SIGN A INDIVIDUAL PROFESSIONAL AGREEMENT AND SUBMIT A FULLY COMPLETED APPLICATION INCLUDING ALL REQUIRED ATTACHMENTS IN ORDER FOR BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA TO BEGIN PROCESSING YOUR APPLICATION. USE THE FOLLOWING CHECKLIST TO ENSURE YOUR APPLICATION IS COMPLETE.**

**CHECK LIST**

**EACH PROVIDER** in a Practice Group, Partnership or Corporation must individually:

- \_\_\_\_\_ Sign and date the signature page (p.11) of Individual Preferred Provider Agreement\*
- \_\_\_\_\_ Complete the S.C. Uniform Managed Care Provider Credentialing Application
- \_\_\_\_\_ Sign and date Credentialing Application Authorization Page (p. 4 of 8)\*
- \_\_\_\_\_ Enclose copy of your current State License
- \_\_\_\_\_ Enclose copy of your current DEA License
- \_\_\_\_\_ Enclose copy of W-9 form (proof of federal identification number)
- \_\_\_\_\_ Enclose copy of your Board Specialist Certificate, if applicable
- \_\_\_\_\_ Enclose proof of your malpractice coverage currently in effect
- \_\_\_\_\_ Enclose a letter from hospital(s) indicating status of hospital privileges (if applicable)
- \_\_\_\_\_ Keep a copy of this Individual Preferred Provider Agreement for your files.

\*All signatures must be dated within thirty (30) days of receipt of the completed application package by Preferred Blue. Rubber stamped signatures are not acceptable.

Please allow up to ninety (90) days for Blue Cross and Blue Shield of South Carolina to review your application and credentials. You will be notified, in writing, of the final determination.

**RETURN THE CONTRACT SIGNATURE PAGE AND COMPLETED  
CREDENTIALING PACKAGE TO:**

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA  
ATTN: PROVIDER SYSTEMS AND CREDENTIALING, AF-326  
I-20 AT ALPINE ROAD  
COLUMBIA, SC 29219

OR FAX TO (803) 264-4080

**TABLE OF CONTENTS**

|       |                                               |   |
|-------|-----------------------------------------------|---|
| I.    | INTRODUCTION .....                            | 1 |
| II.   | DEFINITION OF TERMS.....                      | 1 |
| III.  | RESPONSIBILITIES OF BCBSSC .....              | 4 |
| IV.   | RESPONSIBILITIES OF THE NETWORK PROVIDER..... | 4 |
| V.    | RELATIONSHIP BETWEEN THE PARTIES .....        | 6 |
| VI.   | TERM, TERMINATION AND AMENDMENT .....         | 7 |
| VII.  | ASSIGNMENT .....                              | 8 |
| VIII. | LIABILITY AND INDEMNITY .....                 | 8 |
| IX.   | MISCELLANEOUS .....                           | 9 |

APPENDIX A, Utilization Management Procedures..... i.

ENCLOSURE: S.C. Uniform Managed Care Provider Credentialing Application

This Individual Preferred Provider Agreement (“Agreement”) is between Blue Cross and Blue Shield of South Carolina (“BCBSSC”), a South Carolina mutual corporation, and \_\_\_\_\_, (“Preferred Provider”).

## **I. INTRODUCTION.**

- A. WHEREAS BCBSSC desires to establish effective, cooperative healthcare cost containment programs that will assure the availability and continuity of quality care to BCBSSC’s Members (as defined below); and,
- B. WHEREAS, Preferred Provider wants to participate as a Network Provider (as defined below) in the cooperative health care cost containment programs established by BCBSSC.
- C. NOW THEREFORE, in consideration of the premises and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, BCBSSC and the Preferred Provider hereby agree as follows:

## **II. DEFINITIONS.**

Capitalized terms used in this Agreement shall have the following meanings.

- A. “Agreement” means this Individual Preferred Provider Agreement.
- B. “Associate Plan” means a company, organization or other entity that has a health plan or other program (or who sponsors, provides, indemnifies, or administers another’s health plan or program) who has made arrangements with BCBSSC to access and utilize Network Providers in connection with such health plans or programs. Additionally, Associate Plan includes any other entity that is entitled to the benefit of the terms of this Agreement as a result of such Associate Plan’s entry into an agreement with BCBSSC. Associate Plan also includes members of the Association. Associate Plan also includes BCBSSC’s subsidiaries and affiliates that access this Agreement.
- C. “Association” means an association of independent Blue Cross and Blue Shield Plans known as the Blue Cross and Blue Shield Association.
- D. “BCBSSC” means Blue Cross and Blue Shield of South Carolina.
- E. “Benefits Contract” means any written contract entered into by BCBSSC and a group or individual under which BCBSSC provides, indemnifies for or administers health care benefits including where BCBSSC acts as:
  - (1) a control plan;
  - (2) a participating plan;
  - (3) a service plan; or
  - (4) any agreement for benefits issued by an Associate Plan.
- F. “Continued Stay Review” means the mandatory review conducted under the Utilization Management Program, to determine whether a continued admission is Medically Necessary.
- G. “Covered Services” means the services a Member is entitled to under the terms and conditions of such Member’s Benefits Contract.
- H. “Effective Date” means the date that BCBSSC accepts Preferred Provider as a Network Provider.

- I. "Emergency" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain, such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in:
- (1) placing the health of the individual, or with respect to a pregnant woman the health of a woman or her unborn child, in serious jeopardy,
  - (2) serious impairment of bodily functions, or
  - (3) serious dysfunction of any bodily organ or part.
- J. "Emergency Admission Review" means the mandatory review conducted pursuant to the Utilization Management Program to determine whether an Emergency admission is Medically Necessary
- K. "Fee Allowance" means the lower of: (1) Preferred Provider's normal charge for a procedure, or (2) the charge for a procedure set forth in the Schedule of Fee Allowances. In accordance with the Omnibus Budget Reconciliation Act of 1993, effective January 1, 1995, the Medicare Part B equivalent amount will be applied to claims for physicians' services to retirees and annuitants enrolled in the Preferred Blue Federal Employee Health Benefits Program (FEP) who are 65 years of age and older and who are not covered by Medicare Part B. The Fee Allowance for these Members is the lower of Preferred Provider normal charge, the amount set forth on the Schedule of Fee Allowances or the Medicare Part B equivalent amount.
- L. "Medically Necessary" shall mean health care services that a Physician, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
- (1) in accordance with generally accepted standards of medical practice
  - (2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
  - (3) not primarily for the convenience of the patient, physician, or other health care provider
  - (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
- M. "Member" means any individual who is covered under a Benefits Contract, as well as individuals covered under a Benefits Contract with any Associate Plan.
- N. "Outpatient Review" is the mandatory review conducted pursuant to the Utilization Management Program, to determine whether certain elective outpatient procedures are Medically Necessary
- O. "Patient Pay Amounts" means, with respect to Covered Services, all deductibles, coinsurance, co-payments and other sums that are payable by the Member directly to Preferred Provider and which are not payable by BCBSSC or Associate Plan.
- P. "Point of Service Benefits Contract" means a Benefits Contract that provides maximum benefits for Covered Services provided by:
- (1) the Member's Primary Care Physician;
  - (2) another Network Provider with an appropriate referral from the Member's Primary Care Physician, or

- (3) any other provider with a referral from the Member's Primary Care Physician when the referral has been authorized by BCBSSC or Associate Plan.

Q. "Pre-Admission Review" means the mandatory review conducted pursuant to the Utilization Management Program to determine whether a non-Emergency admission is Medically Necessary.

R. "Network Provider" includes the following types of persons or facilities which

- (1) provide Covered Services to a Member; and
- (2) such persons or facilities have a written agreement with BCBSSC to participate as a Network Provider:
  - a. hospitals;
  - b. skilled nursing facilities;
  - c. home health agencies;
  - d. hospices;
  - e. independent laboratories;
  - f. contracting national laboratories;
  - g. physicians;
  - h. drug stores and pharmacies;
  - i. vendors of durable medical equipment; and
  - j. other eligible providers as specified under a Benefits Contract.

Upon acceptance by BCBSSC, Preferred Provider will be a Network Provider.

S. "Primary Care Physician" under a Point of Service Benefits Contract means:

- (1) a Preferred Physician who is selected by a Member and who has a specialty in
  - a. general practice, or
  - b. family practice, or
  - c. general internal medicine, or
  - d. pediatrics, or
  - e. other specialty designated as a Primary Care Physician
- (2) Primary Care Physicians are responsible for coordinating medical care for Members who have selected them as their Primary Care Physician.

T. "Quality Medical Advisory Panel" means the panel of Preferred Provider peers (in the same or similar specialty) assembled by BCBSSC for the purpose of hearing appeals from the Utilization Management Program. When reasonably possible, the individuals who make up the Quality Medical Advisory Panel will be from outside of Preferred Provider's immediate geographic service area. However, the Preferred Provider understands that appeals for the Associate Plans will have to be appealed directly to the Associate Plan.

- U. "Utilization Management Program" means the series of activities carried out by BCBSSC or the Associate Plan to ensure that the Covered Services that are provided to its Members are Medically Necessary and appropriate. Utilization Management is further defined in Appendix A.

### **III. BCBSSC RESPONSIBILITIES.**

A. BCBSSC or Associate Plan shall:

- (1) Pay Preferred Provider for Covered Services in accordance with the benefit allowance of the Member's Benefits Contract. Payment will be based upon the Fee Allowance amount.
- (2) Directly reimburse Preferred Provider for Covered Services provided to Members without requiring that Preferred Provider obtain the Member's prior authorization.
- (3) Establish procedures and methods whereby Members can be appropriately identified by Network Providers.
- (4) Provide Preferred Provider with a list of all Network Providers via the BCBSSC website ([www.southcarolinablues.com](http://www.southcarolinablues.com) at the time of this writing).

### **IV. PREFERRED PROVIDER'S RESPONSIBILITIES.**

A. Preferred Provider shall:

- (1) Accept payment of the Fee Allowance amount plus any required Patient Pay Amounts as payment in full for Covered Services rendered to Members. All payments are subject to the terms of the Member's Benefits Contract. Payment will be adjusted for payments made to Preferred Provider pursuant to any coordination of benefits provisions in any health plan other than the Benefits Contract.
- (2) While performing services, maintain a physician-patient relationship with enrolled Members. Any and all medical service decisions, treatment decisions or exercises of medical judgment are Preferred Provider's responsibility.
- (3) Not discriminate against any Member on the basis of race, color, sex, age, religion, national origin, handicap or insurance plan in providing services under this Agreement. Preferred Provider may choose to be closed to new Members as a group but only if Preferred Provider is closed to new patients from all payor sources.
- (4) Serve as the Primary Care Physician for Members covered under a Point of Service Benefits Contract if Preferred Provider's specialty is:
  - a. general practice; or
  - b. family practice; or
  - c. general internal medicine; or
  - d. pediatrics; and
  - e. if Preferred Provider is selected by the Member and the Member is accepted by Preferred Provider.
- (5) Use Network Providers in the delivery of Covered Services unless Covered Services, supplies or equipment are not available from any Network Provider, or in the case of an Emergency.

- (6) Provide Covered Services in an appropriate outpatient setting whenever safe, quality care can be provided in such a setting.
- (7) Cooperate fully with the Utilization Management Program.
- (8) Agree to provide a second opinion to Members who have already consulted with another Network Provider.
- (9) Cooperate and participate with BCBSSC and any Associate Plan in any utilization control procedures, quality assurance activities, external audit systems and grievance procedures, as may be established pursuant to the terms of the Benefits Contract, and comply with all final determinations rendered through the peer review process or grievance mechanism.
- (10) Maintain, with respect to each Member for whom Covered Services are provided under this Agreement, standard medical records in such form, containing such information, and meeting such record keeping requirements as might be required by applicable federal and state law. Preferred Provider will keep confidential, and take all reasonable precautions to prevent the unauthorized disclosure of any and all records prepared and/or maintained by this Agreement. BCBSSC or the Associate Plan will have the right to inspect, review and obtain copies of such records upon request at no charge.
- (11) File a claim for all Covered Services rendered to Members within the time frame set forth in the Benefits Contract (typically 180 days). Preferred Provider will not bill BCBSSC, Associate Plan or the member for claims filed outside of the timely filing limit unless the party responsible for payment approves an exception. Preferred Provider will file the claims in a manner acceptable to BCBSSC. Preferred Provider may not charge the Member, BCBSSC or Associate Plan for filing a claim.
- (12) While an appeal of a decision by BCBSSC that a Covered Service was not Medically Necessary is pending, Preferred Provider will not bill BCBSSC, Associate Plan or the Member for any charges for such Covered Services that are the subject of the appeal.
- (13) Not file a claim with BCBSSC or Associate Plan or bill a Member for any charges for services rendered when it has been determined such services are not Medically Necessary. Preferred Provider may seek compensation from the Member for services determined to be not Medically Necessary only if the Member, or lawfully authorized representative thereof, consents in writing to be responsible for the payment of the specific medical services prior to the rendition of the services.
- (14) Not bill BCBSSC, Associate Plan or the Member separately for an item or Covered Service that is considered by BCBSSC to be an integral part of another item or Covered Service.
- (15) Not bill BCBSSC, Associate Plan or the Member for certain medical errors described by the National Quality Forum as "Never Events".
- (16) Reimburse BCBSSC or the Associate Plan for any payment made for services determined not to be payable hereunder. Provided, however, to the extent Preferred Provider is required to reimburse the Member and does reimburse the Member under a coordination of benefits provision of a Member's health plan other than the Benefits Contract, Preferred Provider is not required to reimburse BCBSSC or Associate Plan. If Preferred Provider does not reimburse BCBSSC or Associate Plan for any payment made for services determined not to be payable, then BCBSSC may offset future payments to Preferred Provider (whether resulting from claims related to the same Member or other Members) by the amount of the refund due.
- (16) Maintain active state licensure in the state in which Preferred Provider practices.
- (18) Certify to BCBSSC that Preferred Provider is fully covered by a medical malpractice policy in accordance with the relevant credentialing requirements.

- (19) Allow BCBSSC to use Preferred Provider's name to inform Members and potential Members that Preferred Provider is a Network Provider.
  - (20) Upon written request of the United States Secretary of Health and Human Services or Comptroller General or any of their duly authorized representatives, make available those contracts, books, documents and records necessary to verify the nature and extent of the cost of providing services. Such inspection shall be available up to four years after the rendering of such services. If Preferred Provider carries out any of the duties of this Agreement through a subcontract with a value of \$10,000 or more over a 12 month period with a related individual or organization Preferred Provider will include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of Section 1861 (v)(1) of the Social Security Act and the regulations relating to it
  - (21) Use BCBSSC contracting, independent laboratories for reference lab work for Members.
- B. In accordance with the terms of this Agreement, and in addition to the requirements contained in IV(A), Preferred Provider who is a Primary Care Physician under the terms of a Point of Service Benefits Contract, shall:
- (1) Accept Members covered under the Point of Service Benefits Contract as new patients, and continue to treat current patients who become Members, until Preferred Provider notifies BCBSSC that Preferred Provider is unable to accept new patients.
  - (2) Cooperate and comply with Point of Service Benefits Contract authorization procedures should the Member require Covered Services which cannot be performed by Preferred Provider or which must be performed in a medical setting outside of Preferred Provider's office.
  - (3) In the event Preferred Provider is unable to provide Covered Services, arrange for other Network Providers to provide Covered Services to Preferred Provider's patients who are Members covered under the Point of Service Benefits Contract.
  - (4) Determine the necessity of referrals to other providers (using Network Providers where possible) and complete an authorization form which the Member will deliver to the provider accepting the referral. As the Primary Care Physician, Preferred Provider will request an authorization from BCBSSC for any referrals made to providers who are not Network Providers and complete the authorization form indicating whether authorization was obtained/denied.

#### **V. RELATIONSHIP BETWEEN THE PARTIES.**

- A. Nothing in this Agreement should be construed as an attempt by BCBSSC to abridge, alter or interfere with any Network Provider's physician-patient relationship. Any and all medical service decisions, treatment decisions or exercises of medical judgment are Preferred Provider's responsibility, and BCBSSC shall not be deemed liable for any such decisions or exercise of judgment in any manner.
- B. Preferred Provider is an independent contractor. This Agreement shall not be construed or deemed to create an employer-employee relationship, a joint venture, or a principal-agent relationship between BCBSSC and Preferred Provider or any Network Provider.

## **VI. TERM, TERMINATION AND AMENDMENT.**

- A. TERM. This Agreement shall be effective on the Effective Date and shall continue in effect until terminated pursuant to this Agreement.
- B. TERMINATION
- (1) Either BCBSSC or Preferred Provider may terminate this Agreement for any reason upon one hundred twenty (120) days prior written notice by the other party.
  - (2) BCBSSC may terminate this Agreement for cause upon ninety (90) days prior written notice, for the following reasons:
    - (a) Failure to abide by the terms specified in this Agreement (e.g. Preferred Provider fails to use other Network Providers when available);
    - (b) Failing to cooperate with the continuing credentialing requirements as delineated in the BCBSSC credentialing process.
  - (3) BCBSSC shall have the right to terminate this Agreement for cause, immediately and without prior notice, upon actual notice to BCBSSC of significant deficiencies in licensing or qualification matters, including but not limited to the following reasons:
    - (a) Loss of license required for professional practice;
    - (b) Preferred Provider is convicted of a felony;
    - (c) Preferred Provider loses or otherwise fails to maintain all certificates(s), registration(s), or additional licensure(s) required for professional practice;
    - (d) Preferred Provider misrepresents Preferred Provider's competence or professional capabilities; or
    - (e) Preferred Provider misrepresents or fails to disclose any requested credential information or otherwise fails to meet re-credentialing criteria; or
    - (f) Preferred Provider changes affiliation from a Preferred Blue participating professional association to a professional association that does not participate in the Preferred Blue program. It is Preferred Provider's responsibility to notify BCBSSC's Provider Contracting and Reimbursement Department at least thirty (30) days in advance of such a change; or
    - (g) Preferred Provider files for the protection of the Bankruptcy Court or is involuntarily placed in bankruptcy or has a receiver appointed to manage Preferred Provider's affairs.
  - (4) Nothing contained in this section VI(B) shall impose on BCBSSC any duty to monitor Preferred Provider's performance under this Agreement, the quality of care provided by Preferred Provider or Preferred Provider's physical or mental condition or Preferred Provider's behavior. BCBSSC expressly disclaims any such duty. BCBSSC may monitor or may decline to monitor such performance in its sole discretion.
  - (5) As of the date of termination, this Agreement shall be of no further force or effect whatsoever for services rendered thereafter and each of the parties shall be relieved and discharged from the requirements of this Agreement, except that:

- (a) The parties shall complete any arbitration proceedings initiated pursuant to this Agreement, including requests for arbitration of disputes arising between the parties after the effective date of termination.
- (b) Notwithstanding termination, and without cost to BCBSSC, BCBSSC shall continue to have access to Preferred Provider's records for three (3) years, to the extent permitted by law and as necessary to fulfill the terms of this Agreement and legal requirements.
- (c) Preferred Provider agrees to complete the course of treatment for all Members that have begun a course of treatment by the date of termination notice, even if the course of treatment is completed after the date of termination. Both parties agree to honor the terms of this Agreement for the completion of such courses of treatment.
- (d) The requirements of section IX(K) shall remain in full force and effect.

- C. AMENDMENT. This Agreement may be amended by BCBSSC following ninety (90) days prior written notice, effective at the end of such ninety (90) day period. If Preferred Provider does not accept the terms of the amendment, Preferred Provider may terminate this Agreement by providing written notice within thirty (30) days of the receipt of such proposed amendment. Termination shall be effective at the end of the ninety (90) day period provided by BCBSSC.

## **VII. ASSIGNMENT.**

- A. ASSIGNMENT OF AGREEMENT. Neither party may assign their rights or duties under this Agreement without the prior written consent of the other party, which consent shall not be unreasonably withheld.
- B. ASSIGNMENT OF COVERED SERVICES. BCBSSC may, from time to time, contract with Associate Plans for the purpose of allowing such Associate Plans to avail themselves of the same access to the benefits of this Agreement and related rights as BCBSSC and binding such persons to the payment responsibilities under this Agreement. Preferred Provider agrees to provide Covered Services to Associate Plans Members under the terms of this Agreement and to look to each Associate Plan for reimbursement for Covered Services rendered to that Associate Plan's Members. Such Associate Plans shall not be required to provide for electronic claims transmission for the use of Preferred Provider in filing claims, however, BCBSSC will encourage the use of electronic claims transmission systems by Associate Plans. The duties and obligations of Associate Plans under this Agreement are several and distinct from BCBSSC's duties and obligations under this Agreement and BCBSSC does not guarantee any Associate Plan's performance under this Agreement and BCBSSC will not be responsible for any Associate Plan's actions. Except for references to BCBSSC under Articles V, IV, VIII, and IX, references to BCBSSC shall be deemed to refer to Associate Plans with respect to such Associate Plans duties and obligations under this Agreement and with respect solely to such Associate Plan's Members.

## **VIII. LIABILITY AND INDEMNITY.**

- A. Preferred Provider agrees to indemnify, defend and hold BCBSSC harmless from any and all liability, loss, damage, claim or expense of any kind (including all costs and reasonable attorneys' fees), which results from any breach of this Agreement by Preferred Provider or which results from the negligent or willful acts or omissions by Preferred Provider, its agents or employees regarding the duties and obligations of Preferred Provider under this Agreement, including the duty to maintain the legal standard of care applicable to Preferred Provider. Such obligation to indemnify, defend and hold harmless shall not apply to any matters resulting from negligent or willful acts or omissions of BCBSSC or its agents or employees.
- B. BCBSSC agrees to indemnify, defend and hold Preferred Provider harmless from any and all liability, loss, damage, claim or expenses of any kind (including all costs and reasonable attorneys' fees), which results from any

breach of this Agreement by BCBSSC or results from the negligent or willful acts or omissions by BCBSSC, its agents or employees regarding the duties and obligations of BCBSSC under this Agreement. Such indemnification and hold harmless shall not apply to any matters resulting from negligent or willful acts or omissions of Preferred Provider or its agents or employees.

## **IX. MISCELLANEOUS.**

### **A. PARTIES TO THE AGREEMENT.**

- (1) Preferred Provider expressly acknowledges its understanding that this Agreement constitutes a contract between Preferred Provider and BCBSSC, and that BCBSSC is an independent corporation operating under a license with the Association, permitting BCBSSC to use the Blue Cross and Blue Shield Service Mark in the State of South Carolina, and that BCBSSC is not contracting as the agent of the Association.
- (2) Preferred Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than BCBSSC and that no person, entity, or organization other than BCBSSC (and other than Associate Plans by virtue of Article VII) shall be held accountable or liable to Preferred Provider for any of BCBSSC's obligations to Preferred Provider created under this Agreement. This paragraph VII(A), shall not create any additional obligations whatsoever on the part of BCBSSC other than those obligations created under other provisions of this Agreement.

### **B. ORIGINALS/COPIES OF THE AGREEMENT.** BCBSSC may image this Agreement, related documents and credentials. An imaged copy of this Agreement, related documents and credentials shall be as effective and valid as the original.

### **C. USE OF DOCUMENTS.** Preferred Provider agrees that BCBSC may allow the documents and credentials referenced in this Agreement to be used by any and all subsidiary networks managed by BCBSSC.

### **D. NON-EXCLUSIVITY.** Preferred Provider and BCBSSC agree and acknowledge that this is a non-exclusive contract and that either party is free to contract with other parties to provide the services contemplated under this Agreement.

### **E. WAIVER OF BREACH.** Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision.

ELECTRONICALLY FILED - 2020 Aug 31 7:59 PM - Horry - COMMON PLEAS - CASE#2020CP2601982

- F. SEVERABILITY. In the event any provision of this Agreement is rendered invalid or unenforceable by any federal statute or state law, or by any regulation duly promulgated by officers of the United States or the State of South Carolina in accordance with law, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of this Agreement shall remain in full force and effect.
- G. EFFECT OF SEVERABLE PROVISION. In the event that a provision of this Agreement is rendered invalid or unenforceable or declared null and void as provided in Section IX(F) and its removal has the effect of materially altering the obligations of either party in such manner as in the judgment of the party affected: (1) will cause serious financial hardship to such party; or (2) will cause such party to act in violation of its corporate Articles or Bylaws, the party so affected shall have the right to terminate this Agreement upon thirty (30) days prior written notice to the other party. The applicable provisions of Article VI shall apply to such termination.
- H. PROHIBITION AGAINST PAYMENT OF MEMBERS HEALTH PLAN PREMIUMS. Preferred Provider shall not pay any amount toward health plan premiums or health insurance premiums of any Members, except for its eligible employees and retirees under its own employee welfare benefit plan.
- I. HEADINGS. The headings of Articles and Sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.
- J. GOVERNING LAW. This Agreement shall be construed and enforced in accordance with the laws of the State of South Carolina.
- K. CONFIDENTIALITY.
- (1) Preferred Provider acknowledges and agrees that in the course of obtaining this Agreement it has received, and may continue to receive, BCBSSC's valuable trade secrets, confidential, and proprietary information (collectively referred to as "Confidential Information"), including the reimbursement terms and the terms of this Agreement and any and all records required to be produced or kept under the terms of this Agreement. Preferred Provider further acknowledges that the use of Confidential Information would give Preferred Provider an unfair competitive advantage were Preferred Provider to directly or indirectly compete with BCBSSC for BCBSSC's existing customers, and disclosure of Confidential Information would cause harm to BCBSSC.
  - (2) In consideration of the disclosure by BCBSSC to Preferred Provider of Confidential Information, Preferred Provider agrees to treat the Confidential Information supplied to it by BCBSSC in strict confidence, and to undertake the following additional obligations with respect thereto:
    - (a) to use Confidential Information for the sole purpose of performing its obligations under this Agreement;
    - (b) not to disclose Confidential Information to any person outside of its organization except as needed to comply with Preferred Provider's obligations under this Agreement;
    - (c) to limit dissemination of Confidential Information to only those of its employees who have a need to know to perform the limited tasks set forth in this Agreement;
    - (d) ensure that any pricing disclosed to its billing company, attorneys, CPAs, etc. is not disclosed to any other provider or other organization. Any violation of Confidentiality by such person or entity will be considered the same as if Preferred Provider committed such violation; and
    - (e) to return Confidential Information and all documents, notes or physical evidence thereof to BCBSSC upon termination of this Agreement.

- (3) The restrictions and obligations of this paragraph shall survive any expiration, termination or cancellation of this Agreement and shall continue to bind Preferred Provider, its successors and assigns.
- (4) Preferred Provider acknowledges that if Preferred Provider breaches the terms of this paragraph IX(K), BCBSSC shall be entitled to seek monetary damages against Preferred Provider. Additionally, Preferred Provider acknowledges that if Preferred Provider breaches this section IX(K), such monetary damages may not be a sufficient remedy for such breach and that BCBSSC shall be entitled, without waiving any other rights or remedies, to injunctive or equitable relief as may be deemed proper by a court of competent jurisdiction.

L. ENTIRE AGREEMENT. This Agreement, including all written supplements, exhibits, and amendments hereto constitutes the entire agreement of the parties hereto. No verbal agreement or conversation of the parties hereto shall affect or in any way modify any of the terms and conditions herein contained.

M. DISPUTE RESOLUTION.

- (1) Except for decisions made pursuant to the Utilization Management Program, BCBSSC and Preferred Provider 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, other than a Utilization Management Program decision (which resolution shall be governed by the terms of Appendix A), BCBSSC and Preferred Provider 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.

IN WITNESS WHEREOF, each of the undersigned parties to this Individual Preferred Provider Agreement has caused this Individual Preferred Provider Agreement to be duly executed.

BLUE CROSS AND BLUE SHIELD  
OF SOUTH CAROLINA

By: J. Lance Lockman      /      Date  
Its: Senior Director,  
Professional Network Management

STEVEN ROY BURKHOLZ, DO  
(Please Type or Print)  
Name of Preferred Provider

Effective Date  
(Established by BCBSSC)

 4/8/2017  
Signature of Individual Preferred Provider      Date

**APPENDIX A****UTILIZATION MANAGEMENT PROCEDURES**

The Utilization Management Program is a series of activities carried out by BCBSSC to ensure that the Covered Services that are provided to Members are Medically Necessary. These activities consist of pre-certification of admissions and length of stay and pre-certification of selected medical and surgical procedures. The Utilization Management Program also involves a review of ongoing admissions and may involve the retrospective review of admissions for appropriateness and Medical Necessity. The Utilization Management Program may also involve case management of all Covered Services provided to Members who are severely ill with long-term chronic conditions. In the event that the Preferred Provider fails to follow the requirements of the Utilization Management Program, BCBSSC reserves the right to withhold all or a portion of the payment for otherwise Covered Services.

- A. Preferred Provider and BCBSSC hereby agree:
- (1) To avoid unnecessary or unduly costly Covered Services for Members;
  - (2) To ensure that all Members receive the appropriate and necessary level of Covered Services in accordance with community standards for care and such Members Benefits Contract;
  - (3) To maintain professional standards in the delivery of health care within the meaning of Section 40-71-10 Code of Laws of South Carolina, 1976 as amended.
- B. The Utilization Management Program will be conducted by BCBSSC. In the course of using the Utilization Management Program, payment to Preferred Provider may be denied when it is determined that such Covered Services were not Medically Necessary or where Preferred Provider fails to follow the Utilization Management Program's procedures. Preferred Provider will not bill a Member for charges for Covered Services where Preferred Provider failures to follow the Utilization Management Program procedures.
- C. When service evaluation is requested by BCBSSC or Associate Plan, Preferred Provider will use its best efforts to ensure that all Preferred Provider's relevant records and those of Preferred Provider's facility, if applicable, be made available to BCBSSC upon reasonable notice.
- D. The requirements of the Utilization Management Program must be followed for all Covered Services rendered to Members. The Utilization Management Program includes: Pre-Admission Reviews, Emergency Admission Reviews, Outpatient Reviews and Continued Stay Reviews. Preferred Provider or the admitting Network Provider must request each type of review. Each specific type of review is subject to the following additional requirements:
- (1) Pre-Admission Review. A Pre-Admission Review is required prior to all non-Emergency admissions. Preferred Provider will cooperate with other Network Providers in connection with a Pre-Admission Review, including providing any necessary clinical information relating to a Member's proposed admission.
  - (2) Emergency Admission Reviews. An Emergency Admission Review is required for all Emergency admissions. BCBSSC or Associate Plan must be notified within twenty-four (24) hours of the Emergency admission, or by noon of the next working day if the admission is on Friday, Saturday, Sunday or a holiday. Preferred Provider will cooperate with other Network Providers in connection with an Emergency Admission Review, including providing

any necessary clinical information relating to a Member's proposed admission.

- (3) Continued Stay Review. Each approved admission of a Member is contemplated to last a particular number of days. Accordingly, each admission will be assigned a specific number of days at the time of approval of the admission. Additional days are subject to a Continued Stay Review and approval by BCBSSC. Preferred Provider will cooperate with other Network Providers in connection with a Continued Stay Review, including providing any necessary clinical information relating to a Member's proposed continued stay.
  - (4) Outpatient Review. Elective outpatient surgical procedures may be subject to an Outpatient Review that must be obtained at least three (3) days prior to applicable procedures.
- E. BCBSSC or Associate Plan shall not pay for services that are determined through the Utilization Management Program to be not Medically Necessary or which are not Covered Services. Unless a Member has agreed, in writing, to be personally responsible for such specified Covered Services, Preferred Provider agrees not to bill any Member for services determined through the Utilization Management Program to be not Medically Necessary. In the event Preferred Provider successfully appeals a Utilization Management Program decision in accordance with this Appendix, BCBSSC or Associate Plan shall accept Preferred Provider's bill and make payment pursuant to the terms of the Agreement.
  - F. Preferred Provider and each Member have a right to appeal decisions made through the Utilization Management Program to the Quality Medical Advisory Panel. Preferred Provider or Member may also request reconsideration of a decision made pursuant to the Utilization Management Program through the Quality Medical Advisory Panel.
  - G. Preferred Provider and BCBSSC agree that each shall be responsible for their own costs incurred in the appeal of any Utilization Management Program determination.

**STATE OF SOUTH CAROLINA****) IN THE COURT OF COMMON PLEAS****COUNTY OF HORRY****) CASE NO.: 2020-CP-26-03169**Thuy N. Gasser, individually and on  
behalf of those similarly situated,)  
)

Plaintiff,

)  
)**MOTION TO COMPEL ARBITRATION  
AND DISMISS OR STAY**

v.

)  
)

ACS Primary Care Physicians-Southeast P.C.,

)  
)

Defendant

)  
).  

---

)

Pursuant to Rules 12(b)(1), 12(b)(3) and 12(b)(6), SCRCF, the Federal Arbitration Act, 9 U.S.C. § 4 (the “FAA”), and the South Carolina Uniform Arbitration Act, S.C. Code Ann. § 14-48-10 *et seq.* (the “SCUAA”), Defendant ACS Primary Care Physicians-Southeast P.C. (“ACS”) hereby moves to compel bilateral arbitration (*i.e.*, arbitration on a non-classwide basis) and to dismiss. In the alternative, as opposed to dismissal, ACS requests that the case be stayed pending the bilateral arbitration.

### **INTRODUCTION**

The Court should enter an order compelling Plaintiff’s claims to bilateral arbitration (*i.e.*, arbitration on a non-classwide basis) and dismissing this lawsuit under the FAA. The dispute at issue here traverses state lines and, therefore involves interstate commerce, and the broad arbitration clause at issue covers the dispute. Moreover, the fact that Plaintiff herself was not a signatory to the contract containing the arbitration clause is of no moment; because Plaintiff has

alleged that she is a third-party beneficiary of that contract, she is estopped from denying that she is a signatory to it.

In the alternative, and for the same reasons as discussed in connection with the FAA, the Court should enter an order compelling Plaintiff's claims to bilateral arbitration and dismissing this lawsuit under the SCUAA. The contract at issue here contains the requisite disclaimer and, as with the FAA, the broad arbitration clause covers this dispute.

In sum, under either the FAA or the SCUAA, the court should enter an order compelling Plaintiff's claims to bilateral arbitration and dismissing this lawsuit. In the alternative, as opposed to dismissal, the Court's order should stay this matter pending the bilateral arbitration.

### **BACKGROUND**

Plaintiff, a South Carolina citizen and resident, had health insurance under a health plan with Blue Cross Blue Shield of South Carolina ("BCBSSC"). (Compl. ¶¶ 7, 15.) ACS, a Georgia professional corporation, is an in-network provider for BCBSSC pursuant to a Provider Agreement with BCBSC. (*Id.* ¶¶ 8, 17.) A true and correct copy of the applicable Provider Agreement is attached hereto as Exhibit 1 to the Declaration of Paula Dearolf, attached hereto as Exhibit A.

The Provider Agreement contains a mandatory arbitration clause, stating that BCBSSC and ACS "agree to arbitrate [any] problem or dispute" that "arises under the agreement." (Provider Agreement at 10.) Further, the Provider Agreement states, in bold, capitalized, and underlined text at the top of the first page: "**THE TERMS OF THIS AGREEMENT SHALL BE SUBJECT TO ARBITRATION.**" (*Id.* at 1.)

Plaintiff alleges that, on or about December 9, 2019, she was in car wreck, which required her to go to Grand Strand Regional Medical Center where ACS providers rendered services to her. (Compl. ¶¶ 13-14.) According to the Complaint, ACS did not submit the claim for services to

BCBSSC, but instead billed Plaintiff directly for these services. (*Id.* ¶¶ 19, 22.) Further, Plaintiff alleges that ACS billed her at a rate higher than specified in the Provider Agreement. (*Id.* ¶ 25.)

The Complaint alleges two causes of action: breach of contract and unjust enrichment. First, Plaintiff alleges that ACS breached the Provider Agreement. (*Id.* ¶¶ 35-39.) Plaintiff claims that she is a third-party beneficiary to that agreement, and that she was damaged by the alleged breach in the form of any payments made based on the allegedly incorrect bills. (*Id.*) Second, Plaintiff alleges that ACS was unjustly enriched by violating the Provider Agreement. (*Id.* ¶¶ 40-45.)

### **DISCUSSION**

“The FAA reflects a liberal federal policy favoring arbitration agreements.” *Adkins v. Labor Ready, Inc.*, 303 F.3d 496, 500-01 (4th Cir. 2012) (quoting *Moses H. Cone Mem’l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24 (1983)). “Underlying this policy is Congress’s view that arbitration constitutes a more efficient dispute resolution process than litigation.” *Id.* “Accordingly, ‘due regard must be given to the federal policy favoring arbitration, and ambiguities as to the scope of the arbitration clause itself resolved in favor of arbitration.’” *Id.* (quoting *Volt Info. Sciences, Inc. v. Bd. of Tr. of Leland Stanford Jr. Univ.*, 489 U.S. 468, 475-76 (1989)).

South Carolina law is similar. As with the FAA, “[t]he policy of [] South Carolina is to favor arbitration of disputes ... Arbitration is a matter of contract law and general contract principles of state law apply to a court’s evaluation of the enforceability of an arbitration clause.” *Parsons v. John Wieland Homes & Neighborhoods of the Carolinas*, 418 S.C. 1, 6, 791 S.E.2d 128 (2016); *see also Damico v. Lennar Carolinas, LLC*, 884 S.E.2d 66, 430 S.C. 188 (Ct. App. 2020) (“Due to the strong South Carolina and federal policy favoring arbitration, arbitration agreements are presumed valid.”).

**A. Plaintiff's claims are subject to bilateral arbitration under the FAA**

This case is subject to bilateral arbitration under the FAA because all of Plaintiff's causes of action are covered by the broad arbitration clause at issue here. To determine whether to compel arbitration under the FAA, the Court should consider whether: (1) there is a dispute between the parties, (2) there is a written agreement to arbitrate that covers the dispute, (3) the transaction evidenced by the dispute involves interstate commerce, and (4) one party has failed, neglected or refused to arbitrate. *Damico v. Lennar Carolinas, LLC*, 430 S.C. 188, 844 S.E.2d 66, 70 (S.C. Ct. App. 2020); *see also Adkins v. Labor Ready, Inc.*, 303 F.3d 496, 500-01 (4th Cir. 2012). In light of the liberal policy favoring arbitration, the party opposing arbitration bears the burden of proving that the dispute should not be arbitrated. *Green Tree Fin. Corp.-Ala. v. Randolph*, 531 U.S. 79, 91 (2000).

Here, arbitration should be compelled because all four of these factors are present:

**First.** There is plainly a dispute between the parties insofar as Plaintiff has filed a Complaint against ACS.

**Second.** The Provider Agreement contains an arbitration clause that covers the dispute. The arbitration clause provides that the parties "agree to arbitrate [any] problem or dispute" that "arises under the agreement," (Provider Agreement at 10), and the claim for breach of contract is plainly a claim under the terms of the agreement. *See S.C. Pub. Serv. Auth. v. Great W. Coal*, 312 S.C. 559, 563, 437 S.E.2d 22 (1993) ("Arbitration is a matter of contract and controlled by contract law."). Further, Plaintiff's claim for unjust enrichment is also clearly a "problem or dispute" arising under the Provider Agreement. *See American Recovery Corp. v. Computerized Thermal Imaging*, 96 F.3d 88, 93 (4th Cir. 1996) (holding that the FAA applies to any claims "having a significant relationship to the contract regardless of the label attached to the dispute"); *see also*

*Great W. Coal*, 312 S.C. at 563 (“Any doubts concerning the scope of arbitration should be resolved in favor of arbitration”).

ACS anticipates that Plaintiff will argue she should not be bound by the arbitration agreement in the Provider Agreement because she is not a signatory to that agreement, but this argument is foreclosed under the doctrine of equitable estoppel. “Equitable estoppel precludes a party from asserting rights he otherwise would have had against another when his own conduct renders assertion of those rights contrary to equity.” *Pearson v. Hilton Head Hops.*, 400 S.C. 281, 295, 733 S.E.2d 597, 604 (Ct. App. 2012); *see also Wachovia Bank N.A. v. Schmidt*, 445 F.3d 762, 769 (4th Cir. 2006) (The “legal principle [of equitable estoppel] rests on a simple proposition: it is unfair for a party to rely on a contract when it works to its advantage, and repudiate it when it works to its disadvantage.”) (internal quotation marks and alterations omitted). Applying this principle to the arbitration context, “[a] nonsignatory is estopped from refusing to comply with an arbitration clause ‘when it receives a direct benefit from a contract containing an arbitration clause.’” *Pearson*, 400 S.C. at 290; *see also Am. Bankers Ins. Group*, 453 F.3d at 628 (4th Cir. 2006) (quoting *International Paper Co. v. Schwabedissen Maschinen & Analgen GMBH*, 206 F.3d 411, 418 (4th Cir. 2000)). A nonsignatory seeks a “direct benefit” under a contract when she asserts a claim based on her alleged status as a third-party beneficiary of the contract. *Am. Bankers Ins. Group*, 453 F.3d at 629 (The “direct benefit” test “examine[s] whether the plaintiff has asserted claims in the underlying suit that, either literally or obliquely, assert a breach of duty created by the contract containing the arbitration clause.”). In such a situation, the nonsignatory, who is relying on the contract as the basis for her claim, is estopped from denying she is a party to it. *Id.*

Here, Plaintiff seeks a “direct benefit” from the Provider Agreement because she has alleged she is a third party beneficiary of that agreement and she has sued ACS for breach of the

Provider Agreement. (Compl. ¶ 38) Thus, because Plaintiff is relying on the Provider Agreement as the foundation for her breach of contract claim, she is estopped from denying she is not a signatory to that agreement. Because the Provider Agreement contains an arbitration clause that applies to this dispute, the court should compel Plaintiff to submit her claims to arbitration pursuant to that clause.

**Third.** The transaction at issue involves interstate commerce. The FAA defines “commerce” as “commerce among the several States or with Foreign nations . . .” 9 U.S.C. § 1. The Supreme Court has held that the meaning of this provision of the FAA is as broad as the Commerce Clause itself. *Allied-Bruce Terminix Cos. v. Dobson*, 513 U.S. 265, 274 (1994). Courts regularly hold that the fact that the contract containing the arbitration provision is entered into between parties of different states alone demonstrates that the contract “involve[s] interstate commerce under the Supreme Court’s expansive interpretation of the FAA.” *Low Country Rural Health Educ. Consortium Inc. v. Greenway Med.*, No. 9:14-cv-00874-DCN, 2014 U.S. Dist. LEXIS 157418, at \*15-16 (D.S.C. Nov. 5, 2014) (citing *Allied-Bruce*, 513 U.S. at 281).

Here, Plaintiff’s claims involve citizens of different states, involve a contract made between citizens of different states, and therefore involve interstate commerce. Specifically, Plaintiff is a South Carolina citizen, ACS is a Georgia professional corporation licensed to do business in Georgia, South Carolina, and Florida, and currently does business in Georgia and South Carolina. (See Exhibit A ¶ 5,) and BCBSSC is based in South Carolina. Moreover, the Provider Agreement applicable to Plaintiff was negotiated on behalf of ACS from a location other than South Carolina. (*Id.* ¶ 13.) Because the transaction at issue here involves agreements between people and entities that crosses state lines, the transaction involves interstate commerce.

Moreover, the facts of the transaction clearly demonstrates that interstate commerce is present. Here, ACS contracted with a facility in South Carolina, Grand Strand Regional Medical Center, to provide professional medical services. (Exhibit A ¶ 6.) After an ACS clinician treats a patient in that facility, the part of the record documenting treatment rendered on that date is transmitted to a third party billing provider, HCFS Healthcare Financial Services, LLC (“HCFS”), located in Alcoa, Tennessee, where it employs coders to interpret the records and produce CPT codes and charges. (*Id.* ¶ 8.) A bill is then generated and sent to the payer from billing operations in Florida. (*Id.*) Thus, the conduct involved in the billing of Plaintiff and / or BCBSSC on behalf of Plaintiff clearly involves interstate commerce throughout various southeastern states.

**Fourth.** Plaintiff’s act of filing of the Complaint plainly demonstrates a failure, neglect, or refusal to arbitrate.

For these reasons, the Court should compel arbitration under the FAA.

**B. Plaintiff’s claims are subject to arbitration under the SCUAA**

Even if the Provider Agreement did not involve interstate commerce (and it plainly does), arbitration would still be required under the SCUAA. The SCUAA provides that “[a] written agreement . . . in a written contract to submit to arbitration any controversy thereafter arising between the parties is valid, enforceable and irrevocable.” S.C. Code. § 15-48-10(a). For the same reasons as already discussed in connection with the FAA, Plaintiff’s claims are subject to arbitration under the SCUAA as well.

Further, under the SCUAA, “a contract is subject to arbitration pursuant to this chapter shall be typed in underlined capital letters . . . on the first page of the contract.” S.C. Code. § 15-48-10(a). Here, the agreement to arbitrate appears on the first page of the agreement in bold and underlined capital letters. *See* Provider Agreement at 1.

For the foregoing reasons, the Court should also compel arbitration under the SCUAA.

**C. The arbitration must be on a bilateral basis**

Moreover, although Plaintiff has attempted to plead a class action, the arbitration here should be on a bilateral basis only because the Provider Agreement does not authorize class arbitration. (See Provider Agreement at 10.) Instead, the arbitration clause in the Provider Agreement is written on a bilateral basis only. “[A] party may not be compelled . . . to submit to class arbitration unless there is a contractual basis for concluding that the party *agreed* to do so.” *Stolt-Nielsen S.A. v. AnimalFeeds Int’l Corp.*, 559 U.S. 662, 684 (2010); see also *Del Webb Cmtys., Inc. v. Carlson*, 817 F.3d 867, 873 (4th Cir. 2016) (*Carlson I*) (“[A] party may not be compelled to submit to class arbitration absent express agreement.”); *Del Webb Cmtys., Inc. v. Carlson*, No. 9-14-cv-1877-PMD, 2017 U.S. Dist. LEXIS 84291, at \*3-4 (D.S.C. Feb. 1, 2017) *aff’d* No. 17-1347, 2017 U.S. App. LEXIS 20016 (4th Cir. Oct. 13, 2017) (*Carlson II*) (“The principal reason to conclude that [an] arbitration clause does not authorize classwide arbitration is that the clause nowhere mentions it.”); *Grant v. Chevrolet*, No. 5757, 2020 S.C. App. LEXIS 79, at \*5 (S.C. Ct. App. filed Aug. 12, 2020) (quotations omitted) (“[A] party *may not be compelled* under the FAA to submit to class arbitration *unless* there is a contractual basis for concluding that the party *agreed* to do so.”). Because the Provider Agreement does not authorize arbitration on a class basis, the Court should enforce the arbitration agreement according to its terms and compel Plaintiff to pursue her claims in bilateral arbitration.

**D. Plaintiff’s claims should be dismissed**

Finally, Plaintiff’s claims should be dismissed, rather than stayed, because both of her claims are subject to arbitration. Under the FAA, dismissal is the “proper remedy when all of the issues presented in a lawsuit are arbitrable.” *Choice Hotels Int’l, Inc. v. BSR Tropicana Resort*,

*Inc.*, 252 F.3d 707, 709-10 (4th Cir. 2001). Because both of the claims are subject to bilateral arbitration, the Court should compel them to arbitration and dismiss the Complaint. In the alternative to dismissal, the Court should stay any claims that it concludes are not subject to arbitration during the pendency of the arbitration.

### **CONCLUSION**

For the foregoing reasons, the Court should enter an order compelling bilateral arbitration and dismissing the case. In the alternative to dismissal, the Court's order should stay this matter pending the arbitration.

Dated: August 31, 2020

GORDON & REES LLP

By s/Josh Dixon

Josh Dixon (SC 75815)  
E-mail: jdixon@grsm.com  
Victoria T. Kepes (SC 102536)  
E-mail: vkepes@grsm.com  
40 Calhoun Street, Suite 350  
Charleston, SC 29401  
Telephone: (843) 278-5900  
*Attorneys for ACS Primary Care  
Physicians-Southeast P.C.*

# EXHIBIT A

**) IN THE COURT OF COMMON PLEAS**

**) CASE NO.: 2020-CP-26-03169**

)

i

(

1

1

1

**AFFIDAVIT OF  
PAULA DEAROLF**

1. My name is Paula Dearolf. I am over 18 years of age. I have personal knowledge of the facts set forth below.
2. I work for HCFS Healthcare Financial Services, LLC (“HCFS”). My job title is Executive Vice President, Revenue Cycle Operations. In that role, I am responsible for the day to day oversight of revenue cycle operations to include emergency department billing centers and support departments in their role of providing coding and billing services.
3. HCFS is a limited liability company that is organized under the laws of Florida.
4. ACS Primary Care Physicians-Southeast, P.C. (“ACS”) is a Georgia professional corporation.
5. ACS is licensed to do business in Georgia, South Carolina, and Florida and currently does business in Georgia and South Carolina.
6. ACS contracts to provide professional medical services for many medical facilities located in Georgia and South Carolina. One such facility is the Grand Strand Regional Medical Center.

7. When ACS clinicians treat patients in the medical facilities, they document the treatment within the facility's medical record.

8. ACS has a contract with HCFS for HCFS to code and bill for the services rendered by ACS. Pursuant to this contract, a portion of the facility's medical record that includes the clinician's documentation for the particular date of services is transmitted from the facility where the medical services were rendered to HCFS's office located in Alcoa, Tennessee. HCFS employs coders working from its office in Alcoa, Tennessee who are trained to interpret the billing record to produce a CPT code and corresponding charge. Once the CPT code and corresponding charge are determined at HCFS's office in Alcoa, Tennessee, a bill is generated and sent to the payer from billing operations in Florida.

9. The payer can be any number of people / entities, including the patient, the patient's health plan, or, in the case of a motor vehicle accident, the patient's automobile insurer.

10. ACS physicians treat many patients whose health plan is with Blue Cross Blue Shield South Carolina ("BCBSSC").

11. ACS has various Preferred Provider Agreements with Blue Cross Blue Shield South Carolina that govern the relationship with ACS and BCBSSC, including the provider agreement attached here to as Exhibit A.

12. The Preferred Provider Agreement attached as Exhibit A is the agreement that applied to Plaintiff's medical care with ACS.

13. The Preferred Provider Agreement attached as Exhibit A was negotiated on behalf of ACS from a location other than South Carolina.

I, Paula Dearolf, certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment by contempt.

Dated: 8/31/20

Paula R. Dearolf

(Signature)

# EXHIBIT 1

**BLUECROSS BLUESHIELD OF SOUTH CAROLINA INDIVIDUAL HEALTH INSURANCE  
EXCHANGE ("HIX") PREFERRED PROVIDER AGREEMENT**

**WITH THE EXCEPTION OF DISPUTES RELATED TO THE UTILIZATION MANAGEMENT  
PROGRAM, WHICH SHALL BE GOVERNED PURSUANT TO THE PROVISIONS OF APPENDIX A OF  
THIS AGREEMENT, THE TERMS OF THIS AGREEMENT SHALL BE SUBJECT TO ARBITRATION.**

This Group Preferred Provider Agreement ("Agreement") is between BlueCross BlueShield of South Carolina ("BCBSSC"), a South Carolina mutual corporation, and the undersigned herein referred to as "Preferred Provider". Any reference to Preferred Provider in this Agreement applies to individual employed physicians or professional providers of the group as well as the group as a whole.

**I. INTRODUCTION.**

- A. WHEREAS, BCBSSC desires to establish effective, cooperative healthcare cost containment programs for the Individual Health Insurance Exchange ("HIX"; as further defined herein) market that will assure the availability and continuity of quality care to BCBSSC's Members (as defined below); and,
- B. WHEREAS, Preferred Provider wants to participate as a (HIX) Network Provider (as defined below) in the cooperative health care cost containment programs established by BCBSSC.
- C. NOW THEREFORE, in consideration of the premises and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, BCBSSC and the (HIX) Preferred Provider hereby agree as follows:

**II. DEFINITIONS.**

Capitalized terms used in this Agreement shall have the following meanings.

- A. "Agreement" means this Individual Health Insurance Exchange ("HIX") Preferred Provider Agreement.
- B. "Associate Plan" means a company, organization or other entity that is entitled to the benefit of the terms of this Agreement as a result of such Associate Plan's entry into an agreement with BCBSSC. The term "Associate Plan" also includes BCBSSC subsidiaries and other members of the Blue Cross Blue Shield Association.
- C. "Association" means an association of independent Blue Cross and Blue Shield Plans known as the Blue Cross and Blue Shield Association.
- D. "BCBSSC" means Blue Cross and Blue Shield of South Carolina.
- E. "Benefits Contract" means the contract between BCBSSC and a Member or an Associate Plan and its Member entitling the Member to receive Covered Services as designated in the contract. Benefits Contract as defined in this Agreement includes only Benefits Contracts purchased by individuals through an individual (i) State-Based Exchange (SBE), (ii) Federally-Facilitated Exchange (FFE) or (iii) Private Health Insurance Exchange in accordance with the Patient Protection and Affordable Care Act (PPACA).
- F. "Claim" means a paper or electronic billing instrument with the required fields completed as required by BCBSSC and in compliance with HIPAA, which has been properly and accurately completed by Preferred Provider.
- G. "Continued Stay Review" means the mandatory review conducted under the Utilization Management Program, to determine whether a continued admission is Medically Necessary.

- H. "Covered Services" means the services a Member is entitled to and which are reimbursable under the terms and conditions of the applicable Member Benefits Contract.
- I. "Effective Date" means the date that BCBSSC accepts Preferred Provider as a (HIX) Network Provider
- J. "Emergency" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain, such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in:
- (1) placing the health of the individual, or with respect to a pregnant woman the health of a woman or her unborn child, in serious jeopardy,
  - (2) serious impairment of bodily functions, or
  - (3) serious dysfunction of any bodily organ or part.
- K. "Emergency Admission Review" means the mandatory review conducted pursuant to the Utilization Management Program to determine whether an Emergency admission is Medically Necessary
- L. "Fee Allowance" means the lower of: (1) Preferred Provider's normal charge for a procedure, or (2) 100% of the State Health Plan Schedule of Allowances in place on the effective date of this Agreement.
- M. Health Insurance Exchange or "HIX" means an individual (i) State-Based, (ii) Federally-Facilitated or (iii) Private Health Insurance Exchange in which individual consumers may purchase health insurance in accordance with the PPACA.
- N. "Medically Necessary" shall mean health care services that a Physician, exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
- (1) in accordance with generally accepted standards of medical practice
  - (2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
  - (3) not primarily for the convenience of the patient, physician, or other health care provider
  - (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
- O. "Member" means any individual who is eligible for Covered Services under the terms of a Benefits Contract.
- P. "Membership Card" means the card BCBSSC issues to Members to allow Preferred Provider to identify a Member
- Q. "Outpatient Review" is the mandatory review conducted pursuant to the Utilization Management Program, to determine whether certain elective outpatient procedures are Medically Necessary

- R. "Patient Pay Amounts" means, with respect to Covered Services, all deductibles, coinsurance, co-payments and other sums that are payable by the Member directly to Preferred Provider and which are not payable by BCBSSC or Associate Plan.
- S. "Pre-Admission Review" means the mandatory review conducted pursuant to the Utilization Management Program to determine whether a non-Emergency admission is Medically Necessary.
- T. "HIX Network Provider" includes the following types of persons or facilities which
- (1) provide Covered Services to a Member; and
  - (2) such persons or facilities have a written agreement with BCBSSC to participate as a HIX Network Provider:
    - a. hospitals;
    - b. skilled nursing facilities;
    - c. home health agencies;
    - d. hospices;
    - e. independent laboratories;
    - f. contracting national laboratories;
    - g. physicians;
    - h. drug stores and pharmacies;
    - i. vendors of durable medical equipment; and
    - j. other eligible providers as specified under a Benefits Contract.

Upon acceptance by BCBSSC, Preferred Provider will be a HIX Network Provider.

- U. "Utilization Management Program" means a function performed by BCBSSC or by an organization or entity selected by BCBSSC to review and determine whether the services provided, or to be provided, are Medically Necessary, including but not limited to, whether services are appropriate. This Program is established to evaluate, approve and monitor whether Covered Services are Medically Necessary, and includes case management services. The Utilization Management Program is administered pursuant to the terms of Appendix A.

### **III. BCBSSC RESPONSIBILITIES.**

- A. BCBSSC or Associate Plan shall:
- (1) Pay Preferred Provider for Covered Services in accordance with the benefit allowance of the Member's Benefits Contract. Payment will be based upon the Fee Allowance amount.
  - (2) Directly reimburse Preferred Provider for Covered Services provided to Members without requiring that Preferred Provider obtain the Member's prior authorization.
  - (3) Establish procedures and methods whereby Members can be appropriately identified by HIX Network Providers.

- (4) Provide Preferred Provider with a list of all HIX Network Providers via the BCBSSC website ([www.southcarolinablues.com](http://www.southcarolinablues.com) at the time of this writing).

#### IV. **PREFERRED PROVIDER'S RESPONSIBILITIES.**

A. Preferred Provider shall:

- (1) Accept payment of the Fee Allowance amount as payment in full for Covered Services rendered to Members. All payments are subject to the terms of the Member's Benefits Contract. Member shall be solely responsible for any required Patient Pay Amounts and Preferred Provider shall not bill the Member any amount in excess of such Patient Pay Amounts for Covered Services. Payment will be adjusted for payments made to Preferred Provider pursuant to any coordination of benefits provisions in any health plan other than the Benefits Contract.
- (2) While performing services, maintain a physician-patient relationship with enrolled Members. Any and all medical service decisions, treatment decisions or exercises of medical judgment are Preferred Provider's responsibility.
- (3) Not discriminate against any Member on the basis of race, color, sex, age, religion, national origin, handicap or insurance plan in providing services under this Agreement. Preferred Provider may choose to be closed to new Members as a group but only if Preferred Provider is closed to new patients from all payor sources.
- (4) Cooperate and comply with the Provider Office Administrative Manual (located at [www.southcarolinablues.com](http://www.southcarolinablues.com) at the time of this writing).
- (5) Use only HIX Network Providers in the delivery of Covered Services unless Covered Services supplies or equipment are not available from any HIX Network Provider, or in the case of an Emergency.
- (6) Provide Covered Services in an appropriate outpatient setting whenever safe, quality care can be provided in such a setting.
- (7) Cooperate fully with the Utilization Management Program.
- (8) Agree to provide a second opinion to Members who have already consulted with another HIX Network Provider.
- (9) Cooperate and participate with BCBSSC and any Associate Plan in any utilization control procedures, quality assurance activities, analysis of Member's risk status, external audit systems and grievance procedures, as may be established pursuant to the terms of the Benefits Contract, and comply with all final determinations rendered through the grievance process.
- (10) Prepare, with respect to each Member for whom Covered Services are provided under this Agreement, standard medical records in such form, containing such information, and meeting such record keeping requirements as might be required by applicable federal and state law. Preferred Provider will keep confidential, and take all reasonable precautions to prevent the unauthorized disclosure of any and all records prepared and/or maintained by this Agreement. BCBSSC or the Associate Plan will have the right to inspect, review and obtain copies of such records upon request at no charge.
- (11) File a claim for all Covered Services rendered to Members within the time frame set forth in the Benefits Contract (typically 180 days). Preferred Provider will not bill BCBSSC, Associate Plan or

the Member for claims filed outside of the timely filing limit unless the party responsible for payment approves an exception. Preferred Provider will file the claims in a manner acceptable to BCBSSC. Preferred Provider may not charge the Member, BCBSSC or Associate Plan for filing a claim.

- (12) While an appeal of a decision by BCBSSC that a Covered Service was not Medically Necessary is pending, Preferred Provider will not bill BCBSSC, Associate Plan or the Member for any charges for such Covered Services that are the subject of the appeal.
- (13) Not file a claim with BCBSSC or Associate Plan or bill a Member for any charges for services rendered when it has been determined such services are not Medically Necessary. Preferred Provider may seek compensation from the Member for services determined to be not Medically Necessary only if the Member, or lawfully authorized representative thereof, consents in writing to be responsible for the payment of the specific medical services prior to the rendition of the services.
- (14) Not bill BCBSSC, Associate Plan or the Member separately for an item or Covered Service that is considered by BCBSSC to be an integral part of another item or Covered Service.
- (15) Not bill BCBSSC, Associate Plan or the Member for Serious Reportable Adverse Event(s) ("Never Event") which have been identified by the National Quality Forum and for which CMS has issued a final specific National Coverage Determination policy to not cover services related to the Never Event. BCBSSC has the right to recover any payment made in error related to Never Events.
- (16) Reimburse BCBSSC or the Associate Plan for any payment made for services determined not to be payable hereunder. Provided, however, to the extent Preferred Provider is required to reimburse the Member and does reimburse the Member under a coordination of benefits provision of a Member's health plan other than the Benefits Contract, Preferred Provider is not required to reimburse BCBSSC or Associate Plan. If Preferred Provider does not reimburse BCBSSC or Associate Plan for any payment made for services determined not to be payable, then BCBSSC may offset future payments to Preferred Provider (whether resulting from claims related to the same Member or other Members) by the amount of the refund due.
- (17) Maintain active state licensure in the state in which Preferred Provider practices.
- (18) Certify to BCBSSC that Preferred Provider is fully covered by a medical malpractice policy in accordance with BCBSSC's relevant credentialing requirements.
- (19) Allow BCBSSC to use Preferred Provider's name to inform HIX Members and potential Members that Preferred Provider is a HIX Network Provider.
- (20) Upon written request of the United States Secretary of Health and Human Services or Comptroller General or any other governing bodies or any of their duly authorized representatives, make available those contracts, books, documents and records necessary to verify the nature and extent of the cost of providing services. Such inspection shall be available up to four years after the rendering of such services. If Preferred Provider carries out any of the duties of this Agreement through a subcontract with a value of \$10,000.00 or more over a 12 month period with a related individual or organization Preferred Provider will include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of Section 1861 (v)(1) of the Social Security Act and the regulations relating to it.
- (21) Use BCBSSC HIX network laboratories for reference lab work for Members.

## **V. RELATIONSHIP BETWEEN THE PARTIES.**

- A. Nothing in this Agreement should be construed as an attempt by BCBSSC to abridge, alter or interfere with any HIX Network Provider's physician-patient relationship. Any and all medical service decisions, treatment decisions

or exercises of medical judgment are Preferred Provider's responsibility, and BCBSSC shall not be deemed liable for any such decisions or exercise of judgment in any manner.

- B. Preferred Provider is an independent contractor. This Agreement shall not be construed or deemed to create an employer-employee relationship, a joint venture, or a principal-agent relationship between BCBSSC and Preferred Provider or any Network Provider.
- C. BCBSSC may in its discretion, establish, develop, manage and market other provider networks in which Preferred Provider may not be selected to participate.

## **VI. TERM, TERMINATION AND AMENDMENT.**

- A. TERM. This Agreement shall be effective on the Effective Date and shall continue for an Initial Term expiring on December 31, 2015 ("Initial Term"). Thereafter, the Agreement shall be automatically renewed for successive one-year terms (each, a "Renewal Term") on the day immediately following the expiration date of such Initial Term and on each anniversary of such date thereafter, unless sooner terminated as hereinafter provided.
- B. TERMINATION
  - (1) Either BCBSSC or Preferred Provider may terminate this Agreement, with or without cause, by giving written notice at least one hundred twenty (120) days prior to the expiration of any term as described in Article VI (A) with termination to be effective at the end of the term.
  - (2) BCBSSC may terminate this Agreement for cause upon thirty (30) days prior written notice, for the following reason:
    - (a) Failure to abide by the terms specified in this Agreement (e.g. Preferred Provider fails to use other HIX Network Providers when available).
  - (3) BCBSSC shall have the right to terminate this Agreement for cause, immediately and without prior notice, upon actual notice to BCBSSC of significant deficiencies in licensing or qualification matters including but not limited to the following reasons (in the event the deficiency applies to individual practitioners of Preferred Provider as opposed Preferred Provider as a whole then termination shall be limited to the applicable individual practitioner):
    - (a) Loss of license required for professional practice;
    - (b) Preferred Provider is convicted of a felony;
    - (c) Preferred Provider loses or otherwise fails to maintain all certificates(s), registration(s), or additional licensure(s) required for professional practice;
    - (d) Preferred Provider misrepresents Preferred Provider's competence or professional capabilities; or
    - (e) Preferred Provider misrepresents or fails to disclose any requested credential information or otherwise fails to meet ongoing credentialing or re-credentialing criteria; or
    - (f) Preferred Provider changes affiliation from a HIX Network Provider to a professional association that does not participate in the HIX Network. It is Preferred Provider's

responsibility to notify BCBSSC's Provider Contracting and Reimbursement Department at least thirty (30) days in advance of such a change; or

- (g) Preferred Provider files for the protection of the Bankruptcy Court or is involuntarily placed in bankruptcy or has a receiver appointed to manage Preferred Provider's affairs.
- (4) Nothing contained in this Article VI (B) shall impose on BCBSSC any duty to monitor Preferred Provider's performance under this Agreement, the quality of care provided by Preferred Provider or Preferred Provider's physical or mental condition or Preferred Provider's behavior. BCBSSC expressly disclaims any such duty. BCBSSC may monitor or may decline to monitor such performance in its sole discretion.
- (5) As of the date of termination, this Agreement shall be of no further force or effect whatsoever for services rendered thereafter and each of the parties shall be relieved and discharged from the requirements of this Agreement, except that:
  - (a) The parties shall complete any arbitration proceedings initiated pursuant to this Agreement, including requests for arbitration of disputes arising between the parties after the effective date of termination.
  - (b) Notwithstanding termination, and without cost to BCBSSC, BCBSSC shall continue to have access to Preferred Provider's records for three (3) years, to the extent permitted by law and as necessary to fulfill the terms of this Agreement and legal requirements.
  - (c) Preferred Provider agrees to complete the course of treatment for all Members that have begun a course of treatment by the date of termination notice, even if the course of treatment is completed after the date of termination. Both parties agree to honor the terms of this Agreement for the completion of such courses of treatment.
  - (d) The requirements of Article IX (K) shall remain in full force and effect.

- C. AMENDMENT. This Agreement may be amended by BCBSSC following ninety (90) days prior written notice effective at the end of such ninety (90) day period. If Preferred Provider does not accept the terms of the amendment, Preferred Provider may terminate this Agreement by providing written notice within thirty (30) days of the receipt of such proposed amendment. Termination shall be effective at the end of the ninety (90) day period provided by BCBSSC. Notwithstanding the foregoing, any changes to applicable federal and state laws or regulations that may be enacted during the term of this Agreement shall be automatically incorporated into this Agreement as they become effective.

## **VII. ASSIGNMENT.**

- A. ASSIGNMENT OF AGREEMENT. Neither party may assign their rights or duties under this Agreement without the prior written consent of the other party, which consent shall not be unreasonably withheld.
- B. ASSIGNMENT OF COVERED SERVICES. BCBSSC may, from time to time, contract with Associate Plans for the purpose of allowing such Associate Plans to avail themselves of the same access to the benefits of this Agreement and related rights as BCBSSC and binding such persons to the payment responsibilities under this Agreement. Preferred Provider agrees to provide Covered Services to Associate Plans Members under the terms of this Agreement and to look to each Associate Plan for reimbursement for Covered Services rendered to that Associate Plan's Members. Such Associate Plans shall not be required to provide for electronic claims transmission for the use of Preferred Provider in filing claims, however, BCBSSC will encourage the use of electronic claims transmission systems by Associate Plans. The duties and obligations of Associate Plans under this Agreement are several and distinct from BCBSSC's duties and obligations under this Agreement and

BCBSSC does not guarantee any Associate Plan's performance under this Agreement and BCBSSC will not be responsible for any Associate Plan's actions. Except for references to BCBSSC under Articles V, IV, VIII, and IX, references to BCBSSC shall be deemed to refer to Associate Plans with respect to such Associate Plan's duties and obligations under this Agreement and with respect solely to such Associate Plan's Members.

### **VIII. LIABILITY AND INDEMNITY.**

- A. Preferred Provider agrees to indemnify, defend and hold BCBSSC harmless from any and all liability, loss, damage, claim or expense of any kind (including all costs and reasonable attorneys' fees), which results from any breach of this Agreement by Preferred Provider or which results from the negligent or willful acts or omissions by Preferred Provider, its agents or employees regarding the duties and obligations of Preferred Provider under this Agreement, including the duty to maintain the legal standard of care applicable to Preferred Provider. Such obligation to indemnify, defend and hold harmless shall not apply to any matters resulting from negligent or willful acts or omissions of BCBSSC or its agents or employees.
- B. BCBSSC agrees to indemnify, defend and hold Preferred Provider harmless from any and all liability, loss, damage, claim or expenses of any kind (including all costs and reasonable attorneys' fees), which results from any breach of this Agreement by BCBSSC or results from the negligent or willful acts or omissions by BCBSSC, its agents or employees regarding the duties and obligations of BCBSSC under this Agreement. Such indemnification and hold harmless shall not apply to any matters resulting from negligent or willful acts or omissions of Preferred Provider or its agents or employees.

### **IX. MISCELLANEOUS.**

#### **A. PARTIES TO THE AGREEMENT.**

- (1) Preferred Provider expressly acknowledges its understanding that this Agreement constitutes a contract between Preferred Provider and BCBSSC, and that BCBSSC is an independent corporation operating under a license with the Association, permitting BCBSSC to use the Blue Cross and Blue Shield Service Mark in the State of South Carolina, and that BCBSSC is not contracting as the agent of the Association.
- (2) Preferred Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than BCBSSC and that no person, entity, or organization other than BCBSSC (and other than Associate Plans by virtue of Article VII) shall be held accountable or liable to Preferred Provider for any of BCBSSC's obligations to Preferred Provider created under this Agreement. This Article IX (A) shall not create any additional obligations whatsoever on the part of BCBSSC other than those obligations created under other provisions of this Agreement.

- B. ORIGINALS/COPIES OF THE AGREEMENT. BCBSSC may image this Agreement, related documents and credentials. An imaged copy of this Agreement, related documents and credentials shall be as effective and valid as the original.
- C. USE OF DOCUMENTS. Preferred Provider agrees that BCBSC may allow the documents and credentials referenced in this Agreement to be used by any and all subsidiary networks managed by BCBSSC.
- D. NON-EXCLUSIVITY. Preferred Provider and BCBSSC agree and acknowledge that this is a non-exclusive contract and that either party is free to contract with other parties to provide the services contemplated under this Agreement.
- E. WAIVER OF BREACH. Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision.

- F. SEVERABILITY. In the event any provision of this Agreement is rendered invalid or unenforceable by any federal statute or state law, or by any regulation duly promulgated by officers of the United States or the State of South Carolina in accordance with law, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of this Agreement shall remain in full force and effect.
- G. EFFECT OF SEVERABLE PROVISION. In the event that a provision of this Agreement is rendered invalid or unenforceable or declared null and void as provided in Article IX (F) and its removal has the effect of materially altering the obligations of either party in such manner as in the judgment of the party affected: (1) will cause serious financial hardship to such party; or (2) will cause such party to act in violation of its corporate Articles of Bylaws, the party so affected shall have the right to terminate this Agreement upon thirty (30) days prior written notice to the other party. The applicable provisions of Article VI shall apply to such termination.
- H. PROHIBITION AGAINST PAYMENT OF MEMBERS HEALTH PLAN PREMIUMS. Preferred Provider shall not pay any amount toward health plan premiums or health insurance premiums of any Members, except for its eligible employees and retirees under its own employee welfare benefit plan.
- I. HEADINGS. The headings of Articles and Sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.
- J. GOVERNING LAW. This Agreement shall be construed and enforced in accordance with the laws of the State of South Carolina.
- K. CONFIDENTIALITY.
- (1) Preferred Provider acknowledges and agrees that in the course of obtaining this Agreement it has received, and may continue to receive, BCBSSC's valuable trade secrets, confidential, and proprietary information (collectively referred to as "Confidential Information"), including the reimbursement terms and the terms of this Agreement and any and all records required to be produced or kept under the terms of this Agreement. Preferred Provider further acknowledges that the use of Confidential Information would give Preferred Provider an unfair competitive advantage were Preferred Provider to directly or indirectly compete with BCBSSC for BCBSSC's existing customers, and disclosure of Confidential Information would cause harm to BCBSSC.
  - (2) In consideration of the disclosure by BCBSSC to Preferred Provider of Confidential Information, Preferred Provider agrees to treat the Confidential Information supplied to it by BCBSSC in strict confidence, and to undertake the following additional obligations with respect thereto:
    - (a) to use Confidential Information for the sole purpose of performing its obligations under this Agreement;
    - (b) not to disclose Confidential Information to any person outside of its organization except as needed to comply with Preferred Provider's obligations under this Agreement;
    - (c) to limit dissemination of Confidential Information to only those of its employees who have a need to know to perform the limited tasks set forth in this Agreement;
    - (d) ensure that any pricing disclosed to its billing company, attorneys, CPAs, etc. is not disclosed to any other provider or other organization. Any violation of Confidentiality by such person or entity will be considered the same as if Preferred Provider committed such violation; and
    - (e) to return Confidential Information and all documents, notes or physical evidence thereof to BCBSSC upon termination of this Agreement.

- (3) The restrictions and obligations of this Article IX (K) shall survive any expiration, termination or cancellation of this Agreement and shall continue to bind Preferred Provider, its successors and assigns.
- (4) Preferred Provider acknowledges that if Preferred Provider breaches the terms of this Article IX (K), BCBSSC shall be entitled to seek monetary damages against Preferred Provider. Additionally, Preferred Provider acknowledges that if Preferred Provider breaches this Article IX (K), such monetary damages may not be a sufficient remedy for such breach and that BCBSSC shall be entitled, without waiving any other rights or remedies, to injunctive or equitable relief as may be deemed proper by a court of competent jurisdiction.

L. ENTIRE AGREEMENT. This Agreement, including all written supplements, exhibits, and amendments hereto constitutes the entire agreement of the parties hereto with respect to HIX-related services. No verbal agreement or conversation of the parties hereto shall affect or in any way modify any of the terms and conditions herein contained. Notwithstanding the foregoing, any existing agreements between the parties which are not related to HIX-related services shall remain in full force and effect.

M. DISPUTE RESOLUTION.

- (1) Except for decisions made pursuant to the Utilization Management Program, BCBSSC and Preferred Provider 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, other than a Utilization Management Program decision (which resolution shall be governed by the terms of Appendix A), BCBSSC and Preferred Provider 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 Columbia, South Carolina. The Arbitrator shall not have authority to re-write this Agreement between the parties, but rather, is bound to follow legal contract construction rules to render any decision. The arbitrator is prohibited for awarding any punitive, special or consequential damages. The arbitrator's determination shall be final and binding upon the parties. The parties agree to bear their own costs and fees relating to the arbitration and agree to equally share the arbitrator's fees and costs. By entering into this Agreement and selecting arbitration as a dispute resolution mechanism the parties waive any right to jury trial.

**IN WITNESS WHEREOF**, each of the undersigned parties to this Group Preferred Provider Agreement has caused this Group Preferred Provider Agreement to be duly executed.

BLUECROSS BLUESHIELD  
OF SOUTH CAROLINA

ACS Emergency Physicians of SC, PC  
ACS Primary Care Physicians SE, PC

 9/10/14  
By: J. Lance Lockman Date  
Its: Assistant Vice President,  
Professional Network Management

 9/10/14  
Authorized Signature of Preferred Provider / Date

Effective Date  
(Established by BCBSSC)

**APPENDIX A****UTILIZATION MANAGEMENT PROGRAM**

The Utilization Management Program is a series of activities carried out by BCBSSC to ensure that the Covered Services that are provided to Members are Medically Necessary. These activities consist of pre-certification of admissions and length of stay and pre-certification of selected medical and surgical procedures. The Utilization Management Program also involves a review of ongoing admissions and may involve the retrospective review of admissions for appropriateness and Medical Necessity. The Utilization Management Program may also involve case management of all Covered Services provided to Members who are severely ill with long-term chronic conditions. In the event that the Preferred Provider fails to follow the requirements of the Utilization Management Program or any authorization requirements listed in the Provider Office Administrative Manual, BCBSSC reserves the right to withhold all or a portion of the payment for otherwise Covered Services which may not be billed to Member.

- A. Preferred Provider and BCBSSC hereby agree:
- (1) To avoid unnecessary or unduly costly Covered Services for Members;
  - (2) To ensure that all Members receive the appropriate and necessary level of Covered Services in accordance with community standards for care and such Members Benefits Contract;
  - (3) To maintain professional standards in the delivery of health care within the meaning of Section 40-71-10 Code of Laws of South Carolina, 1976 as amended.
- B. The Utilization Management Program will be conducted by BCBSSC. Payment to Preferred Provider may be denied when it is determined that such Covered Services were not Medically Necessary or where Preferred Provider fails to follow the Utilization Management Program's procedures. Preferred Provider will not bill a Member for charges for Covered Services where Preferred Provider fails to follow the Utilization Management Program procedures.
- C. When service evaluation is requested by BCBSSC or Associate Plan, Preferred Provider will use its best efforts to ensure that all Preferred Provider's relevant records and those of Preferred Provider's facility, if applicable, be made available to BCBSSC upon reasonable notice.
- D. The requirements of the Utilization Management Program must be followed for all Covered Services rendered to Members. The Utilization Management Program includes: Pre-Admission Reviews, Emergency Admission Reviews, Outpatient Reviews and Continued Stay Reviews. Preferred Provider or the admitting HIX Network Provider must request each type of review. Each specific type of review is subject to the following additional requirements:
- (1) Pre-Admission Review. A Pre-Admission Review and authorization is required prior to all non-Emergency admissions. Preferred Provider will cooperate with other HIX Network Providers in connection with a Pre-Admission Review, including providing any necessary clinical information relating to a Member's proposed admission.
  - (2) Emergency Admission Reviews. An Emergency Admission Review and authorization is required for all Emergency admissions. BCBSSC or Associate Plan must be notified within twenty-four (24) hours of the Emergency admission, or by noon of the next working day if the

admission is on Friday, Saturday, Sunday or a holiday. Preferred Provider will cooperate with other HIX Network Providers in connection with an Emergency Admission Review, including providing any necessary clinical information relating to a Member's proposed admission.

- (3) Continued Stay Review. Each approved admission of a Member is contemplated to last a particular number of days. Accordingly, each admission will be assigned a specific number of days at the time of approval of the admission. Additional days are subject to a Continued Stay Review and approval by BCBSSC. Preferred Provider will cooperate with other HIX Network Providers in connection with a Continued Stay Review, including providing any necessary clinical information relating to a Member's proposed continued stay.
  - (4) Outpatient Review. Elective outpatient surgical procedures may be subject to an Outpatient Review and authorization that must be obtained at least three (3) days prior to applicable procedures.
- E. BCBSSC or Associate Plan shall not pay for services that are determined through the Utilization Management Program to be not Medically Necessary or which are not Covered Services. Unless a Member has agreed, in writing, to be personally responsible for such specified Covered Services, Preferred Provider agrees not to bill any Member for services determined through the Utilization Management Program to be not Medically Necessary. In the event Preferred Provider successfully appeals a Utilization Management Program decision in accordance with this Appendix, BCBSSC or Associate Plan shall accept Preferred Provider's bill and make payment pursuant to the terms of the Agreement.
  - F. Preferred Provider may appeal a Utilization Management Program decision by requesting consideration by the BCBSSC Medical Director. Any request for appeal shall be made to the BCBSSC Medical Director in writing within sixty (60) days following receipt of the Utilization Management Program's written decision. A complete medical record should accompany any request for an appeal. The decisions of the BCBSSC Medical Director shall be final and binding on the parties except for the following:  
  
Upon request of Preferred Provider, the BCBSSC Medical Director may (at his/her discretion) agree to submit the appeal to an external review party. The external review shall be conducted by a physician of the same or similar specialty of the requested service. For appeals that are submitted for external review Preferred Provider and BCBSSC agree that the decision of the external review shall be final and binding on the parties.
  - G. Preferred Provider and BCBSSC agree that each shall be responsible for their own costs incurred in the appeal of any Utilization Management Program determination.

STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

COUNTY OF HORRY

C/A no. 2020-CP-26-01982

Jessica Bennett, individually and on  
behalf of those similarly situated,

Plaintiff,

v.

ACS Primary Care Physicians-Southeast  
P.C.,

Defendant.

---

**PLAINTIFF'S RESPONSE IN OPPOSITION TO DEFENDANT'S MOTION TO  
COMPEL ARBITRATION AND DISMISS OR STAY**

---

Defendant ACS Primary Care Physicians-Southeast P.C. (ACS) moves to stay / dismiss this action and compel arbitration of plaintiff's claims. Plaintiff opposes the motion.

The court must scrutinize ACS's motion keeping in mind there is a presumption against arbitration where the party opposing arbitration did not agree to, negotiate, or sign the agreement, as is the case here. Bearing that in mind, ACS's motion fails for a number of reasons. First, plaintiff's claims do not fall within the scope of the arbitration provision here. Second, South Carolina law reverse preempts the Federal Arbitration Act (FAA) and prohibits the arbitration of claims brought by a beneficiary involving insurance benefits. Third, the arbitration agreement is rendered unenforceable by the arbitration provision's selected forum's unavailability to arbitrate this dispute. Last, the arbitration provision is unenforceable as to plaintiff, a nonsignatory to the agreement, because ACS cannot show it is entitled to equitable estoppel under South Carolina law.

## **I. Procedural history**

Plaintiff, individually and on behalf of those similarly situated, initiated this action on March 17, 2020. ACS removed the case to the United States District Court for the District of South Carolina on April 20, 2020. Plaintiff moved to have the matter remanded to this Court. After consideration of plaintiff's motion, Judge Bryan Harwell remanded the action on August 13, 2020. ACS then filed the present motion to compel arbitration.

## **II. Factual history and nature of the claims**

Defendant ACS provides professional medical services in various locations, including at a number of medical facilities in South Carolina.<sup>1</sup> On or around November 18, 2017, ACS contracted with Blue Cross Blue Shield of South Carolina (BCBSSC) to become a preferred provider within the BCBS preferred provider organization (PPO), a network of hospitals and medical practices marketed to BCBS's insured members as "preferred providers." In order to be a part of that network, ACS agreed to bill BCBS directly for covered medical services provided to BCBS's insured members. ACS also agreed to accept a discounted rate from BCBS for those covered services.

Specifically, the PPO agreement provides that ACS "shall: Accept payment of [BCBS's] Fee Allowance amount plus any Patient Pay Amounts as payment in full for Covered Services rendered to Members." Ex. A – PPO agreement at p.4, § IV(A)(1). The PPO agreement requires ACS to file claims directly with BCBS for covered services to insured members within a certain time and prohibits ACS from billing the insured member

---

<sup>1</sup> ACS primarily staffs emergency room providers for hospital systems. Instead of the doctor being employed by the hospital, the physician is employed by ACS, and ACS contracts with the hospital for those physicians' services. These third party staffing agreements are likely unknown to the vast majority of patients receiving medical care from an ACS physician within a hospital, as was the case with Jessica Bennett.

directly or for claims filed outside of the filing time limit. *Id.* at p.5, § IV(A)(11). Importantly, the PPO agreement requires ACS to accept payment for covered services rendered to insured members according to the fee allowance and “subject to the terms of the Member’s Benefit Contract.” *Id.* at p.4, § IV(A)(1).

On December 14, 2018, Ms. Bennett sustained injuries as a result of a car crash. On December 16, 2018, Bennett was treated by ACS physicians during an admission to the Mary Black Memorial Hospital’s emergency department in Spartanburg. At the time, Ms. Bennett was an insured member and beneficiary under a BCBS health insurance plan. While admitted, Bennett provided her BCBS insurance information to ACS. Despite this, ACS failed to bill BCBS directly for Bennett’s covered care, opting instead to bill Bennett directly for an amount in excess of the BCBS fee allowance for the covered service. The net effect is that ACS seeks to recover more money from Bennett than what ACS agreed to accept from BCBS, Bennett’s insurer. This suit followed.

Bennett alleges two causes of action. First, Bennett alleges ACS is in breach of its agreement with BCBS to accept her health insurance benefits for services provided to her. Second, Bennett alleges unjust enrichment and equity as a result of ACS’s scheme to circumvent Bennett’s health insurance in order to increase ACS’s reimbursement rate for medical services provided to Bennett.

After unsuccessfully seeking to remove the case to federal court, ACS now seeks to bind Bennett to an arbitration provision contained in the PPO agreement between ACS and BCBS. There is no dispute that Bennett is not a party or signatory to the PPO agreement. Nor was Bennett involved in the negotiation of that agreement. And the

arbitration provision itself does not contemplate the resolution of claims brought by anyone outside of BCBSSC and ACS:

(1) Except for decisions made pursuant to the Utilization Management Program, BCBSSC and Preferred Provider [ACS] 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 . . . BCBSSC and Preferred Provider [ACS] 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.

Ex. A, p.11, § IX(M) (emphasis added). Importantly, the above provision mandates that the American Arbitration Association “shall appoint” one of its arbitrators to hear the matter.

ACS argues this matter should be sent to arbitration because plaintiff, a non-signatory to the agreement containing the arbitration provision, is a third-party beneficiary of the agreement and should be equitably estopped from denying the application of the arbitration provision to her claims. ACS is wrong. The arbitration provision is void *ab initio* and unenforceable for three reasons: (1) Bennett's claims clearly fall outside of the provision's scope; (2) South Carolina law prohibits the arbitration provision at issue; and (3) the arbitration provision is rendered unenforceable by the selected forum's unavailability. Even if the provision survived these three fatal flaws, ACS cannot meet

the elements required to equitably estop Bennett from avoiding application of the arbitration provision. ACS's motion must be denied.

Finally, it is worth nothing this is not an isolated event. ACS's efforts to take advantage of motor vehicle crash victims who receive emergency medical care from ACS physicians by ignoring its contractual obligations with BCBS is apparently widespread.<sup>2</sup> This scheme is as simple as it is inequitable. ACS seeks to recover more money from BCBS-insured accident victims by disregarding its fee allowance with BCBS. This is despite that in each case the victims suffer injuries requiring BCBS-covered emergency medical treatment. What's more is that these victims (as was the case with Ms. Bennett) have no knowledge of ACS until they receive a bill.<sup>3</sup> In light of this practice, the Court must view with great skepticism any argument for equity by ACS.

### **III. Legal analysis – Presumption *against* arbitration**

While arbitration is presumptively favored by our courts, that presumption usually rests upon an explicit agreement between parties to waive fundamental rights to access to our courts in favor of arbitration. See *E.E.O.C. v. Waffle House, Inc.*, 534 U.S. 279, 294 (2002) (arbitration under the FAA "is a matter of consent, not coercion" (citation omitted)); *Arrants v. Buck*, 130 F.3d 636, 640 (4th Cir. 1997) ("Even though arbitration has a favored place, there still must be an underlying agreement between the parties to arbitrate."); *Zabinski v. Bright Acres Assocs.*, 346 S.C. 580, 596 (2001) ("Arbitration is a

---

<sup>2</sup> See *Gasser v. ACS Primary Care Physicians Southeast, PC*, 2020-CP-26-03169, Horry County Common Pleas (filed June 26, 2020) (alleging similar facts as to ACS).

<sup>3</sup> In the case of Jessica Bennett, she thought she was treated by a Mary Black Hospital emergency medicine physician. At no point prior to her receiving her medical bill was she aware of ACS's existence.

matter of contract, and a party cannot be required to submit to arbitration any dispute which he has not agreed to submit.").

That presumption does not apply here because of Bennett's nonsignatory status. Bennett never consented to arbitration and is not a party or signatory to the PPO agreement. Thus, "a presumption *against* arbitration arises where the party resisting arbitration is a nonsignatory to the written agreement to arbitrate." *Wilson v. Willis*, 426 S.C. 326, 337-38 (2019) (emphasis in original). As such, whether an arbitration provision is enforceable against a nonsignatory is an issue controlled by South Carolina law. *Id.* at 338.

Assuming its arbitration provision to be valid and enforceable, ACS advances but one theory for binding Bennett to the arbitration provision between ACS and BCBSSC: equitable estoppel. See ACS motion to compel at p.5-6. Under South Carolina it is axiomatic that one who "seeks equity must do equity." *Norton v. Matthews*, 249 S.C. 71, 80 (1967). Here, ACS not only fails to meet the basic elements of equitable estoppel but, by its conduct, seeks to deprive Bennett the benefit of her health insurance (and access to this Court) to advance ACS's pecuniary interests. ACS is not entitled to equity.

In any event, this Court can dispatch with ACS's motion without resort to equity because the arbitration provision is, by law, unenforceable as to Bennett. But, to be sure, ACS is not entitled to the exceptional and rare remedy of equity on these facts.

**A. The arbitration provision fails because its scope does not encompass this dispute and its condition precedent was not met**

To compel Bennett to arbitrate her claims, ACS must demonstrate that (1) the arbitration provision is valid; and (2) the claims fall within the scope of the provision. See

*Weaver v. Brookdale Senior Living, Inc.*, App. Case no. 2017-002241, 2020 WL 4342679, at \*1 (S.C. 2020).

Before addressing the invalidity of the arbitration provision, it is clear that the scope of the provision does not encompass this claim. While it is true that doubts about the scope of arbitration provisions are resolved in favor of arbitration, it should not be compelled where, as here, "the arbitration clause is not susceptible to an interpretation that covers the dispute..." *Zabinski*, 346 S.C. at 597.

The arbitration provision here only contemplates arbitration of "problems or disputes" that arise under the agreement between two explicit entities: BCBSSC and ACS. Moreover, there is a condition precedent that must be met prior to arbitration: BCBSSC and ACS must first meet and confer in a good faith and attempt to resolve their dispute. See Ex. A, p.11, § IX(M).

This is significant for two obvious reasons. Bennett, a nonsignatory, has no right (and did not agree) to participate in a pre-arbitration meet and confer. It is impossible for this condition precedent<sup>4</sup> to apply to Bennett, a non-party, because the provision explicitly contemplates a process involving only BCBSSC and ACS. Without meeting the condition precedent, the arbitration provision fails as to Bennett. See *Perdue Farms Inc. v. Design Build Contracting 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

---

<sup>4</sup> "A condition precedent to a contract is any fact other than the lapse of time, which, unless excused, must exist or occur before a duty of immediate performance arises." *M & M Group, Inc. v. Holmes*, 379 S.C. 468, 477 (S.C. App. 2008) (internal quotations / citations omitted). "If a contract contains a condition precedent, that condition must either occur or it must be excused before a party's duty to perform arises." *McGill v. Moore*, 381 S.C. 179, 187 (2009).

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 provision does not permit a third party, like Bennett, pre-arbitration dispute resolution rights. Rather, the arbitration provision is plainly limited to disputes that persist following such a conference between only BCBSSC and ACS. It does not require the arbitration of “any and all disputes arising under or relating to the agreement.” To the contrary, it limits itself solely to arbitration of BCBSSC and ACS’s disputes.

The import of that distinction is laid bare by reference to the *Pearson* case relied upon by ACS. In *Pearson*, the provision at issue required that “[a]ny controversy or claim arising out of or relating to the interpretation, enforcement or breach of this Agreement . . . shall be resolved by binding arbitration . . .” *Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 286 (S.C. App. 2012). Such broad language as seen in *Pearson*, encompassing any controversy or claim arising under the underlying contract, is the type whose scope is to be construed broadly in favor of arbitration. See *Landers v. Fed. Deposit Ins. Corp.*, 402 S.C. 100, 109 (2013). Similarly in *American Bankers Ins. Group, Inc. v. Long*, 453 F.3d 623 (4th Cir. 2006) (also cited by ACS), the provision at issue required “that any dispute, controversy or claim arising out of or in connection with, or relating to, any subscription of the Note, or any breach or alleged breach hereof” be subject to arbitration. *American Bankers Ins. Group, Inc.*, 453 F.3d 623, 625 (4th Cir. 2006). ACS also cites

*Wachovia Bank N.A. v. Schmidt*, 445 F.3d 762 (4th Cir. 2006) but, again, the provision there is broad requiring arbitration of "any claim or controversy arising out of, or relating to" the note at issue. *Wachovia Bank, Nat. Ass'n*, 445 F.3d 762, 766 (4th Cir. 2006).

The breadth of scope required by the cases is not present here. Each of the provisions in those cases include language requiring arbitration of "any" claims "arising from" or "**relating to**" the underlying agreements. And those provisions do not limit the provision to only disputes amongst the named parties.<sup>5</sup> None of the provisions at issue in those cases contain a condition precedent and none are narrowly limited to only disputes between two named entities, as is the case here. "A party cannot be compelled to arbitrate a particular dispute unless his agreement expressly encompasses the subject matter of the dispute." *Simmons v. Lucas & Stubbs Assocs.*, 283 S.C. 326, 332-33 (Ct. App. 1984).

By the omission of broad "relating to" language, the inclusion of a condition precedent in which only two named entities may participate, and the inclusion of only two, explicit entities permitted to participate (after the condition precedent is met), the scope of the provision "is not susceptible to an interpretation that covers" Bennett's claims. See *Zabinski*, 346 S.C. at 597. And, again, the decision to compel arbitration here must be analyzed keeping in mind that "a presumption *against* arbitration arises where the party resisting arbitration is a nonsignatory to the written agreement to arbitrate." *Wilson v. Willis*, 426 S.C. 326, 337-38 (2019).

---

<sup>5</sup> For example, the *Pearson* arbitration clause provides: "Any controversy or claim arising out of or relating to the interpretation, enforcement or breach of this Agreement or the relationship between the parties hereto shall be resolved by binding arbitration . . ." *Pearson*, 400 S.C. at 286.

ACS's motion can be denied on this basis alone. The arbitration agreement between ACS and BCBSSC simply does not encompass or permit arbitration of Bennett's claims.

**B. The arbitration provision violates the South Carolina Uniform Arbitration Act because it impermissibly seeks to arbitrate a claim involving insurance benefits**

In addition, the arbitration provision at issue is invalid under the S.C. Uniform Arbitration Act which provides that arbitration provisions do not apply to "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)).

This dispute centers on Bennett's attempt to receive the benefit of the health insurance for which she paid. ACS seeks to deny Bennett the benefit of her health insurance plan by circumventing BCBSSC's fee schedule in a scheme to receive a higher reimbursement directly from Bennett. One of ACS's core obligations under the provider 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 Bennett) with such payment being "subject to the terms of the Member's Benefits Contract" (Bennett's health insurance plan). Ex. A, p.4, § 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 BCBSSC's Members." *Id.* at p.1, § I(A).<sup>6</sup>

---

<sup>6</sup> "Members" is defined as "any individual who is covered under a Benefits Contract . . ." Ex. A, p.2, § II(M).

It is ACS's failure to bill BCBSSC, and failure to accept payment from BCBSSC, that results in Bennett losing 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).

To the extent ACS argues 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 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).

ACS may 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).

However, the relationship between the PPO agreement and Bennett's health insurance here is far from tangential. The PPO agreement is a promise by ACS to accept

BCBS patients and BCBS's payment of those patients' health insurance benefits. Moreover, ACS seeks to impose arbitration on Bennett who, through her claims, is seeking to enforce her rights to her health insurance benefits. This case more closely resembles *Rock v. Atl. Specialty Ins. Co.*, C/A no. 4:19-cv-01433-SAL, 2020 WL 1892193 (D.S.C. Apr. 16, 2020) which is instructive.

In *Rock*, the plaintiff sought to recover insurance benefits under a group occupational accident insurance policy arising from the death of her husband. The insurance policy at issue was a group policy issued to one Courier Industry Group Insurance Trust. In seeking to compel arbitration, the defendants relied upon an arbitration provision in a Certificate of Insurance issued to a participating organization. Judge Lydon notes in *Rock* that "the certificate describes the Policy *but is not, in-and-of-itself, the Policy*." *Rock*, 2020 WL 1892193, at \*1. The certificate itself noted that the policy was "the only contract under which benefit payments are made." *Id.*

Judge Lydon nonetheless found that the arbitration provision was invalid under a D.C. statute that renders void and unenforceable any "provision in an insurance policy with a consumer that requires binding arbitration." *Rock*, 2020 WL 1892193 at \*3. The court also noted that the result would be the same if S.C. Code Ann. § 15-48-10(b)(4) applied to the matter. *Id.* at n.4. Accordingly, the court analyzed the enforceability of the arbitration provision under the anti-arbitration statutes despite the fact the arbitration provision at issue was not contained in an insurance policy because the claims clearly involved the receipt or denial of insurance benefits. Such is the case at bar.

This is the correct approach where the underlying agreement and dispute involve entitlement to insurance benefits. There would be no purpose in having a PPO agreement

but for ACS's promise to accept health insurance payments by BCBS for care rendered to members like Bennett. The PPO Agreement repeatedly references BCBS's members' Benefits Contracts and ACS agrees to accept payment from BCBS "subject to the terms of the Member's Benefits Contract." Ex. A, p.4, § IV(A)(1).

Consider this: had ACS properly submitted Bennett's medical bills to BCBS and BCBS denied them, BCBS could not compel arbitration of a claim by Bennett for wrongful denial of benefits because § 15-48-10(b)(4) would prohibit it. Why then should ACS be exempted from the application of § 15-48-10(b)(4) when it is, in essence, doing the same thing -- denying Bennett 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 Bennett's health insurance. To the contrary, it depends upon it. As such, plaintiff must not be required to arbitrate her claims and S.C. Code Ann. § 15-48-10(b)(4) prohibits application of the arbitration provision at issue.

**C. The arbitration provision is unenforceable because the selected forum for arbitration is unavailable, rendering the provision void**

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 apply, but also that "The American Arbitration Association shall appoint an

arbitrator who is knowledgeable in the healthcare management field.” Ex. A, p.11, § 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.*”<sup>7</sup> 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.*

Ex. B, AAA Healthcare Due Process Protocol, at p.1 (emphasis added). The protocol goes on to discuss its 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.* at p.16 (emphasis added).

---

<sup>7</sup>See

[https://www.adr.org/sites/default/files/document\\_repository/AAA\\_Healthcare\\_Policy\\_Statement.pdf](https://www.adr.org/sites/default/files/document_repository/AAA_Healthcare_Policy_Statement.pdf) (last visited Sept. 25, 2020).

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.<sup>8</sup>

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*, 408 S.C. 371 (2014), 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.” *Dean*, 408 S.C. at 384. 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

---

<sup>8</sup> See [https://www.adr.org/sites/default/files/Consumer\\_Rules\\_Web\\_1.pdf](https://www.adr.org/sites/default/files/Consumer_Rules_Web_1.pdf) (last visited September 25, 2020); see also AAA Rule R-2 for Commercial Disputes: <https://www.adr.org/sites/default/files/Commercial%20Rules.pdf> (last visited September 25, 2020).

AAA administration. This was the factor that caused the Supreme Court to distinguish the arbitration provision in *Dean* from the one in *Grant*.

In *Grant*, the arbitration provision at issue required that the arbitration be “administered by the National Health Lawyers Association.” 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. *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 Bennett in that the arbitration provision at issue mandates the AAA “shall” select the arbitrator. See Ex. A, p.11, § 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 Bennett 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.

**D. Equitable estoppel cannot be used to compel Bennett to arbitrate her claims**

If ACS can demonstrate the arbitration provision is enforceable, its only argument for application as to Bennett is equitable estoppel. And a presumption against arbitration applies because Bennett did not sign, negotiate, or agree to the provision at issue. See *Wilson v. Willis*, 426 S.C. 326, 337-38 (2019) (presumption against arbitration applies when enforcement sought against nonsignatory). Bennett has never agreed to waive her rights to a jury trial or to bring this action on behalf of others.

Equitable estoppel is “a theory designed to prevent injustice, and it should be used sparingly.” *Wilson*, 426 S.C. at 601; 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).

Importantly, 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.* None are present here as Bennett played no role in the formation of the underlying agreement and has done nothing to mislead ACS in any way.

ACS does not attempt to meet any of the traditional requirements of estoppel. Nor does it point to any South Carolina authority for the proposition that these traditional state law principles should be divorced from the analysis here. ACS’s motion refers solely to “direct benefits” estoppel, but that doctrine is a creature of federal substantive law. ACS must also meet the traditional elements of estoppel under South Carolina law in order to use it as a sword here. This they cannot do because Bennett has not misled or prejudiced ACS in any way.

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. *Thompson*, 416 S.C. at 60. This is the correct approach.

Our Supreme Court in *Wilson* agreed, holding state law governs this issue. *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<sup>9</sup>, 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).<sup>10</sup>

It was error for the Court of Appeals in *Pearson and Wilson v. Willis*, 416 S.C. 326 (Ct. App. 2016) (*reversed by Wilson v. Willis*, 426 S.C. 326 (2019)) to apply the federal direct benefits estoppel test in favor of, or without also applying, South Carolina's traditional equitable estoppel test. And as set forth above, ACS cannot meet the latter test as there is no evidence of conduct by Bennett as to ACS "which amounts to a false representation or concealment of material facts" made with intent to deceive. Bennett did not know about the PPO Agreement. All she knew is that ACS charged her directly instead of filing the claims with her health insurance plan. Now, ACS seeks to deprive Bennett both the benefit of her health insurance and her right to access to the courts and a jury trial.

---

<sup>9</sup> *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).

<sup>10</sup> Note the lack of knowledge in this case is even greater, as Jessica Bennett had no knowledge that an ACS physician was even treating her, much less that ACS could compel her to arbitrate these claims after ACS's actions deprived her the benefit of her health insurance.

Even assuming the federal “direct benefits estoppel” is the sole test to apply, ACS cannot meet its burden here either. Direct benefits estoppel “is not implicated simply because a claim relates to or would not have arisen ‘but for’ a contract’s existence.” *Weaver*, 2020 WL 4342679, at \*2 (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.”). Neither is present here.

The direct benefit Bennett seeks is under her health insurance plan with BCBSSC for which she pays premiums in exchange for coverage of medical expenses. The benefit to Bennett is the reduced cost of medical services which flows from her insurance plan. A major incentive for the purchase of health insurance is to ensure an unforeseen medical emergency does not financially overwhelm an insured. Unfortunately, Bennett was in an automobile crash that required her to seek emergency medical care at a local hospital. Later she received a bill directly from ACS for the full retail cost of its emergency medical

care. Prior to receipt of that bill, Bennett knew nothing of ACS or its PPO agreement with BCBSSC. Bennett can hardly be said to have “knowingly exploited” or “knowingly accepted” a benefit under the PPO Agreement. Rather, ACS is knowingly exploiting Bennett’s status as an automobile crash victim in order to seek a higher rate for its services – despite its promise to BCBSSC to bill Bennett’s health plan and accept the fee allowance amount.

This is a classic indirect benefit. To be sure, Bennett seeks a benefit from the contractual relationship between BCBSSC and ACS, but only to the extent that ACS uphold its obligations as to BCBS. Restated, if ACS does not bill and accept payment from BCBS, Bennett cannot receive the benefit under her health insurance with BCBS. Thus far she has received no benefit at all under any agreement. Bennett cannot force BCBSSC to take action against ACS for failing to file the claims with BCBS. And this is not *Pearson* -- Bennett is not an ACS physician seeking BCBS’s preferred provider status under the PPO agreement. Any benefit to Bennett under the PPO agreement is indirect as the ultimate benefit flows to Bennett through her health insurance contract. The ACS agreement only establishes the condition precedent (ACS billing BCBS), all of which is incidental to ACS’s effort to be included in the BCBS physician network.

The estoppel ACS seeks “is not implicated simply because a claim relates to or would not have arisen ‘but for’ a contract’s existence.” *Weaver*, 2020 WL 4342679, at \*2 (quoting *Wilson*, 426 S.C. at 343). The direct benefit for any BCBSSC insured is reduced health care costs under their health insurance plan, regardless of the medical services provider. To compel Bennett to arbitrate her claim would incentivize all BCBSSC preferred providers to refuse to bill BCBSSC 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, nondiscounted rate.

As mentioned previously, estoppel in this context should apply only in rare circumstances to “prevent injustice,” *Wilson*, 426 S.C. at 601, and to ensure the party seeking estoppel is not “misled to his injury,” *S.C. Pub. Serv. Auth.*, 275 S.C. at 554. To permit ACS to force arbitration of Bennett’s claims, which ACS invited by its greed, would be unjust. Particularly where Bennett did not agree to give up her rights to access to this Court and has not knowingly exploited or knowingly accepted any benefit of the agreement between BCBSSC and ACS.

As such, the court must deny ACS’s motion for this reason as well.

#### **IV. Conclusion**

For these reasons, ACS cannot show that the arbitration provision is valid and enforceable or that it is entitled to equitable estoppel in order to compel arbitration of Bennett’s claims. As such, ACS’s motion should be denied.

Respectfully submitted,

**RICHARDSON PATRICK WESTBROOK  
& BRICKMAN, LLC**

By: s/Chris Moore

Chris Moore (cmoore@rpwb.com)  
Will Lewis (wlewis@rpwb.com)  
1513 Hampton Street  
Columbia, South Carolina 29201  
T: 803.541.7850

September 30, 2020.

**Attorneys for Jessica Bennett**

THIS INDIVIDUAL PROFESSIONAL AGREEMENT IS SUBJECT TO ARBITRATION PURSUANT TO THE SOUTH CAROLINA UNIFORM ARBITRATION ACT. HOWEVER, THE ARBITRATION PROCEDURES FOR DISPUTES REGARDING UTILIZATION MANAGEMENT ARE GOVERNED BY THE ARBITRATION PROVISIONS CONTAINED IN APPENDIX A OF THIS AGREEMENT AND NOT BY THE UNIFORM ARBITRATION ACT.



# INDIVIDUAL PREFERRED PROVIDER AGREEMENT

®Registered mark of the Blue Cross and Blue Shield Association

1/15/08  
PREFERRED BLUE (INDIVIDUAL)

EXHIBIT  
A

**INSTRUCTIONS:**

**EACH PROVIDER IN A PRACTICE GROUP, PARTNERSHIP OR CORPORATION MUST INDIVIDUALLY SIGN A INDIVIDUAL PROFESSIONAL AGREEMENT AND SUBMIT A FULLY COMPLETED APPLICATION INCLUDING ALL REQUIRED ATTACHMENTS IN ORDER FOR BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA TO BEGIN PROCESSING YOUR APPLICATION. USE THE FOLLOWING CHECKLIST TO ENSURE YOUR APPLICATION IS COMPLETE.**

**CHECK LIST**

**EACH PROVIDER** in a Practice Group, Partnership or Corporation must individually:

- \_\_\_\_\_ Sign and date the signature page (p.11) of Individual Preferred Provider Agreement\*
- \_\_\_\_\_ Complete the S.C. Uniform Managed Care Provider Credentialing Application
- \_\_\_\_\_ Sign and date Credentialing Application Authorization Page (p. 4 of 8)\*
- \_\_\_\_\_ Enclose copy of your current State License
- \_\_\_\_\_ Enclose copy of your current DEA License
- \_\_\_\_\_ Enclose copy of W-9 form (proof of federal identification number)
- \_\_\_\_\_ Enclose copy of your Board Specialist Certificate, if applicable
- \_\_\_\_\_ Enclose proof of your malpractice coverage currently in effect
- \_\_\_\_\_ Enclose a letter from hospital(s) indicating status of hospital privileges (if applicable)
- \_\_\_\_\_ Keep a copy of this Individual Preferred Provider Agreement for your files.

\*All signatures must be dated within thirty (30) days of receipt of the completed application package by Preferred Blue. Rubber stamped signatures are not acceptable.

Please allow up to ninety (90) days for Blue Cross and Blue Shield of South Carolina to review your application and credentials. You will be notified, in writing, of the final determination.

**RETURN THE CONTRACT SIGNATURE PAGE AND COMPLETED  
CREDENTIALING PACKAGE TO:**

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA  
ATTN: PROVIDER SYSTEMS AND CREDENTIALING, AF-326  
I-20 AT ALPINE ROAD  
COLUMBIA, SC 29219

OR FAX TO (803) 264-4080

## TABLE OF CONTENTS

|       |                                               |   |
|-------|-----------------------------------------------|---|
| I.    | INTRODUCTION .....                            | 1 |
| II.   | DEFINITION OF TERMS.....                      | 1 |
| III.  | RESPONSIBILITIES OF BCBSSC .....              | 4 |
| IV.   | RESPONSIBILITIES OF THE NETWORK PROVIDER..... | 4 |
| V.    | RELATIONSHIP BETWEEN THE PARTIES .....        | 6 |
| VI.   | TERM, TERMINATION AND AMENDMENT .....         | 7 |
| VII.  | ASSIGNMENT .....                              | 8 |
| VIII. | LIABILITY AND INDEMNITY .....                 | 8 |
| IX.   | MISCELLANEOUS .....                           | 9 |

APPENDIX A, Utilization Management Procedures..... i.

ENCLOSURE: S.C. Uniform Managed Care Provider Credentialing Application

This Individual Preferred Provider Agreement (“Agreement”) is between Blue Cross and Blue Shield of South Carolina (“BCBSSC”), a South Carolina mutual corporation, and \_\_\_\_\_, (“Preferred Provider”).

## **I. INTRODUCTION.**

- A. WHEREAS BCBSSC desires to establish effective, cooperative healthcare cost containment programs that will assure the availability and continuity of quality care to BCBSSC’s Members (as defined below); and,
- B. WHEREAS, Preferred Provider wants to participate as a Network Provider (as defined below) in the cooperative health care cost containment programs established by BCBSSC.
- C. NOW THEREFORE, in consideration of the premises and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, BCBSSC and the Preferred Provider hereby agree as follows:

## **II. DEFINITIONS.**

Capitalized terms used in this Agreement shall have the following meanings.

- A. “Agreement” means this Individual Preferred Provider Agreement.
- B. “Associate Plan” means a company, organization or other entity that has a health plan or other program (or who sponsors, provides, indemnifies, or administers another’s health plan or program) who has made arrangements with BCBSSC to access and utilize Network Providers in connection with such health plans or programs. Additionally, Associate Plan includes any other entity that is entitled to the benefit of the terms of this Agreement as a result of such Associate Plan’s entry into an agreement with BCBSSC. Associate Plan also includes members of the Association. Associate Plan also includes BCBSSC’s subsidiaries and affiliates that access this Agreement.
- C. “Association” means an association of independent Blue Cross and Blue Shield Plans known as the Blue Cross and Blue Shield Association.
- D. “BCBSSC” means Blue Cross and Blue Shield of South Carolina.
- E. “Benefits Contract” means any written contract entered into by BCBSSC and a group or individual under which BCBSSC provides, indemnifies for or administers health care benefits including where BCBSSC acts as:
  - (1) a control plan;
  - (2) a participating plan;
  - (3) a service plan; or
  - (4) any agreement for benefits issued by an Associate Plan.
- F. “Continued Stay Review” means the mandatory review conducted under the Utilization Management Program, to determine whether a continued admission is Medically Necessary.
- G. “Covered Services” means the services a Member is entitled to under the terms and conditions of such Member’s Benefits Contract.
- H. “Effective Date” means the date that BCBSSC accepts Preferred Provider as a Network Provider.

- I. "Emergency" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain, such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in:
- (1) placing the health of the individual, or with respect to a pregnant woman the health of a woman or her unborn child, in serious jeopardy,
  - (2) serious impairment of bodily functions, or
  - (3) serious dysfunction of any bodily organ or part.
- J. "Emergency Admission Review" means the mandatory review conducted pursuant to the Utilization Management Program to determine whether an Emergency admission is Medically Necessary
- K. "Fee Allowance" means the lower of: (1) Preferred Provider's normal charge for a procedure, or (2) the charge for a procedure set forth in the Schedule of Fee Allowances. In accordance with the Omnibus Budget Reconciliation Act of 1993, effective January 1, 1995, the Medicare Part B equivalent amount will be applied to claims for physicians' services to retirees and annuitants enrolled in the Preferred Blue Federal Employee Health Benefits Program (FEP) who are 65 years of age and older and who are not covered by Medicare Part B. The Fee Allowance for these Members is the lower of Preferred Provider normal charge, the amount set forth on the Schedule of Fee Allowances or the Medicare Part B equivalent amount.
- L. "Medically Necessary" shall mean health care services that a Physician, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
- (1) in accordance with generally accepted standards of medical practice
  - (2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
  - (3) not primarily for the convenience of the patient, physician, or other health care provider
  - (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
- M. "Member" means any individual who is covered under a Benefits Contract, as well as individuals covered under a Benefits Contract with any Associate Plan.
- N. "Outpatient Review" is the mandatory review conducted pursuant to the Utilization Management Program, to determine whether certain elective outpatient procedures are Medically Necessary
- O. "Patient Pay Amounts" means, with respect to Covered Services, all deductibles, coinsurance, co-payments and other sums that are payable by the Member directly to Preferred Provider and which are not payable by BCBSSC or Associate Plan.
- P. "Point of Service Benefits Contract" means a Benefits Contract that provides maximum benefits for Covered Services provided by:
- (1) the Member's Primary Care Physician;
  - (2) another Network Provider with an appropriate referral from the Member's Primary Care Physician, or

- (3) any other provider with a referral from the Member's Primary Care Physician when the referral has been authorized by BCBSSC or Associate Plan.

Q. "Pre-Admission Review" means the mandatory review conducted pursuant to the Utilization Management Program to determine whether a non-Emergency admission is Medically Necessary.

R. "Network Provider" includes the following types of persons or facilities which

- (1) provide Covered Services to a Member; and
- (2) such persons or facilities have a written agreement with BCBSSC to participate as a Network Provider:
  - a. hospitals;
  - b. skilled nursing facilities;
  - c. home health agencies;
  - d. hospices;
  - e. independent laboratories;
  - f. contracting national laboratories;
  - g. physicians;
  - h. drug stores and pharmacies;
  - i. vendors of durable medical equipment; and
  - j. other eligible providers as specified under a Benefits Contract.

Upon acceptance by BCBSSC, Preferred Provider will be a Network Provider.

S. "Primary Care Physician" under a Point of Service Benefits Contract means:

- (1) a Preferred Physician who is selected by a Member and who has a specialty in
  - a. general practice, or
  - b. family practice, or
  - c. general internal medicine, or
  - d. pediatrics, or
  - e. other specialty designated as a Primary Care Physician
- (2) Primary Care Physicians are responsible for coordinating medical care for Members who have selected them as their Primary Care Physician.

T. "Quality Medical Advisory Panel" means the panel of Preferred Provider peers (in the same or similar specialty) assembled by BCBSSC for the purpose of hearing appeals from the Utilization Management Program. When reasonably possible, the individuals who make up the Quality Medical Advisory Panel will be from outside of Preferred Provider's immediate geographic service area. However, the Preferred Provider understands that appeals for the Associate Plans will have to be appealed directly to the Associate Plan.

- U. "Utilization Management Program" means the series of activities carried out by BCBSSC or the Associate Plan to ensure that the Covered Services that are provided to its Members are Medically Necessary and appropriate. Utilization Management is further defined in Appendix A.

### **III. BCBSSC RESPONSIBILITIES.**

A. BCBSSC or Associate Plan shall:

- (1) Pay Preferred Provider for Covered Services in accordance with the benefit allowance of the Member's Benefits Contract. Payment will be based upon the Fee Allowance amount.
- (2) Directly reimburse Preferred Provider for Covered Services provided to Members without requiring that Preferred Provider obtain the Member's prior authorization.
- (3) Establish procedures and methods whereby Members can be appropriately identified by Network Providers.
- (4) Provide Preferred Provider with a list of all Network Providers via the BCBSSC website ([www.southcarolinablues.com](http://www.southcarolinablues.com) at the time of this writing).

### **IV. PREFERRED PROVIDER'S RESPONSIBILITIES.**

A. Preferred Provider shall:

- (1) Accept payment of the Fee Allowance amount plus any required Patient Pay Amounts as payment in full for Covered Services rendered to Members. All payments are subject to the terms of the Member's Benefits Contract. Payment will be adjusted for payments made to Preferred Provider pursuant to any coordination of benefits provisions in any health plan other than the Benefits Contract.
- (2) While performing services, maintain a physician-patient relationship with enrolled Members. Any and all medical service decisions, treatment decisions or exercises of medical judgment are Preferred Provider's responsibility.
- (3) Not discriminate against any Member on the basis of race, color, sex, age, religion, national origin, handicap or insurance plan in providing services under this Agreement. Preferred Provider may choose to be closed to new Members as a group but only if Preferred Provider is closed to new patients from all payor sources.
- (4) Serve as the Primary Care Physician for Members covered under a Point of Service Benefits Contract if Preferred Provider's specialty is:
  - a. general practice; or
  - b. family practice; or
  - c. general internal medicine; or
  - d. pediatrics; and
  - e. if Preferred Provider is selected by the Member and the Member is accepted by Preferred Provider.
- (5) Use Network Providers in the delivery of Covered Services unless Covered Services, supplies or equipment are not available from any Network Provider, or in the case of an Emergency.

- (6) Provide Covered Services in an appropriate outpatient setting whenever safe, quality care can be provided in such a setting.
- (7) Cooperate fully with the Utilization Management Program.
- (8) Agree to provide a second opinion to Members who have already consulted with another Network Provider.
- (9) Cooperate and participate with BCBSSC and any Associate Plan in any utilization control procedures, quality assurance activities, external audit systems and grievance procedures, as may be established pursuant to the terms of the Benefits Contract, and comply with all final determinations rendered through the peer review process or grievance mechanism.
- (10) Maintain, with respect to each Member for whom Covered Services are provided under this Agreement, standard medical records in such form, containing such information, and meeting such record keeping requirements as might be required by applicable federal and state law. Preferred Provider will keep confidential, and take all reasonable precautions to prevent the unauthorized disclosure of any and all records prepared and/or maintained by this Agreement. BCBSSC or the Associate Plan will have the right to inspect, review and obtain copies of such records upon request at no charge.
- (11) File a claim for all Covered Services rendered to Members within the time frame set forth in the Benefits Contract (typically 180 days). Preferred Provider will not bill BCBSSC, Associate Plan or the member for claims filed outside of the timely filing limit unless the party responsible for payment approves an exception. Preferred Provider will file the claims in a manner acceptable to BCBSSC. Preferred Provider may not charge the Member, BCBSSC or Associate Plan for filing a claim.
- (12) While an appeal of a decision by BCBSSC that a Covered Service was not Medically Necessary is pending, Preferred Provider will not bill BCBSSC, Associate Plan or the Member for any charges for such Covered Services that are the subject of the appeal.
- (13) Not file a claim with BCBSSC or Associate Plan or bill a Member for any charges for services rendered when it has been determined such services are not Medically Necessary. Preferred Provider may seek compensation from the Member for services determined to be not Medically Necessary only if the Member, or lawfully authorized representative thereof, consents in writing to be responsible for the payment of the specific medical services prior to the rendition of the services.
- (14) Not bill BCBSSC, Associate Plan or the Member separately for an item or Covered Service that is considered by BCBSSC to be an integral part of another item or Covered Service.
- (15) Not bill BCBSSC, Associate Plan or the Member for certain medical errors described by the National Quality Forum as "Never Events".
- (16) Reimburse BCBSSC or the Associate Plan for any payment made for services determined not to be payable hereunder. Provided, however, to the extent Preferred Provider is required to reimburse the Member and does reimburse the Member under a coordination of benefits provision of a Member's health plan other than the Benefits Contract, Preferred Provider is not required to reimburse BCBSSC or Associate Plan. If Preferred Provider does not reimburse BCBSSC or Associate Plan for any payment made for services determined not to be payable, then BCBSSC may offset future payments to Preferred Provider (whether resulting from claims related to the same Member or other Members) by the amount of the refund due.
- (16) Maintain active state licensure in the state in which Preferred Provider practices.
- (18) Certify to BCBSSC that Preferred Provider is fully covered by a medical malpractice policy in accordance with the relevant credentialing requirements.

- (19) Allow BCBSSC to use Preferred Provider's name to inform Members and potential Members that Preferred Provider is a Network Provider.
  - (20) Upon written request of the United States Secretary of Health and Human Services or Comptroller General or any of their duly authorized representatives, make available those contracts, books, documents and records necessary to verify the nature and extent of the cost of providing services. Such inspection shall be available up to four years after the rendering of such services. If Preferred Provider carries out any of the duties of this Agreement through a subcontract with a value of \$10,000 or more over a 12 month period with a related individual or organization Preferred Provider will include this requirement in any such subcontract. This section is included pursuant to and is governed by the requirements of Section 1861 (v)(1) of the Social Security Act and the regulations relating to it
  - (21) Use BCBSSC contracting, independent laboratories for reference lab work for Members.
- B. In accordance with the terms of this Agreement, and in addition to the requirements contained in IV(A), Preferred Provider who is a Primary Care Physician under the terms of a Point of Service Benefits Contract, shall:
- (1) Accept Members covered under the Point of Service Benefits Contract as new patients, and continue to treat current patients who become Members, until Preferred Provider notifies BCBSSC that Preferred Provider is unable to accept new patients.
  - (2) Cooperate and comply with Point of Service Benefits Contract authorization procedures should the Member require Covered Services which cannot be performed by Preferred Provider or which must be performed in a medical setting outside of Preferred Provider's office.
  - (3) In the event Preferred Provider is unable to provide Covered Services, arrange for other Network Providers to provide Covered Services to Preferred Provider's patients who are Members covered under the Point of Service Benefits Contract.
  - (4) Determine the necessity of referrals to other providers (using Network Providers where possible) and complete an authorization form which the Member will deliver to the provider accepting the referral. As the Primary Care Physician, Preferred Provider will request an authorization from BCBSSC for any referrals made to providers who are not Network Providers and complete the authorization form indicating whether authorization was obtained/denied.

#### **V. RELATIONSHIP BETWEEN THE PARTIES.**

- A. Nothing in this Agreement should be construed as an attempt by BCBSSC to abridge, alter or interfere with any Network Provider's physician-patient relationship. Any and all medical service decisions, treatment decisions or exercises of medical judgment are Preferred Provider's responsibility, and BCBSSC shall not be deemed liable for any such decisions or exercise of judgment in any manner.
- B. Preferred Provider is an independent contractor. This Agreement shall not be construed or deemed to create an employer-employee relationship, a joint venture, or a principal-agent relationship between BCBSSC and Preferred Provider or any Network Provider.

## **VI. TERM, TERMINATION AND AMENDMENT.**

- A. TERM. This Agreement shall be effective on the Effective Date and shall continue in effect until terminated pursuant to this Agreement.
- B. TERMINATION
- (1) Either BCBSSC or Preferred Provider may terminate this Agreement for any reason upon one hundred twenty (120) days prior written notice by the other party.
  - (2) BCBSSC may terminate this Agreement for cause upon ninety (90) days prior written notice, for the following reasons:
    - (a) Failure to abide by the terms specified in this Agreement (e.g. Preferred Provider fails to use other Network Providers when available);
    - (b) Failing to cooperate with the continuing credentialing requirements as delineated in the BCBSSC credentialing process.
  - (3) BCBSSC shall have the right to terminate this Agreement for cause, immediately and without prior notice, upon actual notice to BCBSSC of significant deficiencies in licensing or qualification matters, including but not limited to the following reasons:
    - (a) Loss of license required for professional practice;
    - (b) Preferred Provider is convicted of a felony;
    - (c) Preferred Provider loses or otherwise fails to maintain all certificates(s), registration(s), or additional licensure(s) required for professional practice;
    - (d) Preferred Provider misrepresents Preferred Provider's competence or professional capabilities; or
    - (e) Preferred Provider misrepresents or fails to disclose any requested credential information or otherwise fails to meet re-credentialing criteria; or
    - (f) Preferred Provider changes affiliation from a Preferred Blue participating professional association to a professional association that does not participate in the Preferred Blue program. It is Preferred Provider's responsibility to notify BCBSSC's Provider Contracting and Reimbursement Department at least thirty (30) days in advance of such a change; or
    - (g) Preferred Provider files for the protection of the Bankruptcy Court or is involuntarily placed in bankruptcy or has a receiver appointed to manage Preferred Provider's affairs.
  - (4) Nothing contained in this section VI(B) shall impose on BCBSSC any duty to monitor Preferred Provider's performance under this Agreement, the quality of care provided by Preferred Provider or Preferred Provider's physical or mental condition or Preferred Provider's behavior. BCBSSC expressly disclaims any such duty. BCBSSC may monitor or may decline to monitor such performance in its sole discretion.
  - (5) As of the date of termination, this Agreement shall be of no further force or effect whatsoever for services rendered thereafter and each of the parties shall be relieved and discharged from the requirements of this Agreement, except that:

ELECTRONICALLY FILED - 2020 Aug 30 2:59 PM - Horry - COMMON PLEAS - CASE#2020CP2601982

- (a) The parties shall complete any arbitration proceedings initiated pursuant to this Agreement, including requests for arbitration of disputes arising between the parties after the effective date of termination.
- (b) Notwithstanding termination, and without cost to BCBSSC, BCBSSC shall continue to have access to Preferred Provider's records for three (3) years, to the extent permitted by law and as necessary to fulfill the terms of this Agreement and legal requirements.
- (c) Preferred Provider agrees to complete the course of treatment for all Members that have begun a course of treatment by the date of termination notice, even if the course of treatment is completed after the date of termination. Both parties agree to honor the terms of this Agreement for the completion of such courses of treatment.
- (d) The requirements of section IX(K) shall remain in full force and effect.

- C. AMENDMENT. This Agreement may be amended by BCBSSC following ninety (90) days prior written notice, effective at the end of such ninety (90) day period. If Preferred Provider does not accept the terms of the amendment, Preferred Provider may terminate this Agreement by providing written notice within thirty (30) days of the receipt of such proposed amendment. Termination shall be effective at the end of the ninety (90) day period provided by BCBSSC.

## **VII. ASSIGNMENT.**

- A. ASSIGNMENT OF AGREEMENT. Neither party may assign their rights or duties under this Agreement without the prior written consent of the other party, which consent shall not be unreasonably withheld.
- B. ASSIGNMENT OF COVERED SERVICES. BCBSSC may, from time to time, contract with Associate Plans for the purpose of allowing such Associate Plans to avail themselves of the same access to the benefits of this Agreement and related rights as BCBSSC and binding such persons to the payment responsibilities under this Agreement. Preferred Provider agrees to provide Covered Services to Associate Plans Members under the terms of this Agreement and to look to each Associate Plan for reimbursement for Covered Services rendered to that Associate Plan's Members. Such Associate Plans shall not be required to provide for electronic claims transmission for the use of Preferred Provider in filing claims, however, BCBSSC will encourage the use of electronic claims transmission systems by Associate Plans. The duties and obligations of Associate Plans under this Agreement are several and distinct from BCBSSC's duties and obligations under this Agreement and BCBSSC does not guarantee any Associate Plan's performance under this Agreement and BCBSSC will not be responsible for any Associate Plan's actions. Except for references to BCBSSC under Articles V, IV, VIII, and IX, references to BCBSSC shall be deemed to refer to Associate Plans with respect to such Associate Plans duties and obligations under this Agreement and with respect solely to such Associate Plan's Members.

## **VIII. LIABILITY AND INDEMNITY.**

- A. Preferred Provider agrees to indemnify, defend and hold BCBSSC harmless from any and all liability, loss, damage, claim or expense of any kind (including all costs and reasonable attorneys' fees), which results from any breach of this Agreement by Preferred Provider or which results from the negligent or willful acts or omissions by Preferred Provider, its agents or employees regarding the duties and obligations of Preferred Provider under this Agreement, including the duty to maintain the legal standard of care applicable to Preferred Provider. Such obligation to indemnify, defend and hold harmless shall not apply to any matters resulting from negligent or willful acts or omissions of BCBSSC or its agents or employees.
- B. BCBSSC agrees to indemnify, defend and hold Preferred Provider harmless from any and all liability, loss, damage, claim or expenses of any kind (including all costs and reasonable attorneys' fees), which results from any

breach of this Agreement by BCBSSC or results from the negligent or willful acts or omissions by BCBSSC, its agents or employees regarding the duties and obligations of BCBSSC under this Agreement. Such indemnification and hold harmless shall not apply to any matters resulting from negligent or willful acts or omissions of Preferred Provider or its agents or employees.

## **IX. MISCELLANEOUS.**

### **A. PARTIES TO THE AGREEMENT.**

- (1) Preferred Provider expressly acknowledges its understanding that this Agreement constitutes a contract between Preferred Provider and BCBSSC, and that BCBSSC is an independent corporation operating under a license with the Association, permitting BCBSSC to use the Blue Cross and Blue Shield Service Mark in the State of South Carolina, and that BCBSSC is not contracting as the agent of the Association.
- (2) Preferred Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than BCBSSC and that no person, entity, or organization other than BCBSSC (and other than Associate Plans by virtue of Article VII) shall be held accountable or liable to Preferred Provider for any of BCBSSC's obligations to Preferred Provider created under this Agreement. This paragraph VII(A), shall not create any additional obligations whatsoever on the part of BCBSSC other than those obligations created under other provisions of this Agreement.

### **B. ORIGINALS/COPIES OF THE AGREEMENT.** BCBSSC may image this Agreement, related documents and credentials. An imaged copy of this Agreement, related documents and credentials shall be as effective and valid as the original.

### **C. USE OF DOCUMENTS.** Preferred Provider agrees that BCBSC may allow the documents and credentials referenced in this Agreement to be used by any and all subsidiary networks managed by BCBSSC.

### **D. NON-EXCLUSIVITY.** Preferred Provider and BCBSSC agree and acknowledge that this is a non-exclusive contract and that either party is free to contract with other parties to provide the services contemplated under this Agreement.

### **E. WAIVER OF BREACH.** Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision.

ELECTRONICALLY FILED - 2020 Aug 30 2:59 PM - Horry - COMMON PLEAS - CASE#2020CP2601982

- F. SEVERABILITY. In the event any provision of this Agreement is rendered invalid or unenforceable by any federal statute or state law, or by any regulation duly promulgated by officers of the United States or the State of South Carolina in accordance with law, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of this Agreement shall remain in full force and effect.
- G. EFFECT OF SEVERABLE PROVISION. In the event that a provision of this Agreement is rendered invalid or unenforceable or declared null and void as provided in Section IX(F) and its removal has the effect of materially altering the obligations of either party in such manner as in the judgment of the party affected: (1) will cause serious financial hardship to such party; or (2) will cause such party to act in violation of its corporate Articles or Bylaws, the party so affected shall have the right to terminate this Agreement upon thirty (30) days prior written notice to the other party. The applicable provisions of Article VI shall apply to such termination.
- H. PROHIBITION AGAINST PAYMENT OF MEMBERS HEALTH PLAN PREMIUMS. Preferred Provider shall not pay any amount toward health plan premiums or health insurance premiums of any Members, except for its eligible employees and retirees under its own employee welfare benefit plan.
- I. HEADINGS. The headings of Articles and Sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.
- J. GOVERNING LAW. This Agreement shall be construed and enforced in accordance with the laws of the State of South Carolina.
- K. CONFIDENTIALITY.
- (1) Preferred Provider acknowledges and agrees that in the course of obtaining this Agreement it has received, and may continue to receive, BCBSSC's valuable trade secrets, confidential, and proprietary information (collectively referred to as "Confidential Information"), including the reimbursement terms and the terms of this Agreement and any and all records required to be produced or kept under the terms of this Agreement. Preferred Provider further acknowledges that the use of Confidential Information would give Preferred Provider an unfair competitive advantage were Preferred Provider to directly or indirectly compete with BCBSSC for BCBSSC's existing customers, and disclosure of Confidential Information would cause harm to BCBSSC.
  - (2) In consideration of the disclosure by BCBSSC to Preferred Provider of Confidential Information, Preferred Provider agrees to treat the Confidential Information supplied to it by BCBSSC in strict confidence, and to undertake the following additional obligations with respect thereto:
    - (a) to use Confidential Information for the sole purpose of performing its obligations under this Agreement;
    - (b) not to disclose Confidential Information to any person outside of its organization except as needed to comply with Preferred Provider's obligations under this Agreement;
    - (c) to limit dissemination of Confidential Information to only those of its employees who have a need to know to perform the limited tasks set forth in this Agreement;
    - (d) ensure that any pricing disclosed to its billing company, attorneys, CPAs, etc. is not disclosed to any other provider or other organization. Any violation of Confidentiality by such person or entity will be considered the same as if Preferred Provider committed such violation; and
    - (e) to return Confidential Information and all documents, notes or physical evidence thereof to BCBSSC upon termination of this Agreement.

- (3) The restrictions and obligations of this paragraph shall survive any expiration, termination or cancellation of this Agreement and shall continue to bind Preferred Provider, its successors and assigns.
- (4) Preferred Provider acknowledges that if Preferred Provider breaches the terms of this paragraph IX(K), BCBSSC shall be entitled to seek monetary damages against Preferred Provider. Additionally, Preferred Provider acknowledges that if Preferred Provider breaches this section IX(K), such monetary damages may not be a sufficient remedy for such breach and that BCBSSC shall be entitled, without waiving any other rights or remedies, to injunctive or equitable relief as may be deemed proper by a court of competent jurisdiction.

L. ENTIRE AGREEMENT. This Agreement, including all written supplements, exhibits, and amendments hereto constitutes the entire agreement of the parties hereto. No verbal agreement or conversation of the parties hereto shall affect or in any way modify any of the terms and conditions herein contained.

M. DISPUTE RESOLUTION.

- (1) Except for decisions made pursuant to the Utilization Management Program, BCBSSC and Preferred Provider 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, other than a Utilization Management Program decision (which resolution shall be governed by the terms of Appendix A), BCBSSC and Preferred Provider 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.

IN WITNESS WHEREOF, each of the undersigned parties to this Individual Preferred Provider Agreement has caused this Individual Preferred Provider Agreement to be duly executed.

BLUE CROSS AND BLUE SHIELD  
OF SOUTH CAROLINA

By: J. Lance Lockman      /      Date  
Its: Senior Director,  
Professional Network Management

STEVEN ROY BURKHOLZ, DO  
(Please Type or Print)  
Name of Preferred Provider

Effective Date  
(Established by BCBSSC)

 4/8/2017  
Signature of Individual Preferred Provider      Date

**APPENDIX A****UTILIZATION MANAGEMENT PROCEDURES**

The Utilization Management Program is a series of activities carried out by BCBSSC to ensure that the Covered Services that are provided to Members are Medically Necessary. These activities consist of pre-certification of admissions and length of stay and pre-certification of selected medical and surgical procedures. The Utilization Management Program also involves a review of ongoing admissions and may involve the retrospective review of admissions for appropriateness and Medical Necessity. The Utilization Management Program may also involve case management of all Covered Services provided to Members who are severely ill with long-term chronic conditions. In the event that the Preferred Provider fails to follow the requirements of the Utilization Management Program, BCBSSC reserves the right to withhold all or a portion of the payment for otherwise Covered Services.

- A. Preferred Provider and BCBSSC hereby agree:
- (1) To avoid unnecessary or unduly costly Covered Services for Members;
  - (2) To ensure that all Members receive the appropriate and necessary level of Covered Services in accordance with community standards for care and such Members Benefits Contract;
  - (3) To maintain professional standards in the delivery of health care within the meaning of Section 40-71-10 Code of Laws of South Carolina, 1976 as amended.
- B. The Utilization Management Program will be conducted by BCBSSC. In the course of using the Utilization Management Program, payment to Preferred Provider may be denied when it is determined that such Covered Services were not Medically Necessary or where Preferred Provider fails to follow the Utilization Management Program's procedures. Preferred Provider will not bill a Member for charges for Covered Services where Preferred Provider failures to follow the Utilization Management Program procedures.
- C. When service evaluation is requested by BCBSSC or Associate Plan, Preferred Provider will use its best efforts to ensure that all Preferred Provider's relevant records and those of Preferred Provider's facility, if applicable, be made available to BCBSSC upon reasonable notice.
- D. The requirements of the Utilization Management Program must be followed for all Covered Services rendered to Members. The Utilization Management Program includes: Pre-Admission Reviews, Emergency Admission Reviews, Outpatient Reviews and Continued Stay Reviews. Preferred Provider or the admitting Network Provider must request each type of review. Each specific type of review is subject to the following additional requirements:
- (1) Pre-Admission Review. A Pre-Admission Review is required prior to all non-Emergency admissions. Preferred Provider will cooperate with other Network Providers in connection with a Pre-Admission Review, including providing any necessary clinical information relating to a Member's proposed admission.
  - (2) Emergency Admission Reviews. An Emergency Admission Review is required for all Emergency admissions. BCBSSC or Associate Plan must be notified within twenty-four (24) hours of the Emergency admission, or by noon of the next working day if the admission is on Friday, Saturday, Sunday or a holiday. Preferred Provider will cooperate with other Network Providers in connection with an Emergency Admission Review, including providing

any necessary clinical information relating to a Member's proposed admission.

- (3) Continued Stay Review. Each approved admission of a Member is contemplated to last a particular number of days. Accordingly, each admission will be assigned a specific number of days at the time of approval of the admission. Additional days are subject to a Continued Stay Review and approval by BCBSSC. Preferred Provider will cooperate with other Network Providers in connection with a Continued Stay Review, including providing any necessary clinical information relating to a Member's proposed continued stay.
  - (4) Outpatient Review. Elective outpatient surgical procedures may be subject to an Outpatient Review that must be obtained at least three (3) days prior to applicable procedures.
- E. BCBSSC or Associate Plan shall not pay for services that are determined through the Utilization Management Program to be not Medically Necessary or which are not Covered Services. Unless a Member has agreed, in writing, to be personally responsible for such specified Covered Services, Preferred Provider agrees not to bill any Member for services determined through the Utilization Management Program to be not Medically Necessary. In the event Preferred Provider successfully appeals a Utilization Management Program decision in accordance with this Appendix, BCBSSC or Associate Plan shall accept Preferred Provider's bill and make payment pursuant to the terms of the Agreement.
  - F. Preferred Provider and each Member have a right to appeal decisions made through the Utilization Management Program to the Quality Medical Advisory Panel. Preferred Provider or Member may also request reconsideration of a decision made pursuant to the Utilization Management Program through the Quality Medical Advisory Panel.
  - G. Preferred Provider and BCBSSC agree that each shall be responsible for their own costs incurred in the appeal of any Utilization Management Program determination.



## Healthcare Due Process Protocol

American Arbitration Association®  
American Bar Association  
American Medical Association  
Commission On Health Care Dispute Resolution  
Final Report  
July 27, 1998

The views expressed herein have not yet been approved by the ABA House of Delegates or the Board of Governors of the American Bar Association and accordingly should not be construed as representing the policy of the American Bar Association. Similar approval processes are also necessary at the AAA® and AMA.

### I. Introduction

In the Fall of 1997, the leading associations involved in alternative dispute resolution, law, and medicine collaborated to form a Commission on Health Care Dispute Resolution (the Commission). The Commission's goal was to issue, by the Summer of 1998, a Final Report on the appropriate use of alternative dispute resolution (ADR) in resolving disputes in the private managed health care environment. This Final Report discusses the activities of the Commission from its formation in September 1997 through the date of this report, and sets forth its unanimous recommendations.

### II. Summary of Recommendations

The Commission unanimously makes the following recommendations:

- 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.
- Alternative dispute resolution can and should be used to resolve disputes over health care coverage and access arising out of the relationship between health care providers 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.
- It is essential that due process protections be afforded to all participants in the ADR process.
- Review of managed health care decisions alternative dispute resolution complements the concept of internal review of determinations made by private managed health care organizations.

These findings and recommendations are articulated in detail in this Final Report. They are meant to provide guidance not only to private managed health care organizations considering the voluntary adoption of ADR programs as a form of review of plan determinations, but also to legislative and regulatory bodies considering the establishment of standards governing the use of ADR in the health plan environment.



### III. Formation of the Commission

In August 1997, leaders of the American Arbitration Association (AAA), American Bar Association (ABA), and American Medical Association (AMA) met in Chicago and determined to form a commission to study and make recommendations on the appropriate use of ADR in the private managed health care environment. This first time joint effort by the AAA, ABA, and AMA underscored the need to provide the public with a fast, just, and efficient system of resolving health care disputes without having to resort to costly and time-consuming court litigation.

In forming the Commission, the convening institutions expressed the hope that as the health care environment continues to evolve, the dispute resolution models and due process safeguards developed by the Commission will be implemented by managed health care organizations across the nation to give consumers the opportunity to have a prompt resolution of their disputes, while at the same time assuring that the parties' Constitutional and other legal rights and remedies are protected. A concomitant goal was to provide guidance to legislative and related bodies who are developing systems to regulate the managed health care relationship.

Another main goal identified in the early stages of the Commission's deliberations is promoting greater awareness and understanding of the use of mediation, arbitration, and other out-of-court settlement techniques as methods for resolving disputes over health care coverage and access in the managed health care environment.

The conveners established the following objectives of the Commission: studying and making recommendations on the application of alternative dispute resolution to coverage and access issues in the managed health care arena, the development of appropriate due process standards to be applied to ADR in this context, and the development of model ADR procedures for use in managed health care relationships.

In the weeks following the Chicago organizational meeting, each institution named its representatives to the Commission, and the first working session took place on September 22, 1997, in Chicago.

Each of the convening institutions possesses expertise and guidance essential to the success of the Commission:

*The leader in conflict management since 1926, the American Arbitration Association is a not-for-profit, public service organization dedicated to the resolution of disputes through the use of negotiation, mediation, arbitration, and other voluntary dispute settlement techniques. In 1997, more than 78,000 cases were filed with the Association in a full range of matters. Through 37 offices nationwide and cooperative agreements with arbitral institutions in 38 other nations, the AAA provides a forum for the hearing of disputes, rules and procedures and a roster of impartial experts to hear and resolve cases.*

*The American Bar Association is the world's largest voluntary professional association with more than 392,000 members. As the national voice for the legal community, the ABA's mission is to serve the public and the profession by promoting justice, professional excellence, and respect for a just rule of law.*



*The American Medical Association is the nation's leading organization of physicians. Formed more than 150 years ago, the AMA is a partnership of physicians and their professional associations dedicated to promoting the art and science of medicine and the betterment of public health. The AMA serves its nearly 300,000 member physicians and their patients by establishing and promoting ethical, educational, and clinical standards for the medical profession and by advocating for the highest principle of all—integrity of the patient/physician relationship.*

The Commission met as follows:

- September 22, 1997 in Chicago
- October 27, 1997 in Chicago
- December 8, 1997 in New York City
- January 12, 1998 in Washington
- March 6, 1998 in New York City
- April 29, 1998 in Washington

In the course of these meetings, the Commission accomplished the following:

- established its membership and governance
- established its mission
- identified objectives
- identified substantive areas of study
- established its methodology
- issued a press release on November 17, 1997
- identified presenters (oral and written)
- established funding for presenter reimbursement
- heard presentations
- received written submissions
- made various governmental leaders aware of the Commission's work
- issued an Interim Progress Report on January 20, 1998
- issued this Final Report on July 27, 1998



#### IV. Membership and Governance

The Commission is co-chaired by Jerome J. Shestack, president of the ABA, William K. Slate II, president and chief executive officer of the AAA, and Dr. Percy Wootton, president of the AMA. The Secretary and Rapporteur is George H. Friedman, Senior Vice President of the AAA. The Recording Secretary is Scott Carfello, Regional Vice President of the Chicago office of the AAA.

Each of the institutions has four representatives on the Commission, as follows:

For the American Arbitration Association:

Howard J. Aibel, Esq.  
 Thomasina Rogers, Esq.  
 J. Warren Wood, III, Esq.  
 Max Zimny, Esq.

For the American Bar Association:

Hon. Arlin Adams  
 Kimberlee K. Kovach, Esq.  
 Lawrence A. Manson, Esq.  
 Roderick B. Mathews, Esq.

For the American Medical Association:

Dr. Charles Barone  
 Dr. Donald Palmisano  
 Carter Phillips, Esq.  
 Ron Pollack, Esq.

A roster describing the affiliations of the Commission members appears as Exhibit I of the Appendix of this Final Report.

#### V. Mission

The Commission on Health Care Dispute Resolution adopted the following mission statement:

*...to evaluate and make recommendations as to how alternative dispute resolution should be used to provide a just, prompt, and economical means of resolving disputes over access to health care treatment, and coverage, in the private health plan/managed care environment.*



## VI. Identified Need

The determination of the three sponsoring institutions to form the Commission was prescient. In the several months that followed the creation of the Commission, the general topic of health care has become a subject of national discourse. The President's Advisory Commission on Consumer Protection and Quality (President's Advisory Commission) in March 1998 issued a final report to the President. This group, comprised of representatives from a broad base of participants in the health care process, was formed in March 1997. In its final report to the President, this Commission urges the creation of a Patient's Bill of Rights. Legislative initiatives, at both the state and federal levels, were commenced with a goal of addressing the emerging issues in health care. Parties in the health care arena engaged in a national dialogue on how to address the many issues relating to the delivery of health care in the United States. A recurrent theme in all of these efforts was a recognized need to establish fair, neutral, swift, and economical means for settling disputes among participants in managed health care relationships.

While the Commission recognized that there are a variety of other health care relationships, its primary focus was on private managed care. According to the Final Report of the President's Advisory Commission (March 1998, p. 164), some 140 million Americans are covered by some form of private (i.e., non-governmental) health insurance. Today, three-fourths of Americans with private health insurance are enrolled in some form of managed care system (*Report of Proposed Recommendations on Process for Resolving Consumer Differences with Managed Health Care Plans*, ABA Commission on Legal Problems of the Elderly, June 1998, p.1). Given the nature of these relationships, and the sheer number of covered persons, disputes are inevitable.

Alternative dispute resolution has emerged as an accepted means of resolving disputes outside of the court system. The early working hypothesis of the convening institutions and the Commission members was that ADR can and should play an important, effective role in resolving disputes among participants in private managed health care relationships. After hearing often compelling presentations about the need for appropriate means of resolving disputes quickly, fairly, and efficiently, the Commission believes this hypothesis has been borne out.

The Commissioners note that a few states have enacted some form of legislation regulating the relationships between patients and managed health care organizations, (see, for example, Ohio's Physician-Health Plan Partnership Act of 1997), providing at some point for external review of certain health plan determinations. They also observe that similar legislation has been introduced in Congress, and that the President's Advisory Commission in Chapter Ten of its *Final Report to the President* encourages independent, external review of certain claim denials.

While these myriad efforts and activities to one extent or another involve various forms of ADR as part of the internal review process, external appeals, or both, the Commissioners concluded that there was a clear need to add definition and depth to these concepts. Stated differently, as managed health care organizations move to voluntarily embrace ADR as a form of external review, and as legislative and regulatory bodies provide direction to health plans regarding the development of external review programs, guidance and information will be needed to address how best to utilize ADR in this context. It is the Commission's objective to provide such guidance by issuing this Final Report.



## VII. Objectives

There was unanimity among Commission members that ADR would facilitate the resolution of disputes in the private managed health care area which are not resolved through internal review procedures offered by the managed health care organization. In view of its overall objective of promoting the prompt and fair application of ADR in the managed health care area, the Commission identified the following main objectives:

- develop model ADR procedures for use in the managed care area (in effect, a “Restatement on Health Care ADR”);
- identify substantive areas in the managed health care environment that would be suitable for resolution by alternative dispute resolution. Examples discussed included a host of coverage and access issues, such as access to specific healthcare providers, access to needed treatment or necessary care, experimental treatment, medical necessity, and reasonableness of cost;
- establish due process criteria for the use of ADR to resolve health care disputes. Examples discussed included due process procedures for ADR systems, timing of the agreement to use ADR, and informed, knowing, and voluntary use of ADR.

## VIII. Areas of Study

The Commission’s general focus was to study and make recommendations on the applicability of alternative dispute resolution in the private managed health care environment. It identified the following general subject matters for consideration:

- access to specific health care providers
- access to needed treatment
- access to specific health care facilities
- medical necessity of treatment
- experimental treatment
- reasonableness of cost
- continuity of care
- disclosure of information to consumers
- development of drug formularies
- out-of-area coverage
- provider communication with patients
- utilization management

Given the complexity and importance of ADR in the private managed health care setting, the Commission determined not to study the applicability of ADR to medical malpractice, Medicare, specific provisions of health care insurance contracts, or general access to health care outside of the private managed health care relationship. This does not mean that the concepts articulated in this report are not applicable to other health care relationships, such as indemnity plans



(i.e., those in which the patient seeks reimbursement from a health insurer for the cost of medical care received). The Commission is also aware that managed health care tort liability concepts are developing. These concepts may result in new types of civil claims that may be resolved by means of ADR, just as ADR is used today in many jurisdictions for resolving personal injury civil claims.

## IX. Methodology

The Commission's method of operation was to seek oral and written presentations from a wide array of key organizations and individuals, to inform the Commission's thinking in developing specific ADR models and areas of application. Included in this pool of advisors were: health care providers, patient advocacy groups, health care insurers (managed health care organizations, health maintenance organizations, and indemnity plans), health insurance associations, public health officials and groups, elder care groups, and law and medical school faculty.

Overall, thirty-seven individuals or organizations responded orally or in writing to 79 written invitations to submit comments or other information to the Commission. A listing of these individuals/organizations appears as Exhibit II of the Appendix of this Report (Individuals and Organizations Contacted by the Commission for Written Submissions). The Commission's Secretary also corresponded with the President's Advisory Commission, advising of the work of the AAA/ABA/AMA Commission. The information was directed specifically to Secretary of Health & Human Services Donna Shalala and Secretary of Labor Alexis Herman (co-chairs), with a copy delivered to President Clinton. Also, various Congressional leaders were advised of the work of the Commission. ABA President Shestack arranged for the Commission's work to be showcased at the ABA's 1998 Annual Meeting, in the form of a program devoted to the use of ADR to resolve health care disputes.

Oral presentations were made at Commission meetings held on October 27, 1997; December 8, 1997; January 12, 1998; March 6, 1998; and April 29, 1998, by the following individuals:

### **Mary Ellen Bliss**

Federal Affairs Action Team  
American Association of Retired Persons

### **Chris Carey**

Staff Member  
House Committee on Education and the Workforce

### **Edward Dauer**

Dean Emeritus  
University of Denver College of Law

### **Michael Duffy**

Director, Office of Consumer Affairs and Business  
Regulation  
Massachusetts Consumer Affairs Commission  
(and Boaz Yavnai - research assistant)

### **Elizabeth Hadley**

Legislative Counsel for Health Policy  
National Association of Insurance Commissioners

### **Matt Keast**

Staff Member  
Office of Congressman Charles Norwood

### **Kurt Lawson**

ABA Section of Taxation

### **Len Marcus**

Director, Health Care Negotiations  
Harvard School of Public Health

**F. William McCalpin***Chair*

ABA Commission on Legal Problems of the Elderly

**Julie Miller**

Director, Policy Analysis

Blue Cross &amp; Blue Shield Association

**Dr. Donald Palmisano***Trustee***Ron Pollack**

Executive Director

Families USA

(member of Commission)

**David Richardson**

President

Center for Health Dispute Resolution

**Elizabeth Rolph**

RAND

**Dr. Clarke Russ**

Institute for Conflict Resolution in Health Care

(Chair, Board of Medicine, Commonwealth of Virginia)

**Grey Till**

General Counsel

Blue Cross &amp; Blue Shield of Alabama

(member of Commission)

American Medical Association

Oral presentations were followed by questioning from the Commission and its staff. In some instances, this process was quite intense, but the intention always was to illuminate the nature of the problem and to evaluate carefully the range of realistic alternatives available.



## X. Alternative Dispute Resolution Methods and Models

### A. Introduction

As courts and administrative agencies become less accessible to civil litigants, patients, health care providers, and managed health care organizations have begun to explore ADR as a way promptly and effectively to resolve disputes. A wide range of dispute prevention and resolution procedures allow the participants to develop a fair, cost-effective, and private forum to resolve disputes.

As part of its work, the Commission reviewed a number of ADR processes which may be appropriate for the resolution of disputes and disagreements which occur among patients, families, health care providers, and managed health care organizations. The use of external, independent ADR is typically not available until after all remedies are exhausted within the managed health care organization. Usually, managed health care plans will offer some form of internal review, by which a provider or participant can challenge the plan's action. While this review can and should include some elements of ADR, the Commissioners contemplate ADR playing a role in the next step - i.e., as a form of independent external review or appeal. Based on the information adduced during the course of its work, the Commission has concluded that there is a clear need to help all participants better understand how ADR works, what forms ADR takes, and what problems to avoid.

In submitting these ADR Models, the Commission does not wish to suggest that these methods are exclusive or that in some instances other procedures may not be appropriate. Rather, in its study the Commission has concluded that these are the primary ADR methods or procedures which would be most responsive to the types of managed health care disputes as outlined in Section XI of this Final Report (Areas in the Private Managed Health Care Environment Where ADR Can Be Helpful). The ADR processes summarized below also assume the presence and need for a neutral third party. To be sure, the Commission recognizes and affirms that direct negotiation among the parties and internal appeal mechanisms are often appropriate first steps in any dispute resolution scheme. The work of the Commission, however, was to explore processes which involve the use of a neutral third party dispute resolver, either to facilitate a negotiated resolution among the parties (e.g., mediation) or to render a decision (e.g., arbitration).

The Commission submits that perhaps of greatest importance are the fundamental guiding principles of efficiency, of both time and money, and fairness. Characteristics of the ADR procedures presented here, and in detail in Exhibit III of the Appendix to this Final Report (Alternative Dispute Resolution Models, are to be supplemented by the due process protocols set forth in Section XII (Due Process Standards).



## B. ADR Models

The Commission submits the following proposed neutral models for ADR as prototypes for use in those matters or disputes involving managed health care. A consistent theme throughout is an effort to maintain a “level playing field” for all participants. Fully-developed models and explanations are set forth in Exhibit III of the Appendix.

**Ombuds:** A neutral third party (either from within or outside the program) is designated to receive information regarding managed health care disputes, and to confidentially investigate and propose settlement of complaints. The ombudsperson may also provide information on how the dispute resolution process works.

**Fact-finding:** The investigation of a complaint by an impartial third person (or team) who examines the complaint, considers the facts ascertained, and issues a non-binding report.

**Consensus-building:** A process which involves the use of a neutral third party, often referred to as a convener, who assists numerous persons or groups in arriving at a consensus through a structured negotiation among chosen representatives of all stakeholders.

**Mediation:** The process in which the parties discuss their disputes with an impartial person who assists them in reaching a settlement. The mediator may suggest ways of resolving the dispute but may not impose a settlement on the parties. Mediation offers the advantage of informality, with reduced time and expense needed to resolve disputes.

**Arbitration:** The submission of disputes to one or more impartial persons pursuant to established procedures, generally for final and binding determination. Variants include non-binding arbitration. There are four major types of arbitration agreements:

- pre-dispute, final and binding arbitration
- pre-dispute, nonbinding arbitration
- post-dispute, final and binding arbitration, and
- post-dispute, nonbinding arbitration.

The concept of the timing of the agreement to arbitrate is discussed in Section XII of this Final Report (Due Process Standards) and in Exhibit III of the Appendix (Alternative Dispute Resolution Models). *It is worth noting here, however, that the Commission’s unanimous view is that in disputes involving patients and/or plan subscribers, binding arbitration should be used only where the parties agree to same after a dispute arises.*

**ADR Hybrids:** The combination of one or more ADR formats, frequently in sequence. For example: “Med/Arb” is mediation followed by arbitration in the event mediation is not successful. The number of potential ADR hybrids is virtually unlimited.



### C. The “ERISA Problem”

As stated above, the Commission's focus was on the use of ADR in the private managed health care environment. It is worth noting that the overwhelming majority of individuals covered by private health plans obtained this coverage through an employer-provided health plan. According to the President's Advisory Commission, 123 million Americans receive health insurance through their employer, while only 10 to 16 million Americans purchase directly their own coverage (*Final Report*, p. 164). The Employee Retirement Income Security Act of 1974 (ERISA) governs, among other things, all health benefit plans that are employer-provided, establishing standards for the enforcement of “consumer” rights under employer-provided health plans.

By its terms, ERISA preempts the states from providing different remedies for denials of health benefits. Thus, an individual covered by an employer-provided health plan, under ERISA, may not invoke tort or contract law remedies in state courts, and is thus limited to seeking judicial intervention for only the following remedies:

- providing the covered service, or reimbursing the cost of the service;
- directing the plan to act;
- clarifying future benefits.

A question arose concerning whether the use of ADR as a form of external review of health plan determinations might be precluded by the ERISA preemption. It was the conclusion of the Commission, however, that ERISA does not preclude the parties from voluntarily adopting the use of ADR— even binding forms of ADR—to resolve disputes among them. It may well be that legislative clarification would be helpful to avoid confusion or concern over the appropriate use of ADR in the managed health care area, but specific recommendations in this regard would be beyond the scope of the Commission's charge from the convening institutions.



## XI. Areas in the Private Managed Health Care Environment Where ADR Can Be Helpful

### A. Introduction

The Commission's major focus was on one type of dispute in the private managed health care context—"consumer v. plan." Nevertheless, the Commission recognizes that managed care involves a range of disputes (and alliances) among a number of participants, including buyers, plans, providers in the plans, providers not in the plans, as well as consumers. The disputes that exist in this area are those that exist in the traditional insurance context as well, i.e., the long-standing insurance coverage issues, which now more frequently arise because the insurer/managed plan may simply be saying "no" more frequently.

In addition, in managed care, the "consumer v. plan" dispute is often a "consumer + provider v. plan" dispute, in which the issue is whether the provider can perform services with the expectation of payment from the plan, and the consumer is convinced by the provider that the services will be beneficial. There are also "provider v. plan" disputes that can involve a provider not in the plan. For example, the provider may want to participate in, or dispute, some out-of-plan payment policy.

Finally, there are also a series of "purchaser/plan/provider" disputes arising. In some markets, the larger employers are beginning to determine and select provider networks without regard to a plan's decisions. Thus, it can be anticipated that "provider v. purchaser v. plan" disputes will arise, especially as data collection and reporting begin to dominate, and plans and providers dispute the data/reports.

### B. Matching ADR Process to Dispute Type

The Commission considered developing a matrix that matched specific types of managed health care disputes to specific ADR methods. In the final analysis, however, it seemed more efficient and useful to identify both broad categories of potential disputes and subcategories of areas of conflict that would be well served by an ADR procedure. This is presented schematically in Exhibit IV of the Appendix (Matrix of Areas of Disputes Amenable to ADR). It was the consensus of the Commission that a form of ADR would be appropriate for resolving the identified categories and subcategories of disputes, but that identifying a particular form of ADR as the single most appropriate means of resolving a particular dispute type was an inappropriate limitation on the parties' discretion.

### C. Detailed Analysis of Potential Disputes

Managed health care disputes for which alternate dispute resolution is particularly appropriate include: medical necessity; length of stay; medical appropriateness of place or provider; situations requiring early coordination of treatment by various disciplines such as mental health or substance abuse planning or planning for outcomes among medical, social, psychological, legal and ethical experts; reduction or termination of services; over or under-utilization of resources or facilities; physician or patient concerns about utilization incentives or disincentives; bioethical conflicts; staff disagreements; interpersonal disputes; access to appropriate procedures and equipment and access between providers and outside networks; and, in general, disputes involving non-monetary outcomes.



Health care ADR is best and most effective where the parties have legitimate and serious issues in dispute, and external review of a decision made by a managed health care organization is called for. Generally, limitations on such use of ADR processes for external review should be by exception only. At the same time, appropriate thresholds should be established so as not to overburden available health care ADR resources with either frivolous claims involving mere misunderstandings or miscommunications, or disputes of such high complexity as to defy resolution (e.g. whether the plan should be essentially re-written to cover new cutting edge, experimental technology or treatment). Unequivocal contract provisions, such as health care insurance eligibility requirements and coverage limitations and exclusions, are generally not appropriate for health care ADR because it is usually not the province of ADR to rewrite unambiguous contract provisions. Intra-family disputes over treatment plans or modalities are probably best dealt with by other means.

ADR processes are, however, well suited to managed health care situations where the need for specialized, confidential, non-precedential disposition is critical. ADR is particularly valuable when rules are unclear or are ambiguous or where the stakes for the interested parties are very high, or where strong emotions such as distrust or the need for retribution are present. In a typical indemnity health plan, grievances by consumers usually involve denial of payment to providers after services have been rendered. In a managed health care arrangement, services are pre-authorized and disputes usually involve denial of access to health care services. The majority of disputes between the consumer and the private managed health care organization thus involve benefit coverage issues and coverage for out of plan services. These potential areas of conflict are set forth below.

1. Health Plan Coverage Issues (within health plan or with affiliated providers)
  - a. Surgical procedures (denial for surgery, usually elective surgery)
  - b. Cosmetic surgery (denial of request for service)
  - c. Dental/oral surgery (denial of request for service)
  - d. Durable medical equipment (denial of requests for equipment)
  - e. Procedures and tests (denial of specific lab tests, x-rays, other diagnostic procedures)
  - f. Physical therapy/occupational therapy (denial of request for services)
  - g. Denial of referral from primary care provider to specialists or other providers requiring Referrals
  - h. Mental health services (denial of request for specific therapy or treatment program length)
  - i. Second opinions
  - j. Restricted formulary (denial of specific medications and treatment regimens not included in health plan formulary)
  - k. Excessive wait time for access to needed service
  - l. Home health care benefits
  - m. Length of stay (discharge from hospital or other health care facility before consumer feels he/she is able)
  - n. Hospice
2. Out of Health Plan Coverage Issues (not part of plan or nonaffiliated providers)
  - a. Out of area (out-of-state) coverage for needed medical services
  - b. Emergency services (nonaffiliated hospital/ER)



- c. Access to nonaffiliated primary care providers
- d. Access to nonaffiliated specialty care providers
- e. Access to nonaffiliated mental health services
- f. Admission to nonaffiliated hospitals
- g. Second opinions with nonaffiliated providers (primary care or specialty care)
- h. Access to nonaffiliated dental/oral surgery
- 3. Access to nontraditional/"alternative" Medical Care
- 4. Experimental Care/"Last Chance" Therapy (as stated above, the issue amenable to ADR is not whether the contract should be re-written to include experimental care or "Last Chance" Therapies—since managed health care plans may specifically exclude such coverage—but, in instances in which experimental care is a covered benefit, whether such treatment is medically necessary or appropriate)
- 5. Continuity of Care Issues (continued treatment of preexisting conditions by current provider not affiliated with the health plan when health plan coverage is switched: pregnancy, oncology, primary care/continuation of treatment plan including prescriptions)
- 6. Time-Sensitive Situations (any dispute between a consumer and a health plan where the timing of access to the disputed service has a permanent adverse effect on treatment outcome: emergency care, out-of-state care, transplants, oncology, surgery, potentially terminal conditions)
- 7. Customer Service Issues (complaints regarding health care providers, health care workers, processes, wait times)



## XII. Due Process Standards

### A. Background

The members of the Commission believe that mediation and arbitration of health care disputes—conducted with proper due process safeguards—should be encouraged in order to provide expeditious, accessible, inexpensive, and fair resolution of disputes. As ADR systems are developed for resolving private managed health care disputes, it is essential that such systems provide adequate levels of procedural due process protections for all involved.

The nature of the relationship between plans and patients or providers is such that little, if any, negotiation over terms—including external review or ADR systems—takes place. Since these ADR systems or external review procedures will invariably not be the product of a negotiated agreement, the Commission believes it would be especially useful to set forth key aspects of procedural due process, to ensure a “level playing field” for resolving health care disputes by ADR. Similarly, these due process protocols can serve as guidance for legislators or regulators as they focus on establishing fair and appropriate methods for resolving health care disputes.

Due process protocols for the use of ADR have also been developed in two other areas—employment and consumer—where, as in health care, the establishment and terms of the ADR system are matters not generally subject to negotiation. Those protocols, which the Commissioners drew upon in developing the *Due Process Protocol for the Resolution of Health Care Disputes*, appear respectively as Exhibits V and VI of the Appendix of this Report.

### B. Covered Relationships

The Due Process Protocol for the Resolution of Health Care Disputes contained in this section was developed for a wide range of transactions arising out of the private managed health care relationship. As described in Section XI of this Report (Areas in the Private Managed Health Care Environment Where ADR Can Be Helpful), these can include: “consumer v. plan” disputes, “provider v. plan” disputes, and “purchaser v. plan v. provider” disputes.

The purpose of the Protocol is not to define each and every type of health care dispute in which due process standards for the use of ADR are needed. The Commission believes that as a matter of general principle, any ADR system developed in the health care environment would be well-served by adhering to the due process concepts articulated below.

### C. A Due Process Protocol for Resolution of Health Care Disputes

#### *Principle 1: Fundamentally Fair Process*

All parties are entitled to a fundamentally fair ADR process. As embodiments of fundamental fairness, these Principles should be observed in structuring ADR Programs.



### *Principle 2: Access to Information Regarding ADR Program*

Full and accurate information regarding the program, in writing, should be provided by the plan to patients and providers in plain, easily understood language. If a substantial number of users speak languages other than English, the material describing the program should be available in other languages. The information regarding the program should include a description of the process, the role of the parties, the means of selecting neutrals, the rules of conduct of the parties and the neutrals, and an accurate description of fees and expenses.

After a dispute arises, participants should have access to all information necessary for effective participation in ADR. Disputes over exchanges of information should be resolved by the neutral.

### *Principle 3: Knowing and Voluntary Agreement to use ADR*

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.

### *Principle 4: Neutrality and Independence*

1. *Independent and Impartial Neutral:* All parties are entitled to a neutral who is independent and impartial.
2. *Independent Administration:* Administration of the ADR program should be neutral, and independent of the parties. In no event should the ADR program be administered by the health plan. Administrative services should include the maintenance of a panel of prospective neutrals, facilitation of neutral selection, collection and disbursement of neutral fees and expenses, oversight and implementation of ADR rules and procedures, and monitoring neutral qualifications, performance, and adherence to pertinent rules, procedures, and ethical standards.
3. *Standards for Neutrals:* The rules of administration should guarantee impartiality in selecting neutrals and require conformity with ethical standards of conduct.
4. *Selection of Neutrals:* All parties should have an equal voice in the selection of neutrals in connection with a specific dispute.
5. *Disclosure and Disqualification:* Neutrals should be required to disclose to the administering agency any circumstance likely to affect impartiality, including any bias or financial or personal interest which might affect the result of the ADR proceeding, or any past or present relationship or experience with the parties or their representatives, including past ADR experiences. The administrator should communicate any such information to the parties and other neutrals, if any. Upon objection of a party to the continued service of a neutral, the administrator should determine whether the neutral should be disqualified and should inform the parties of its decision. The disclosure obligation of the neutral and procedure for disqualification should continue throughout the period of appointment.

### *Principle 5: Quality and Competence of Neutrals*

All parties are entitled to competent, qualified neutrals. ADR administrators are responsible for establishing and maintaining standards for neutrals in ADR programs they administer. Neutrals serving in health care disputes should have



knowledge and experience in health care matters. Disputes concerning the provision of medical care based on medical necessity standards should be resolved by neutrals who are qualified to render medical decisions in the particular medical branch and related specialty involved in the dispute.

The creation of a roster containing the foregoing qualifications dictates the development of a training program to educate existing and potential mediators and arbitrators as to the relevant law, and the substantive, procedural and remedial issues likely to be encountered in the conduct and control of arbitration hearings and mediation sessions.

#### *Principle 6: Right to Representation*

It is recommended that plans provide, at their expense, the services of an ombudsperson whose function would be to explain the dispute resolution process to patients, and to provide an initial screening of the case.

All parties participating in the ADR process have the right, at their own expense, to be represented by an attorney or other spokesperson of their own choosing. The ADR procedures should direct the parties to referral services for representation of bar associations, legal service associations, unions, consumer organizations, and the like.

#### *Principle 7: ADR Hearings*

1. *Fair Hearing:* The pre-hearing and hearing should be conducted with adequate notice and with a fair opportunity to be heard and to present relevant evidence and witnesses. There should be a right to examine and cross-examine witnesses, and to argue orally and/or in writing. The right to present relevant evidence should include access to relevant books and records. The hearing and determination through mediation or arbitration should be private and confidential, unless the parties agree otherwise.
2. *Place of Arbitration or Mediation:* The place of the proceedings should be reasonably accessible to the parties and to the production of relevant evidence and witnesses. In cases involving a patient, the place should be in close proximity to the patient's place of residence. If the parties are unable to agree on the place of arbitration or mediation, the administering agency or the neutral should determine that issue. In a case of acute emergency, it may be appropriate to conduct the arbitration or mediation by telephone or other electronic means.
3. *Confidentiality:* Consistent with general expectations of privacy in ADR, the neutral should make reasonable efforts to maintain the privacy of ADR hearings to the extent permitted by applicable law. In arbitration, the arbitrator should carefully consider claims of privilege and confidentiality in addressing evidentiary issues.

#### *Principle 8: Reasonable Time Limits*

ADR proceedings should occur within a reasonable time, and without undue delay. The rules governing ADR should establish specific reasonable time periods for each step in the ADR process and, where necessary, set forth default procedures in the event a party fails to participate in the process after reasonable notice. The Commission recommends the following general timeframes for resolving disputes: acute emergencies—24 hours; emergencies—72 hours; non-emergencies—60 days.



### *Principle 9: Settlement in Mediation or Award in Arbitration*

1. *Mediation Settlement:* Any settlement in mediation or other non-binding form of ADR should be in writing.
2. *Arbitration Award:* The arbitration award should be in writing, and should be accompanied by an opinion, where requested by any party. In the case of an acute emergency, the arbitrator may make a preliminary award orally. The arbitrator should be empowered to grant whatever relief would be available in court under law or in equity. There should be limited judicial review. Courts should defer to the arbitrator's award absent manifest disregard of clearly defined governing law.

### *Principle 10: Costs in Mandated, Nonbinding ADR Processes*

If mediation is mandated, the cost thereof should be at the expense of the health plan.

As provided in Principle 3, binding ADR arbitration should not be mandated in cases involving patients. Nonbinding arbitration may be required, as can binding arbitration in cases not involving patients, in which case the plan should pay the costs of at least one day of hearing before a single arbitrator, including the arbitrator's fees and expenses. If there are additional days of arbitration, or more than one arbitrator, the costs should be shared equally, subject to the arbitrator's authority to determine the allocation of costs.

## XIII. Conclusion

The Commission concludes that alternative dispute resolution has a valuable role to play in the resolution of disputes arising out of the private managed health care relationship. ADR complements internal review programs, serving as the next efficient and effective step for resolving unsettled claims. ADR can function effectively as a means of external review or appeal of determinations made by managed health care organizations. It is essential, however, that ADR programs be developed with due process safeguards for the rights of all participants in the process.

The Commission urges that its recommendations be used as guidance by legislative bodies, regulators, and policy leaders, as well as private managed health care organizations establishing ADR programs.



#### XIV. Planned Course of Future Action

The Commission met both its short-term major goal of the promulgation of an Interim Progress Report by late January 1998, and the longer-term goal of publication of this Final Report by the Summer of 1998. Each of the Commissioners has signed off on the Final Report as individuals representing, but not necessarily binding, their respective organizations. The Final Report will be presented for timely review by the three sponsoring organizations, and will then be widely disseminated to diverse groups (i.e., provider organizations, patient advocacy groups, employer groups, employee groups, labor, consumer groups, academia, government, regulatory agencies, managed health care organizations and health plans).

Following review by the three sponsoring organizations, a Final Report will be released.

The members of the Commission appreciate the opportunity to play a role in helping to shape the public debate over the use of ADR as a means of resolving disputes in the private managed health care arena.

Submitted this 27<sup>th</sup> day of July 1998

**George H. Friedman**

Commission Rapporteur and Secretary,

**To the Co-Chairs:** Jerome J. Shestack, Esq.; William K. Slate II, Esq.; Percy Wootton, M.D.



## Appendix

### I. Commission Roster

#### Commissioners

**Jerome J. Shestack, Esq.**

*Commission Co-Chair*  
President  
American Bar Association

**William K. Slate II, Esq.**

*Commission Co-Chair*  
President & CEO  
American Arbitration Association

**Percy Wootton, M.D.**

*Commission Co-Chair*  
President  
American Medical Association

#### For the AAA:

**Howard J. Aibel, Esq.**

*Partner*  
LeBoeuf, Lamb, Greene & MacRae

**Thomasina Rogers, Esq.**

*Former Director*  
Administrative Conference of the  
United States

**J. Warren Wood, III, Esq.**

*Vice President, General Counsel &  
Secretary*  
The Robert Wood Johnson  
Foundation

**Max Zimny, Esq.**

*General Counsel*  
UNITE

#### For the ABA:

**Arlin Adams, Esq.**

*Of Counsel*  
Schnader, Harrison, Segal & Lewis

**Kimberlee Kovach, Esq.**

University of Texas School of Law

**Lawrence Manson, Esq.**

*Partner*  
Lord, Bissell & Brook

**Roderick Mathews, Esq.**

*Partner*  
Hazel & Thomas, P.C.

#### For the AMA:

**Charles Barone, M.D.**

Henry Ford Health System

**Donald J. Palmisano, M.D., J.D.**

*Trustee*  
American Medical Association

**Carter Phillips, Esq.**

*Partner*  
Sidley & Austin

**Ron Pollack, Esq.**

*Executive Director*  
Families USA Foundation  
Staff

**George H. Friedman, Esq.**

*Commission Rapporteur and Secretary*  
Senior Vice President  
American Arbitration Association

**Scott Carfello, Esq.**

*Commission Recording Secretary*  
Regional Vice President, Chicago  
American Arbitration Association

**Jack Hanna, Esq.**

*Director*  
Section of Dispute Resolution  
American Bar Association

**Karla Kinderman, Esq.**

Health Law Division  
American Medical Association

**Marcia Kladder**

*Director, Media Relations*  
American Bar Association

**Carol O'Brien, Esq.**

*Director*  
Division of Representation  
American Medical Association

**Edwin Yohnka, Esq.**

*Special Presidential Assistant*  
American Bar Association



## II. Individuals and Organizations Contacted by the Commission for Written Submissions

| First Name | Last Name    | Title                    | Affiliation                                  |
|------------|--------------|--------------------------|----------------------------------------------|
| W. Andrew  | Adams        | CEO                      | National Health Care L.P.                    |
| Karen      | Agnagni      | CEO & President          | American Association of Health Plans         |
| Douglas    | Arpert       | Partner                  | Norton, Arpert, Sheehy & Higgins, P.C.       |
| Mike       | Astrue       |                          | Biogen, Inc.                                 |
| Mary Ellen | Bliss        | Federal Affairs Team     | American Association of Retired Persons      |
| Charles    | Birkett      | President & CEO          | Advocate Inc.                                |
| Chris      | Carey        | Staff Member             | House Comte. on Education & the Workforce    |
| E. Thomas  | Chaney       | CEO Community            | Health Systems, Inc.                         |
| Jay D.     | Christiansen | Chair Health             | Law Section, Faegre & Bensen                 |
| Jeanne A.  | Clement      | Assoc. Prof.             | Dept. of Community, Parent-Child & Psych.    |
| Leah       | Curtin       | Editor                   | Nursing Mgmt. Editorial Office               |
| James E.   | Dalton, Jr.  | CEO                      | Quorum Health Group, Inc.                    |
| Edward A.  | Dauer        | Dean                     | Emeritus University of Denver College of Law |
| Robert M.  | Dohrmann     | Chair                    | Schwartz, Steinsapir, Dohrmann & Sommers     |
| Michael    | Duffy        | Director                 | Mass. Consumers Affairs Commission           |
| Thomas     | Frist, Jr.   | CEO                      | Columbia/HCA                                 |
| Jeff       | Gabardi      | Counsel & Legal Director | Health Insurance Association of America      |
| John       | Gillmor      | Partner                  | Boult, Cummings, Connors & Berry             |
| Elizabeth  | Hadley       | Legislative Counsel      | National Association of Insurance Comms.     |



| First Name | Last Name | Title                     | Affiliation                                    |
|------------|-----------|---------------------------|------------------------------------------------|
| Jennifer   | Harwell   | General Counsel           | American Home Patient                          |
| Martin     | Hatlie    | Executive Director        | National Patient Safety Foundation at the AMA  |
| Alexis     | Herman    | Secretary of Labor        | U.S. Department of Labor                       |
| Thomas G.  | Hermann   | Chair                     | Squire, Sanders & Dempsey                      |
| Samuel H.  | Howard    | CEO                       | Phoenix Healthcare Corp.                       |
| William    | Hubbard   | Partner                   | Reed, Hubbard, Berry & Doughty                 |
| Cathy      | Hurwit    |                           | AFSCME                                         |
| Joseph C.  | Hutts     | CEO                       | Phycor, Inc.                                   |
| Michael A. | Jennings  |                           | The Prudential Insurance Co. of America        |
| Tom        | Jorgenson |                           | Calfee, Halter & Griswold                      |
| Matt       | Keast     | Staff Member              | Office of Hon. Cong. Charles Norwood           |
| Irene      | Koch      | Assistant General Counsel | Maimonides Medical Center                      |
| William    | Kowalski  |                           | AETNA                                          |
| Kurt       | Lawson    | Representative            | ABA Section of Taxation                        |
| Brian      | Lindberg  | Director                  | Coalition on Cons. Protection/Qlty. Hlth. Care |
| Ronald E.  | Mallen    | Chair                     | Special Committee on Medical Prof. Liability   |
| Mark       | Manner    | Partner                   | Harwell, Howard, Hyne, Gabbert & Manner        |
| Len        | Marcus    | Director                  | Health Care Negotiations                       |
| F. William | McAlpin   | Chair                     | ABA Commission - Legal Problems of the Elderly |
| Clayton    | McWhorter | Chairman                  | LifeTrust America                              |



| First Name    | Last Name        | Title                      | Affiliation                                     |
|---------------|------------------|----------------------------|-------------------------------------------------|
| Leigh B.      | Middleditch, Jr. | Chair                      | McGuire, Woods, Battle & Booth, LLP             |
| Julie         | Miller           | Director - Policy Analysis | Blue Cross & Blue Shield Association            |
| Mary C.       | Morgan           |                            |                                                 |
| Neil P.       | Motenko          | Partner                    | Nutter McConnen & Fish                          |
| Josephine     | Musser           | President                  | Office of the Commissioner of Insurance         |
| Jay           | Naftzger         | Chair                      | Rush Prudential Health Plans                    |
| Martha R.     | Nolan            |                            | United HealthCare                               |
| Margaret      | O'Kane           | President                  | National Comm. for Qual. Assurance ("NCQA")     |
| Kevin Francis | O'Malley         |                            |                                                 |
| Donald        | Palmisano        | Trustee                    | American Medical Association                    |
| Scott         | Phelps           |                            |                                                 |
| Ron           | Pollack          | Executive Director         | Families USA Foundation                         |
| Samuel H.     | Porter           | Partner                    | Porter, Wright, Morris & Arthur                 |
| Richard G.    | Porter           | Partner                    | Grenn & Grenn, P.C.                             |
| Harriet       | Rabb             | General Counsel            | Department of Health & Human Services           |
| Paul Williams | Raymond          | Chair                      | Employment Benefits Committee, Sec. of Taxation |
| David         | Richardson       | President                  | Center for Health Care Dispute Resolution       |
| Elizabeth     | Rolph            | Representative             | RAND Corporation                                |
| John          | Rother           | Director                   | Legislation & Public Affairs, AARP              |
| Mary          | Rowe             | Ombudsperson               | Sloan School                                    |



| First Name  | Last Name | Title              | Affiliation                                      |
|-------------|-----------|--------------------|--------------------------------------------------|
| Clarke      | Russ      | Director           | Institute for Conflict Resolution in Health Care |
| Ronald L.   | Sauders   | Executive VP       | Health Insurance Association of America          |
| Andrea      | Schleifer |                    | Solo Practice & Small Firms                      |
| Alan G.     | Selbst    |                    | Houston Endodontic Specialists                   |
| Howard      | Shapiro   |                    | McCalla Thompson et al                           |
| Robin S.    | Shapiro   | Chair              | Michael, Best & Friedrich                        |
| Robin       | Siegel    | Chair              | Gordon, Feinblatt, Rothman et al.                |
| Louis       | Soccoccio | General Counsel    | American Association of Health Plans             |
| Robert A.S. | Silberman | Chair              | Edwards & Angell                                 |
| Carl M.     | Stevens   | Emeritus Professor | Reed College                                     |
| Lance       | Tibbles   | Co-Director        | Capital University Law School Ethics Institute   |
| Grey        | Till      | General Counsel    | Blue Cross & Blue Shield Association             |
| David       | Vladeck   | Director           | Public Citizen Litigation Group                  |
| Katie       | Wade      |                    | CIGNA                                            |
| Robert      | Wagener   |                    | Center for Medical Ethics & Mediation            |
| Gayle       | Warden    | President & CEO    | Henry Ford Health Systems                        |
| Linda R.    | Williams  |                    |                                                  |
| Roger       | Wilson    | Senior VP & GC     | Blue Cross & Blue Shield Association             |
| Alan        | Wise      | CEO                | Coventry Corp                                    |
| Edward K.   | Wissing   | CEO                | American Home Patient, Inc.                      |



### III. Alternative Dispute Resolution Models

The models set forth below are by no means exhaustive; they represent sensible approaches to the major forms of alternative dispute resolution. In designing any ADR system, care should be taken to tailor the system to the specific needs of the parties. Guidance on the process of developing dispute resolution systems, as well as model language for various provisions and features of ADR clauses, can be found in *Drafting Dispute Resolution Clauses*, published by the American Arbitration Association (1997).

#### A. Ombuds

The ombuds process involves a neutral third party who is often employed or appointed by an institution, whose primary role is the investigation of complaints, as well as their prevention and resolution. An ombudsperson may also make recommendations with respect to the resolution of the matter, but cannot make a binding decision.

The most even-handed, fair, and appropriate ADR system will not work effectively if parties are not aware of the existence of the program, or are not educated as to how the system works. Therefore, another key role of the ombudsperson is to provide information on the dispute resolution process, both internal and external. In effect, the ombudsperson serves as a system guide to users, providing useful information about how the managed health care organization resolves disputes.

With regard to those matters involving the provision of health care, it is suggested that those plans which desire to put in place an ombuds system of dispute resolution observe the following guidelines. The ombuds should be a person with a medical education and experience. While the ombuds will likely be an employee of the managed health care organization, it is suggested that the ombuds process, if opted for, should also involve the participation of the patient's family and/or significant other, where desired and appropriate. While much should be left to the discretion of the ombudsperson, it is recommended that the health care provider, as well as the plan decision maker, also be included in the preliminary discussions and fact gathering.

In some models, the ombudsperson's function is strictly neutral. In others, the ombudsperson acts as a patient advocate. The Commission takes no position on which model is most desirable.

#### B. Mediation

In mediation, a neutral third party, the mediator, facilitates the voluntary and mutually acceptable resolution of a dispute. A non-adversarial approach to dispute resolution, mediation emphasizes direct communication among the parties and creativity in problem solving. The mediator's role is to help the disputants explore issues, needs and settlement options. The mediator may point out issues that the disputants may have overlooked and in some instances offer suggestions, but resolution of the dispute rests with the disputants themselves.

- The benefits of successfully mediating a dispute to settlement vary, depending on the needs and interests of the parties. The most common advantages are that:
  - parties are directly engaged in the negotiation of the settlement;



- the mediator, as a neutral third party, can view the dispute objectively and can assist the parties in exploring alternatives which they might not have considered on their own;
- as mediation can be scheduled at an early stage in the dispute, a settlement can be reached more quickly than in litigation;
- parties generally save money through reduced legal costs and less staff time;
- parties enhance the likelihood of continuing their business relationship;
- creative solutions or accommodations to special needs of the parties can become a part of the settlement;
- a high probability of settlement. A frequently-cited mediation settlement rate is 85% (statistical data provided by the American Arbitration Association, Client Services Group, June 1998).

## 1. Providing for Mediation

The parties can provide for the resolution of future disputes by including a mediation clause in their contract. A typical mediation clause reads as follows:

*If a dispute arises out of or relates to this policy/contract or the breach thereof and if the dispute cannot be settled through negotiation, the parties agree first to try in good faith to settle the dispute by mediation administered by [named ADR provider], prior to resorting to arbitration, litigation, or some other dispute resolution procedure.*

The clause may also provide for the qualifications of the mediator, the method of payment, the locale of meetings, and any other item of concern to the parties.

## 2. Requesting and Scheduling the Mediation

Although mediations can originate at various times, including as an adjunct procedure to pending litigation (including appeals), it is anticipated that mediation will occur when a dispute between the patient and the managed health care organization initially arises and before other, more formal means of dispute resolution such as arbitration or a lawsuit is initiated.

In the case of health care, timing is of the essence and the mediation agreement (or mediation clause) should specifically spell out the time within which a mediation must be conducted, after such has been requested or demanded. In fact, one of the primary advantages to the mediation process is that a mediation conference can be scheduled very quickly and requires a relatively small amount of preparation time. In cases of emergency, the mediation should be scheduled in accordance with the time frames in Principle 8 of the *Due Process Protocol for the Mediation and Arbitration of Health Care Disputes* (Section XII of this Final Report).

When a party files a Request for Mediation, the requesting party should forward a copy of the mediation clause contained in the contract under which the dispute arose.



The mediation should be conducted at a location which is convenient for both the patient and family as well as the provider and the plan decision maker. Priority consideration should also be given to the health and well being of the patient in terms of the ability to travel, when determining the location of the mediation session. The duration of the mediation session itself may also need to be abridged if the patient's health imposes such limitations. Consideration should also be given to the managed health care organization decision-maker, particularly in non-emergency matters, such as the ability to participate in several mediations at a given time.

In those situations where the health of a party makes it difficult for their personal appearance at the mediation, latitude should be given to the mediator for the use of telephones, video conferencing, and the Internet as alternative methods for communication and participation (*Protocol*, Principle 7(2)).

### 3. Qualifications and Selection of the Mediator(s)

Upon receipt of a Request for Mediation or the Submission to Dispute Resolution, the administrator will appoint a qualified mediator to serve on the case. All participants (which include family members or significant others of the patient seeking treatment, who are not considered actual parties) will be provided biographical information about the mediator. The parties are instructed to review the sketch closely and advise the administrator of any objections they may have to the appointment. Since it is essential that all parties have complete confidence in the mediator's ability to be fair and impartial, any mediator not acceptable to the parties will generally not serve. In the situation where there has not been a designation of an administrator, the party seeking the mediation should notify the other by the means specified in the mediation agreement, and the mediator will be selected as provided in the agreement of the parties.

Mediators serving in health care disputes should have knowledge and experience in health care matters. Disputes concerning the provision of medical care based on medical necessity standards should be heard by mediators who are qualified to render medical decisions in the particular medical branch and related specialty involved in the dispute (*Protocol*, Principle 5), although this is ultimately a matter for determination by the parties given the consensual, nonbinding nature of mediation. General dispute resolution qualities in mediators for these cases include, but are not limited to the following: commitment to impartiality and objectivity; dispute management skills, including excellent communication abilities; judicious temperament: impartiality; patience; courtesy; respect of bar or business community for integrity; strong academic background and professional or business credentials. The mediator must also be committed to compliance with the nationally-recognized *Model Standards of Conduct for Mediators*, promulgated by the American Arbitration Association, the American Bar Association, and the Society of Professionals in Dispute Resolution.

In some instances, the use of co-mediation may be appropriate. Co-mediation involves two mediators who simultaneously and equally mediate the matter. For example, in situations that are quite complex in terms of technology or science, where expertise from two or more disciplines is needed, it is advocated that the parties consider using a co-mediation model. And, in some cases where the number of parties affected, and hence participants in the process is large, or, where the issues presented for resolution are very diverse, co-mediation is also recommended.



#### 4. Participant Preparation for Mediation

To prepare for mediation, each of the participants may wish to define and analyze the primary issues in dispute, and recognize the parameters of the given situation. This would include what can realistically be expected, time constraints, available resources, legal ramifications, generally accepted practices, options for alternative treatment, costs, and the like. Each person or organization should also attempt to identify and prioritize the needs and interests in settling the dispute. Determination of alternative courses of action, positions, tradeoffs, and exploration of a variety of possible solutions in advance of the session can be helpful. To reach a mutually acceptable agreement through mediation, it is usually necessary that each party be willing to make reasonable and legitimate proposals, which accommodate needs of the other party. Since disputes are often the result of misunderstandings or a lack of understanding about the matter, parties should be prepared with facts, documents, and sound reasoning to support claims and desired outcome. In doing so, it is also helpful to the process if some consideration is given to the other party's needs, demands, strengths and weaknesses, positions, and version of facts and perceptions.

#### 5. Presence and Participation in the Mediation

All participants in the mediation should come to the session prepared with all of the information, including documentation that they feel will be necessary to discuss their respective cases. Parties are, of course, entitled to representation by counsel. At the beginning of the session, mediators describe the procedures and ground rules covering each party's opportunity to talk, order of presentation, decorum, discussion of unresolved issues, use of caucuses, and confidentiality of proceedings.

After the introductory matters, each party will be provided the opportunity to describe respective views of the dispute. The initiating party discusses his/her understanding of the issues, the facts surrounding the dispute, what he/she wants, and why. The other parties then have the same opportunity to make presentations. In this initial session, the mediator gathers as much information as possible and appropriate under the circumstances as well as attempts to clarify discrepancies. The mediator tries to understand the perceptions of each party, their interests, and their positions on the issues. It is imperative, however, that the mediator remain neutral on the issues, and refrain from providing an opinion on the ultimate outcome of the matter.

When joint discussions have reached a stage where no further progress is being made, the mediator may decide to meet with each party privately, or in caucuses. While holding separate sessions with each party, the mediator may shuttle back and forth. By discussing all options, parties can assess the consequences of continuing or resolving the dispute.

- Gaining certain knowledge or facts from these meetings, a mediator can selectively use the information derived from each side to:
- reduce the hostility between the parties and help them to engage in a meaningful dialogue on the issues at hand;
- open discussions into areas not previously considered or inadequately developed;
- communicate positions or proposals in understandable or more palatable terms;
- probe and uncover additional facts and the real interests of the parties;



- help each party to better understand the other parties' views and evaluations of a particular issue, without violating confidences;
- narrow the issues and each party's positions and deflate extreme demands;
- gauge the receptiveness for a proposal or suggestion;
- explore alternatives and search for solutions;
- identify what is important and what is expendable;
- prevent regression or raising of surprise issues; and
- structure a settlement to resolve current problems and future parties' needs.

## 6. The Role of the Mediator

The mediator acts as a facilitator to keep discussions focused and avoid new outbreaks of disagreement. The mediator also assists the parties in communicating with, and ultimately understanding, the other parties. In particular, the mediator should work with the parties to: narrow the issues and each party's positions, and deflate extreme demands; gauge the receptiveness for a proposal or suggestion; explore alternatives and search for solutions; structure a resolution which will not only resolve current problems, but moreover is likely to meet and satisfy the parties' needs in the future. The mediator serves not as an advocate for any party or position, but rather as an "agent of reality." The mediator is likely to urge each party to think through demands, priorities, and views, and deal with the other party's contentions.

During the mediation, whether in private or joint sessions, the mediator works with the parties to narrow differences and attempts to acquire agreement on both major and minor issues. At appropriate times, the mediator may offer suggestions about a final settlement, stress the consequences of failure to reach agreement, emphasize the progress which has been made, and formalize offers to achieve an agreement.

The mediator will often have the parties negotiate the final terms of a settlement while together in a joint session. The mediator will then verify the specifics of the agreement and make sure that the terms are comprehensive, specific, and clear in the final session.

## 7. The Mediated Settlement

It is anticipated that in the majority of cases, the mediation session will result in an agreement among the parties. In these cases, when the parties reach an agreement, the terms should be reduced to writing, usually by the mediator, or in the event of legal representation, the parties' lawyers, signed by all present, and copies distributed. In those matters where pending litigation exists, the parties or their counsel may also request that the agreement be put in the form of an agreed judgment or consent award. In the event that the issue is critical, from a medical standpoint, and time is of the essence, a party may elect to telephonically or electronically convey the agreement to the appropriate and necessary person or organization.

If the mediation fails to reach a settlement of any or all of the issues, the parties may agree to submit to binding arbitration. Such arbitration would be administered under the appropriate arbitration rules as agreed by the parties. In



accordance with most available mediation rules, court rules of evidence, or the parties' submission to mediation, the information offered in mediation may not be used in arbitration (or in subsequent litigation).

## 8. Costs

As provided in Principle 10 of the *Due Process Protocol for the Resolution of Health Care Disputes*, if mediation is mandated by the managed health care organization, the costs of the process (mediation filing fee, and mediator compensation and expenses) should be borne by the plan. If the parties mutually agree to utilize mediation, these costs should be borne equally or as otherwise agreed to by the parties.

In no instance should the mediator's compensation be contingent upon a specific outcome. Should any dispute arise about the costs of the mediation, it is recommended that such be submitted first to mediation, and in the event of no agreement, to arbitration. The neutral mediator or arbitrator should have no interest in the outcome of the fee dispute.

## C. Arbitration

Arbitration is referral of a dispute to one or more impartial persons for a decision on the matter. Arbitrations may result in either final and binding determinations, or alternatively, be merely advisory in nature. An adversarial process, arbitration results in a determination being made by a neutral third party, based upon the presentation of evidence and argument by the parties or their counsel. Private and confidential, it is designed for quick, practical, and economical settlements.

### 1. Providing for Arbitration

Arbitration clauses are common in a number of contracts. The clause will govern the procedure, and can be simple or quite detailed in the elements included. As provided in Principle 3 of the *Protocol*, in disputes involving patients, binding forms of ADR, such as arbitration, should be used only where the parties agree to same after a dispute arises. A binding arbitration clause, however, may be perfectly appropriate for other relationships in the private managed health care area, such as disputes between health care providers and managed health care organizations. A sample of a simple contractual arbitration clause for use in such instances is as follows:

*Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration administered by [named ADR provider] in accordance with its [applicable] rules and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.*

Parties can exercise additional control over the arbitration process by adding specific provisions to arbitration clauses or, when a dispute arises, through the modification of certain of the arbitration rules to suit a particular dispute. For example, stipulations may be made regarding confidentiality of proprietary information used, evidence, locale, the number of arbitrators, and the issues subject to arbitration. The parties may also provide for expedited arbitration procedures, including the time limit for rendering an award, if they anticipate a need for hearings to be scheduled on short notice. It is anticipated that this will likely be the case in a number of situations addressed in the health care area. All such mutual agreements will be binding on the administrator of the process, as well as the arbitrator.



For disputes involving patients, there are two ways to provide for post-dispute submission to binding arbitration. The first is to include a provision in the managed health care policy providing consideration of submission to binding arbitration, after a dispute arises. The following clause can be utilized:

*Any controversy or claim arising out of or relating to this policy/contract that is not resolved by the parties, shall, upon the written agreement of the parties after the dispute arises, be settled by arbitration administered by [named ADR provider] under its [applicable] rules, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.*

If the managed health care policy does not provide for optional, post-dispute binding arbitration, the parties are free to submit an existing dispute to arbitration by using the following clause:

*We, the undersigned parties, hereby agree to submit to arbitration administered by the [named ADR provider] under its [applicable] rules the following controversy: (cite briefly). We further agree that the above controversy be submitted to (one) (three) arbitrator(s). We further agree that we will faithfully observe this agreement and the rules, that we will abide and perform any award rendered by the arbitrator(s), and that judgment of the court having jurisdiction may be entered on the award.*

## 2. Timing of Agreement to Arbitrate

As stated in Section X(B) of this Final Report (ADR Models) there are four major types of agreements to arbitrate:

- pre-dispute, final and binding arbitration
- pre-dispute, nonbinding arbitration
- post-dispute, final and binding arbitration, and
- post-dispute, nonbinding arbitration.

It is worth elaborating on what these concepts mean:

**Pre-dispute, final and binding arbitration:** The parties agree in advance to use arbitration to resolve disputes and they are bound by the outcome.

**Pre-dispute, nonbinding arbitration:** The parties agree in advance to use arbitration to resolve disputes, but they are not bound by the outcome.

**Post-dispute, final and binding arbitration:** The parties have the option, after a dispute arises, of deciding to arbitrate unresolved issues, and they are bound by the outcome.

**Post-dispute, nonbinding arbitration:** The parties have the option, after a dispute arises, of deciding to arbitrate unresolved issues, but they are not bound by the outcome.



The first form of arbitration (pre-dispute, final and binding arbitration) engendered considerable discussion among the Commission members. As provided in Principle 3 of the *Due Process Protocol for the Resolution of Health Care Disputes*, the agreement to use arbitration (or any form of ADR) should be knowing and voluntary. This of course assumes that full and accurate information regarding the ADR program is provided by the plan to participants (*Protocol*, Principle 2). In the Commission's view, participation in ADR should not be a requirement for receiving emergency medical care or treatment, (*Protocol*, Principle 3), and good practice dictates that a patient in an emergency situation not be approached at that time to consent to ADR.

As regards binding arbitration, it may be technically correct that a provision in a managed health care plan requiring binding arbitration is "voluntary" in the sense that a patient or subscriber who has received clear notice of this fact has, by accepting the health coverage, agreed to this term of the policy. Nonetheless, it was the Commissioners view that in disputes involving patients, binding arbitration should be used only where the parties agree to arbitrate after a dispute arises (*Protocol*, Principle 3).

### 3. Benefits of Arbitration

Arbitration has several claimed or perceived benefits. To a certain extent, the benefits may be inferred either from experience or from knowledge of the arbitration process. There has been some research which sets forth the perceptions of participants in the ADR process (see, for example, Deloitte & Touche Litigation Services 1993 *Survey of General and Outside Counsels: Alternative Dispute Resolution* (1993)). Major benefits of arbitration are as follows:

- *Expert Neutrals*: The arbitrators have expertise in the subject matter in dispute, as well as training in the arbitration process;
- *Speed*: There is no docket or backlog in arbitration. Hearings are scheduled as soon as the parties and the arbitrator have dates available;
- *Cost Savings*: Because of the limited discovery and the informal hearing procedures, as well as the expedited nature of the process, the parties save on legal fees and transactional costs;
- *Confidentiality*: Arbitration is a private process. There is generally no public record of the proceedings; and
- *Limited Discovery*: Extensive, litigation-like discovery is generally not associated with arbitration. Necessary document exchanges will take place as directed by the arbitrator.

### 4. Administration; Requesting and Scheduling Arbitration

It was the Commission's view that administration of ADR arising out of health plans be neutral and independent of the parties, and that in no event should an ADR program be administered by a health plan (*Protocol*, Principle 4(1)). This will ensure to a reasonable extent that administration of disputes will be handled with dispatch and without inherent conflicts of interest. This element of the Protocol is in accord with the leading court case dealing with the issue of independence of ADR case administration, *Engalla v. Kaiser Permanente Medical Group Inc.*, 938 P.2d 903 (Cal. 1998).

In an administered system, the administrator will be responsible for the management of most details and arrangements. In each matter, the designated administrator would consult all parties and arbitrators to determine a mutually convenient day and time for the hearing. If the parties cannot agree, the arbitrator is empowered to set dates.



All parties should endeavor to conduct the arbitration hearing at a location that is convenient for both the patient and family as well as the provider and the plan decision-maker. In some instances, this will require travel costs for the arbitrator, and such should be allocated in the agreement to arbitrate, if not in a prior arbitration clause. As provided in Principle 8 of the *Due Process Protocol*, consideration should also be given to the health and well-being of the patient in terms of the ability to travel, when determining the location of the hearing.

At the request of any party, or at the discretion of the administrator, an administrative conference with the administrator and the parties and/or their representatives will be scheduled in appropriate cases to expedite the proceedings. This is particularly pertinent in cases where time is critical and life threatening matters are at issue.

## 5. Qualifications and Selection of Arbitrators

Selected qualities in arbitrators include the following: commitment to impartiality and objectivity; dispute management skills; judicious temperament: impartiality, patience, courtesy; respect of bar or business community for integrity; and strong academic background and professional credentials. Arbitrators serving in health care disputes should have knowledge and experience in health care matters. Disputes concerning the provision of medical care based on medical necessity standards should be resolved by arbitrators who are qualified to render medical decisions in the particular medical branch and related specialty involved in the dispute (*Protocol*, Principle 5).

The conduct of arbitrators should be guided by the *Code of Ethics for Arbitrators in Commercial Disputes* of the AAA and ABA (*Protocol*, Principle 4(3)).

## 6. Preparation for the Arbitration Hearing

The administrator will usually be in contact with the parties and/or their representatives in advance of the hearing. Because arbitration is an adversarial procedure, direct communication between the parties should be generally prohibited so to avoid the danger that one side will offer arguments or evidence that the other has no opportunity to rebut.

In complex cases, at the request of any party or at the discretion of the arbitrator or the administrator, a preliminary hearing with the parties and/or their representatives may be conducted. In addition, in order to expedite the process, documents should be exchanged and provided to the arbitrator(s) at least three days in advance, except for those cases scheduled within less than seven days. In those instances, the document exchange shall be no less than 24 hours, unless so waived by agreement.

The right to representation in arbitration by counsel or another authorized person is guaranteed by the *Due Process Protocol* set forth herein (Principle 6), as well all modern arbitration statutes. A party who desires to be represented should notify the other side and file a copy of the notice with the case administrator at least three days before the hearing. When arbitration is initiated by a representative or when the respondent replies through a representative, however, such notice is deemed to have been given.



If a transcript of the hearing is needed, the parties are responsible for making the arrangements and notifying the other parties of such arrangements in advance of the hearing. In those instances where a party is unable, due to health difficulties, to be present at the arbitration, the arbitrator should be immediately notified and measures undertaken to provide an alternative method of testimony, such as telephone, videotape, video-conferencing and the use of the Internet.

## 7. Presentation of the Case

Arbitration hearings are conducted somewhat like court trials, except that arbitration is usually less formal. Arbitrators are generally not required to follow strict rules of evidence, unless otherwise agreed by the parties. They must hear all of the evidence material to an issue but they may determine for themselves what is relevant. Arbitrators will therefore be inclined to accept evidence that might not be allowed by judges. However, this does not mean that all evidence will be considered of equal weight. Direct testimony of witnesses is usually more persuasive than hearsay evidence, and facts will be better established by documents and exhibits than by argument only.

In these situations where the health of one party makes it difficult for personal appearance at the arbitration hearing, wide latitude should be given by the arbitrator(s) for the use of video-conferencing, the Internet, and other modes of communication that can obviate the need for an in-person hearing, if deemed necessary by the arbitrator. Furthermore, in cases of acute emergency, the arbitrator may determine to conduct the hearing by telephone (*Protocol*, Principle 7(2)), and other creative means, such as the Internet.

It is customary for the claimant to proceed first with its case, followed by the respondent. This order may be varied, however, when the arbitrator thinks it necessary. In any event, the “burden of proof” is not on one side more than the other; each party must try to convince the arbitrator of the correctness of its position and no hearing is closed until both have had a full opportunity to do so. That is why it is equally the responsibility of the claimant and the respondent to present their cases to the arbitrator in an orderly and logical manner. This may include:

- An opening statement that clearly but briefly describes the controversy and indicates what is to be proved. Such a statement lays the groundwork and helps the arbitrator understand the relevance of testimony to be presented.
- A discussion of the remedy sought. This is important because the arbitrator’s power is conferred by the agreement of the parties. Each party should try to show that the relief it requests is within the arbitrator’s authority to grant.
- Introduction of witnesses in a systematic order to clarify the nature of the controversy and to identify documents and exhibits. Cross examination of witnesses is important, but each party should plan to establish its case by its own witnesses.
- A closing statement that should include a summary of the evidence and arguments and a refutation of points made by the opposition.

Above all, a cooperative attitude is essential for effective arbitration. Overemphasis or exaggeration, concealment of facts, introduction of legal technicalities with the objective of delaying proceedings is discouraged.



## 8. The Role of the Arbitrators

The arbitrator's role is akin to that of a judge hearing a case without a jury: to listen to the presentations, review the evidence presented, and upon evaluation, make a decision on the matter. The arbitrator is not bound by the strict rules of evidence or trial procedure, unless same is desired by the parties.

## 9. The Award

The award is the decision of the arbitrator on the matters submitted to him or her under the arbitration agreement. If the arbitration panel consists of more than one arbitrator, the majority decision is binding. The purpose of the award is to dispose of the controversy finally and conclusively, and to rule on each claim submitted. While the arbitrator is generally viewed as a "creature of the parties' contract," and must make his or her award within the limits of the arbitration agreement, the *Protocol* (Principle 9(2)) provides that "the arbitrator should be empowered to grant whatever relief would have been available in court under law or in equity."

The award as a matter of law must be in writing. The *Protocol* (Principle 9(2)) relaxes that requirement somewhat, in that in cases of acute emergency, the arbitrator is permitted to make a preliminary award orally. In such instances, however, a written award would still follow as required by law.

In general business disputes, arbitrators are not as a rule required to write opinions explaining the reasons for their decisions. In view of the issues involved in health care disputes, however, the Commission recommends that the award be accompanied by an opinion where requested by any party (*Protocol*, Principle 9(2)). An opinion would serve the dual purposes of helping a patient or provider better understand the outcome, and also serving as guidance to health plans in terms of future actions and behavior.

The power of the arbitrator ends with the making of the award. An award may not be changed by the arbitrator, once it is made, unless the parties agree to restore the power of the arbitrator or unless the law provides otherwise.

## 10. Costs

As provided in the *Protocol* (Principle 10) binding arbitration should not be mandated in disputes involving patients. It may be mandated in disputes not involving patients, as can nonbinding arbitration in any dispute. Where arbitration is mandated, the plan should pay the costs of at least one day of hearing before a single arbitrator (including the arbitrator's fee and expenses). If there are additional days of arbitration, the costs should be shared equally, subject to the power of the arbitrator to allocate costs. In some jurisdictions, the dominant party may be required to pay all arbitrator compensation where the use of arbitration is mandated by that party (see, e.g., *Cole v. Burns International Security Services*, 105 F.3d 1465 (D.C. Cir. 1997) (employment arbitration)).

Where arbitration is consensual, the administrative fees and the costs of compensating the arbitrator will generally be borne as provided in the parties' arbitration agreement. Failing that, administrative fees are generally advanced by the



filing party, and arbitrator's compensation is advanced equally by the parties. Both of these costs may be allocated by the arbitrator in the award.

Arbitrators generally charge a rate consistent with his or her stated rate of compensation, beginning with the first day of service. Should any dispute arise about the costs of the proceeding, it is recommended that such be submitted first to mediation, and, in the event of no agreement, to arbitration.

#### D. Hybrid Processes of ADR

In some instances, two or more ADR processes may be combined or used succeeding one another; this is often referred to as hybrid procedures. The advantage of such an arrangement is that if one process fails to achieve resolution, additional procedural options exist, and, where the final step is binding arbitration, comes with the assurance of finality. In situations where time is of the essence, it is important that the parties have the capability of achieving a final resolution rapidly.

One example of a hybrid ADR form is Mediation/Arbitration (Med/Arb). A clause can be inserted into a contract that provides first for mediation under an agreed upon set of mediation rules. In the event the mediation does not reach resolution of the matter, then the dispute would then go to arbitration under the agreed upon arbitration rules. Set forth below is a sample med/arb clause:

*If a dispute arises out of or relates to this policy/contract, or the breach thereof, and if said dispute cannot be settled through direct discussions, the parties agree to first endeavor to settle the dispute in an amicable manner by mediation administered [named ADR provider] under its Mediation Rules. Thereafter, any unresolved controversy or claim arising out of or relating to this contract, or breach thereof, shall upon the written agreement of the parties after the dispute arises, be settled by arbitration administered by [named ADR provider] in accordance with its [applicable] Rules, and judgment upon the Award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.*



#### IV. Matrix of Areas of Disputes Amenable to ADR

##### *In Plan*

| Disputed Service                        | Timeframe for resolution                | Example                                                               | Comments                                                                          |
|-----------------------------------------|-----------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| Surgical Services                       | Depends on procedure<br>Maximum 30 days | Hysterectomy                                                          | 2nd opinion useful; clinical guidelines                                           |
| Cosmetic Surgery                        | 6 months +                              | Breast reduction or augmentation                                      | Psychological effects of not doing need consideration                             |
| Dental/Oral Surgery                     | 90 days                                 | TMJ dysfunction                                                       | Separate dental insurance may cover                                               |
| Durable Medical Equipment               | 30 days                                 | Glucose monitor for diabetics, wheel chairs, nebulizers               | Clinical standards/ guidelines useful                                             |
| Procedures & Tests                      | 30 days                                 | CT Scan for headaches, repeat cholesterol tests, abdominal ultrasound | Clinical standards/ guidelines useful                                             |
| Physical Therapy & Occupational Therapy | 30 to 60 days                           | Excess services per plan<br>speech therapy for children               | For children: overlap<br>Coverage with school system;<br>work disability an issue |
| Denial of Referral                      | 30 days                                 | Dermatology, OB/GYN, Ortho                                            | Limited referral may be acceptable;<br>open access to OB/GYN recommended          |
| Mental Health                           | 30 to 60 days                           | Length of treatment, length of stay                                   | opinion useful                                                                    |
| Second Opinion                          | 30 days                                 | In Network vs out of Network<br>2 <sup>nd</sup> opinion               | Can be used in mediation                                                          |



| Disputed Service                                     | Timeframe for resolution                   | Example                                                                                                      | Comments                                                                    |
|------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| Hospice                                              | 30 days                                    | Terminal cancer care                                                                                         | Quality of "end of life"                                                    |
| Restricted Formulary                                 | 60 days                                    | Paxil instead of Prozac;<br>generic vs nongeneric; switch<br>of medication                                   | 2nd opinion; clinical guidelines                                            |
| Excessive Wait Times                                 | 30 days                                    | Waits of 60 days for<br>diagnostic services                                                                  | Service standards should be in place                                        |
| Home Health Care                                     | 30 days                                    | Number of visits for specific<br>care 24hr neonatal discharge<br>follow-up; early discharge<br>from hospital | With decreasing LOS in hospitals, more<br>need for home health care nursing |
| Length of Stay                                       | 24 hours                                   | Any discharge felt to be early                                                                               | Goal of hospitalization should be<br>communicated to patient on admission   |
| Out of area coverage for<br>medical services         | 30 days—sooner if care is<br>emergent      | Dispute would normally be<br>regarding payment after<br>services rendered                                    | Health plans should have provisions for<br>out of area coverage             |
| Emergency services                                   | 30-60 days if service has been<br>rendered | Dispute would normally be<br>regarding payment after<br>services rendered                                    | Health plans should have "prudent<br>layperson" language for ER services    |
| Access to non affiliated<br>primary care providers   | 60 days                                    | Desire to keep personal<br>doctor                                                                            | Continuity of care issues                                                   |
| Access to non affiliated<br>specialty care providers | 30 days                                    | Desire to see previously seen<br>specialist or specific program                                              | Limited referral a possibility                                              |
| Access to nonaffiliated<br>mental health providers   | 30-60 days                                 | Desire to keep current<br>specialist; desire for specific<br>program                                         | Limited referral a possibility                                              |



| Disputed Service                                    | Timeframe for resolution                 | Example                                                              | Comments                                                              |
|-----------------------------------------------------|------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------|
| Admission to nonaffiliated hospital                 | Depends on nature of admission           | Desire for admission to University Hospital/ Mayo Clinic             | Limited referral a possibility                                        |
| Second opinion with nonaffiliated providers         | 30 days                                  | Desire for consultation at a University Hospital/Mayo Clinic         | Limited referral a possibility                                        |
| Access to nonaffiliated dental/oral surgery         | 30-60 days                               |                                                                      | Limited referral a Possibility                                        |
| Access to nontraditional "alternative" medical care | 60 days                                  | Chiropractic/podiatry if not covered; herbal treatments, acupuncture |                                                                       |
| Experimental care                                   | 30 days (or less depending on condition) | In the past, bone marrow treatments                                  | Should be part of study conducted by reputable health science program |
| Continuity of care issues                           | 30 days                                  | Switch of insurance during pregnancy, cancer treatment               |                                                                       |
| Time sensitive situations                           | Depends on medical condition             | Dialysis, cancer treatments, withdrawal                              |                                                                       |
| Customer service                                    | Varies                                   | Failure to respond to inquiry                                        |                                                                       |



## A Due Process Protocol for Mediation and Arbitration of Statutory Disputes arising out of the Employment Relationship

May 9, 1995

The following protocol is offered by the undersigned individuals, members of the Task Force on Alternative Dispute Resolution in Employment, as a means of providing due process in the resolution by mediation and binding arbitration of employment disputes involving statutory rights. The signatories were designated by their respective organizations, but the protocol reflects their personal views and should not be construed as representing the policy of the designating organizations.

### Genesis

This Task Force was created by individuals from diverse organizations involved in labor and employment law to examine questions of due process arising out of the use of mediation and arbitration for resolving employment disputes. In this protocol we confine ourselves to statutory disputes.

The members of the Task Force felt that mediation and arbitration of statutory disputes conducted under proper due process safeguards should be encouraged in order to provide expeditious, accessible, inexpensive and fair private enforcement of statutory employment disputes for the 100,000,000 members of the workforce who might not otherwise have ready, effective access to administrative or judicial relief. They also hope that such a system will serve to reduce the delays which now arise out of the huge backlog of cases pending before administrative agencies and courts and that it will help forestall an even greater number of such cases.

### A. Pre or Post Dispute Arbitration

The Task Force recognizes the dilemma inherent in the timing of an agreement to mediate and/or arbitrate statutory disputes. It did not achieve consensus on this difficult issue. The views in this spectrum are set forth randomly, as follows:

- Employers should be able to create mediation and/or arbitration systems to resolve statutory claims, but any agreement to mediate and/or arbitrate disputes should be informed, voluntary, and not a condition of initial or continued employment.
- Employers should have the right to insist on an agreement to mediate and/or arbitrate statutory disputes as a condition of initial or continued employment. Postponing such an agreement until a dispute actually arises, when there will likely exist a stronger predisposition to litigate, will result in very few agreements to mediate and/or arbitrate, thus negating the likelihood of effectively utilizing alternative dispute resolution and overcoming the problems of administrative and judicial delays which now plague the system.
- Employees should not be permitted to waive their right to judicial relief of statutory claims arising out of the employment relationship for any reason.
- Employers should be able to create mediation and/or arbitration systems to resolve statutory claims, but the decision to mediate and/or arbitrate individual cases should not be made until after the dispute arises.



The Task Force takes no position on the timing of agreements to mediate and/or arbitrate statutory employment disputes, though it agrees that such agreements be knowingly made. The focus of this protocol is on standards of exemplary due process.

## B. Right of Representation

### 1. Choice of Representative

Employees considering the use of or, in fact, utilizing mediation and/or arbitration procedures should have the right to be represented by a spokesperson of their own choosing. The mediation and arbitration procedure should so specify and should include reference to institutions which might offer assistance, such as bar associations, legal service associations, civil right organizations, trade unions, etc.

### 2. Fees for Representation

The amount and method of payment for representation should be determined between the claimant and the representative. We recommend, however, a number of existing systems which provide employer reimbursement of at least a portion of the employee's attorney fees, especially for lower paid employees. The arbitrator should have the authority to provide for fee reimbursement, in whole or in part, as part of the remedy in accordance with applicable law or in the interests of justice.

### 3. Access to Information

One of the advantages of arbitration is that there is usually less time and money spent in pre-trial discovery. Adequate but limited pre-trial discovery is to be encouraged and employees should have access to all information reasonably relevant to mediation and/or arbitration of their claims. The employees' representative should also have reasonable pre-hearing and hearing access to all such information and documentation.

Necessary pre-hearing depositions consistent with the expedited nature of arbitration should be available. We also recommend that prior to selection of an arbitrator, each side should be provided with the names, addresses and phone numbers of the representatives of the parties in that arbitrator's six most recent cases to aid them in selection.

## C. Mediator and Arbitrator Qualification

### 1. Roster Membership

Mediators and arbitrators selected for such cases should have skill in the conduct of hearings, knowledge of the statutory issues at stake in the dispute, and familiarity with the workplace and employment environment. The roster of available mediators and arbitrators should be established on a non-discriminatory basis, diverse by gender, ethnicity, background, experience, etc. to satisfy the parties that their interests and objectives will be respected and fully considered.



Our recommendation is for selection of impartial arbitrators and mediators. We recognize the right of employers and employees to jointly select as mediator and/or arbitrator one in whom both parties have requisite trust, even though not possessing the qualifications here recommended, as most promising to bring finality and to withstand judicial scrutiny. The existing cadre of labor and employment mediators and arbitrators, some lawyers, some not, although skilled in conducting hearings and familiar with the employment milieu is unlikely, without special training, to consistently possess knowledge of the statutory environment in which these disputes arise and of the characteristics of the non-union workplace.

There is a manifest need for mediators and arbitrators with expertise in statutory requirements in the employment field who may, without special training, lack experience in the employment area and in the conduct of arbitration hearings and mediation sessions. Reexamination of rostering eligibility by designating agencies, such as the American Arbitration Association, may permit the expedited inclusion in the pool of this most valuable source of expertise.

The roster of arbitrators and mediators should contain representatives with all such skills in order to meet the diverse needs of this caseload.

Regardless of their prior experience, mediators and arbitrators on the roster must be independent of bias toward either party. They should reject cases if they believe the procedure lacks requisite due process.

## 2. Training

The creation of a roster containing the foregoing qualifications dictates the development of a training program to educate existing and potential labor and employment mediators and arbitrators as to the statutes, including substantive, procedural and remedial issues to be confronted and to train experts in the statutes as to employer procedures governing the employment relationship as well as due process and fairness in the conduct and control of arbitration hearings and mediation sessions.

Training in the statutory issues should be provided by the government agencies, bar associations, academic institutions, etc., administered perhaps by the designating agency, such as the AAA, at various locations throughout the country. Such training should be updated periodically and be required of all mediators and arbitrators. Training in the conduct of mediation and arbitration could be provided by a mentoring program with experienced panelists.

Successful completion of such training would be reflected in the resume or panel cards of the arbitrators supplied to the parties for their selection process.

## 3. Panel Selection

Upon request of the parties, the designating agency should utilize a list procedure such as that of the AAA or select a panel composed of an odd number of mediators and arbitrators from its roster or pool. The panel cards for such individuals should be submitted to the parties for their perusal prior to alternate striking of the names on the list, resulting in the designation of the remaining mediator and/or arbitrator.



The selection process could empower the designating agency to appoint a mediator and/or arbitrator if the striking procedure is unacceptable or unsuccessful. As noted above, subject to the consent of the parties, the designating agency should provide the names of the parties and their representatives in recent cases decided by the listed arbitrators.

#### **4. Conflicts of Interest**

The mediator and arbitrator for a case has a duty to disclose any relationship which might reasonably constitute or be perceived as a conflict of interest. The designated mediator and/or arbitrator should be required to sign an oath provided by the designating agency, if any, affirming the absence of such present or preexisting ties.

#### **5. Authority of the Arbitrator**

The arbitrator should be bound by applicable agreements, statutes, regulations and rules of procedure of the designating agency, including the authority to determine the time and place of the hearing, permit reasonable discovery, issue subpoenas, decide arbitrability issues, preserve order and privacy in the hearings, rule on evidentiary matters, determine the close of the hearing and procedures for post-hearing submissions, and issue an award resolving the submitted dispute.

The arbitrator should be empowered to award whatever relief would be available in court under the law. The arbitrator should issue an opinion and award setting forth a summary of the issues, including the type(s) of dispute(s), the damages and/or other relief requested and awarded, a statement of any other issues resolved, and a statement regarding the disposition of any statutory claim(s).

#### **6. Compensation of the Mediator and Arbitrator**

Impartiality is best assured by the parties sharing the fees and expenses of the mediator and arbitrator. In cases where the economic condition of a party does not permit equal sharing, the parties should make mutually acceptable arrangements to achieve that goal if at all possible. In the absence of such agreement, the arbitrator should determine allocation of fees. The designating agency, by negotiating the parties' share of costs and collecting such fees, might be able to reduce the bias potential of disparate contributions by forwarding payment to the mediator and/or arbitrator without disclosing the parties' share therein.



#### D. Scope of Review

The arbitrator's award should be final and binding and the scope of review should be limited.

Dated: May 9, 1995

**Christopher A. Barreca, Co-Chair**

Partner  
Paul, Hastings, Janofsky & Walker  
Rep., Council of Labor & Employment Section, American  
Bar Association

**Max Zimny, Co-Chair**

General Counsel  
International Ladies' Garment Workers' Union Association  
Rep., Council of Labor & Employment Section  
American Bar Association

**Arnold Zack, Co-Chair**

President  
National Academy of Arbitrators

**Carl E. VerBeek**

Management Co-Chair Union Co-Chair  
Partner  
Varnum Riddering Schmidt & Howlett  
Arbitration Committee of Labor & Employment Section,  
ABA

**Robert D. Manning**

Angoff, Goldman, Manning, Pyle, Wanger & Hiatt, P.C.  
Union Co-Chair  
Arbitration Committee of Labor & Employment Section,  
ABA

**Charles F. Ipavec, Arbitrator**

Neutral Co-Chair  
Arbitration Committee of Labor & Employment Section,  
ABA

**George H. Friedman**

Senior Vice President  
American Arbitration Association

**Michael F. Hoellering**

General Counsel  
American Arbitration Association

**W. Bruce Newman**

Rep., Society of Professionals in Dispute Resolution

**Wilma Liebman**

Special Assistant to the Director Federal Mediation  
& Conciliation

**Joseph Garrison, President**

National Employment Lawyers Association

**Lewis Maltby**

Director  
Workplace Rights Project, American Civil Liberties Union



## VI. Due Process Protocol for Consumer Disputes

### **A Due Process Protocol for the Mediation and Arbitration of Consumer Disputes** **April 17, 1998**

#### *Principle 1. Fundamentally-Fair Process*

All parties are entitled to a fundamentally-fair ADR process. As embodiments of fundamental fairness, these Principles should be observed in structuring ADR Programs.

#### *Principle 2. Access to Information Regarding ADR Program*

Providers of goods or services should undertake reasonable measures to provide consumers with full and accurate information regarding Consumer ADR Programs. At the time the Consumer contracts for goods or services, such measures should include (1) clear and adequate notice regarding the ADR provisions, including a statement indicating whether participation in the ADR Program is mandatory or optional, and (2) reasonable means by which Consumers may obtain additional information regarding the ADR Program. After a dispute arises, Consumers should have access to all information necessary for effective participation in ADR.

#### *Principle 3. Independent and Impartial Neutral; Independent Administration*

1. *Independent and Impartial Neutral.* All parties are entitled to a Neutral who is independent and impartial.
2. *Independent Administration.* If participation in mediation or arbitration is mandatory, the procedure should be administered by an Independent ADR Institution. Administrative services should include the maintenance of a panel of prospective Neutrals, facilitation of Neutral selection, collection and distribution of Neutral's fees and expenses, oversight and implementation of ADR rules and procedures, and monitoring of Neutral qualifications, performance, and adherence to pertinent rules, procedures and ethical standards.
3. *Standards for Neutrals.* The Independent ADR Institution should make reasonable efforts to ensure that Neutrals understand and conform to pertinent ADR rules, procedures and ethical standards.
4. *Selection of Neutrals.* The Consumer and Provider should have an equal voice in the selection of Neutrals in connection with a specific dispute.
5. *Disclosure and Disqualification.* Beginning at the time of appointment, Neutrals should be required to disclose to the Independent ADR Institution any circumstance likely to affect impartiality, including any bias or financial or personal interest which might affect the result of the ADR proceeding, or any past or present relationship or experience with the parties or their representatives, including past ADR experiences. The Independent ADR Institution should communicate any such information to the parties and other Neutrals, if any. Upon objection of a party to continued service of the Neutral, the Independent ADR Institution should determine whether the Neutral should be disqualified and should inform the parties of its decision. The disclosure obligation of the Neutral and procedure for disqualification should continue throughout the period of appointment.



#### *Principle 4. Quality and Competence of Neutrals*

All parties are entitled to competent, qualified Neutrals. Independent ADR Institutions are responsible for establishing and maintaining standards for Neutrals in ADR Programs they administer.

#### *Principle 5. Small Claims*

Consumer ADR Agreements should make it clear that all parties retain the right to seek relief in a small claims court for disputes or claims within the scope of its jurisdiction.

#### *Principle 6. Reasonable Cost*

1. *Reasonable Cost.* Providers of goods and services should develop ADR programs which entail reasonable cost to Consumers based on the circumstances of the dispute, including, among other things, the size and nature of the claim, the nature of goods or services provided, and the ability of the Consumer to pay. In some cases, this may require the Provider to subsidize the process.
2. *Handling of Payment.* In the interest of ensuring fair and independent Neutrals, the making of fee arrangements and the payment of fees should be administered on a rational, equitable and consistent basis by the Independent ADR Institution.

#### *Principle 7. Reasonably Convenient Location*

In the case of face-to-face proceedings, the proceedings should be conducted at a location which is reasonably convenient to both parties with due consideration of their ability to travel and other pertinent circumstances. If the parties are unable to agree on a location, the determination should be made by the Independent ADR Institution or by the Neutral.

#### *Principle 8. Reasonable Time Limits*

ADR proceedings should occur within a reasonable time, without undue delay. The rules governing ADR should establish specific reasonable time periods for each step in the ADR process and, where necessary, set forth default procedures in the event a party fails to participate in the process after reasonable notice.

#### *Principle 9. Right to Representation*

All parties participating in processes in ADR Programs have the right, at their own expense, to be represented by a spokesperson of their own choosing. The ADR rules and procedures should so specify.

#### *Principle 10. Mediation*

The use of mediation is strongly encouraged as an informal means of assisting parties in resolving their own disputes.



### *Principle 11. Agreements to Arbitrate*

Consumers should be given:

- a. clear and adequate notice of the arbitration provision and its consequences, including a statement of its mandatory or optional character;
- b. reasonable access to information regarding the arbitration process, including basic distinctions between arbitration and court proceedings, related costs, and advice as to where they may obtain more complete information regarding arbitration procedures and arbitrator rosters;
- c. notice of the option to make use of applicable small claims court procedures as an alternative to binding arbitration in appropriate cases; and,
- d. a clear statement of the means by which the Consumer may exercise the option (if any) to submit disputes to arbitration or to court process.

### *Principle 12. Arbitration Hearings*

1. *Fundamentally-Fair Hearing.* All parties are entitled to a fundamentally-fair arbitration hearing. This requires adequate notice of hearings and an opportunity to be heard and to present relevant evidence to impartial decision-makers. In some cases, such as some small claims, the requirement of fundamental fairness may be met by hearings conducted by electronic or telephonic means or by a submission of documents. However, the Neutral should have discretionary authority to require a face-to-face hearing upon the request of a party.
2. *Confidentiality in Arbitration.* Consistent with general expectations of privacy in arbitration hearings, the arbitrator should make reasonable efforts to maintain the privacy of the hearing to the extent permitted by applicable law. The arbitrator should also carefully consider claims of privilege and confidentiality when addressing evidentiary issues.

### *Principle 13. Access to Information*

No party should ever be denied the right to a fundamentally-fair process due to an inability to obtain information material to a dispute. Consumer ADR agreements which provide for binding arbitration should establish procedures for arbitrator-supervised exchange of information prior to arbitration, bearing in mind the expedited nature of arbitration.

### *Principle 14. Arbitral Remedies*

The arbitrator should be empowered to grant whatever relief would be available in court under law or in equity.

### *Principle 15. Arbitration Awards*

1. *Final and Binding Award; Limited Scope of Review.* If provided in the agreement to arbitrate, the arbitrator's award should be final and binding, but subject to review in accordance with applicable statutes governing arbitration awards.
2. *Standards to Guide Arbitrator Decision-Making.* In making the award, the arbitrator should apply any identified, pertinent contract terms, statutes and legal precedents.



3. *Explanation of Award.* At the timely request of either party, the arbitrator should provide a brief written explanation of the basis for the award. To facilitate such requests, the arbitrator should discuss the matter with the parties prior to the arbitration hearing.

Dated: April 17, 1998

Some of the signatories to this Protocol were designated by their respective organizations, but the Protocol reflects their personal views and should not be construed as representing the policy of the designating organizations

**The Honorable Winslow Christian**

*Co-chair*

Justice (Retired California Court of Appeals)

**William N. Miller**

*Co-chair*

Director of the ADR Unit

Office of Consumer Affairs

Virginia Division of Consumer Protection

Designated by National Association of Consumer Agency Administrators

**David B. Adcock**

Office of the University Counsel

Duke University

**Steven G. Gallagher**

Senior Vice President

American Arbitration Association

**Michael F. Hoellering**

General Counsel

American Arbitration Association

**J. Clark Kelso**

Director

Institute for Legislative Practice

University of the Pacific

McGeorge School of Law

**Elaine Kolish**

Associate Director

Division of Enforcement

Bureau of Consumer Protection

Federal Trade Commission

**Robert Marotta**

Wolcott, Rivers, Wheary, Basnight & Kelly, P.C.

Formerly Office of the General Counsel

General Motors Corporation

**Robert E. Meade**

Senior Vice President

American Arbitration Association

**Ken McEldowney**

Executive Director

Consumer Action

**Michelle Meier**

Former Counsel for Government Affairs

Consumers Union

**Anita B. Metzen**

Executive Director

American Council on Consumer Interests

**James A. Newell**

Associate General Counsel

Freddie Mac

**Shirley F. Sarna**

Assistant Attorney General-In-Charge  
Consumer Frauds and Protection Bureau  
Office of the Attorney General  
State of New York  
Designated by National Association of Attorneys General

**Daniel C. Smith**

Vice President and Deputy General Counsel  
Fannie Mae

**Terry L. Trantina**

Member  
Ravin, Sarasohn, Cook, Baumgarten, Fisch & Rosen, P.C.  
Formerly General Attorney  
AT&T Corp

**Deborah M. Zuckerman**

Staff Attorney  
Litigation Unit  
American Association of Retired Persons

**Thomas Stipanowich**

Academic Reporter  
W.L. Matthews Professor of Law  
University of Kentucky College of Law