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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 II OF II

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FOR THE FIFTEENTH JUDICIAL CIRCUIT
COUNTY OF HORRY	)	CASE NO.: 2020-CP-26-03169
Thuy N. Gasser, individually and	)	
on behalf of other similarly	)	
situated,	)	
	)	
Plaintiffs,	)	PLAINTIFFS' MEMORANDUM IN
	)	OPPOSITION TO DEFENDANT'S
v.	)	MOTION TO COMPEL ARBITRATION
	)	AND DISMISS OR STAY
ACS Primary Care Physicians -	)	
Southeast, P.C.,	)	
	)	
Defendant.	)	
_____	)	

PROCEDURAL HISTORY

On May 21, 2020, Thuy Gasser (hereinafter "Plaintiff") brought this action by filing a Complaint in the Court of Common Pleas for Horry County, South Carolina, asserting claims for breach of contract and unjust enrichment both individually, and on behalf of a class of similarly situated persons, respectively. On June 26, 2020, ACS Primary Care Physicians Southeast, P.C. ("Defendant") removed the case to the United States District Court for the District of South Carolina, Florence Division, alleging federal question jurisdiction under 28 U.S.C. § 1331, diversity jurisdiction under § 1332(d) and supplemental jurisdiction under § 1367.

Thereafter, Plaintiff filed a motion to remand the action to the Horry County Court of Common Pleas disputing jurisdiction of the federal court. On August 13, 2020, the Honorable Bryan Harwell issued an Order remanding the case to the Horry County Court for Common Pleas. After remand, Defendant filed a Motion to Compel Arbitration and Dismiss or Stay. Plaintiff now submits this response in opposition the motion.

STATEMENT OF FACTS

On December 9, 2019, Plaintiff was involved in a motor vehicle collision where she sustained serious injuries. Plaintiff received medical treatment at Grand Strand Regional Medical Center, and, specifically, one of Defendant's Emergency Room physician employees. On the date of her treatment, Plaintiff was covered by a health insurance policy issued by Blue Cross Blue Shield of South Carolina (hereinafter "BCBSSC"). Plaintiff provided her insurance information to Defendant who, at all times relevant herein, was a preferred provider in the BCBSSC network according to its Provider Agreement with BCBSSC. See Def.'s Mot. Ex. 1. Thereafter, Defendant, and its representatives refused to submit Plaintiff's medical bills for the December 9, 2019 Emergency Room visit to BCBSSC for payment. Rather, despite her BCBSSC health insurance coverage and its preferred provider contract under the Provider Agreement, Defendant demanded Plaintiff make payment in full to it directly.

DISCUSSION

I. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., does not encompass the relationship between the nonsignatory Plaintiff and Defendant's Provider Agreement with BCBSSC.

Here, Defendant is bound by the contract language it chose to include in its Provider Agreement with BCBSSC. First, that agreement is only between Defendant and BCBSSC, and does not include any language that clearly include Plaintiff's claims within its arbitration provision(s). Second, that agreement does not show that Plaintiff agreed to submit any of her claims to arbitration. For those reasons, Defendant cannot compel her to do so.

The purpose of the FAA is "to make arbitration agreements as enforceable as other contracts, but not more so." Prima Paint Corp. v. Flood & Conklin Mfg. Co., 388 U.S. 395, 404 n.12, 87 S. Ct. 1801, 18 L. Ed. 2d 1270 (1967). A party seeking to compel arbitration under the FAA must establish that (1) there is a valid agreement, and (2) the claims fall within the scope of the agreement. Carr v. Main Carr Dev., LLC, 337 S.W.3d 489, 494 (Tex. App. 2011).

"A party cannot be required to submit to arbitration any dispute which he has not agreed so to submit." Landers v. Fed. Deposit Ins. Corp., 402 S.C. 100, 108, 739 S.E.2d 209, 213 (2013) (quoting United Steelworkers v. Warrior & Gulf Navigation Co., 363 U.S. 574, 582 (1960)). Further, whether a party has agreed to arbitrate an issue is a matter of contract interpretation. American Recovery Corp. v. Computerized Thermal Imaging, Inc., 96 F.3d 88 (4th Cir. 1996).

The arbitration agreement at issue was not signed by Gasser and there is no evidence she was even informed of it, much less agreed to it. The provision specifically only refers to ACS and BCBSSC and is clear it does not contemplate the resolution of claims brought by anyone other than these two signatories. Specifically, the provision states:

(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 a jury trial.

Def.'s Mot. Ex. 1., p. 11, § IX(M) (emphasis added).

The language of the arbitration provision clearly contemplates arbitration of disputes only between “BCBSSC and Preferred Provider” and in no way mentions or refers to Members or Subscribers. Put simply, there is nothing in the Provider Agreement, or in Defendant’s Motion and subsequent exhibits, showing Gasser formed the intent or had the requisite knowledge to mislead Defendant or to assent to the Provider Agreement’s arbitration terms.

This precise issue has been decided by at least one other court and held that when an insurer-health care provider contract specifically limits arbitration to its parties, a third-party beneficiary’s claims are not subject to arbitration. In Rath v. Managed Health Network, Inc., 844 P.2d 12 (Idaho 1992), the court refused to submit a third-party beneficiary’s claim to arbitration when the contract specifically limited arbitration to disputes “between the parties to this Agreement.” Here, ACS is bound by the contract language it chose. Since that language clearly does not include Ms. Gasser’s claims within its arbitration provision, and Ms. Gasser has not agreed to submit any claim she has to arbitration, Defendant cannot compel her to do so. Defendant cannot point to any evidence where Plaintiff has agreed to arbitrate her claims. The plain language of the Agreement specifically limits arbitration to “the parties,” and specifically naming each in turn.

Because Gasser is not a signatory to the agreement and did not agree to arbitrate any dispute(s) she may have, the FAA does not apply and her claims are not subject to arbitration.

A. Equitable Estoppel is Inapplicable in This Case.

Here, the only theory Defendant advanced supporting its contention that Plaintiff, as a nonsignatory to its agreement with BCBSSC, should be bound by the agreement's arbitration provision is estoppel. See Def.'s Mot. at 5 (“[Defendant] 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.”).

“Whether an arbitration agreement may be enforced against nonsignatories, and under what circumstances, is an issue controlled by state law. See Arthur Andersen LLP v. Carlisle, 556 U.S. 624, 630–31, 630 n.5, 129 S. Ct. 1896, 173 L. Ed. 2d 832 (2009) (observing state law is applicable to determine which contracts are binding under the FAA’s §2, and traditional principles of state law may permit a contract to be enforced by or against nonparties to a contract through theories of assumption, piercing the corporate veil, and estoppel, among others); Kroma Makeup EU, LLC v. Boldface Licensing + Branding, Inc., 845 F.3d 1351, 1355 n.1 (11th Cir. 2017) (citing Arthur Andersen LLP and noting state, not federal, law controls the analysis of equitable estoppel issues in the arbitration context); Walker v. Collyer, 85 Mass. App. Ct. 311, 9 N.E.3d 854, 858–59 (Mass. App. Ct. 2014) (relying on Arthur Andersen LLP and stating traditional principles of state contract law determine whether nonsignatories can be compelled to arbitrate) Wilson v. Willis, 426 S.C. 326, 827 S.E.2d 167 (2019).

The South Carolina Supreme Court has recognized five (5) theories “aris[ing] out of common law principles of contract and agency law’ could provide a basis ‘for binding nonsignatories to arbitration agreements: 1) incorporation by references; 2) assumption;

3) agency; 4) veil piercing/alter ego; and 5) estoppel.” Malloy v. Thompson (In re Estate of Chamblee), 409 S.C. 557, 762 S.E.2d 690 (2014) (quoting Int’l Paper Co. v. Schwabedissen Maschinen & Anlagen GMBH, 206 F.3d 411, 416 (4th Cir. 2000)). Defendant has failed to establish Plaintiff is bound by its Provider Agreement with BCBSSC under any of these theories.

In Thompson, the appellants asserted the circuit court should have concluded the "estate was equitably estopped from refusing to comply with the [arbitration agreement]. [The] [a]ppellants argue[d] Mother benefited from the [arbitration agreement] because she was admitted to [the facility], received medical care, and became capable of enforcing the [arbitration agreement]." 416 S.C. at 58, 784 S.E.2d at 687. The Court recognized a

recent conflict between the United States Supreme Court and our state courts concerning the application of state law in determining whether a non-signatory is bound by an arbitration agreement. Compare Arthur Andersen LLP, 556 U.S. at 630, 632 (holding that a nonparty to an agreement is entitled to invoke the FAA "if the relevant state contract law allows him to enforce the agreement"), and id. at 631 ("Because 'traditional principles' of state law allow a contract to be enforced by or against nonparties to the contract through 'assumption, piercing the corporate veil, alter ego, incorporation by reference, third-party beneficiary theories, waiver and estoppel,' the Sixth Circuit's holding that nonparties to a contract are categorically barred from [FAA] relief was error." (citation omitted)), with Pearson v. Hilton Head Hosp., 400 S.C. 281, 288-89, 733 S.E.2d 597, 601 (Ct. App. 2012) (decided in 2012 and holding "[b]ecause the determination of whether a non[-]signatory is bound by a contract presents no state law question of contract formation or validity, the court looks to the federal substantive law of arbitrability to resolve the question").

Thompson, 416 S.C. at 58-59, 784 S.E.2d at 687-88 (alterations by court).

The Thompson Court determined the conflict was irrelevant in that case because "the doctrine of equitable estoppel d[id] not apply to [the] estate under either South Carolina law or federal substantive law concerning arbitrability." Id. at 59, 784 S.E.2d at

688. The court noted that under federal substantive law, the equitable estoppel doctrine in an arbitration setting allows a party to "be estopped from asserting that the lack of his signature on a written contract precludes enforcement of the contract's arbitration clause when he has consistently maintained that other provisions of the same contract should be enforced to benefit him." Id. (emphasis omitted) (quoting Pearson, 400 S.C. at 290, 733 S.E.2d at 601). Restated, when a signatory seeks to enforce an arbitration agreement against a nonsignatory, the doctrine prevents the nonsignatory from averring he or she is not bound to the arbitration agreement when he or she receives a direct benefit from a contract that contains an arbitration clause. Id.

Notably, in those opinions addressing equitable estoppel in the arbitration context, the nonsignatory's contractual benefit is not typically an alleged benefit of arbitration such as "avoiding the expense and delay of extended court proceedings" or being "capable of enforcing the [arbitration agreement]," as touted by [the] [a]ppellants in the present case—rather, the contractual benefit typically arises from another provision of the same contract that includes the arbitration provision.

Id. at 59-60, 784 S.E.2d at 688.

The Thompson Court determined the arbitration agreement in that case was

not incorporated into the [a]dmission [a]greement; therefore, [the] [a]ppellants' assertion that Mother received benefits under the [a]dmission [a]greement, i.e., being admitted to the facility and receiving medical care, is of no moment. The two agreements are independent of one another, as reflected in the language of the [arbitration agreement] indicating its execution is not a condition for being admitted to the nursing home. Further, any possible benefit emanating from the [arbitration agreement] alone is offset by the [arbitration agreement]'s requirement that Mother waive her right to access to the courts and her right to a jury trial. Therefore, equitable estoppel under federal substantive law has no application to the present case.

Id. at 60, 784 S.E.2d at 688.

i. Plaintiff has not received a direct benefit under the Provider Agreement.

Defendant primarily argues that Plaintiff should not be permitted to seek a direct benefit covered by the Provider Agreement while simultaneously avoiding the contract's arbitration provision. See Def.'s Mot. at 5.

Under direct benefits estoppel, "[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, 733 S.E.2d at 601 (quoting Int'l Paper Co., 206 F.3d at 418). "In the arbitration context, the doctrine recognizes that a party may be estopped from asserting that the lack of his signature on a written contract precludes enforcement of the contract's arbitration clause when he has consistently maintained that other provisions of the same contract should be enforced to benefit him." Id. (quoting Int'l Paper Co., 206 F.3d at 418).

Stated another way, "[u]nder the direct benefits theory of estoppel, a nonsignatory may be compelled to arbitrate where the nonsignatory 'knowingly exploits' the benefits of an agreement containing an arbitration clause, and receives benefits flowing directly from the agreement" Belzberg v. Verus Invs. Holdings Inc., 21 N.Y.3d 626, 977 N.Y.S. 2d 685, 999 N.E.2d 1130, 1134 (2013).

It is important to distinguish direct benefits from indirect benefits because when the benefits to a nonsignatory are merely indirect, arbitration cannot be compelled. Wilson v. Willis, 426 S.C. 326, 827 S.E.2d 167 (2019) (citing Belzberg, 977 N.Y.S.2d 685, 999 N.E.2d at 1134. A benefit is direct if it flows directly from the agreement. Id.; see also MAG Portfolio Consult, GMBH v. Merlin Biomed Grp. LLC, 268 F.3d 58, 61 (2d Cir. 2001) (stating direct benefits estoppel requires that a nonsignatory knowingly accept the

benefits of an agreement with an arbitration clause in order to be bound by an arbitration clause).

In contrast, “any 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.” Wilson, 426 S.C. at 343, 827 S.E.2d at 176; MAG Portfolio Consult, 268 F.3d at 61; accord Belzberg, 977 N.Y.S.2d 685, 999 N.E.2d at 1134; cf. Lawson v. Life of the S. Ins. Co., 648 F.3d 1166, 1172 (11th Cir. 2011) (observing that, under Georgia law, a plaintiff's claims must be directly, not just indirectly, based on the contract containing the arbitration clause for equitable estoppel to compel arbitration of those claims); In re Kellogg Brown & Root, Inc., 166 S.W.3d 732, 740–41 (Tex. 2005) (stating that, under direct benefits estoppel, although a nonsignatory's claim may relate to a contract containing an arbitration provision, that relationship does not, in itself, bind the nonsignatory to arbitration, and a nonsignatory plaintiff cannot be compelled to arbitrate on the sole ground that, but for the contract containing the arbitration provision, it would have no basis to sue; rather, a nonsignatory should be compelled to arbitrate a claim only if it seeks, through the claim, to derive a direct benefit from the contract containing the arbitration provision).

Notably, in those opinions addressing equitable estoppel in the arbitration context, the nonsignatory's contractual benefit is not typically an alleged benefit of arbitration such as “avoiding the expense and delay of extended court proceedings” or being “capable of enforcing the [AA],” but, rather, the contractual benefit typically arises from another provision of the same contract that includes the arbitration provision. See Pearson, 400 S.C. at 296–97, 733 S.E.2d at 605 (ability to work at the defendant's hospital facility and

receive payment for work); see also Int'l Paper Co., 206 F.3d at 418 (warranty provisions); Jackson, 524 F. Supp. 2d at 750 (entitlement to retain a \$150,000 payment pursuant to the contract's liquidated damages provision); Am. Bureau of Shipping v. Tencara Shipyard S.P.A., 170 F.3d 349, 353 (2d Cir. 1999) (lower insurance rates on a yacht and the ability to sail under the French flag); Deloitte Noraudit A/S v. Deloitte Haskins & Sells, U.S., 9 F.3d 1060, 1064 (2d Cir. 1993) (continuing use of a name).

Here, Plaintiff has not knowingly exploited and received a direct benefit from the Provider Agreement. The Provider Agreement executed by Defendant and BCBSSC was purely for the benefit of the parties to the contract in outlining their business relationships and the rights of the parties to the Provider Agreement. In fact, the Provider Agreement says just that:

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

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See Def.'s Mot. Ex. 1, at 5.

Furthermore, Plaintiff has not attempted to procure any direct benefit from the Agency Agreement itself while attempting to avoid its arbitration provision. Moreover, the Provider Agreement by its express terms, was inapplicable to other parties, and Defendant does not attempt to argue that it did. As a BCBSSC insured, Plaintiff would have received medical treatment at the Grand Strand Regional Medical Center Emergency Room regardless of whether Defendant was a preferred provider. According to the Provider Agreement, Plaintiff's only "benefit" would be (1) the negotiated "network rate," which is presumably less than the "market rate," and (2) Defendant's promise that

it would not seek any money from Plaintiff other than the payment from BCBSSC – neither of which she received from Defendant. Plaintiff received no benefit from the Provider Agreement because Defendant sought the entire balance directly from her and refused to accept its negotiated or reduced rate from the agreement. Since Plaintiff received no benefit from the Provider Agreement, Defendant should, in fairness, be estopped from arguing she is a beneficiary of the agreement.

Instead of complying with its Provider Agreement with BCBSSC, Defendant billed Plaintiff directly. Defendant unilaterally deprived Plaintiff of any benefits or savings under her health insurance policy with BCBSSC by rejecting its own obligations to her, and, primarily, with BCBSSC. Defendant's assertion that Plaintiff received a direct benefit from the Provider Agreement is simply a distortion of the truth. Defendant also fail to argue that its patients, or customers of BCBSSC, knew when they submitted their health insurance information to healthcare providers like Defendant that any claims nonpayment would be subjected to an arbitration provision in an agreement between other parties. See Wilson, 426 S.C. at 345, 827 S.E.2d at 177.

Furthermore, “any possible benefit emanating from the [Provider Agreement] alone is offset by the agreement's requirement that [Plaintiff] waive her right to access to the courts and her right to a jury trial. Therefore, equitable estoppel under federal substantive law has no application to the present case.” Thompson v. Pruitt Corp., 416 S.C. 43, 784 S.E.2d 679 (Ct. App. 2016).

“Equitable estoppel is, ultimately, a theory designed to prevent injustice, and it should be used sparingly.” Wilson, 426 S.C. at 345, 827 S.E.2d at 177 (citing Hirsch v. Amper Fin. Servs., LLC, 215 N.J. 174, 71 A.3d 849, 852 (2013) (observing equitable

estoppel should be used sparingly to compel arbitration and noting it "is more properly viewed as a shield to prevent injustice rather than a sword to compel arbitration"); 28 Am. Jur. 2d Estoppel and Waiver § 29 (2011) (stating equitable estoppel should be used with restraint and only in exceptional circumstances).

For these reasons, this Court should decline to impose it on Plaintiff and the class of individuals she seeks to represent – a group that includes patients of Defendant seeking to have the terms of their insurance contracts enforced. Considerations of equity do not warrant estopping such attenuated individuals from asserting their nonsignatory status. Id.

II. South Carolina law clearly and specifically exempts insurance contracts from mandatory arbitration provisions.

Even if Defendant could establish that the contract between it and BCBSSC applies to Plaintiff, which it cannot, the arbitration argument still fails. Defendant and BCBSSC agreed that their “Agreement shall be construed and enforced in accordance with the laws of the State of South Carolina.” Def.’s Mot. Ex. 1 at ¶9 J.

South Carolina Code Ann. § 15-48-10(b)(4), under the Uniform South Carolina Arbitration Act (“SCUAA”), specifically provides that a written agreement to arbitrate shall not apply to “any claim arising out of personal injury, based on contract or tort, or to any insured or beneficiary under any insurance policy or annuity contract.” S.C. Code Ann. §15-48-10(b)(4) (2019) (emphasis added). Defendant agreed that South Carolina law would apply in interpreting and enforcing its contract. Defendant is therefore bound by the state statute and is legally precluded from forcing Plaintiff into arbitration where it has no such right under South Carolina law.

South Carolina appellate courts have found that "§15-48-10(b)(4) specifically exempts any insured or beneficiary under any insurance policy or annuity contract' from the South Carolina Arbitration Act' find that '§15-48-10(b)(4) was enacted for the purpose of regulating the business of insurance." Walden v. Harrelson Nissan, Inc., 399 S.C. 205, 731 S.E.2d 324 (Ct. App. 2012) (citing Cox v. Woodmen of World Ins. Co., 347 S.C. 460, 556 S.E.2d 397 (Ct. App. 2001); and Am. Health & Life Ins. Co. v. Heyward, 272 F. Supp. 2d 578, 582 (D.S.C. 2003) (holding §15-48-10(b)(4)'s prohibition on arbitration "reverse preempts" the FAA through application of the McCarran-Ferguson Act¹ and "prohibits the enforcement of arbitration clauses in insurance policies governed by South Carolina law"))).

"[Section] 4 of the FAA does not confer a right to compel arbitration of any dispute at any time; it confers only the right to obtain an order directing that "arbitration proceed in the manner provided for in [the parties'] agreement." Volt Info. Scis. Inc. v. Board of Trs., 489 U.S. 468, 109 S. Ct. 1248, 103 L. Ed. 2d 488 (1989). In addition to the fact that Plaintiff did not sign the Provider Agreement, the FAA was not intended to govern the Plaintiff's relationship to Defendant and BCBSSC. "Despite [the] expansive interpretation

¹ It's important to note that the "the purpose of the McCarran-Ferguson Act was to restore regulatory and taxing authority to the States." City of Charleston v. GEICO, 334 S.C. 67, 512 S.E.2d 504 (1999). "No Act of Congress shall be construed to invalidate, impair, supersede any law enacted by any State for the purpose of regulating the business of insurance [...]" Id. (quoting 15 U.S.C. § 1012(b) (1998)). "South Carolina responded to the McCarran-Ferguson Act by enacting a comprehensive insurance law, now codified in Title 38 of the South Carolina Code of Laws." Id. The United States Supreme Court cites Moses H. Cone Mem. Hospital v. Mercury Construction Corp., 460 U.S. 1, 24-25, 103 S. Ct. 927, 941-942, 74 L. Ed. 2d 765 in its discussion of federal law in favor of arbitration. Moses and its progeny promote, "a healthy regard for the federal policy favoring arbitration," but the ruling in Volt dispenses the argument that a finding against arbitration flies in the face of Moses.

of the FAA, the FAA does not reflect a congressional intent to occupy the entire field of arbitration.” Volt, at 474 (citing 9 U.S.C. § 4). Defendant gives short shrift to Volt and the United States Supreme Court when the facts in Volt are almost identical to the facts here.

In Volt, the United States Supreme Court found a California statute was not pre-empted by the FAA where the parties agreed their arbitration agreement would be governed by California law.” Id. The contract in Volt contained an agreement to arbitrate all disputes between the parties “arising out of or relating to this contract or the breach thereof.” Volt at 470. The contract also contained a choice-of-law provision whereby “[t]he Contract shall be governed by the law of the place where the Project is located.” Id. The project was located in California. California Arbitration Code permits a court to stay arbitration for the parties to resolve related disputes with third parties not bound by the arbitration agreement, since there was a possibility of conflicting rulings. Id. at 471. Defendant moved to do stay arbitration. Id. The United States Supreme Court affirmed the California appellate court’s finding that Voltage Services, “had no such right [to arbitration] in the first place, because the parties’ agreement did not require arbitration to proceed in this situation.” Id. (emphasis added). The choice of law provision by which the parties in Volt agreed to enforce their contract is almost identical to the clause in Defendant’s Provider Agreement with BCBSSC.

The Volt Court also addressed displacement of state law by the FAA. The Supreme Court concluded in Volt, “that even if §§3 and 4 of the FAA were fully applicable in state-court proceedings, they do not prevent application of Cal. Civ. Proc. Code Ann. §1281.2(c) to stay arbitration where, as here, the parties have agreed to arbitrate in accordance with California law.” Volt at 477. Without rehashing the arguments above,

Defendant and BCBSSC have chosen South Carolina law to govern their contract and are therefore foreclosed from forcing an insured, in this case Plaintiff, from arbitrating her claims.

III. Any policy favoring arbitration only applies when the parties have agreed and there is an enforceable agreement to arbitrate.

The Supreme Court in Volt also addresses Defendant's assertion that federal policy favors arbitration. "There is no federal policy favoring arbitration under a certain set of procedural rules; the federal policy is simply to ensure the enforceability, according to their terms, of private agreements to arbitrate." Volt at 476. "Interpreting a choice-of-law clause to make applicable state rules governing the conduct of arbitration—rules which are manifestly designed to encourage resort to the arbitral process—simply does not [...] offend any other policy embodied in the FAA." Id.

Specifically, for nonsignatories "[t]he presumption in favor of arbitration applies to the scope of an arbitration agreement; it does not apply to the existence of such an agreement or to the identity of the parties who may be bound to such an agreement." Wilson, 426 S.C. at 337, 827 S.E.2d at 173 (citing Carr v. Main Carr Dev., LLC, 337 S.W.3d 489, 496 (Tex. App. 2011))." (emphasis added). "Even the exceptionally strong policy favoring arbitration cannot justify requiring litigants to forego a judicial remedy when they have not agreed to do so." Id. "Moreover, because arbitration, while favored, exists solely by agreement of the parties, a presumption against arbitration arises where the party resisting arbitration is a nonsignatory to the written agreement to arbitrate. Global Pac., LLC v. Kirkpatrick, 88 N.E.3d 431, 435 (Ohio Ct. App. 2017). Since there is no valid agreement to arbitrate between the parties, there is no South Carolina or federal policy favoring arbitration between the parties to this suit.

IV. The arbitration provision is unenforceable because the selected forum for arbitration is unavailable, rendering the provision void

The arbitration provision is void 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." Def.'s Mot. Ex. 1, p.11, § IX(M). However, the AAA is not available to perform or appoint an arbitrator for this dispute.

First, 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."² 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.

² See https://www.adr.org/sites/default/files/document_repository/AAA_Healthcare_Policy_Statement.pdf (last visited Sept. 25, 2020).

- In disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises.

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).

In addition to the AAA 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.³

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 ... "

³ See 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).

This is a significant point.

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 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 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. 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.

V. Forcing arbitration in this case would be unconscionable.

The Provider Agreement contemplates marketing of the preferred provider advantages to members and the member communications state charges will be at network rate. This is one of the major advantages to a consumer of purchasing this plan. Accordingly, the PPO network is published to consumers and plan members as advantages of doing business with the health care providers "in the network." It would be unforeseeable and unconscionable to the consumer, such as Plaintiff, that an undisclosed, confidential provision in Defendant's Provider Agreement with BCBSSC would foreclose suit when a provider – like Defendant – violates the published terms of the Provider Agreement to consumers by billing patients both directly and in excess of the rate agreed upon by the member's insurance plan.

It would be unconscionable to entice consumers to use the “preferred” providers in the network – healthcare providers – based on promises of the network price discounts, and then, in an undisclosed provision, remove the consumer’s ability to seek legal redress for those healthcare providers who disregard their promises. The South Carolina Supreme Court has raised the issue of whether an arbitration agreement is unconscionable and narrows the applicability of arbitration provisions to claims for “outrageous torts that are unforeseeable to a reasonable consumer in the context of normal business dealings.” Aiken v. World Fin. Corp. of S.C., 373 S.C. 144, 151, 644 S.E.2d 705 (2007). It would follow that, construing the Provider Agreement, Defendant’s conduct is equally unconscionable because not only is the agreement invisible to Plaintiff, but Defendant’s contract violations were unforeseeable. Therefore, Defendant’s Motion should be denied.

This Court should find that Defendant’s unjust billing practices equate to “conduct that does not arise from the contract.” Wilson, 426 S.C. at 342, 827 S.E.2d at 176. Should the Court overlook Defendant’s conduct, the Supreme Court’s contemplated injustice would be permitted. Defendant’s arbitrary billing practices compared with its obligations under the Provider Agreement are as offensive as the alleged misconduct of the defendants in Wilson.⁴

⁴ Petitioners’ allegation that Respondents possibly conspired with Willis and others to commit fraud is misconduct that *does not arise from the contract*. To hold otherwise would arguably allow Respondents to commit unfair trade practices and conspire to destroy the businesses of other insurance agencies *while shielding themselves from the possibility of a jury trial* with an arbitration clause agreed to only by the conspiring parties. Wilson, 426 S.C. at 342, 827 S.E.2d at 176.

VI. Paula Dearolf's Affidavit does not conform to the South Carolina Rules of Civil Procedure and should not be considered in support of Defendant's requested relief.

Defendant's only support provided for its Motion is its Provider Agreement and a purported Affidavit of Paula Dearolf. See Def.'s Mot. Ex. A. The Affidavit does not adhere to the requirements of an affidavit under the SCRCP.

"Affidavits or verifications authorized or permitted under these Rules shall be written statements or declarations by a party or his attorney of record or of a witness, sworn to or affirmed before an officer authorized to administer oaths, that the affiant knows the facts stated to be true of his own knowledge, except as to those matters stated on information and belief and as to those matters that he believes them to be true. When a corporation is a party the verifications may be made by any officer or agent thereof. When a partnership or other unincorporated association is the party under a common name the verification may be made by a member or officer thereof. When the State or any officer thereof in its behalf is a party, verifications may be made by any person acquainted with the facts."

SCRCP 11(c) (2019).

The affidavit of Ms. Dearolf, is not "sworn to or affirmed before an officer authorized to administer oaths." Id. In fact, the purported signature does not even appear to be part of the document. The Court should disregard the affidavit and any information contained therein as it does not comply with Rule 11, SCRCP.

CONCLUSION

Based on the foregoing, Plaintiff, on behalf of herself and a class of individuals similarly situated, respectfully requests the Court deny Defendant's Motion in its entirety.

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October 7, 2020

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,

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Plaintiff,

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v.

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ACS Primary Care Physicians-Southeast P.C.,

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Defendant.

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Defendant ACS Primary Care Physicians-Southeast P.C. (“ACS”) submits this Reply to Plaintiff’s Response in Opposition (“Opposition”) to ACS’s Motion to Compel Arbitration and Dismiss (the “Motion”). For the following reasons, as well as the reasons set forth in the Motion, the Court should grant the Motion, compel arbitration, and dismiss this case.

INTRODUCTION

As ACS demonstrated in its Motion, Plaintiff’s claims are subject to bilateral arbitration under the doctrine of equitable estoppel. Under that doctrine, Plaintiff is estopped from denying the arbitration provision in the Provider Agreement applies to her because she is suing ACS for breach of that Agreement under a third-party beneficiary theory. Because Plaintiff is seeking a direct benefit under the Provider Agreement (through her claim for breach of contract), she is estopped from denying that the Agreement’s arbitration provisions apply to her.

In her Opposition, Plaintiff relies on inapposite cases, overruled case law, and unsupported contentions to argue that she should not be compelled to arbitrate her dispute. Plaintiff’s arguments, however, are unavailing.

First, Plaintiff attempts to avoid the application of the doctrine of equitable estoppel by arguing that the traditional test for equitable estoppel alone applies, but the South Carolina Supreme Court has adopted a direct benefit test that applies in the arbitration context. Applying that test, Plaintiff is seeking a direct benefit under the Provider Agreement because is suing ACS for breach of that Agreement based on a theory that she is a third-party beneficiary to it. This is a textbook case for application of the direct benefits test, and Plaintiff should not be permitted to disavow the Provider Agreement's arbitration clause out of one side of her mouth while invoking other provisions of the Provider Agreement out of the other side of her mouth. For these reasons, Plaintiff is equitably estopped from denying that the arbitration clause applies to her.

Second, Plaintiff argues that the arbitration clause is not broad enough to encompass her claims, but her claims plainly "arise under" the Provider Agreement.

Third, Plaintiff contends that the Court should not to enforce the arbitration provision due to an alleged condition precedent to arbitration—*i.e.*, a meet-and-confer between the parties. It is well-settled however, that the existence and satisfaction of conditions precedent to an arbitration clause are issues for the arbitrator, not the Court, to decide. Moreover, Plaintiff herself is the party that has failed to meet and confer, and the Court should reward her for violating this term of the Provider Agreement.

Fourth, Plaintiff argues that the arbitration provision is unenforceable because the forum chosen by the parties—the American Arbitration Association (the "AAA")—is unavailable. Plaintiff's argument, however, ignores the facts that the AAA's proclamation applies only to medical malpractice disputes, not billing disputes and, in any event, the AAA will readily arbitrate any dispute a court compels to arbitration. Moreover, the arbitration clause does not provide that the AAA is the exclusive forum in which to arbitrate; instead, it merely provides that the AAA

rules must apply. In this situation, even if the AAA were unavailable (and it is not), the Court may simply appoint an alternate arbitrator.

Fifth, Plaintiff argues that § 15-48-10(b)(4) of the South Carolina Uniform Arbitration Act (“SCUAA”) precludes arbitration and reverse preempts the Federal Arbitration Act (“FAA”). This section of the SCUAA, however, only precludes arbitration where the arbitration clause is in an insurance policy. Here, the Provider Agreement is not an insurance policy, nor is this lawsuit against an insurance company, so § 15-48-10(b)(4) and reverse preemption do not apply.

These arguments are discussed in more detail below.

DISCUSSION

“The policy of the United States and South Carolina is to favor arbitration of disputes.”

Zabinski v. Bright Acres Assocs., 346 S.C. 480, 596, 553 S.E. 2d 110, 118 (2001).

I. EQUITABLE ESTOPPEL APPLIES HERE AND PLAINTIFF IS ESTOPPED FROM DENYING THAT THE ARBITRATION CLAUSE APPLIES TO HER

A. The direct benefits test applies under South Carolina law

As ACS demonstrated in its Motion, Plaintiff is equitably estopped from denying that the arbitration clause in the Provider Agreement applies to her. Under the doctrine of equitable estoppel, “[a] non-signatory 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, 290, 733 S.E.2d 597, 601 (Ct. App. 2012); *see also Wilson v. Willis*, 426 S.C. 326, 340, 827 S.E.2d 167, 175 (2019). A non-signatory seeks a “direct benefit” under a contract when, among other things, she asserts a claim based on her alleged status as a third-party beneficiary of the contract. *Wilson*, 426 S.C. at 340, 827 S.E.2d at 175. Here, because Plaintiff is asserting a claim against ACS for breach of the Provider Agreement under a theory that she is a third-party beneficiary to that Agreement, she is equitably estopped from arguing that that the

Provider Agreement's arbitration provision does not apply to her due to the fact she did not sign that Agreement.

In her Opposition, Plaintiff argues that application of the doctrine of equitable estoppel in the arbitration context requires the party invoking the theory to demonstrate the traditional elements of equitable estoppel. (Opp'n at 17.) As to the party to be estopped, those elements 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, 553 S.E.2d at 114. As to the party seeking application of the doctrine, those elements 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.* According to Plaintiff, equitable estoppel does not apply here because these elements have not been met.

This argument misstates South Carolina law. To be sure, a party seeking to estop another from denying that an arbitration clause applies *may* invoke the traditional elements of equitable estoppel. *See Zabinski*, 346 S.C. at 589, 553 S.E.2d at 114. But that is not the only means under which equitable estoppel can apply. In addition, a party may *also* prevail on an estoppel argument under the direct benefits test.

In *Wilson v. Willis*, for example, the Supreme Court of South Carolina applied the direct benefits test—and not the traditional equitable estoppel test—in the context of determining whether the plaintiffs were estopped from denying that the arbitration at issue clause applied to them. 426 S.C. 326, 340, 827 S.E.2d 167, 175 (2019). As the Court in *Wilson* noted, "[u]nder [the] direct benefits [test], a non-signatory is estopped from refusing to comply with an arbitration clause when it receives a direct benefit from a contract containing an arbitration clause." *Id.*

(quoting *Pearson*, 400 S.C. at 290, 733 S.E.2d at 601) (internal quotations and alterations omitted). The Court explained that a direct benefit is one that “flows directly from the agreement,” *id.* at 343, 827 S.E. 2d 176, and it noted that such a test is satisfied “where plaintiffs sue and seek relief based on contracts containing arbitration clauses.” *Id.* at 344, 827 S.E.2d at 177 (citing *Int’l Paper Co. v. Schwabedissen Maschinen & Analgen GMBH*, 206 F.3d 411, 417-18 (4th Cir. 2000)).

Similarly, in *Pearson v. Hilton Head Hosp.*, the South Carolina Court of Appeals applied the direct benefits test to hold that a non-signatory was equitably estopped from denying that he was bound by an arbitration clause when he directly benefitted from a contract containing an arbitration clause. 400 S.C. at 296-97, 733 S.E.2d at 605.

In her Opposition, Plaintiff argues that *Thompson v. Pruitt Corp.* held that the traditional equitable estoppel test is the only applicable test for determining whether equitable estoppel exists, (Opp’n at 18), but *Thompson* says nothing of the kind. In *Thompson*, the South Carolina Court of Appeals noted that the Supreme Court of the United States recently held that state—not federal—law determined the elements of estoppel in the arbitration context. 416 S.C. 43, 58-59, 784 S.E.2d 679, 687-88 (Ct. App. 2016) (citing *Arthur Andersen LLP v. Carlisle*, 556 U.S. 624, 630 (2009)). In doing so, the Court questioned language from *Pearson* suggesting that federal—and not state—law determined the elements of estoppel in the arbitration context. *Id.* (quoting 400 S.C. 281, 289-90, 733 S.E.2d at 601). The court in *Thompson*, however, did not make a determination as to the appropriate test, but analyzed the facts under both tests. *Id.* at 59-60, 784 S.E.2d at 688.

Moreover, in *Wilson*—a South Carolina Supreme Court case decided after *Thompson*—the South Carolina Supreme Court put the matter to rest by applying the direct benefits test. 426 S.C. at 338-345, 827 S.E.2d at 174-177. The Court in *Wilson* did not overrule *Pearson*, but instead, clarified that the holding in *Pearson* was predicated on state—not federal—law. 426 S.C. at 339

n.8, 827 S.E.2d at 174 n.8 (“To the extent the decision in *Pearson* indicates federal, rather than state, law is controlling on whether equitable estoppel can bind nonsignatories, we take this opportunity to clarify that state law controls.”). If the Court in *Wilson* wanted to reject the direct benefits test, it could easily have done so; instead, however, it took the opportunity *clarify* *Pearson*, not *overrule* it. Indeed, the United States District Court for the District of South Carolina has subsequently interpreted *Wilson* and *Pearson* to mean that the direct benefits test is available under South Carolina law. See *Kiawah Island Util., Inc. v. Westport Ins. Corp.*, No. 2:19-cv-1359-DCN, 2019 U.S. Dist. LEXIS 182220, at *8-9 (D.S.C. Oct. 2, 2019) (applying the direct benefits test and holding that arbitration agreement was enforceable against a non-signatory). Accordingly, the direct benefits test is a feature of South Carolina law.

Finally, the rationale behind the direct benefits test is compelling, particularly in the arbitration context. As the Court in *Wilson* noted, “[t]he traditional [equitable estoppel] test . . . has been analyzed most often in non-arbitration cases.” 426 S.C. at 340 n.9, 827 S.E.2d at 175 n.9. That is because the traditional test is not suited to application where a non-signatory is seeking to enforce an arbitration agreement. The basis of the equitable estoppel in such a claim is the basic tenant of equity: A person may not seek to enforce one part of an agreement when it suits them, and deny another aspect when it injures them. See *Pearson*, 400 S.C. at 290, 733 S.E.2d at 601 (“To allow a plaintiff to claim the benefit of the contract and simultaneously avoid its burdens would both disregard equity and contravene the purposes underlying enactment of the Arbitration Act.” (quotation omitted)). The direct benefits test is uniquely situated to address just this issue. Moreover, given the strong state and federal public policy in favor of arbitration, this Court should adopt the direct benefits test to promote consistency in state and federal law. See *In re Kellogg Brown & Root*, 165 S.W.3d 723, 739 (Tex. 2005) (noting the importance of consistency in state

and federal law). This Court should therefore apply the test that logically aides the Court in determining whether Plaintiff should be estopped from denying an arbitration clause, the direct benefits test.¹

B. Plaintiff seeks a direct benefit under the Provider Agreement here

As ACS demonstrated in its Motion, Plaintiff is seeking a direct benefit under the Provider Agreement by virtue of her allegation that she is a third-party beneficiary under that Agreement. Indeed, alleging third-party beneficiary status to a contract containing an arbitration agreement is the textbook direct benefits case. *Schwabedissen*, 206 F.3d at 418; *Burlington Ins. Co. v. Trygg-Hansa Ins. Co. AB*, No. 00-1373, 2001 U.S. App. LEXIS 10625, at * 19 (4th Cir. May 23, 2001); *Osborne v. Marina Inn @ Grand Dunes, LLC*, No. 4:08-cv-0490-TLW-TER, 2009 U.S. Dist. LEXIS 87167, at *24-25 (D.S.C. Aug. 31, 2009) *adopted by* No. 4:08-cv-0490, 2009 U.S. Dist. LEXIS 87158 (D.S.C. Sept. 23, 2009); *see also Wilson*, 426 S.C. at 344, 827 S.E.2d at 178 (noting that the direct benefits test is satisfied “where plaintiffs sue and seek relief based on contracts containing arbitration clauses”).

In her Opposition, Plaintiff argues that the direct benefits test requires that the non-signatory have “knowledge of the agreement containing the arbitration clause and a knowing acceptance of benefits under the agreement.” (Opp’n at 20.) But none of the cases that Plaintiff cites for this proposition actually say that knowledge / knowing acceptance of the agreement

¹ Because the direct benefits test applies here, the Court should also ignore Plaintiff’s repeated accusations that ACS acted in its own pecuniary interest or otherwise exhibited bad faith. (Opp’n at 6, 19.) As an initial matter, unlike the traditional equitable estoppel test, the direct benefits test does not look to the actions of the party seeking to compel arbitration. Moreover, Plaintiff’s argument is essentially that because she alleges ACS is at fault in the underlying dispute, ACS cannot invoke equitable estoppel. If the Court adopted Plaintiff’s argument, then the doctrine of equitable estoppel would be non-existent because every complaint alleges that the defendant is at fault in some manner. The place for litigating Plaintiff’s dispute with ACS is in the arbitral forum, not here.

containing the arbitration clause is required under the direct benefits test. Moreover, and more importantly, the only cases that discuss knowledge / knowing acceptance in the direct benefits context are cases where the alleged direct benefit at issue is one that arises in the ***course and scope of the parties' dealings with one another***. Here, by contrast, Plaintiff satisfies the direct benefits test because ***she is alleging that she is a third-party beneficiary under the Provider Agreement***. In such a situation, knowledge / knowing acceptance is simply irrelevant.

In *Weaver v. Brookdale Senior Living, Inc.*, for example, the plaintiff sued a residential care facility for negligence and other torts arising out of her grandmother's death. No. 5752, 2020 S.C. App. LEXIS 74, *9 (Ct. App. July 29, 2020). The residential care contract, to which the plaintiff was not a signatory, contained an arbitration clause, and the facility argued that the plaintiff received a direct benefit from that contract, in part, because the facility's standard of care vis-à-vis the plaintiff's grandmother was set forth in the contract. *Id.* at *7. The court disagreed, holding that the facility's standard of care was set forth in the background law of negligence. *Id.* at *9-10. Because the plaintiff did not allege that she was a third-party beneficiary under the residential care contract, however, *Weaver* is inapposite here.

Similarly, in *Wilson*, the plaintiffs, clients of an insurance agency, filed non-contract claims against the insurance agency and various insurance companies arising out of the agency's alleged fraud. 426 S.C. at 332, 827 S.E.2d at 170. Some of the insurance companies sought to enforce an arbitration clause found in an agreement between themselves and the insurance agency, arguing that the plaintiffs directly benefitted from that contract because the relationship between the agency and the insurance companies would not have existed but for the agreement. *Id.* at 342, 827 S.E.2d at 177. The court ruled that the direct benefits test was not satisfied because that nexus to the plaintiff's claims was too attenuated to form a "direct" benefit. *Id.* at 345, 827 S.E.2d at 177. As

with *Weaver*, however, this holding is inapposite here because the plaintiffs in *Wilson* did not allege that they were third-party beneficiaries under the agreement at issue. *Id.* at 345, 827 S.E.2d at 177.²

Moreover, Plaintiff's argument that knowledge / knowing acceptance is required in order for equitable estoppel to apply under the direct benefits test was expressly rejected in *Kiawah Island*. 2019 U.S. Dist. LEXIS 182220, at *9-11. There, the court explained that *Wilson*'s examination of the nonsignatory's knowledge of the contract containing the arbitration clause was undertaken only for the purpose of determining whether the nonsignatory had benefited from that agreement in light of the parties course and scope of dealing. *Id.* In other words, the

² Plaintiff cites three additional cases in support of her argument, but these cases do not remotely help her.

First, in *Schwabedissen*, the plaintiff non-signatory sought damages under the contract at issue, which contained an arbitration clause. 206 F.3d at 418. The Fourth Circuit held that the plaintiff was estopped under the direct benefits test from denying that it was a signatory to that contract. *Id.* In arriving at this holding, the Fourth Circuit did not base its holding on any particular knowledge of the plaintiff or even suggest that knowledge was relevant. *Id.*

Second, in *MAG Portfolio Consult., GmbH v. Merlin Biomed Group, LLC*, the plaintiff signatory attempted to enforce an arbitration clause against the non-signatory defendants. No. 00-9502, 2001 U.S. App. LEXIS 21693, at *60 (2d Cir. Oct. 10, 2001). The defendants, however, were not alleging they were third-party beneficiaries under any contract, and they had no relationship to the signatories other than as competitors in business. *Id.* Instead, the plaintiff was alleging the defendants were alter egos of the signatories. *Id.* at *63. *MAG Portfolio* simply has no application here.

Third, in *Deloitte Noraudit A/S v. Deloitte Haskins & Sells*, the plaintiff non-signatory attempted to enforce its right to the use of a company name. 9 F.3d 1060, 1062 (2d Cir. 1993). The plaintiff claimed that she sought the benefit under an earlier agreement with defendant (without an arbitration clause). The Court held that a more recent agreement (with an arbitration clause) superseded the first, in part because plaintiff had knowledge of the second agreement and continued to use the name. *Id.* Thus, the court held the plaintiff was bound by the arbitration clause because the benefit she sought, use of the company name, was governed by the second agreement. *Id.* *Deliotte*'s discussion of the plaintiff's knowledge was only to determine under which contract the plaintiff benefited—not as an element of the direct benefits test.

nonsignatory's knowledge can be a factor (though not a requirement) when the alleged direct benefit arises in the ***course and scope of the parties' dealings with one another***, but knowledge is not relevant when the party to be estopped is claiming to be a third-party beneficiary of the contract containing the arbitration clause. Thus, the court in *Kiawah Island* held that it "need not examine whether [the plaintiff] knew about the Arbitration Clause because that factual question only relates to whether [the plaintiff] is seeking a benefit from the [policy agreement], and [the plaintiff] is clearly seeking a benefit by seeking coverage." *Id.* at 11.

Unlike the non-signatories in *Weaver* and *Wilson*, Plaintiff is seeking a direct benefit from the Provider Agreement through her claim for breach of that Agreement as a third-party beneficiary. Thus, under *Kiawah Island*, her knowledge / knowing acceptance of the Provider Agreement is irrelevant.

Even putting aside the fact that Plaintiff is asserting a third-party beneficiary claim based on the Provider Agreement, Plaintiff's own factual allegations establish that the direct benefits test is satisfied here. In her Opposition, Plaintiff sets forth a series of factual arguments, which are unsupported by any citation to the record, in an effort to demonstrate that any benefit she received from the Provider Agreement was remote and indirect. (Opp'n at 20-22.) These arguments, however, are ***inconsistent with Plaintiff's own factual allegations***. Specifically, the Complaint plainly alleges that Plaintiff "received ***direct benefits*** from the Provider Agreement" in the form of lowered health care costs from ACS. (Compl. ¶ 20, 14 (emphasis added); see also ¶ 46 ("These breaches [of the Provider Agreement] deprived [Plaintiff] of the ***benefits*** conferred [her] through the Provider Agreement." (emphasis added))). These allegations are conclusive on the point, and Plaintiff should not be permitted to speak out of both sides of her mouth in arguing otherwise.

Finally, Plaintiff also suggests that there is a presumption against arbitration when a signatory to an arbitration agreement seeks to compel a non-signatory to arbitration. (Opp’n at 6.) Any such presumption, however, would be preempted by the FAA. *Buckey Check Cashing, Inc. v. Cardegna*, 546 U.S. 440, 443 (2006) (noting that the FAA “embodies the national policy favoring arbitration and places arbitration agreements on equal footing with all other contracts.”). Moreover, even if such a presumption existed, as noted, this is a prototypical direct benefit case, and Plaintiff herself alleges both that she is a third-party beneficiary to, and that she directly benefitted from, the Provider Agreement. Thus, any presumption against arbitration would easily be overcome. *Wilson*, 426 S.C. at 344, 827 S.E.2d at 178 (stating that the direct benefits test is satisfied “where plaintiffs sue and seek relief based on contract containing arbitration clauses.”).

C. Plaintiff’s argument that the language of the arbitration clause is limited to the “parties” thereto is precluded under the theory of equitable estoppel

In her Opposition, Plaintiff argues that the fact the arbitration clause states that it applies to the “parties” to the Provider Agreement—and not to her—means that the arbitration clause does not apply to her. This argument, however, misapprehends the scope of the equitable estoppel doctrine. That doctrine does not simply preclude Plaintiff from arguing that she is a signatory to the Provider Agreement; rather, it also precludes Plaintiff from arguing that the Provider Agreement’s arbitration clause ***applies to her***. *Swane Co. v. Berkeley Cnty. S.C.*, No. 2:15-cv-2586, 2015 U.S. Dist. LEXIS 147235, at *17 n.4 (D.S.C. Oct. 30, 2015) (holding, in a case involving arbitration agreement that applied only to the “parties” to the agreement, that a non-signatory was nevertheless bound by it under the theory of equitable estoppel). If the law were otherwise, because contracts generally only bind the parties thereto, the equitable estoppel doctrine would only apply in a narrow set of cases in which the language of the arbitration clause did not specify who was bound by it. That is not the state of the law.

In any event, this argument ignores the header on the first page of the Provider Agreement, which states in bold, capitalized, and underlined letters that “**THIS . . . AGREEMENT IS SUBJECT TO ARBITRATION.**” That header contains no limitation whatsoever on the parties who are bound by the arbitration provision.

Accordingly, the direct benefits test applies here, and, under it, Plaintiff is estopped from denying that she is a signatory to the arbitration clause here.

II. THE ARBITRATION CLAUSE APPLIES TO THIS DISPUTE

As ACS demonstrated in its Motion, the language of the arbitration clause covers the dispute here. That clause provides that the parties to the Provider Agreement “agree to arbitrate [any] problem or dispute” that “arises under the agreement.” (Provider Agreement at 11). Plaintiff’s claim for breach of the Provider Agreement plainly “arises under” that Agreement, as do Plaintiff’s claims for unjust enrichment and equity.

In her Opposition, Plaintiff points out that the arbitration clause does not state that it also applies to claims “relating to” the Provider Agreement, but the omission of that language is immaterial here. For one thing, it is clear beyond legitimate dispute that a claim for breach of the contract containing the arbitration clause “arises under” that contract. *See, e.g., Fleetwood Transp. Corp. v. Packaging Corp. of Am.*, No. 6:10-0129-JMC, 2012 U.S. Dist. LEXIS 31421, at *15 (D.S.C. Mar. 8, 2012) (compelling claim for breach of contract to arbitration under arbitration clause that applies to disputes “arising under the agreement”). 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”); *Fleetwood Transp.*, 2012 U.S. Dist. LEXIS 31421, at *15 (compelling claim for

unjust enrichment to arbitration under arbitration clause that applies to disputes “arising under the agreement”). Accordingly, all of Plaintiff’s claims here “arise under” the Provider Agreement.

III. QUESTIONS REGARDING THE EXISTENCE AND SATISFACTION OF CONDITIONS PRECEDENT TO AN ARBITRATION CLAUSE ARE FOR THE ARBITRATOR, NOT THE COURT, TO DECIDE

In her Opposition, Plaintiff also contends that the fact the arbitration clause requires a pre-arbitration meet-and-confer means that the dispute may not be arbitrated. This is not a serious argument. Plaintiff may not openly violate the arbitration provision—an arbitration provision she is estopped from denying she is party to—and then claim, ***based on her own violation of the contract***, that her claim may not be arbitrated. The law does not aid parties in their own breaches of contract. *See, e.g., Champion v. Whaley*, 280 S.C. 116, 121, 311 S.E.2d 404, 407 (Ct. App. 1984) (“Where a party’s repudiation contributes materially to the nonoccurrence of a condition precedent to his duty of performance, the nonoccurrence of the condition is excused.”).

More importantly, the issues of (1) whether a contractual provision is, in fact, a condition precedent to arbitration and (2) if a condition precedent, whether it is fulfilled, are questions for the arbitrator, not the court, to decide. As the Fourth Circuit recently held, “arbitrators—not courts—must decide whether a condition precedent to arbitrability has been fulfilled.” *Chorley Enters. v. Dickey’s Barbecue Rests., Inc.*, 807 F.3d. 553, 565 (4th Cir. 2015) (citing *BG Group PLC v. Republic of Arg.*, ___ U.S. ___, 134 S. Ct. 1198, 1207-1208 (2014)). Notably, in *Chorley*, the Fourth Circuit noted that ***every single case*** that Plaintiff cites in her Opposition in support of her argument otherwise has been overruled by the Supreme Court of the United States. *Id.* at 565 n.14 (noting that *Perdue Farms, Inc. v. Design Build Contr. Corp.*, No. 07-1056, 2008 U.S. App. LEXIS 2861 (4th Cir. Feb. 8, 2008), *HIM Portland LLC v. Devito Builders Inc.*, 317 F.3d 41 (1st Cir. 2003), and *Kemiron-Atl. Inc. v. Aguakem Int’l Inc.*, 290 F.3d 1287, 1291 (11th Cir. 2002),

have all been overruled). Accordingly, Plaintiff's argument regarding the alleged existence of a condition precedent is for the arbitrator—not the Court—to resolve.

IV. THE AAA IS AVAILABLE TO RESOLVE THIS DISPUTE

In her Opposition, Plaintiff argues that the arbitration clause is not enforceable because the AAA will refuse to arbitrate the dispute. (Opp'n at 13-15.) This argument, however, misreads just how narrow the AAA pronouncement on this point actually is, and ignores the fact that the AAA will arbitrate (1) disputes between providers and their patients involving billing issues and (2) disputes that are compelled to arbitration pursuant to a court order.

It is true, as Plaintiff claims, that the AAA announced in 2003 that it would not voluntarily “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.” See AAA Healthcare Policy Statement, American Arbitration Association, https://www.adr.org/sites/default/files/document_repository/AAA_Healthcare_Policy_Statement.pdf (last visited October 15, 2020), attached hereto as **Exhibit A**). As the text of this provision reveals, however, the pronouncement applies only to disputes that “relate to *medical services*, such as *negligence and medical malpractice disputes*.” *Id.* (emphases added). To make this limitation clear, the AAA further specified that it “will continue to administer arbitrations that involve solely *billing or collections matters* between an individual and a . . . healthcare provider.” *Id.* (emphasis added). Moreover, the AAA also clarified that it “will administer disputes between patients and healthcare providers to the extent a *court order directs such a dispute to arbitration* where the parties’ agreement provides for the AAA’s rules or AAA administration.” *Id.* (emphasis added).

This case falls squarely within both exceptions noted by the AAA in the Healthcare Policy Statement. For one thing, this is a dispute between an individual (Plaintiff) and a healthcare provider (ACS) that “involve[s] solely billing or collections matters.” Plaintiff does not allege a medical malpractice or related negligence claim against ACS; instead, the crux of Plaintiff’s Complaint is allegations that ACS improperly billed her. Thus, this is indisputably a “billing . . . matter.” In addition, the AAA will arbitrate any case that is compelled to them by a court, as this case should be. Therefore, the AAA policy provides no impediment to arbitration.

Moreover, even if the AAA were actually unavailable (and it is not), the proper remedy is not to hold the arbitration clause unenforceable. Instead, the Court should simply appoint a substitute arbitrator. Indeed, the FAA specifically provides for the manner in which to name an arbitrator in this situation. Section 5 of the FAA provides in relevant part:

[i]f in the agreement provision be made for a method of naming or appointing an arbitrator or arbitrators or an umpire, such method shall be followed; but if no method be provided therein, or if a method be provided and any party thereto shall fail to avail himself of such method, or if for any other reason there shall be a lapse in the naming of an arbitrator or arbitrators or umpire, or in filling a vacancy, then upon the application of either party to the controversy, the court shall designate and appoint an arbitrator or arbitrators or umpire, as the case may require...

9 U.S.C. § 5. Thus, even if the AAA were unavailable, the remedy would simply be for the Court to appoint a substitute arbitrator.

Plaintiff argues that *Grant v. Magnolia Manor-Greenwood, Inc.*, is analogous to this case, but that case is easily distinguishable. In *Grant*, the arbitration provision provided in relevant part: “any action, dispute, claim, or controversy of any kind . . . shall be resolved by binding arbitration **administered by** the National Health Lawyers Association (the “NHLA”).” 383 S.C. 125, 128, 578 S.E.2d 435, 436-37 (2009) (emphasis added). After the parties entered into the arbitration agreement, but before the dispute arose, the NHLA amended its rules to provide that it would only

honor arbitration agreements entered into after the dispute arose. *Id.* The Court denied enforcement of the arbitration provision, reasoning that, because the parties' agreed-upon exclusive forum was unavailable, section 5 of the FAA did not permit the court to enforce the arbitration provision by appointing a substitute arbitrator. *Id.* at 132.

Here, by contrast, the arbitration provision invokes the AAA—not the NHLA—and, as noted, the AAA Healthcare Policy Statement does not apply to billing disputes or to cases compelled to arbitration by a court. For this reason alone, *Grant* is inapposite. Moreover, the arbitration provision at issue here does not state that the arbitration will be “administered” by the AAA, as was the case in *Grant*. Instead, the Provider Agreement provides only that the AAA will “appoint” an arbitrator and that the AAA “commercial rules” will apply. (Provider Agreement at 11.) Thus, even if the AAA were unavailable to appoint an arbitrator (and it is not), the Court should appoint a substitute arbitrator under section 5 of the FAA, and the parties can arbitrate under the AAA rules. Indeed, the Supreme Court of South Carolina has held exactly that. *See Dean v. Heritage Healthcare of Ridgeway, LLC*, 408 S.C. 371, 384, 729 S.E.2d 727, 734 (2014) (holding that arbitration service is integral to arbitration clauses that provide the arbitration service shall be “administered by” a particular arbitration service, and, conversely, arbitration service is not integral to arbitration clauses that provide the arbitration shall be conducted “in accordance with” the selected arbitration service’s rules).

For these reasons, the fact that the arbitration clause here provides that the AAA will select and arbitrator and that the AAA commercial rules apply is no impediment to arbitration.

V. THE SCUAA DOES NOT PRECLUDE ARBITRATION HERE AND, THUS, THE SCUAA DOES NOT REVERSE PREEMPT THE FAA

In her Opposition, Plaintiff argues that the arbitration provision at issue here is unenforceable under SCUAA because it calls for arbitration of a claim involving insurance benefits

and, further, that the SCUAA reverse preempts the FAA under the McCarran-Ferguson Act. Plaintiff's argument is fatally flawed, however, because the arbitration here is not located in an insurance policy and ACS is not an insurance company.

It is true, as Plaintiff argues, that the SCUAA provides that arbitration clauses are unenforceable insofar as they apply to "any insured or beneficiary under any insurance policy or annuity contract." S.C. Code Ann. § 15-48-10(b)(4). The problem for Plaintiff is that this provision only applies "when a litigant seeks to enforce an arbitration agreement contained **in an insurance policy** governed by South Carolina law." *Walden v. Harrelson Nissan Inc.*, 399 S.C. 205, 210, 731 S.E. 2d 324, 326 (Ct. App. 2012) (emphasis added). In *Walden*, the plaintiff urged the Court to read § 15-48-10(b)(4) to include contracts related to insurance policies, but the Court rejected this expansive reading of the statute. *Id.* at 209, 731 S.E.2d at 326. Instead, the Court held that the contract at issue—a lease agreement containing a provision that the defendant would secure insurance for the plaintiff—was not exempt from arbitration because it itself was not an insurance policy. *Id.* at 210, 731 S.E.2d at 327; *see also Cox v. Woodmen of World Ins. Co.*, 347 S.C. 460, 468, 556 S.E.2d at 402 (Ct. App. 2001) (holding that S.C. Code. Ann. § 15-48-10(b)(4) is a "specific exemption limited to entities **within the insurance industry**") (emphasis added). For these reasons, the court in *Walden* held:

we reject [the plaintiff's] expansive interpretation of the statute and conclude the General Assembly did not intend for the arbitration exception of section 15-48-10(b)(4) to apply to automobile lease agreements that have only a tangential relationship to an insurance policy, but was instead **intended to apply directly to an insurance contract.**

399 S.C. at 210, 731 S.E. 2d at 326 (emphasis added); *see also Blue Ridge Emergency Physicians, P.A. v. Emergency Physicians Ins. Co.*, RRG C/A no. 6:10-cv-00428-JMC, at *5-6 (D.S.C. Mar.

15, 2011) (noting that “S.C. Code Ann. § 15-48-10(b)(4) prohibits the enforcement of arbitration clause in *insurance policies* under South Carolina law” (emphasis added)).

By her argument, Plaintiff asks the Court to make the same mistake the plaintiff in *Walden* made—she asks the Court to expand § 15-48-10(b)(4) to preclude the arbitration of claims that are merely *related to* a contract for insurance (and tangentially so, at that). This argument is as unpersuasive here as it was in *Walden* for the simple reasons that the Provider Agreement is not an insurance policy.

In support of her argument, Plaintiff cites *Rock v. Atl. Specialty Ins. Co.*, for the proposition that § 15-48-10(b)(4) applies to more than insurance policies themselves, (Opp’n at 12), but *Rock* does not help Plaintiff. In *Rock*, the court—applying the law of the District of Columbia—held that an arbitration clause contained in a certificate of insurance was unenforceable. No. 4-19-cv-01433-SAL, 2020 U.S. Dist. LEXIS 66641, at *8 (D.S.C. April 16, 2020). The District of Columbia statute at issue provided that arbitration clauses in insurance policies are unenforceable. See D.C. Code § 16-4403(c)(1). The court, noting that the certificate of insurance “describes the main features of the Policy,” held that the District of Columbia statute precluded application of the arbitration clause. *Id.* at *3. In a footnote, the court stated, in *dicta*, and without any reasoning or explanation, that the arbitration clause would also be unenforceable under § 15-48-10(b)(4). *Id.* at * 7 n.4.

Plaintiff’s reliance on *Rock* is misplaced for multiple reasons—it is not final, it contains *dicta*, and it is inapposite in any event. First, on appeal, the Fourth Circuit has remanded the case to the district court with directions to *vacate the very order* cited by Plaintiff, in part because “it is arguably incorrect.” See Order, *Rock v. Atlanta Specialty Ins. Co.*, No. 20-1569 (4th Cir. Oct. 6, 2020), attached hereto as **Exhibit B**. The order cited by Plaintiff is therefore not final and will

soon be vacated, if it has not been vacated already. Second, as noted, the court in *Rock* applied the law of the District of Columbia, and the footnoted statement regarding § 15-48-10(b)(4) was pure *dicta*.

Third, the facts in *Rock* are materially different from the facts in this case in any event. In *Rock*, the document at issue was a certificate of insurance, issued by an insurance company, that described the benefits available to the policyholder under a policy of insurance. *Id.* at *2-4. Thus, the certificate had a direct relationship with the insurance policy it was evidencing. *Id.* at 3 (noting that the certificate of insurance “describes the main features of the Policy”). Here, by contrast, the Provider Agreement is only tangentially related to Plaintiff’s insurance policy with BCBSSC; it governs certain aspects of the relationship between BCBSSC and ACS regarding ACS’s provision of medical care to participants under certain BCBSSC medical plans. Unlike a certificate of insurance, the Provider Agreement does not describe the benefits available under any insurance policy that Plaintiff has, nor does it bestow any benefits on any beneficiary or participant of any insurance policy. Moreover, unlike the situation in *Rock*, Plaintiff here is not suing her insurance company. Instead, she is suing her medical provider, which is a type of lawsuit that falls outside of the situations contemplated under § 15-48-10(b)(4). (See Pl. Mot. to Remand at 2 (Plaintiff “is not alleging a denial of benefits under her ERISA plan. Indeed, she makes no claim whatsoever under her ERISA plan or against its administrators.... She is suing Defendant for its billing practices and alleges those practices violate the contractual duties contained in the Provider Agreement between Defendant and BCBS.”), attached hereto as **Exhibit C.**) Accordingly, even if *Rock* were good law (and it is not), it has no bearing whatsoever on this case.

For all of these reasons, § 15-48-10(b)(4) does not render the arbitration provision at issue in this case unenforceable and, therefore, it does not reverse preempt the FAA.³

CONCLUSION

For the foregoing reasons, as well as those set forth in ACS's Motion, ACS respectfully requests that the Court 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 bilateral arbitration.

Dated: October 15, 2020

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³ Finally, it is worth noting that, in her Opposition, Plaintiff does not argue either (1) that the FAA does not apply or (2) that, if the case is compelled to arbitration, the arbitration should be on a bilateral basis only.

EXHIBIT A



AAA® Healthcare Policy Statement

In 2003, the American Arbitration Association® (“AAA”) announced that 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. This policy is consistent with the *American Arbitration Association/American Bar Association/American Medical Association Due Process Protocol for the Mediation and Arbitration of Health Care Disputes*.

However, the AAA will administer disputes between patients and healthcare providers to the extent a court order directs such a dispute to arbitration where the parties’ agreement provides for the AAA’s rules or AAA administration. In addition, the AAA will continue to administer arbitrations that involve solely billing or collections matters between an individual and a doctor or healthcare provider, although such billing or collections disputes may be governed by the AAA’s *Consumer Rules and Consumer Due Process Protocol*.

The AAA notes that this policy does not relate to or impact the administration of all other types of disputes in the healthcare field, such as disputes among providers, healthcare companies, insurance carriers and related entities. For more information on the AAA’s administration of these types of cases and the AAA’s *Healthcare Payor Provider Arbitration Rules*, please visit **www.adr.org**.

EXHIBIT B

FILED: October 6, 2020

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 20-1569
(4:19-cv-01433-SAL)

LINDA ROCK, as the Personal Representative for the Estate of Gerald Lindsay

Plaintiff - Appellee

v.

ATLANTIC SPECIALTY INSURANCE COMPANY; MICHAEL KLUG;
BRENTWOOD SERVICES ADMINISTRATORS, INC.

Defendants - Appellants

and

BRENTWOOD SERVICES, INC.

Defendant

O R D E R

Upon consideration of the joint motion for a limited remand, the court grants the motion and remands this case to the district court for the limited purpose of reconsidering its order entered on April 16, 2020.

The clerk shall forward a copy of this order, accompanied by a copy of the motion to remand, to the district court. This appeal shall remain on the active docket of this court and the parties shall file a status report on November 5, 2020, and every 30 days thereafter, and shall immediately notify this court when the district court proceedings have concluded.

For the Court

/s/ Patricia S. Connor, Clerk

No. 20-1569

**United States Court of Appeals
for the Fourth Circuit****LINDA ROCK, as the Personal Representative for the Estate of Gerald
Lindsay,**

Plaintiff – Appellee

v.

**ATLANTIC SPECIALTY INSURANCE COMPANY; MICHAEL KLUG;
BRENTWOOD SERVICES ADMINISTRATORS, INC.**

Defendants – Appellants

On Appeal from the United States District Court,
District of South Carolina, Florence Division
Civil Action No. 4:19-cv-01433-SAL
District Judge Sherri A. Lydon

JOINT MOTION FOR LIMITED REMAND

All parties in this case jointly move this Court, pursuant to Rule 12.1 of the Federal Rules of Appellate Procedure, for a limited remand of this case to the United States District of South Carolina for the purpose of issuing an order vacating its order entered on April 16, 2020, which is the order that is the subject of this appeal. The grounds for this motion are as follows.

1. Plaintiff-Appellee, Linda Rock, filed this lawsuit to recover benefits under an insurance policy issued by Atlantic Specialty Insurance Company after Gerald Lindsay was involved in a motor vehicle accident while

he was driving as a courier for Sun Logistics. Defendants-Appellants, Atlantic Specialty Insurance Company, Brentwood Services Administrators, Inc., and Michael Klug (collectively referred to as “Atlantic Specialty”), filed a motion to stay litigation and to compel arbitration because there is an arbitration clause in the insurance policy.

2. On April 16, 2020, the district court denied the motion, finding that the arbitration clause is void because a D.C. statute provides that any provision in an insurance policy with a consumer that requires binding arbitration is void. Atlantic Specialty appealed to this Court from that order to argue that the D.C. statute does not apply because this is not an insurance policy with a consumer, but instead is a policy that provides coverage to a courier who is under dispatch as a part of the courier’s occupation. This is that appeal.

3. On June 3, 2020, this Court sent the parties a Notice of Scheduled Mediation, pursuant to Fourth Circuit Local Rule 33, requiring the parties to participate in a mediation with Fourth Circuit Mediator Cynthia Mabry-King. At that time, there were no on-going settlement negotiations between the

parties, but all parties participated in the mediation in compliance with the Fourth Circuit's directive. The mediation occurred on June 15, 2020.

4. Under the guidance of Ms. Mabry-King, the parties were successful in negotiating a conditional settlement agreement that would resolve all disputes in this litigation. A mandatory condition of the settlement is the vacatur of district court's April 16, 2020, Order, so the parties filed with the district court a joint motion to vacate the April 16, 2020, Order pursuant to Fed. R. Civ. Pro. 60(b).

5. The procedure governing a district court's ability to grant a Rule 60(b) motion while the case is on appeal is well-settled and was explained in *Fobian v. Storage Technology Corp.*, [164 F.3d 887](#) (4th Cir. 1999). After the parties file a Rule 60(b) motion with the district court, "[i]f the district court is inclined to grant the motion, it should issue a short memorandum so stating." *Id.* Second, the litigants are to provide to this Court the district court's memorandum to advise this Court that the district court is inclined to grant the Rule 60(b) motion. Third, this Court grants a limited remand so that the district court has jurisdiction to grant the Rule 60(b) motion. *Id.* "By saving judicial resources and avoiding expense and delay, this procedure accords with the overarching mandate in the Federal Rules of Civil Procedure that the rules 'shall be construed to secure the just, speedy, and inexpensive

determination of every action.” *Id.* (quoting Fed. R. Civ. Pro. 1). This Court has followed the procedure set forth in *Fobian* numerous times, some of which are published in the Federal Appendix. *See, e.g., Herriott v. McCabe*, [813 F. App’x 897](#) (4th Cir. 2020); *Howard v. Red Lobster Operated by Darden Restaurants, Inc.*, [693 F. App’x 270](#) (4th Cir. 2017); *Boyd v. South Carolina*, [475 F. App’x 909](#) (4th Cir. 2012); *Stevenson v. Shoup*, [390 F. App’x 286](#) (4th Cir. 2010); *Stepney v. Beckwith*, [360 F. App’x 418](#) (4th Cir. 2010); *Sindram v. Sengel*, [108 F. App’x 745](#) (4th Cir. 2004); *Columbia Gas Transmission Corp. v. Burdette Realty Improvement, Inc.*, [48 F. App’x 910](#) (4th Cir. 2002); *Davis v. City of Jacksonville*, [22 F. App’x 316](#) (4th Cir. 2001).

6. Following the procedure set forth in *Fobian*, on September 23, 2020, the district court in this case entered a short memorandum to state that it is inclined to grant the joint motion to vacate and to request that this Court grant a limited remand for that purpose. The district court’s memorandum is attached as Exhibit A.

7. All parties agree—and the district court agrees as well, as Exhibit A demonstrates—that a limited remand from this Court so that the district court can vacate its April 16, 2020, order is appropriate in light of the “exceptional circumstances” in this case. *Valero Terrestrial Corp. v. Paige*, [211](#)

E.3d 112, 121 (4th Cir. 2000) (quoting *U.S. Bancorp Mortgage Co. v. Bonner Mall P'ship*, 513 U.S. 18, 29 (1994)).

8. Specifically, exceptional circumstances exist to vacate the April 16 Order for three independent reasons: (1) the April 16 Order is at least arguably wrong; (2) the April 16 Order concerns the important issue of arbitration, which is favored both under federal and D.C. law; and (3) the circumstances surrounding the conditional settlement. Plaintiff-Appellee Linda Rock does not join in paragraphs 9 to 11 of this joint motion so as to preserve her arguments in the event that this Court were to deny this motion for limited remand.

9. ***Exceptional circumstances exist because the April 16 Order is arguably incorrect.*** Exceptional circumstances justifying a vacatur of the April 16, 2020, Order exist in this case because that the order is arguably incorrect. *See, e.g., In re Gen. Motors Corp.*, No. 94-2435, 1995 WL 940063, at *1 (4th Cir. Feb. 17, 1995) (*U.S. Bancorp* requirements satisfied for an incorrect district court order).

10. The D.C. statute that forms the basis of the April 16, 2020, Order states: “Any provision in an insurance policy with a consumer that requires binding arbitration is void and unenforceable.” D.C. Code § 16-4403(C)(1)). However, the Atlantic Specialty insurance policy is not an insurance policy

with a consumer, so this provision does not apply. This insurance policy instead provides insurance to a courier who is under dispatch as a part of the courier's occupation. When someone obtains insurance as a part of their work, they are not acting a consumer. The D.C. Code itself makes that clear. The same chapter of the D.C. Code that contains § 16-4403 also defines a "consumer" as "a party to an arbitration agreement who, in the context of that arbitration agreement, is an individual, not a business, who seeks or acquires, including by lease, any goods or services primarily for personal, family, or household purposes including, but not limited to, financial services, healthcare services, or real property." D.C. Code § 16-4401(3). Here, Gerald Lindsay obtained insurance that would provide coverage when he was working, not when he was acting for personal, family, or household purposes. This is clear from the title of the policy itself—an "Occupational Accident" policy. It is also clear from the requirements for coverage under the occupational policy, which provide coverage only when someone is acting as a courier under dispatch. And jurisprudence in other contexts confirms that someone is not acting as a consumer when they are working. *See, e.g., In re Runski*, 102 F.3d 744, 747 (4th Cir. 1996) (under the Bankruptcy Code, "courts have concluded uniformly that debt incurred for a business venture or with a profit motive does not fall into the category of" consumer debt); *Am. Exp. Co. v.*

Koerner, [452 U.S. 233, 245](#) (1981) (transaction relating to the purchase of airline tickets was not an extension of “consumer credit” because the tickets were purchased for business trips). Because the April 16, 2020, Order is arguably incorrect when it fails to enforce an arbitration clause, exceptional circumstances exist to justify the district court’s decision to vacate its prior interlocutory order.

11. ***Exceptional circumstances exist because federal and D.C. law strongly support upholding arbitration.*** The April 16, 2020, Order not only declined to enforce a binding arbitration provision in a contract, but it did so on a basis that may be argued in later cases to effectively read the provision out of the contract. This is inconsistent with federal and D.C. law, both of which overwhelmingly favor upholding binding arbitration provisions. *Moses H. Cone Mem’l Hosp. v. Mercury Constr. Corp.*, [460 U.S. 1, 24](#) (1983) (noting the “liberal federal policy favoring arbitration agreements”); *Hill v. Peoplesoft USA, Inc.*, [412 F.3d 540, 543](#) (4th Cir. 2005) (same); *TRG Customer Sols., Inc. v. Smith*, [226 A.3d 751, 755](#) (D.C. 2020) (“Our case law has expressed a strong preference favoring arbitration when a contract contains an arbitration clause.”). By not enforcing an arbitration clause, the April 16, 2020, Order is contrary to this public policy, and this is another reason that exceptional

circumstances justify the district court's decision to vacate its prior interlocutory order.

12. ***Exceptional circumstances exist because of the circumstances surrounding the conditional settlement.*** When a settlement results from a court referring a case to mediation, when that settlement is expressly contingent upon vacatur, when the order to be vacated is being challenged on appeal at the time of the conditional settlement, and when the order to be vacated is a federal court interpretation of state court law, then exceptional circumstances exist and vacatur is warranted. The Eleventh Circuit addressed this exact situation in *Hartford Cas. Ins. Co. v. Crum & Forster Specialty Ins. Co.*, [828 F.3d 1331](#) (11th Cir. 2016). In that case, which involved an insurance policy, the district court applied state law and granted summary judgment on an issue regarding the scope of the insurance policy. The losing insurance company appealed, and the Eleventh Circuit ordered the parties to attempt to resolve the dispute through mediation. The mediation resulted in a conditional settlement agreement whereby the parties were willing to settle their differences, but that was contingent upon a court of competent jurisdiction vacating the order that was being appealed. *Id.* at 1333. The Eleventh Circuit stayed the appeal so that the parties could file a Rule 60(b) motion with the district court. They did so, but the district court did not

believe that exceptional circumstances existed. *Id.* The Eleventh Circuit reversed, explaining that vacatur was appropriate because exceptional circumstances did exist.

13. First, the court noted that it had referred the parties to the mediation, and thus it was not a case in which one party voluntarily forfeited a legal remedy. *Id.* at 1336. Second, the court noted that the settlement was conditioned upon there being a vacatur, and thus without a vacatur, settlement would be impossible. *Id.* “Taken together, these considerations weigh heavily in favor of vacating the District Court’s orders. The parties’ interests are best served through the voluntary disposition of this case, and further proceedings are curtailed, conserving judicial resources.” *Id.* The court also noted that there is only “slight value” in preserving a district court opinion on an issue of state law, and explained that any such value was “outweighed by the direct and substantial benefit of settling this case to [the parties] and to the judicial system (and thus to the public as well).” *Id.* The court explained that its decision was consistent with prior decisions from the First Circuit (*Motta v. Dist. Dir. of I.N.S.*, 61 F.3d 117 (1st Cir. 1995)) and the

Second Circuit (*Major League Baseball Properties, Inc. v. Pac. Trading Cards, Inc.*, [150 F.3d 149](#) (2d Cir. 1998)). *Id.* at 1334-35.

14. Similarly, the productive settlement negotiations in this case were the result of a court-ordered mediation with a Fourth Circuit mediator. And just like *Hartford*, a condition of the settlement is vacatur of the April 16, 2020, Order that is on appeal. The only solution that avoids the necessity of Atlantic Specialty's appeal of the April 16 Order is a vacatur of that decision. And just like *Hartford*, where the opinion sought to be vacated was an interpretation of state court law, here, the opinion sought to be vacated is a federal court interpretation of District of Columbia law. *Hartford*, [828 F.3d at 1336](#); *see also Microsoft Corp. v. Bristol Tech., Inc.*, [250 F.3d 152, 155](#) (2d Cir. 2001) (exceptional circumstances exist and vacatur is warranted when a federal court opinion concerns an issue of state law).

15. Accordingly, all parties in this case jointly move this Court to grant a limited remand of this case to the district court so that the district court can vacate its April 16, 2020, Order. Once the district court vacates its prior order, Defendants-Appellants will notify this Court and will move to voluntarily dismiss their appeal at that time.

WHEREFORE, Plaintiff-Appellee, Linda Rock, and Defendants-Appellants, Atlantic Specialty Insurance Company, Brentwood Services

Administrators, Inc., and Michael Klug, move this Court for a limited remand so that the district court can rule on the pending Fed. R. Civ. Pro. 60(b) motion.

Respectfully submitted:

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Certificate of Service

On September 30, 2020, I caused this joint motion to be filed electronically with the Clerk of the Fourth Circuit Court of Appeal through ECF, which constitutes services on all parties through their counsel pursuant to Fourth Circuit Local Rule 25(a)(4).

s/ Jeffrey E. Richardson

Jeffrey E. Richardson

Certificate of Compliance with Type-Volume Limit, Typeface Requirements, and Type-Style Requirements

1. This motion complies with type-volume limits of Fed. R. App. P. 27(d)(2)(A) and Fed. R. App. P. 32(c)(1) because, excluding the parts of this document exempted by Fed. R. App. P. 32(f), this motion contains 2,200 words.

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s/ Jeffrey E. Richardson

Jeffrey E. Richardson

Dated: September 30, 2020

EXHIBIT 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 ERISA¹ 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

¹ 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.² 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,³ 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).⁴

² 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).

³ 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).

⁴ 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. ¶ 4.⁵ 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.

⁵ 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 ERISA⁶— 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

⁶ 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 provision⁷: “[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).⁸ 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).

⁷ 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).

⁸ 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 action⁹ 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.¹⁰ The Court addressed the first prong of *Davila*, noting:

⁹ She also alleges related equitable remedies. Comp ¶¶ 69-79.

¹⁰ *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:¹¹

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).¹²

¹¹ *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).

¹² 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,¹³ 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.¹⁴ 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

¹³ 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.”).

¹⁴ *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,

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ATTORNEYS FOR THE PLAINTIFF

Dated: May 18, 2020

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,

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Plaintiff,

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v.

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ACS Primary Care Physicians-Southeast P.C.,

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Defendant

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Defendant ACS Primary Care Physicians-Southeast P.C. (“ACS”) submits this Reply to Plaintiff’s Response in Opposition (“Opposition”) to ACS’s Motion to Compel Arbitration and Dismiss (the “Motion”). For the following reasons, as well as the reasons set forth in the Motion, the Court should grant the Motion, compel arbitration, and dismiss this case.

INTRODUCTION

As ACS demonstrated in its Motion, Plaintiff’s claims are subject to bilateral arbitration under the doctrine of equitable estoppel. Under that doctrine, Plaintiff is estopped from denying the arbitration provision in the Provider Agreement applies to her because she is suing ACS for breach of that Agreement under a third-party beneficiary theory. Because Plaintiff is seeking a direct benefit under the Provider Agreement (through her claim for breach of contract), she is estopped from denying that the Agreement’s arbitration provisions apply to her.

In her Opposition, Plaintiff relies on inapposite cases, overruled case law, and unsupported contentions to argue that she should not be compelled to arbitrate her dispute. Plaintiff’s arguments, however, are unavailing.

First, Plaintiff attempts to avoid the application of the doctrine of equitable estoppel by suggesting that South Carolina law does not apply the direct benefits test, but the Supreme Court of South Carolina has adopted a direct benefit test that applies in the arbitration context. Applying that test, Plaintiff is seeking a direct benefit under the Provider Agreement because she is suing ACS for breach of that Agreement based on a theory that she is a third-party beneficiary to it. This is a textbook case for application of the direct benefits test, and Plaintiff should not be permitted to disavow the Provider Agreement's arbitration clause out of one side of her mouth while invoking other provisions of the Provider Agreement out of the other side of her mouth. For these reasons, Plaintiff is equitably estopped from denying that the arbitration clause applies to her.

Second, Plaintiff argues that the arbitration clause is not broad enough to encompass her claims, but her claims plainly "arise under" the Provider Agreement. Plaintiff further contends that the arbitration clause should not apply because ACS's actions fall under the "outrageous and unforeseeable torts" exception announced in *Aiken v. World Fin. Corp. of S.C.*, but that exception does not apply here for the simple reason that Plaintiff's claims are contract-based claims, not torts.

Third, Plaintiff argues that the arbitration provision is unenforceable because the forum chosen by the parties—the American Arbitration Association (the "AAA")—is unavailable. Plaintiff's argument, however, ignores the facts that the AAA's proclamation applies only to medical malpractice disputes, not billing disputes and, in any event, the AAA will readily arbitrate any dispute a court compels to arbitration. Moreover, the arbitration clause does not provide that the AAA is the exclusive forum in which to arbitrate; instead, it merely provides that the AAA rules must apply. In this situation, even if the AAA were unavailable (and it is not), the Court may simply appoint an alternate arbitrator.

Fourth, Plaintiff argues that § 15-48-10(b)(4) of the South Carolina Uniform Arbitration Act (“SCUAA”) precludes arbitration and reverse preempts the Federal Arbitration Act (“FAA”). This section of the SCUAA, however, only precludes arbitration where the arbitration clause is in an insurance policy. Here, the Provider Agreement is not an insurance policy, nor is this lawsuit against an insurance company, so § 15-48-10(b)(4) and reverse preemption do not apply.

Fifth, Plaintiff argues that ACS’s affidavit authenticating the Provider Agreement is improper because it is not notarized, but this argument ignores that, in response to the coronavirus pandemic, the Supreme Court of South Carolina entered an order that excuses the notary requirement so long as the witness certifies that their statement is true and that they are subject to the penalties of perjury. That is precisely what the authenticating witness certified here. Thus, ACS’s authenticating affidavit is proper.

These arguments are discussed in more detail below.

DISCUSSION

“The policy of the United States and South Carolina is to favor arbitration of disputes.”

Zabinski v. Bright Acres Assocs., 346 S.C. 480, 596, 553 S.E. 2d 110, 118 (2001).

I. EQUITABLE ESTOPPEL APPLIES HERE AND PLAINTIFF IS ESTOPPED FROM DENYING THAT THE ARBITRATION CLAUSE APPLIES TO HER

A. The direct benefits test applies under South Carolina law

As ACS demonstrated in its Motion, Plaintiff is equitably estopped from denying that the arbitration clause in the Provider Agreement applies to her. Under the doctrine of equitable estoppel, “[a] non-signatory 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, 290, 733 S.E.2d 597, 601 (Ct. App. 2012); *see also Wilson v. Willis*, 426 S.C. 326, 340, 827 S.E.2d 167, 175 (2019). A non-signatory seeks a “direct benefit” under a

contract when, among other things, she asserts a claim based on her alleged status as a third-party beneficiary of the contract. *Wilson*, 426 S.C. at 340, 827 S.E.2d at 175. Here, because Plaintiff is asserting a claim against ACS for breach of the Provider Agreement under a theory that she is a third-party beneficiary to that Agreement, she is equitably estopped from arguing that that the Provider Agreement's arbitration provision does not apply to her due to the fact she did not sign that Agreement.

In her Opposition, Plaintiff suggests that the direct benefits test is not available under South Carolina law. (Opp'n at 5-6.) This argument misstates South Carolina law. In *Wilson v. Willis*, for example, the Supreme Court of South Carolina applied the direct benefits test in the context of determining whether the plaintiffs were estopped from denying that the arbitration at issue clause applied to them. 426 S.C. 326, 340, 827 S.E.2d 167, 175 (2019). As the Court in *Wilson* noted, "[u]nder [the] direct benefits [test], a non-signatory is estopped from refusing to comply with an arbitration clause when it receives a direct benefit from a contract containing an arbitration clause." *Id.* (quoting *Pearson*, 400 S.C. at 290, 733 S.E.2d at 601) (internal quotations and alterations omitted). The Court explained that a direct benefit is one that "flows directly from the agreement," *id.* at 343, 827 S.E. 2d 176, and it noted that such a test is satisfied "where plaintiffs sue and seek relief based on contracts containing arbitration clauses." *Id.* at 344, 827 S.E.2d at 177 (citing *Int'l Paper Co. v. Schwabedissen Maschinen & Analgen GMBH*, 206 F.3d 411, 417-18 (4th Cir. 2000)).

Similarly, in *Pearson v. Hilton Head Hosp.*, the South Carolina Court of Appeals applied the direct benefits test to hold that a non-signatory was equitably estopped from denying that he was bound by an arbitration clause when he directly benefitted from a contract containing an arbitration clause. 400 S.C. at 296-97, 733 S.E.2d at 605.

In her Opposition, Plaintiff suggests that *Thompson v. Pruitt Corp.* held that the direct benefits test was a feature of federal, and not state, law, (Opp’n at 6-7), but *Thompson* says nothing of the kind. In *Thompson*, the South Carolina Court of Appeals noted that the Supreme Court of the United States recently held that state—not federal—law determined the elements of estoppel in the arbitration context. 416 S.C. 43, 58-59, 784 S.E.2d 679, 687-88 (Ct. App. 2016) (citing *Arthur Andersen LLP v. Carlisle*, 556 U.S. 624, 630 (2009)). In doing so, the Court questioned language from *Pearson* suggesting that federal—and not state—law determined the elements of estoppel in the arbitration context. *Id.* (quoting 400 S.C. 281, 289-90, 733 S.E.2d at 601). The court in *Thompson*, however, did not make a determination as to the appropriate test, but analyzed the facts under both tests. *Id.* at 59-60, 784 S.E.2d at 688.

Moreover, in *Wilson*—a case the Supreme Court of South Carolina decided after *Thompson*—the Supreme Court of South Carolina put the matter to rest by applying the direct benefits test. 426 S.C. at 338-345, 827 S.E.2d at 174-177. The Court in *Wilson* did not overrule *Pearson*, but instead, clarified that the holding in *Pearson* was predicated on state—not federal—law, as dictated by the Supreme Court of the United States. 426 S.C. at 339 n.8, 827 S.E.2d at 174 n.8 (“To the extent the decision in *Pearson* indicates federal, rather than state, law is controlling on whether equitable estoppel can bind nonsignatories, we take this opportunity to clarify that state law controls.”). If the Court in *Wilson* wanted to reject the direct benefits test, it could easily have done so; instead, however, it took the opportunity *clarify* *Pearson*, not *overrule* it. Indeed, the United States District Court for the District of South Carolina has subsequently interpreted *Wilson* and *Pearson* to mean that the direct benefits test is available under South Carolina law. *See Kiawah Island Util., Inc. v. Westport Ins. Corp.*, No. 2:19-cv-1359-DCN, 2019 U.S. Dist. LEXIS 182220, at *8-9 (D.S.C. Oct. 2, 2019) (applying the direct benefits test and holding that arbitration

agreement was enforceable against a non-signatory). Accordingly, the direct benefits test is a feature of South Carolina law.

Finally, the rationale behind the direct benefits test is compelling, particularly in the arbitration context. As the Court in *Wilson* noted, the direct benefits test is the product of simple fairness: “the doctrine recognizes that a party may be estopped from asserting that the lack of his signature on a written contract precludes enforcement of the contract's arbitration clause when he has consistently maintained that other provisions of the same contract should be enforced to benefit him.” 426 S.C. at 340, 827 S.E.2d at 175. Phrased differently, a person may not seek to enforce one part of an agreement when it suits them, and deny another aspect when it injures them. *See Pearson*, 400 S.C. at 290, 733 S.E.2d at 601 (“To allow a plaintiff to claim the benefit of the contract and simultaneously avoid its burdens would both disregard equity and contravene the purposes underlying enactment of the Arbitration Act.” (quotation omitted)). The direct benefits test is uniquely situated to address just this issue. Moreover, given the strong state and federal public policy in favor of arbitration, this Court should adopt the direct benefits test to promote consistency in state and federal law. *See In re Kellogg Brown & Root*, 165 S.W.3d 723, 739 (Tex. 2005) (noting the importance of consistency in state and federal law). This Court should therefore apply the direct benefits test here.

B. Plaintiff seeks a direct benefit under the Provider Agreement here

As ACS demonstrated in its Motion, Plaintiff is seeking a direct benefit under the Provider Agreement by virtue of her allegation that she is a third-party beneficiary under that Agreement. Indeed, alleging third-party beneficiary status to a contract containing an arbitration agreement is the textbook direct benefits case. *Schwabedissen*, 206 F.3d at 418; *Burlington Ins. Co. v. Trygg-Hansa Ins. Co. AB*, No. 00-1373, 2001 U.S. App. LEXIS 10625, at * 19 (4th Cir. May 23, 2001);

Osborne v. Marina Inn @ Grand Dunes, LLC, No. 4:08-cv-0490-TLW-TER, 2009 U.S. Dist. LEXIS 87167, at *24-25 (D.S.C. Aug. 31, 2009) *adopted by* No. 4:08-cv-0490, 2009 U.S. Dist. LEXIS 87158 (D.S.C. Sept. 23, 2009); *see also Wilson*, 426 S.C. at 344, 827 S.E.2d at 178 (noting that the direct benefits test is satisfied “where plaintiffs sue and seek relief based on contracts containing arbitration clauses”).

In her Opposition, Plaintiff argues that the direct benefits test requires that the non-signatory “knowingly exploit[s]” the agreement containing the arbitration clause.” (Opp’n at 8.) But the cases that Plaintiff cites in support of this argument are cases where the alleged direct benefit at issue is one that arises in the *course and scope of the parties’ dealings with one another*. Here, by contrast, Plaintiff satisfies the direct benefits test because *she is alleging that she is a third-party beneficiary under the Provider Agreement*. In such a situation, the non-signatory’s knowledge of the arbitration clause is simply irrelevant.

In support of her argument that a non-signatory’s knowledge of the arbitration clause is necessary, Plaintiff cites *Wilson*, for example, but that case is easily distinguishable. In *Wilson*, the plaintiffs, clients of an insurance agency, filed non-contract claims against the insurance agency and various insurance companies arising out the agency’s alleged fraud. 426 S.C. at 332, 827 S.E.2d at 170. Some of the insurance companies sought to enforce an arbitration clause found in an agreement between themselves and the insurance agency, arguing that the plaintiffs directly benefitted from that contract because the relationship between the agency and the insurance companies would not have existed but for the agreement. *Id.* at 342, 827 S.E.2d at 177. The court ruled that the direct benefits test was not satisfied because that nexus to the plaintiff’s claims was too attenuated to form a “direct” benefit. *Id.* at 345, 827 S.E.2d at 177. This holding is inapposite

here for the simple reason that the plaintiffs in *Wilson* did not allege that they were third-party beneficiaries under the agreement at issue. *Id.* at 345, 827 S.E.2d at 177.¹

Moreover, Plaintiff's argument that the estopped party must "knowingly exploit" the contract containing the arbitration clause in order for equitable estoppel to apply under the direct

¹ The other cases that Plaintiff cites in support of her argument do not help her either:

First, like *Wilson*, *Belzberg v. Verus Investment Holdings, Inc.*, involved an alleged direct benefit that arose in the course and scope of the parties' dealings. 21 N.Y.3d 626, 977 N.Y.S. 2d 685, 999 N.E.2d 1130, 1134 (N.Y. 2013). Because, as noted, ACS's primary theory is that Plaintiff is seeking a direct benefit under the Provider Agreement by virtue of her third-party beneficiary claim for breach of contract, *Belzberg* is not applicable here.

Second, *In re Kellogg Brown & Root, Inc.*, the issue was whether a second tier subcontractor who sued the first tier subcontractor and general contractor sought a direct benefit of the contract between the first tier subcontractor and general contractor, which contained an arbitration clause. 166 S.W.3d 732 (Tex. 2004). The court held that the second-tier subcontractor did not seek a direct benefit under that contract because it was too remote from the contract the second tier subcontractor entered into with the first tier subcontractor, which did not contain an arbitration clause. *Id.* at 740. Here, by contrast, there is no two-tiered subcontractor relationship. As such, *Kellogg Brown & Root* is not applicable. Indeed, the court in that case noted that "a non-signatory plaintiff may be compelled to arbitrate if its claims are based on a contract containing an agreement to arbitrate." *Id.* (internal quotation marks omitted). That is precisely the situation here.

Third, in *Lawson v. Life of the South Ins. Co.*, the issue was whether the plaintiffs, car buyers, were estopped from denying the defendant, a life insurance company that issued insurance in connection with the plaintiffs' purchase of the car, was a signatory to an arbitration clause in the loan agreement with the car dealership when the plaintiffs sued the insurance company for not refunding certain premiums. 648 F.3d 1166, 1168 (11th Cir. 2011). The court held that the plaintiffs were not estopped from denying the arbitration clause applied to the defendants because the loan agreement was "not the legal basis for the [plaintiff's] claims." *Id.* at 1173. Here, by contrast, the Provider Agreement forms the legal basis for Plaintiff's claims.

Fourth, in *MAG Portfolio Consult., GmbH v. Merlin Biomed Group, LLC*, the plaintiff signatory attempted to enforce an arbitration clause against the non-signatory defendants. No. 00-9502, 2001 U.S. App. LEXIS 21693, at *60 (2d Cir. Oct. 10, 2001). The defendants, however, were not alleging they were third-party beneficiaries under any contract, and they had no relationship to the signatories other than as competitors in business. *Id.* Instead, the plaintiff was alleging the defendants were alter egos of the signatories. *Id.* at *63. *MAG Portfolio* simply has no application here.

benefits test was expressly rejected in *Kiawah Island*. 2019 U.S. Dist. LEXIS 182220, at *9-11. There, the court explained that *Wilson*'s examination of the non-signatory's knowledge of the contract containing the arbitration clause was undertaken only for the purpose of determining whether the non-signatory had benefited from that agreement in light of the parties course and scope of dealing. *Id.* In other words, the non-signatory's knowledge can be a factor (though not a requirement) when the alleged direct benefit arises in the ***course and scope of the parties' dealings with one another***, but knowledge is not relevant when the party to be estopped is claiming to be a third-party beneficiary of the contract containing the arbitration clause. Thus, the court in *Kiawah Island* held that it "need not examine whether [the plaintiff] knew about the Arbitration Clause because that factual question only relates to whether [the plaintiff] is seeking a benefit from the [policy agreement], and [the plaintiff] is clearly seeking a benefit by seeking coverage." *Id.* at 11.

Unlike the non-signatories in *Wilson*, Plaintiff is seeking a direct benefit from the Provider Agreement through her claim for breach of that Agreement as a third-party beneficiary. Thus, under *Kiawah Island*, whether or not she "knowingly exploited" the Provider Agreement is irrelevant.²

Even putting aside the fact that Plaintiff is asserting a third-party beneficiary claim based on the Provider Agreement, Plaintiff's own factual allegations establish that the direct benefits test is satisfied here. In her Opposition, Plaintiff sets forth a series of factual arguments, which are unsupported by any citation to the record, in an effort to demonstrate that any benefit she received from the Provider Agreement was remote and indirect. (Opp'n at 10-11.) These arguments,

² In any event, Plaintiff is seeking to "knowingly exploit" the Provider Agreement because she is now suing ACS claiming that she is a third-party beneficiary under that Agreement.

however, are *inconsistent with Plaintiff's own factual allegations in the Complaint*. In sum, in the Complaint, Plaintiff alleges that she directly benefitted from the Provider Agreement because, through that Agreement, she received a discount for health care service. Specifically, the Complaint alleges that Plaintiff “entered into a contractual agreement with BCBS[SC]” for health insurance, wherein BCBSSC, “as a part of its service to Plaintiff . . . , contracted with [ACS] to provide payments for” Plaintiff’s medical services for “discounted payments,” and that ACS “deprived [Plaintiff] of the *benefits* of the discounts and other provisions” of the Provider Agreement. (Compl. ¶¶ 36-38 (emphasis added); *see also* ¶ 6 (“[ACS’s] conduct deprived [Plaintiff] of the *benefit* of . . . [her] insurance coverage and premiums.” (emphasis added))). These allegations are conclusive on the point, and Plaintiff should not be permitted to speak out of both sides of her mouth in arguing otherwise.

Finally, Plaintiff also suggests that there is a presumption against arbitration when a signatory to an arbitration agreement seeks to compel a non-signatory to arbitration. (Opp’n at 6.) Any such presumption, however, would be preempted by the FAA because it would run afoul of the requirement that arbitration not be disfavored. *Buckeye Check Cashing, Inc. v. Cardegna*, 546 U.S. 440, 443 (2006) (noting that the FAA “embodies the national policy favoring arbitration and places arbitration agreements on equal footing with all other contracts.”). Moreover, even if such a presumption existed, as noted, this is a prototypical direct benefit case, and Plaintiff herself alleges both that she is a third-party beneficiary to, and that she directly benefitted from, the Provider Agreement. Thus, any presumption against arbitration would easily be overcome. *Wilson*, 426 S.C. at 344, 827 S.E.2d at 178 (stating that the direct benefits test is satisfied “where plaintiffs sue and seek relief based on contract containing arbitration clauses.”).

C. Plaintiff's argument that the language of the arbitration clause is limited to the "parties" thereto is precluded under the theory of equitable estoppel

In her Opposition, Plaintiff argues that the fact the arbitration clause states that it applies to the "parties" to the Provider Agreement—and not to her—means that the arbitration clause does not apply to her. This argument, however, misapprehends the scope of the equitable estoppel doctrine. That doctrine does not simply preclude Plaintiff from arguing that she is a signatory to the Provider Agreement; rather, it also precludes Plaintiff from arguing that the Provider Agreement's arbitration clause *applies to her*. *Swane Co. v. Berkeley Cnty. S.C.*, No. 2:15-cv-2586, 2015 U.S. Dist. LEXIS 147235, at *17 n.4 (D.S.C. Oct. 30, 2015) (holding, in a case involving arbitration agreement that applied only to the "parties" to the agreement, that a non-signatory was nevertheless bound by it under the theory of equitable estoppel). If the law were otherwise, because contracts generally only bind the parties thereto, the equitable estoppel doctrine would only apply in a narrow set of cases in which the language of the arbitration clause did not specify who was bound by it. That is not the state of the law.³

In any event, this argument ignores the header on the first page of the Provider Agreement, which states in bold, capitalized, and underlined letters that "**THIS . . . AGREEMENT IS SUBJECT TO ARBITRATION.**" That header contains no limitation whatsoever on the parties who are bound by the arbitration provision.

³ In support of her argument that the arbitration clause in the Provider Agreement applies only to the "parties" of that Agreement, Plaintiff cites an older case from the Supreme Court of Idaho, *Rath v. Managed Health Network, Inc.*, but that case did not involve the application of the doctrine of equitable estoppel. Instead, the court in *Rath* merely held that the plaintiffs were not bound by an arbitration agreement in a contract they were not a party to. 844 P.2d 12 (Idaho 1992). Here, by contrast, because ACS is invoking the doctrine of equitable estoppel, *Rath* is inapposite. See, e.g., *Detroit Edison Co. v. Burlington N. & Santa Fe Ry. Co.*, 442 F. Supp. 2d 387, 392 (E.D. Mich. 2006) (distinguishing *Rath* because it did not involve application of the doctrine of equitable estoppel).

Accordingly, the direct benefits test applies here, and, under it, Plaintiff is estopped from denying that she is a signatory to the arbitration clause here.

II. THE TEXT OF THE ARBITRATION CLAUSE APPLIES TO THIS DISPUTE

As ACS demonstrated in its Motion, the language of the arbitration clause covers the dispute here. That clause provides that the parties to the Provider Agreement “agree to arbitrate [any] problem or dispute” that “arises under the agreement.” (Provider Agreement at 11). Plaintiff’s claims—breach of the Provider Agreement and unjust enrichment—“arise under” the Provider Agreement. *See, e.g., Fleetwood Transp. Corp. v. Packaging Corp. of Am.*, No. 6:10-0129-JMC, 2012 U.S. Dist. LEXIS 31421, at *15 (D.S.C. Mar. 8, 2012) (compelling claim for breach of contract to arbitration under arbitration clause that applies to disputes “arising under the agreement”); *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 Timmons v. Starkey*, 380 S.C. 590, 596, 671 S.E.2d 101, 105 (Ct. App. 2016) (compelling arbitration of contract and non-contract claims where “[a]ny duty that [the defendant] owed toward [the plaintiff] arose solely from their contractual relationship”).

In her Opposition, Plaintiff does not argue that the language of the Provider Agreement does not cover the dispute here. Instead, citing *Aiken v. World Fin. Corp. of S.C.*, she argues that the arbitration clause does not apply because ACS’s alleged actions were outrageous and unforeseeable and, thus, not covered by the language of the arbitration clause. (Opp’n at 20.) *Aiken*, however, has no application here.

In *Aiken*, the plaintiff applied for a loan with the defendant, a consumer finance company. 373 S.C. 144, 146, 644 S.E.2d 705, 707 (2007). In connection with the loan, the plaintiff provided

personal information to the defendant, including his social security number. *Id.* at 146-47, 644 S.E.2d at 707. The plaintiff later discovered that certain of the defendant's employees had conspired together to use his personal information to obtain sham loans, and he sued the defendant alleging claims for outrage, negligent hiring / supervision, and unfair trade practices. *Id.* at 147, 644 S.E.2d at 707. The plaintiff had signed an arbitration agreement with the defendant, and the defendant argued that the dispute was arbitrable. The Supreme Court of South Carolina disagreed, holding that, as a matter of contract interpretation, it would not interpret an arbitration agreement to apply to "outrageous torts that are unforeseeable to a reasonable consumer in the context of normal business dealings." *Id.* at 151, 644 S.E.2d at 709. According to the Supreme Court, this rule recognizes that parties to even broadly worded arbitration agreements do not anticipate that outrageous and unforeseeable torts will be subjected to arbitration. *Id.* at 152, 644 S.E.2d at 710.⁴

The rule of *Aiken* does not apply here. As the language of *Aiken* reveals, the rule announced in that case is limited to "outrageous and unforeseeable **torts**," and it does not apply to contract-based claims. Indeed, the Court in *Aiken* drew this very distinction:

In establishing the line for claims subject to arbitration, this Court does not seek to exclude all intentional torts from the scope of arbitration. For instance, the parties in the instant case stipulate that a tort claim which essentially alleges a breach of the underlying contract (e.g., breach of fiduciary duty, misappropriation of trade secrets), would be within the contemplation of the parties in agreeing to arbitration. We only seek to distinguish those outrageous torts, which although factually related

⁴ In her Opposition, Plaintiff phrases this argument in terms of "unconscionability," (Opp'n at 19), but the Supreme Court of South Carolina made clear in *Aiken* that the rule it was announcing was a rule of contract interpretation, not unconscionability. *Id.* at 151 n.4, 644 S.E.2d at 709 n.4. In any event, Plaintiff has not make any showing that enforcing the arbitration clause here would be unconscionable. *See, e.g., Simpson v. MSA of Myrtle Beach, Inc.*, 373 S.C. 14, 22, 644 S.E.2d 663, 667 (2007) (noting that the question of unconscionability in the arbitration context focusses on "whether the arbitration clause is geared toward achieving an unbiased decision by a neutral decision-making"). Indeed, the Provider Agreement calls for the application of AAA rules, which are the paradigm of neutrality.

to the performance of the contract, are *legally distinct from the contractual relationship between the parties*.

Id. at 152, 644 S.E.2d at 709 (emphasis added). Indeed, consistent with this limitation, the *Supreme Court of South Carolina has never applied Aiken to contract-based claims*. See, e.g., *Partain v. Upstate Auto. Group*, 386 S.C. 488, 689 S.E.2d 601 (2009) (applying *Aiken* to non-contract-based claim premised on alleged “bait and switch” in connection with the sale of a car); *Chassereau v. Global Sun Pools, Inc.*, 373 S.C. 168, 644 S.E.2d 718 (2007) (applying *Aiken* to non-contract-based tort claims arising out of defendant’s employee’s harassment and stalking of customer); *Simpson v. World Fin. Corp. of S.C.*, 373 178, 644 S.E.2d 723 (2007) (applying *Aiken* to non-contract-based claims arising out of defendant’s employee’s use of the plaintiff’s personal information for fraudulent loans). Because Plaintiff asserts claims for breach of contract and unjust enrichment based on ACS’s alleged non-performance of its duties under the Provider Agreement, *Aiken* has no application here. See, e.g., *Parsons v. John Weiland Homes & Neighborhoods of the Carolina, Inc.*, 418 S.C. 1, 14, 79 S.E. 2d 128, 135 (2016) (Hearn, J., concurring opinion) (holding *Aiken* does not apply where home seller allegedly failed to disclose hazardous waste on property because the buyers “could not bring their claim against [the seller] absent the sales contract, as the claim is entirely reliant on the parties’ statuses under the contract”).⁵

III. THE AAA IS AVAILABLE TO RESOLVE THIS DISPUTE

In her Opposition, Plaintiff argues that the arbitration clause is not enforceable because the AAA will refuse to arbitrate the dispute. (Opp’n at 16-19.) This argument, however, misreads

⁵ Even if *Aiken* applied (and it does not), *Aiken* is preempted by the FAA. See *Parsons*, 418 S.C. at 10-12, 79 S.E. 2d at 133 (Pleicones, J., minority opinion) (concluding that *Aiken* is preempted by the FAA because it is a unique rule, applicable only in the arbitration context, that disfavors arbitration). Although the Supreme Court of South Carolina in *Parsons* concluded, 3-2, that the FAA does not preempt *Aiken*, the Supreme Court of the United States has the final say on that issue. Under federal case law, the rule announced in *Aiken* is preempted by the FAA.

just how narrow the AAA pronouncement on this point actually is, and ignores the fact that the AAA will arbitrate (1) disputes between providers and their patients involving billing issues and (2) disputes that are compelled to arbitration pursuant to a court order.

It is true, as Plaintiff claims, that the AAA announced in 2003 that it would not voluntarily “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.” *See* AAA Healthcare Policy Statement, American Arbitration Association, https://www.adr.org/sites/default/files/document_repository/AAA_Healthcare_Policy_Statement.pdf (last visited October 26, 2020), attached hereto as **Exhibit A**). As the text of this provision reveals, however, the pronouncement applies only to disputes that “relate to *medical services*, such as *negligence and medical malpractice disputes*.” *Id.* (emphasis added). To make this limitation clear, the AAA further specified that it “will continue to administer arbitrations that involve solely *billing or collections matters* between an individual and a . . . healthcare provider.” *Id.* (emphasis added). Moreover, the AAA also clarified that it “will administer disputes between patients and healthcare providers to the extent a *court order directs such a dispute to arbitration* where the parties’ agreement provides for the AAA’s rules or AAA administration.” *Id.* (emphasis added).

This case falls squarely within both exceptions noted by the AAA in the Healthcare Policy Statement. For one thing, this is a dispute between an individual (Plaintiff) and a healthcare provider (ACS) that “involve[s] solely billing or collections matters.” Plaintiff does not allege a medical malpractice or related negligence claim against ACS; instead, the crux of Plaintiff’s Complaint is that ACS improperly billed her. Thus, this is indisputably a “billing . . . matter.” In

addition, the AAA will arbitrate any case that is compelled to them by a court, as this case should be. Therefore, the AAA policy provides no impediment to arbitration.

Moreover, even if the AAA were actually unavailable (and it is not), the proper remedy is not to hold the arbitration clause unenforceable. Instead, the Court should simply appoint a substitute arbitrator. Indeed, the FAA specifically provides for the manner in which to name an arbitrator in this situation. Section 5 of the FAA provides in relevant part:

[i]f in the agreement provision be made for a method of naming or appointing an arbitrator or arbitrators or an umpire, such method shall be followed; but if no method be provided therein, or if a method be provided and any party thereto shall fail to avail himself of such method, or if for any other reason there shall be a lapse in the naming of an arbitrator or arbitrators or umpire, or in filling a vacancy, then upon the application of either party to the controversy, the court shall designate and appoint an arbitrator or arbitrators or umpire, as the case may require...

9 U.S.C. § 5. Thus, even if the AAA were unavailable (and it is not), the remedy would simply be for the Court to appoint a substitute arbitrator.

Plaintiff argues that *Grant v. Magnolia Manor-Greenwood, Inc.*, is analogous to this case, but that case is easily distinguishable. In *Grant*, the arbitration provision provided in relevant part: “any action, dispute, claim, or controversy of any kind . . . shall be resolved by binding arbitration **administered by** the National Health Lawyers Association (the “NHLA”).” 383 S.C. 125, 128, 578 S.E.2d 435, 436-37 (2009) (emphasis added). After the parties entered into the arbitration agreement, but before the dispute arose, the NHLA amended its rules to provide that it would only honor arbitration agreements entered into after the dispute arose. *Id.* The Court denied enforcement of the arbitration provision, reasoning that, because the parties’ agreed-upon exclusive forum was unavailable, section 5 of the FAA did not permit the court to enforce the arbitration provision by appointing a substitute arbitrator. *Id.* at 132.

Here, by contrast, the arbitration provision invokes the AAA—not the NHLA—and, as noted, the AAA Healthcare Policy Statement does not apply to billing disputes or to cases compelled to arbitration by a court. For this reason alone, *Grant* is inapposite. Moreover, the arbitration provision at issue here does not state that the arbitration will be “administered” by the AAA, as was the case in *Grant*. Instead, the Provider Agreement provides only that the AAA will “appoint” an arbitrator and that the AAA “commercial rules” will apply. (Provider Agreement at 11.) This difference is crucial. Indeed, the Supreme Court of South Carolina has held that an arbitration service is not unavailable when, as here, the arbitration clause provides that the arbitration shall be conducted “in accordance with” the selected arbitration service’s rule. *See Dean v. Heritage Healthcare of Ridgeway, LLC*, 408 S.C. 371, 384, 729 S.E.2d 727, 734 (2014).

For these reasons, the arbitration clause’s invocation of the AAA here is no impediment to arbitration.

IV. THE SCUAA DOES NOT PRECLUDE ARBITRATION HERE AND, THUS, THE SCUAA DOES NOT REVERSE PREEMPT THE FAA

In her Opposition, Plaintiff argues that the arbitration provision at issue here is unenforceable under the SCUAA because it calls for arbitration of a claim involving insurance benefits and, further, that the SCUAA reverse preempts the FAA under the McCarran-Ferguson Act. Plaintiff’s argument is fatally flawed, however, because the arbitration here is not located in an insurance policy and ACS is not an insurance company.

It is true, as Plaintiff argues, that the SCUAA provides that arbitration clauses are unenforceable insofar as they apply to “any insured or beneficiary under any insurance policy or annuity contract.” S.C. Code Ann. § 15-48-10(b)(4). The problem for Plaintiff is that this provision only applies “when a litigant seeks to enforce an arbitration agreement contained *in an insurance policy* governed by South Carolina law.” *Walden v. Harrelson Nissan Inc.*, 399 S.C.

205, 210, 731 S.E. 2d 324, 326 (Ct. App. 2012) (emphasis added). In *Walden*, the plaintiff urged the Court to read § 15-48-10(b)(4) to include contracts related to insurance policies, but the Court rejected this expansive reading of the statute. *Id.* at 209, 731 S.E.2d at 326. Instead, the Court held that the contract at issue—a lease agreement containing a provision that the defendant would secure insurance for the plaintiff—was not exempt from arbitration because it itself was not an insurance policy. *Id.* at 210, 731 S.E.2d at 327; *see also Cox v. Woodmen of World Ins. Co.*, 347 S.C. 460, 468, 556 S.E.2d at 402 (Ct. App. 2001) (holding that S.C. Code. Ann. § 15-48-10(b)(4) is a “specific exemption limited to entities *within the insurance industry*”) (emphasis added). For these reasons, the court in *Walden* held:

we reject [the plaintiff’s] expansive interpretation of the statute and conclude the General Assembly did not intend for the arbitration exception of section 15-48-10(b)(4) to apply to automobile lease agreements that have only a tangential relationship to an insurance policy, but was instead *intended to apply directly to an insurance contract*.

399 S.C. at 210, 731 S.E. 2d at 326 (emphasis added); *see also Blue Ridge Emergency Physicians, P.A. v. Emergency Physicians Ins. Co.*, RRG C/A no. 6:10-cv-00428-JMC, at *5-6 (D.S.C. Mar. 15, 2011) (noting that “S.C. Code Ann. § 15-48-10(b)(4) prohibits the enforcement of arbitration clause in *insurance policies* under South Carolina law” (emphasis added)).

By her argument, Plaintiff asks the Court to make the same mistake the plaintiff in *Walden* made—she asks the Court to expand § 15-48-10(b)(4) to preclude the arbitration of claims that are merely *related to* a contract for insurance (and tangentially so, at that). This argument is as unpersuasive here as it was in *Walden* for the simple reasons that the Provider Agreement is not an insurance policy.⁶

⁶ In her Opposition, Plaintiff also cites *Volt Info. Scis. Inc. v. Board of Trs.* in support of her argument, (Opp’n at 13-15) but *Volt* does not help Plaintiff. In *Volt*, the Supreme Court of the United States noted that parties to an arbitration provision may agree that state arbitration statutes

Moreover, *Rock v. Atl. Specialty Ins. Co.*, does not help Plaintiff. In *Rock*, the court—applying the law of the District of Columbia—held that an arbitration clause contained in a certificate of insurance was unenforceable. No. 4-19-cv-01433-SAL, 2020 U.S. Dist. LEXIS 66641, at *8 (D.S.C. April 16, 2020). The District of Columbia statute at issue provided that arbitration clauses in insurance policies are unenforceable. *See* D.C. Code § 16-4403(c)(1). The court, noting that the certificate of insurance “describes the main features of the Policy,” held that the District of Columbia statute precluded application of the arbitration clause. *Id.* at *3. In a footnote, the court stated, in *dicta*, and without any reasoning or explanation, that the arbitration clause would also be unenforceable under § 15-48-10(b)(4). *Id.* at * 7 n.4.

Rock does not apply here for multiple reasons—it is not final, it is *dicta*, and it is inapposite in any event. First, on appeal, the Fourth Circuit has remanded the case to the district court with directions to *vacate* the order examining this issue, in part because “it is arguably incorrect.” *See* Order, *Rock v. Atlanta Specialty Ins. Co.*, No. 20-1569 (4th Cir. Oct. 6, 2020), attached hereto as **Exhibit B**. The District Court order is therefore not final and will soon be vacated, if it has not been vacated already. Second, as noted, the court in *Rock* applied the law of the District of Columbia, and the footnoted statement regarding § 15-48-10(b)(4) was pure *dicta*.

Third, the facts in *Rock* are materially different from the facts in this case in any event. In *Rock*, the document at issue was a certificate of insurance, issued by an insurance company, that

will govern instead of the FAA. 489 U.S. 468, 474 (1989). Here, however, the Provider Agreement cannot be read to select the SCUAA to the exclusion of the FAA. *See Mastrobuono v. Shearson Lehman Hutton, Inc.*, 514 U.S. 52, (1995) (holding standard choice-of-law clause providing state law applies to agreement does not displace FAA); *Smith Barney, Inc. v. Critical Health Systems of North Carolina, Inc.*, 212 F.3d 858, 861 n.1 (4th Cir. 2000) (same); *Osteen v. T.E. Cuttino Constr. Co.*, 315 S.C. 422, 434 S.E.2d 281, 284 (1993) (same). Moreover, even if the SCUAA applied, for the reasons discussed in the text, the SCUAA does not prohibit the arbitration provision in the Provider Agreement. Thus, *Volt* has not application here.

described the benefits available to the policyholder under a policy of insurance. *Id.* at *2-4. Thus, the certificate had a direct relationship with the insurance policy it was evidencing. *Id.* at 3 (noting that the certificate of insurance “describes the main features of the Policy”). Here, by contrast, the Provider Agreement is only tangentially related to Plaintiff’s insurance policy with BCBSSC; it governs certain aspects of the relationship between BCBSSC and ACS regarding ACS’s provision of medical care to participants under certain BCBSSC medical plans. Unlike a certificate of insurance, the Provider Agreement does not describe the benefits available under any insurance policy that Plaintiff has, nor does it bestow any benefits on any beneficiary or participant of any insurance policy. Moreover, unlike the situation in *Rock*, Plaintiff here is not suing her insurance company. Instead, she is suing her medical provider, which is a type of lawsuit that falls outside of the situations contemplated under § 15-48-10(b)(4). (See Pl. Mem. In Supp. Mot. to Remand at 5 (“Gasser is not alleging that her insurer did not administer its plan according to its contract with her or Defendant [This] is not a suit, ‘by a beneficiary to recover benefits from a covered plan.’ 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.” (citations omitted)), attached hereto as **Exhibit C**, and Pl. Reply In Supp. Mot. to Remand at 3 (“The sole duty alleged by Gasser which was breached by Defendant (to submit the bill for payment to BCBS) arose . . . from the preferred provider contract entered by Defendant with Blue Cross Blue Shield.”), attached hereto as **Exhibit D**.) Accordingly, even if *Rock* were good law (and it is not), it has no bearing whatsoever on this case.

For all of these reasons, § 15-48-10(b)(4) does not render the arbitration provision at issue in this case unenforceable and, therefore, it does not reverse preempt the FAA.

V. THE PROVIDER AGREEMENT IS PROPERLY AUTHENTICATED

In a last gasp effort to avoid arbitration, Plaintiff argues that ACS did not properly authenticate the Provider Agreement because its authenticating affidavit from Paula Dearolf does not comply with the South Carolina Rules of Civil Procedure. In response to the coronavirus pandemic, however, the Supreme Court of South Carolina issued an order relieving parties of the normal requirement that an affidavit be signed by a notary. *See* Appellate Case No. 2020-000447, available online at <https://www.sccourts.org/whatsnew/displaywhatsnew.cfm?indexID=2474>, last visited October 23, 2020. Specifically, the order provides that “the requirement of an affidavit may be satisfied by a signed certification of the maker stating, “I 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.” *Id.* That is precisely what Ms. Dearolf’s certification says here. Thus, her affidavit is valid, and there are no legitimate objections to the authenticity of the Provider Agreement.⁷

CONCLUSION⁸

For the foregoing reasons, as well as those set forth in ACS’s Motion, ACS respectfully requests that the Court enter an order compelling bilateral arbitration and dismissing the case. In

⁷ Due to the fact that Ms. Dearolf is working from home due to the coronavirus pandemic and does not have a scanner in her home office, Ms. Dearolf signed her certification, took a photograph of it, and emailed it to the undersigned. The undersigned reproduced the text of the certification—instead of the photograph—to make it more readable for the Court. The undersigned attaches the full photograph here to avoid any further question regarding the authenticity of the Provider Agreement. (*See* Original Certification of Paula Dearolf, attached hereto as **Exhibit E.**)

⁸ Finally, it is worth noting that, in her Opposition, Plaintiff does not argue either (1) that the FAA does not apply or (2) that, if the case is compelled to arbitration, the arbitration should be on a bilateral basis only.

the alternative to dismissal, the Court's order should stay this matter pending the bilateral arbitration.

Dated: October 26, 2020

GORDON & REES LLP

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EXHIBIT A



AAA® Healthcare Policy Statement

In 2003, the American Arbitration Association® (“AAA”) announced that 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. This policy is consistent with the *American Arbitration Association/American Bar Association/American Medical Association Due Process Protocol for the Mediation and Arbitration of Health Care Disputes*.

However, the AAA will administer disputes between patients and healthcare providers to the extent a court order directs such a dispute to arbitration where the parties’ agreement provides for the AAA’s rules or AAA administration. In addition, the AAA will continue to administer arbitrations that involve solely billing or collections matters between an individual and a doctor or healthcare provider, although such billing or collections disputes may be governed by the AAA’s *Consumer Rules and Consumer Due Process Protocol*.

The AAA notes that this policy does not relate to or impact the administration of all other types of disputes in the healthcare field, such as disputes among providers, healthcare companies, insurance carriers and related entities. For more information on the AAA’s administration of these types of cases and the AAA’s *Healthcare Payor Provider Arbitration Rules*, please visit www.adr.org.

EXHIBIT B

FILED: October 6, 2020

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 20-1569
(4:19-cv-01433-SAL)

LINDA ROCK, as the Personal Representative for the Estate of Gerald Lindsay

Plaintiff - Appellee

v.

ATLANTIC SPECIALTY INSURANCE COMPANY; MICHAEL KLUG;
BRENTWOOD SERVICES ADMINISTRATORS, INC.

Defendants - Appellants

and

BRENTWOOD SERVICES, INC.

Defendant

O R D E R

Upon consideration of the joint motion for a limited remand, the court grants the motion and remands this case to the district court for the limited purpose of reconsidering its order entered on April 16, 2020.

The clerk shall forward a copy of this order, accompanied by a copy of the motion to remand, to the district court. This appeal shall remain on the active docket of this court and the parties shall file a status report on November 5, 2020, and every 30 days thereafter, and shall immediately notify this court when the district court proceedings have concluded.

For the Court

/s/ Patricia S. Connor, Clerk

No. 20-1569

**United States Court of Appeals
for the Fourth Circuit****LINDA ROCK, as the Personal Representative for the Estate of Gerald
Lindsay,**

Plaintiff – Appellee

v.

**ATLANTIC SPECIALTY INSURANCE COMPANY; MICHAEL KLUG;
BRENTWOOD SERVICES ADMINISTRATORS, INC.**

Defendants – Appellants

On Appeal from the United States District Court,
District of South Carolina, Florence Division
Civil Action No. 4:19-cv-01433-SAL
District Judge Sherri A. Lydon

JOINT MOTION FOR LIMITED REMAND

All parties in this case jointly move this Court, pursuant to Rule 12.1 of the Federal Rules of Appellate Procedure, for a limited remand of this case to the United States District of South Carolina for the purpose of issuing an order vacating its order entered on April 16, 2020, which is the order that is the subject of this appeal. The grounds for this motion are as follows.

1. Plaintiff-Appellee, Linda Rock, filed this lawsuit to recover benefits under an insurance policy issued by Atlantic Specialty Insurance Company after Gerald Lindsay was involved in a motor vehicle accident while

he was driving as a courier for Sun Logistics. Defendants-Appellants, Atlantic Specialty Insurance Company, Brentwood Services Administrators, Inc., and Michael Klug (collectively referred to as “Atlantic Specialty”), filed a motion to stay litigation and to compel arbitration because there is an arbitration clause in the insurance policy.

2. On April 16, 2020, the district court denied the motion, finding that the arbitration clause is void because a D.C. statute provides that any provision in an insurance policy with a consumer that requires binding arbitration is void. Atlantic Specialty appealed to this Court from that order to argue that the D.C. statute does not apply because this is not an insurance policy with a consumer, but instead is a policy that provides coverage to a courier who is under dispatch as a part of the courier’s occupation. This is that appeal.

3. On June 3, 2020, this Court sent the parties a Notice of Scheduled Mediation, pursuant to Fourth Circuit Local Rule 33, requiring the parties to participate in a mediation with Fourth Circuit Mediator Cynthia Mabry-King. At that time, there were no on-going settlement negotiations between the

parties, but all parties participated in the mediation in compliance with the Fourth Circuit's directive. The mediation occurred on June 15, 2020.

4. Under the guidance of Ms. Mabry-King, the parties were successful in negotiating a conditional settlement agreement that would resolve all disputes in this litigation. A mandatory condition of the settlement is the vacatur of district court's April 16, 2020, Order, so the parties filed with the district court a joint motion to vacate the April 16, 2020, Order pursuant to Fed. R. Civ. Pro. 60(b).

5. The procedure governing a district court's ability to grant a Rule 60(b) motion while the case is on appeal is well-settled and was explained in *Fobian v. Storage Technology Corp.*, [164 F.3d 887](#) (4th Cir. 1999). After the parties file a Rule 60(b) motion with the district court, "[i]f the district court is inclined to grant the motion, it should issue a short memorandum so stating." *Id.* Second, the litigants are to provide to this Court the district court's memorandum to advise this Court that the district court is inclined to grant the Rule 60(b) motion. Third, this Court grants a limited remand so that the district court has jurisdiction to grant the Rule 60(b) motion. *Id.* "By saving judicial resources and avoiding expense and delay, this procedure accords with the overarching mandate in the Federal Rules of Civil Procedure that the rules 'shall be construed to secure the just, speedy, and inexpensive

determination of every action.” *Id.* (quoting Fed. R. Civ. Pro. 1). This Court has followed the procedure set forth in *Fobian* numerous times, some of which are published in the Federal Appendix. *See, e.g., Herriott v. McCabe*, [813 F. App’x 897](#) (4th Cir. 2020); *Howard v. Red Lobster Operated by Darden Restaurants, Inc.*, [693 F. App’x 270](#) (4th Cir. 2017); *Boyd v. South Carolina*, [475 F. App’x 909](#) (4th Cir. 2012); *Stevenson v. Shoup*, [390 F. App’x 286](#) (4th Cir. 2010); *Stepney v. Beckwith*, [360 F. App’x 418](#) (4th Cir. 2010); *Sindram v. Sengel*, [108 F. App’x 745](#) (4th Cir. 2004); *Columbia Gas Transmission Corp. v. Burdette Realty Improvement, Inc.*, [48 F. App’x 910](#) (4th Cir. 2002); *Davis v. City of Jacksonville*, [22 F. App’x 316](#) (4th Cir. 2001).

6. Following the procedure set forth in *Fobian*, on September 23, 2020, the district court in this case entered a short memorandum to state that it is inclined to grant the joint motion to vacate and to request that this Court grant a limited remand for that purpose. The district court’s memorandum is attached as Exhibit A.

7. All parties agree—and the district court agrees as well, as Exhibit A demonstrates—that a limited remand from this Court so that the district court can vacate its April 16, 2020, order is appropriate in light of the “exceptional circumstances” in this case. *Valero Terrestrial Corp. v. Paige*, [211](#)

E.3d 112, 121 (4th Cir. 2000) (quoting *U.S. Bancorp Mortgage Co. v. Bonner Mall P'ship*, 513 U.S. 18, 29 (1994)).

8. Specifically, exceptional circumstances exist to vacate the April 16 Order for three independent reasons: (1) the April 16 Order is at least arguably wrong; (2) the April 16 Order concerns the important issue of arbitration, which is favored both under federal and D.C. law; and (3) the circumstances surrounding the conditional settlement. Plaintiff-Appellee Linda Rock does not join in paragraphs 9 to 11 of this joint motion so as to preserve her arguments in the event that this Court were to deny this motion for limited remand.

9. ***Exceptional circumstances exist because the April 16 Order is arguably incorrect.*** Exceptional circumstances justifying a vacatur of the April 16, 2020, Order exist in this case because that the order is arguably incorrect. *See, e.g., In re Gen. Motors Corp.*, No. 94-2435, 1995 WL 940063, at *1 (4th Cir. Feb. 17, 1995) (*U.S. Bancorp* requirements satisfied for an incorrect district court order).

10. The D.C. statute that forms the basis of the April 16, 2020, Order states: "Any provision in an insurance policy with a consumer that requires binding arbitration is void and unenforceable." D.C. Code § 16-4403(C)(1)). However, the Atlantic Specialty insurance policy is not an insurance policy

with a consumer, so this provision does not apply. This insurance policy instead provides insurance to a courier who is under dispatch as a part of the courier's occupation. When someone obtains insurance as a part of their work, they are not acting a consumer. The D.C. Code itself makes that clear. The same chapter of the D.C. Code that contains § 16-4403 also defines a "consumer" as "a party to an arbitration agreement who, in the context of that arbitration agreement, is an individual, not a business, who seeks or acquires, including by lease, any goods or services primarily for personal, family, or household purposes including, but not limited to, financial services, healthcare services, or real property." D.C. Code § 16-4401(3). Here, Gerald Lindsay obtained insurance that would provide coverage when he was working, not when he was acting for personal, family, or household purposes. This is clear from the title of the policy itself—an "Occupational Accident" policy. It is also clear from the requirements for coverage under the occupational policy, which provide coverage only when someone is acting as a courier under dispatch. And jurisprudence in other contexts confirms that someone is not acting as a consumer when they are working. *See, e.g., In re Runski*, [102 F.3d 744, 747](#) (4th Cir. 1996) (under the Bankruptcy Code, "courts have concluded uniformly that debt incurred for a business venture or with a profit motive does not fall into the category of" consumer debt); *Am. Exp. Co. v.*

Koerner, [452 U.S. 233, 245](#) (1981) (transaction relating to the purchase of airline tickets was not an extension of “consumer credit” because the tickets were purchased for business trips). Because the April 16, 2020, Order is arguably incorrect when it fails to enforce an arbitration clause, exceptional circumstances exist to justify the district court’s decision to vacate its prior interlocutory order.

11. ***Exceptional circumstances exist because federal and D.C. law strongly support upholding arbitration.*** The April 16, 2020, Order not only declined to enforce a binding arbitration provision in a contract, but it did so on a basis that may be argued in later cases to effectively read the provision out of the contract. This is inconsistent with federal and D.C. law, both of which overwhelmingly favor upholding binding arbitration provisions. *Moses H. Cone Mem’l Hosp. v. Mercury Constr. Corp.*, [460 U.S. 1, 24](#) (1983) (noting the “liberal federal policy favoring arbitration agreements”); *Hill v. Peoplesoft USA, Inc.*, [412 F.3d 540, 543](#) (4th Cir. 2005) (same); *TRG Customer Sols., Inc. v. Smith*, [226 A.3d 751, 755](#) (D.C. 2020) (“Our case law has expressed a strong preference favoring arbitration when a contract contains an arbitration clause.”). By not enforcing an arbitration clause, the April 16, 2020, Order is contrary to this public policy, and this is another reason that exceptional

circumstances justify the district court's decision to vacate its prior interlocutory order.

12. ***Exceptional circumstances exist because of the circumstances surrounding the conditional settlement.*** When a settlement results from a court referring a case to mediation, when that settlement is expressly contingent upon vacatur, when the order to be vacated is being challenged on appeal at the time of the conditional settlement, and when the order to be vacated is a federal court interpretation of state court law, then exceptional circumstances exist and vacatur is warranted. The Eleventh Circuit addressed this exact situation in *Hartford Cas. Ins. Co. v. Crum & Forster Specialty Ins. Co.*, [828 F.3d 1331](#) (11th Cir. 2016). In that case, which involved an insurance policy, the district court applied state law and granted summary judgment on an issue regarding the scope of the insurance policy. The losing insurance company appealed, and the Eleventh Circuit ordered the parties to attempt to resolve the dispute through mediation. The mediation resulted in a conditional settlement agreement whereby the parties were willing to settle their differences, but that was contingent upon a court of competent jurisdiction vacating the order that was being appealed. *Id.* at 1333. The Eleventh Circuit stayed the appeal so that the parties could file a Rule 60(b) motion with the district court. They did so, but the district court did not

believe that exceptional circumstances existed. *Id.* The Eleventh Circuit reversed, explaining that vacatur was appropriate because exceptional circumstances did exist.

13. First, the court noted that it had referred the parties to the mediation, and thus it was not a case in which one party voluntarily forfeited a legal remedy. *Id.* at 1336. Second, the court noted that the settlement was conditioned upon there being a vacatur, and thus without a vacatur, settlement would be impossible. *Id.* “Taken together, these considerations weigh heavily in favor of vacating the District Court’s orders. The parties’ interests are best served through the voluntary disposition of this case, and further proceedings are curtailed, conserving judicial resources.” *Id.* The court also noted that there is only “slight value” in preserving a district court opinion on an issue of state law, and explained that any such value was “outweighed by the direct and substantial benefit of settling this case to [the parties] and to the judicial system (and thus to the public as well).” *Id.* The court explained that its decision was consistent with prior decisions from the First Circuit (*Motta v. Dist. Dir. of I.N.S.*, 61 F.3d 117 (1st Cir. 1995)) and the

Second Circuit (*Major League Baseball Properties, Inc. v. Pac. Trading Cards, Inc.*, [150 F.3d 149](#) (2d Cir. 1998)). *Id.* at 1334-35.

14. Similarly, the productive settlement negotiations in this case were the result of a court-ordered mediation with a Fourth Circuit mediator. And just like *Hartford*, a condition of the settlement is vacatur of the April 16, 2020, Order that is on appeal. The only solution that avoids the necessity of Atlantic Specialty's appeal of the April 16 Order is a vacatur of that decision. And just like *Hartford*, where the opinion sought to be vacated was an interpretation of state court law, here, the opinion sought to be vacated is a federal court interpretation of District of Columbia law. *Hartford*, [828 F.3d at 1336](#); *see also Microsoft Corp. v. Bristol Tech., Inc.*, [250 F.3d 152, 155](#) (2d Cir. 2001) (exceptional circumstances exist and vacatur is warranted when a federal court opinion concerns an issue of state law).

15. Accordingly, all parties in this case jointly move this Court to grant a limited remand of this case to the district court so that the district court can vacate its April 16, 2020, Order. Once the district court vacates its prior order, Defendants-Appellants will notify this Court and will move to voluntarily dismiss their appeal at that time.

WHEREFORE, Plaintiff-Appellee, Linda Rock, and Defendants-Appellants, Atlantic Specialty Insurance Company, Brentwood Services

Administrators, Inc., and Michael Klug, move this Court for a limited remand so that the district court can rule on the pending Fed. R. Civ. Pro. 60(b) motion.

Respectfully submitted:

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Certificate of Service

On September 30, 2020, I caused this joint motion to be filed electronically with the Clerk of the Fourth Circuit Court of Appeal through ECF, which constitutes services on all parties through their counsel pursuant to Fourth Circuit Local Rule 25(a)(4).

s/ Jeffrey E. Richardson

Jeffrey E. Richardson

Certificate of Compliance with Type-Volume Limit, Typeface Requirements, and Type-Style Requirements

1. This motion complies with type-volume limits of Fed. R. App. P. 27(d)(2)(A) and Fed. R. App. P. 32(c)(1) because, excluding the parts of this document exempted by Fed. R. App. P. 32(f), this motion contains 2,200 words.
2. This document complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this document has been prepared in a proportionally-spaced typeface using Microsoft Word 2016 (16.0.5017.1000) in Cambria 14-point.

s/ Jeffrey E. Richardson

Jeffrey E. Richardson

Dated: September 30, 2020

EXHIBIT 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 other similarly)	
situated,)	
)	
Plaintiff,)	
v.)	MEMORANDUM OF LAW IN
)	SUPPORT OF PLAINTIFF'S MOTION
)	TO REMAND
ACS Primary Care Physicians -)	
Southeast, P.C.,)	
)	
Defendant.)	
_____)	

PROCEDURAL HISTORY

This case arises from the filing of a Complaint in the Horry County Court of Common Pleas on May 21, 2020. The Complaint includes class action allegations and asserts claims for breach of contract and unjust enrichment. Plaintiff, Thuy Gasser, individually and on behalf of others similarly situated, seeks, *inter alia*, certification of a class and money damages for herself and class members. Defendant removed the case to the United States District Court for the District of South Carolina, Florence Division, June 26, 2020, asserting federal question jurisdiction under 28 U.S.C. § 1331, diversity jurisdiction under § 1332(d) and supplemental jurisdiction under § 1367. Plaintiff disputes the jurisdictional arguments and seeks remand to state court.

STATEMENT OF FACTS

Ms. Gasser was involved in a motor vehicle collision on December 9, 2019, in which she sustained serious injuries. Gasser received medical treatment at Grand Strand Regional Medical Center Emergency Department where a physician employee of Defendant provided medical services for her injuries. At the time, Gasser was covered by

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.¹

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

¹ 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 82nd 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, 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 Croxton 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.

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Attorneys for Plaintiff

July 27, 2020

EXHIBIT D

**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 other similarly)	
situated,)	
)	
Plaintiff,)	
v.)	PLAINTIFF'S REPLY TO
)	DEFENDANT'S RESPONSE IN
ACS Primary Care Physicians -)	OPPOSITION TO PLAINTIFF'S
Southeast, P.C.,)	MOTION TO REMAND
)	
Defendant.)	
_____)	

Plaintiff Thuy N. Gasser, individually and on behalf of those similarly situated, hereby submits this Reply to Defendant's Response in Opposition to Plaintiff's Motion to Remand (ECF No. 9). As set out in the motion, and more fully in the reply herein, Defendant's assertion of jurisdiction is fundamentally and legally flawed and inaccurate and the motion to remand should be granted.

I. Fiduciary Duty Argument

Although this is the second argument presented by Defendant, Plaintiff will address it first since it is easily disposed and rejected. Defendant argues Plaintiff's action is preempted by §§ 502(a)(2) and 502(a)(3) because the claim is based upon a "breach of fiduciary duty." Not only did Plaintiff neither assert nor allege a fiduciary relationship between the parties, much less a breach of any fiduciary duty, the South Carolina Court of Appeals just held, based upon virtually identical facts, there is no fiduciary relationship between a medical provider and the patient, at least with regard to submission of medical bills to an insurer for payment.

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 (4th 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.

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Attorneys for Plaintiff

August 12, 2020

EXHIBIT E

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 other similarly situated,

Plaintiffs,

v.

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

Defendant

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 hereto as Exhibit A.

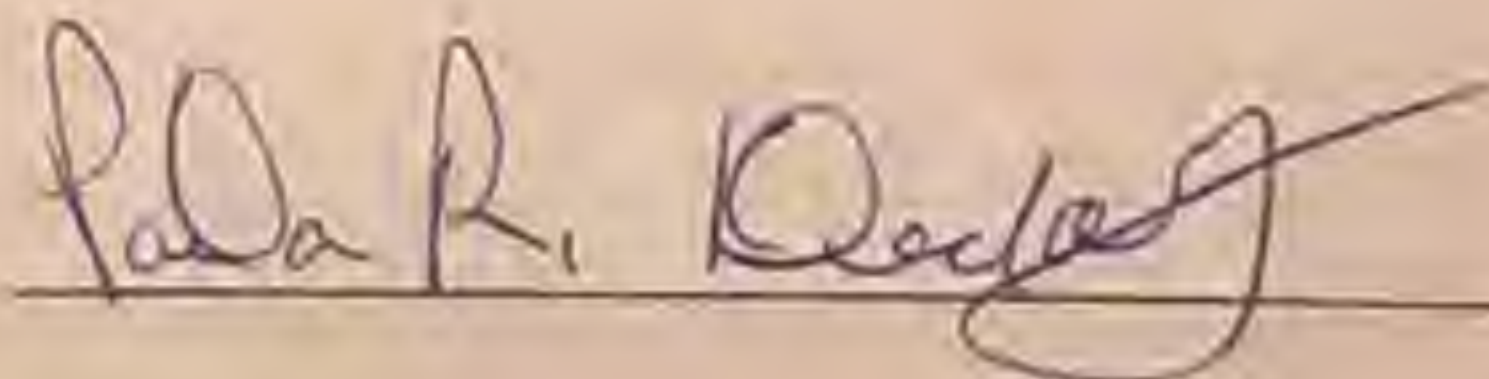
12. The Preferred Provider Agreement attached as Exhibit A is the agreement that applied to Plaintiff's medical care with ACS.

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



(Signature)

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,

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)

v.

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ACS Primary Care Physicians-Southeast P.C.,

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Defendant

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Defendant ACS Primary Care Physicians-Southeast P.C. (“ACS”) submits this supplemental brief in support of its Motion to Compel Arbitration and Dismiss (the “Motion”). ACS submits this supplemental brief only to respond to the arguments made by Plaintiff in her supplemental brief in opposition to Motion.

1. In her supplemental brief, Plaintiff notes that in a recent case from the Spartanburg County Court of Common Pleas, *Blackwell v. Mary Black Health System, LLC*, Judge Mark Hayes refused to apply the doctrine of equitable estoppel on facts similar those here, and she argues that this Court should follow *Blackwell*. It is worth noting, at the outset, that the defendants in *Blackwell* have appealed Judge Hayes rulings in that case. See *Blackwell* Notice of Appeal, attached hereto as Exhibit A.

Moreover, a closer review of *Blackwell*, reveals that it does not support Plaintiff’s argument because the arbitration agreements at issue in that case were starkly different from the Provider Agreement here.

Blackwell involved claims by a patient against her healthcare provider that are similar to those at issue here and, like here, the plaintiff’s provider sought to compel arbitration under

agreements with plaintiff's healthcare insurer. In his original order denying arbitration, which Plaintiff did not attach to her supplemental brief, Judge Hayes *did not address the question of whether plaintiff was estopped from denying arbitration*. See *Blackwell* Form 4 Order, attached hereto as Exhibit B. Rather, Judge Hayes held that arbitration was not required under the language of either of the two contracts at issue. As to the first contract, it did not even contain an arbitration clause, and, thus, clearly could not require the plaintiff to arbitrate her dispute. See Exhibit A at 3 (noting that "[t]he Court could not find an arbitration agreement in the [contract]"). As to the second contract, Judge Hayes concluded that the arbitration clause in it suffered from two defects. First, the arbitration clause was "discretionary and not mandatory" and thus could not require the plaintiff to pursue an arbitration she did not want to pursue. *Id.* Second, the arbitration clause specifically stated that it did "not apply to third parties," which, obviously, precluded its application to the plaintiff. *Id.* Based on that language, Judge Hayes denied the motion to compel arbitration.

Here, the Provider Agreement is entirely different from the contracts at issue in *Blackwell*. First, the Provider Agreement indisputably contains an arbitration provision. See Provider Agreement ¶ M(2), previously attached to Defendant's Motion to Dismiss as Exhibit 1 to Exhibit A. Second, the arbitration provision in the Provider Agreement is mandatory, and not merely permissive. *Id.* Third, the Provider Agreement does not state that the arbitration provision is inapplicable to third parties. *Id.* Accordingly, *Blackwell* is easily distinguishable from the situation here.

To be sure, in his Order denying the defendants' motion to alter or amend, Judge Hayes stated, in passing, that estoppel did not apply on the facts at issue in *Blackwell*. See Order Denying Motion to Alter or Amend at 5. That conclusion, however, follows naturally from the language in

the arbitration agreement in *Blackwell* providing that the arbitration clause did “not apply to third parties.” Arbitration is a matter of contract, and if the contract states that it does “not apply to third parties,” then it does not apply to third parties, even under a theory of estoppel. Here, by contrast, the Provider Agreement here does not contain any limiting language stating that the arbitration provision does not apply to third parties. Accordingly, the Provider Agreement compels Plaintiff to arbitrate her dispute here.

2. In her supplemental brief, Plaintiff also contends that ACS had a practice of identifying patients who were involved in an automobile accident as a way of (somehow) furthering its alleged scheme of unlawfully collecting higher reimbursements than were permitted under its contracts with its patients’ health insurance plans. Putting aside the facts that this argument goes to the merits of this dispute—and is thus not proper for the Court to consider at this stage in the proceedings—the argument is entirely without merit.

It is true that ACS had a practice of identifying patients who were involved in automobile accidents. But there is nothing nefarious about such a practice. In fact, it only stands to reason that a medical provider would seek to learn all of the potential payers for medical services for its patients, including patients’ automobile insurers. Far from harming its patients, this practice helps the patients insofar as it seeks to uncover all potential payers—other than the patient—for the medical services rendered.

Moreover, identifying patients who were involved in automobile accident is **required** to comply with the Medicare Secondary Payer Act, 42 U.S.C. § 1395y (the “MSP Act”). The MSP Act **requires** providers to determine when a primary payer—such as an automobile insurer—is responsible for payment of healthcare costs, as opposed to Medicare, and seek payment from that primary payer first. Many jurisdictions have in fact held that the MSP Act explicitly prohibits

medical service providers from seeking payment from Medicare where payment can reasonably be expected from an automobile or liability insurer. *See Parkview Hosp., Inc. v. Roese*, 750 N.E.2d 384, 389 (Ind. Ct. App. 2001) (holding that the healthcare provider may only bill the liability insurer); *Joiner v. Med. Ctr. E., Inc.*, 709 So.2d 1209, 1221 (Ala. 1998) (“The effect of the ‘secondary payer’ provision is to force a health services provider to look to liability insurer for payment, instead of to Medicare.”).

These obvious explanations for ACS’s actions, which do not involve participation in some sinister “scheme,” simply highlight the fact that the Court should not consider this argument at this stage in the proceedings. Rather, whether ACS’s actions were unlawful or not should be determined by the arbitrator, not this Court.

Respectfully submitted,

Dated: January 4, 2021

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EXHIBIT A

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

Case No. 2017-CP-42-00219

RECEIVED
Dec 08 2020
SC Court of Appeals

Jo Ann Blackwell, Michelene Brooks, and Samuel H. Owens, Jr., individually and
on behalf of all others similarly situated,

Respondents,

v.

Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital; CHSPSC, LLC;
and Professional Account Services, Inc.,

Appellants,

NOTICE OF APPEAL

Mary Black Health System, LLC, d/b/a Mary Black Memorial Hospital (“Mary Black”),
CHSPSC, LLC (“CHSPSC”), Professional Account Services, Inc. (“PASI”) (collectively,
“Defendants”) appeal the Honorable J. Mark Hayes, II’s order denying Defendants’ Motion to
Dismiss or in the Alternative to Stay and Compel Arbitration, filed on September 4, 2020, and the
Honorable J. Mark Hayes, II’s order denying Defendants’ Rule 59(e) Motion to Alter or Amend,
filed December 8, 2020. Defendants received notice of the Court’s order denying Defendants’
Rule 59(e) Motion to Alter or Amend on December 8, 2020.

[Signature Page Attached]

s/Katon E. Dawson Jr.

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d/b/a Mary Black Memorial Hospital; CHSPSC, LLC; and
Professional Account Services, Inc.*

December 8, 2020
Columbia, South Carolina

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EXHIBIT B

Jo Ann Blackwell, et al

Mary Black Health System, LLC et al

PLAINTIFF(S)

DEFENDANT(S)

Submitted by: The Honorable J. Mark Hayes II

Attorney for : ☐ Plaintiff ☐ Defendant
or
☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

- ☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.
- ☐ **ACTION DISMISSED (CHECK REASON):** ☐ Rule 12(b), SCRPC; ☐ Rule 41(a), SCRPC (Vol. Nonsuit); ☐ Rule 43(k), SCRPC (Settled); ☐ Other
- ☐ **ACTION STRICKEN (CHECK REASON):** ☐ Rule 40(j), SCRPC; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other
- ☐ **STAYED DUE TO BANKRUPTCY**
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order (formal order to follow) ☒ Statement of Judgment by the Court:

ORDER INFORMATION

This order ☐ ends ☒ does not end the case.

Additional Information for the Clerk : Please see the Information Below.

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
	N/A	N/A
		\$
		\$
If applicable, describe the property, including tax map information and address, referenced in the order:		

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk.

Note: Title abstractors and researchers should refer to the official court order for judgment details.

E-Filing Note: In E-Filing counties, the Court will electronically sign this form using a separate electronic signature page.

Circuit Court Judge

Judge Code

Date

For Clerk of Court Office Use Only

This judgment was entered on the 4th day of September, 2020 and a copy mailed first class or placed in the appropriate attorney's box on this 4th day of September, 2020 to attorneys of record or to parties (when appearing pro se) as follows:

Thomas A. Killoren Jr., Ryan Frederick McCarty,

Katon Edwards Dawson Jr., James Lynn Werner

Marghretta Hagood Shisko, John S. Simmons,

John Belton White, Jr.

ATTORNEY(S) FOR THE PLAINTIFF(S)**ATTORNEY(S) FOR THE DEFENDANT(S)****CLERK OF COURT****Court Reporter:**

E-Filing Note: In E-Filing counties, the date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgement to parties who are not E-Fileers or who are appearing pro se. See Rule 77(d), SCRPC.

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This matter came before the Court on various SCRPC Rule 12(b)(6) motions and a motion to stay and compel arbitration. After receiving the arguments, reviewing the materials submitted, and applying the required respective standards of review to the information presently before the Court, the motions cannot be granted. Even though the present decision predominantly is a denial under SCRPC Rule 12(b) (6) and, thus, decides no issue on its merits, the following observations are made in an effort to assist the parties in moving forward.

Plaintiffs present this case as a putative class action, pursuant to SCRPC Rule 23. Plaintiffs bring this action against Mary Black Memorial Hospital (a local hospital in Spartanburg), as well as the two entities that Plaintiffs allege are responsible for the hospital's billing of patients and filing of liens, Community Health Systems Professional Services Corporation (CHSPSC) and Professional Account Services. The class, which has not yet been certified, is currently defined as;

“All individuals who, since January 20, 2014, received any type of healthcare treatment from any entity located in South Carolina that is owned or affiliated with Defendants, while being covered by valid health insurance, and whose medical bills resulting from that treatment were not submitted to their health insurance carrier for potential payment.”

The allegations are that Defendants regularly refused to submit medical bills to patients' health insurance carriers and instead sought payment directly from the patients themselves. This was done despite the hospital's contracts with health insurance carriers to accept discounted payments from the insurance

providers in full satisfaction of their patients' debt. By circumventing their agreements with the insurance providers, it is alleged, that the hospital system attempted to optimize the amount of payment received for their services, as the hospital system could collect more from their patients if they were able to avoid their patients' health insurance providers.

The three named Plaintiffs in this action are Jo Ann Blackwell; Michelene Brooks; and Samuel Herbert Owens. Plaintiff Blackwell was injured as the result of being struck by an automobile on December 19, 2013, and Plaintiff Blackwell was a patient of Mary Black Memorial Hospital from December 27, 2013 until January 3, 2014. Plaintiff Blackwell received medical treatment at Mary Black for injuries associated with the accident. Plaintiff Brooks was injured in an automobile collision on February 26, 2016. Following the collision, on February 28, 2016, Plaintiff Brooks presented to Mary Black Memorial Hospital where she received medical treatment for injuries associated with the accident. Plaintiff Owens was injured in an automobile collision on October 9, 2015. Immediately following the collision, Plaintiff Owens was transported to Mary Black Health System Emergency Department via private vehicle, where he received medical treatment for injuries associated with the accident.

Generally, each of these Plaintiffs were treated at Mary Black Hospital as a result of and because of their accidents. Their medical bills were not sent to their respective insurance provider, despite, allegedly, each having valid health insurance. After each Plaintiff was billed for their treatment, Defendants placed a third-party lien against their personal injury recovery.

As to Defendants' claim that the present litigation should be stayed and the Plaintiff should be ordered to arbitration because the claim for monetary relief may rely upon the agreed negotiated price arising from the Hospital Services Agreement with Cigna and/or MedCost, LLC Agreement. The Court disagrees with that assertion. The Court has reviewed the Cigna "Hospital Services Agreement" (originally dated 2006) and the "MedCost Hospital Agreement" (originally dated 1991). The enforcement of an arbitration agreement is contractual in nature and for an arbitration provision to be enforceable by this Court; the provision must apply to the parties. The terms of either of the Agreements do not obligate the Plaintiff (Owens) to mandatory arbitration. The Court could not find an arbitration provision in the MedCost agreement and the arbitration provision in the Cigna Agreement (appears to not be mandatory as the word "may" is used) does not apply to the Plaintiff as the Plaintiff is not a "party" to the agreement. In accordance to the terms of the agreement, the Plaintiff is, at best, a "participant" under the agreement's terms but not a "party". Section 6.2 is the Dispute Resolution part of the agreement, which contains the arbitration language. As previously stated, any decision concerning arbitration appears discretionary and not mandatory (see section 6.2.1). Section 6.2.2 sets forth procedural details related to the arbitration "if" a party opted to initiate such proceeding. Buried within the section 6.2.2 is a sentence that appears to make arbitration the exclusive remedy. Nevertheless, section 6.2.2 goes on to be read that the arbitration provision does not apply to third parties and does not apply to "class" matters. As previously stated, the Plaintiff is not a "party" to the agreement and its provisions are not enforceable as binding on the Plaintiff. Plaintiff also raised the issue that the Cigna Agreement had expired. Even though the agreement was for a three (3) terms, it contained a year-to-year renewal. Based on the information provided to this Court, no decision could be made that the agreement was or was not in effect. If the effective date(s) of the agreement(s) is material to merit based decision, further discovery is needed. Therefore, this Court concludes that a SCRCF Rule 12 (b) analysis does not afford any of the Defendant to a stay based on the provisions of either of these agreements. This Court review analysis at his stage of these agreements was limited to the arbitration issue. Any other consideration of the agreements goes beyond a SCRCF Rule 12(b)(6) analysis.

The remaining SCRCF Rule 12(b) (6) arguments offered by the Defendants related to the pleadings. With a SCRCF Rule 12(b)(6) review, the question for the court is whether in a light most favorable to the Plaintiff, and with every doubt resolved in Plaintiff's behalf, the allegations set forth on the face of the complaint state any valid claim for relief. A court cannot sustain a 12(b)(6) motion if the facts alleged and inferences reasonably drawn therefrom would entitle the Plaintiffs to any relief on any theory of the case. Applying the 12 (b)(6) standard of review, the allegation in the amended complaint, and considering the arguments, the motion to dismiss cannot be granted. Again, the Court makes the following observation in an effort to assist the parties in moving forward.

The Court agrees with the Plaintiffs that the Amended Complaint states sufficient allegations against both CHSPSC and Professional Account services, stating that there is no prohibition on pleading facts in the way that they have done here, by referring to the Defendants collectively. Further, this Court agrees that the Amended Complaint provides sufficient notice to all Defendants of the allegations being made against them. Viewing the amended complaint as a whole, the Plaintiffs have alleged sufficient facts to state a claim for tortious interference with contractual relationship. Plaintiff theory being that the allegations in the Amended Complaint can be reasonably construed to mean that Defendants' conduct resulted in a breach of the patients' contracts with their insurers because Plaintiffs alleged they paid premiums and did not have their hospital bills paid by their insurers.

On a SCRCF Rule 12(b) (6) motion, this Court agrees that the Plaintiffs' argues claims do not fail as a matter of law under the Medicare Act. Again, Plaintiffs' theory and the factual presentation is that this Court would have to go outside the amended complaint to rule that the Defendants' were required to seek payment from any applicable liability coverage prior to seeking or obtaining payment from Medicare, it presumes facts not alleged in the Amended Complaint, in that it presumes that the at-fault driver in automobile accidents had a valid insurance policy from which to collect. Thus, Defendants' argument relies on facts outside of the pleadings. If the issue of insurance is material to a merit based decision, the issue should be developed in discovery.

Again, under a SCRCF Rule 12(b)(6) analysis, this Court is bound to accept Plaintiffs' theories of liability to the facts offered in the Amended Complaint. Therefore, this Court, at this stage, cannot accept the voluntary payment doctrine as a defense. Under a 12(b) (6) analysis, this decision is reasonable given the assertion that payments made by the Plaintiffs were not voluntary, as the Plaintiffs only settled with Mary Black after the hospital asserted unlawful liens against them. Plaintiffs strongly assert that payments made as a result of extortion are not considered voluntary.

Once again, under a SCRCF Rule 12(b)(6) analysis, this Court cannot dismiss the Plaintiffs' theory of unjust enrichment. When viewing the Amended Complaint in a light most favorable to the pleader, a reasonable factual conclusion with theory can be that the Defendants were unjustly enriched and it would be inequitable to allow them to retain the benefits of their wrongful billing practices while attempting to collect a higher amount from Plaintiffs.

This Court opinion is that any statute of limitation issue fails at this time because of its relatedness to the original filing of the complaint. Factually, the issue may or may not be significant at a future time.

Thank you all for continued cooperation and attention.



Spartanburg Common Pleas

Case Caption: Jo Ann Blackwell , plaintiff, et al VS Mary Black Health System, Llc
, defendant, et al

Case Number: 2017CP4200219

Type: Order/Form 4

IT IS SO ORDERED

s/ J. Mark Hayes, II #2132

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 SUPPLEMENTAL BRIEF AND AUTHORITIES

Plaintiff opposes Defendant ACS's motion to compel arbitration. Plaintiff previously submitted her brief in opposition to that motion. The court has permitted the parties to submit a supplement to the briefs in lieu of a hearing.

Plaintiff's brief sets forth the applicable law. Plaintiff submits the following additional support / argument:

1. Defendant ACS's equitable estoppel argument has been rejected by South Carolina circuit courts' in at least one matter involving virtually identical facts and claims. In *Blackwell, et al. v. Mary Black Health System, LLC, et al.*, Judge Mark Hayes denied the defendant hospital's motion to compel arbitration under an equitable estoppel theory. The court subsequently denied the defendant hospital's motion for reconsideration finding that neither equitable or benefits estoppel apply and that the facts of that case are "even more compelling than those in *Weaver* or in *Wilson*." See Ex. 1, p.3 (Hayes Order denying motion for reconsideration).

2. Defendant ACS concedes that it has (or had) a practice of attempting to identify which of its patients' were treated because of injuries sustained in motor vehicle collisions. See Ex. 2, p.3 (ACS's answers to plaintiff's first requests to admit). Plaintiff alleges ACS had such a practice to further its scheme to get higher reimbursements, which, consequently, denies patients like plaintiff the benefit of the health insurance for which they pay.

Respectfully submitted,

**RICHARDSON PATRICK WESTBROOK
& BRICKMAN, LLC**

By: s/Chris Moore
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January 4, 2020.

Attorneys for Jessica Bennett

**STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG****IN THE COURT OF COMMON PLEAS
SEVENTH JUDICIAL CIRCUIT**

Jo Ann Blackwell, Michelene Brooks, and
Samuel H. Owens, Jr., individually and on
behalf of all others similarly-situated,

Plaintiffs,

v.

Mary Black Health System, LLC, d/b/a
Mary Black Memorial Hospital; CHSPSC,
LLC; and Professional Account Services,
Inc.,

Defendants.

C.A. No. 2017-CP-42-00219

**ORDER DENYING DEFENDANTS'
MOTION TO ALTER OR AMEND****BACKGROUND**

This matter came before the Court on Defendants' Motion to Alter or Amend, which Defendants filed on September 14, 2020. Plaintiffs filed a Response in Opposition to Defendants' Motion to Alter or Amend on October 9, 2020, and Defendants filed a Reply to Plaintiffs' Response in Opposition on October 19, 2020. Defendants moved, pursuant to Rule 59(e), SCRPC, for the Court to reconsider and alter or amend its prior order denying Defendants' Motions to Dismiss Pursuant to Rule 12(b)(6) or, in the Alternative, to Stay the Case and Compel Arbitration (hereinafter, "Defendants' Motions to Dismiss or Compel Arbitration"). The Court issued an order denying Defendants' Motions to Dismiss or Compel Arbitration on September 4, 2020.

Defendants' Motion to Alter or Amend asks the Court to modify its September 4 Order and: (1) compel Plaintiff Owens to arbitrate his claims against Defendants; (2) dismiss Plaintiff Owens's claims based on the statute of limitations; (3) reconsider its analysis of the voluntary payment doctrine; (4) dismiss Plaintiff Blackwell's unjust enrichment claim; (5) find that Plaintiff Blackwell is barred from enforcing the MedCost Agreement between Defendant Mary Black and

her health insurer as a third-party beneficiary; and (6) conclude that Plaintiffs have improperly engaged in “collective pleading.” The Court has fully considered all of Defendants’ arguments in their Motion, Plaintiffs’ arguments in opposition, and Defendants’ arguments in their reply brief, as well as the parties’ prior submissions in connection with Defendants’ Motions to Dismiss or Compel Arbitration (including the documents filed under seal by Defendants). Consistent with Rule 59(f), the Court has determined, in its discretion, that Defendants’ motion may “be determined on briefs filed by the parties without oral argument.” Rule 59(f), SCRPC. For the following reasons, Defendants’ Motion to Alter or Amend is **DENIED**.

STANDARD OF REVIEW

“The purpose of Rule 59(e), SCRPC, to alter or amend the judgment is to request the trial judge to ‘reconsider matters properly encompassed in a decision on the merits.’” *Pye v. Estate of Fox*, 369 S.C. 555, 565–566, 633 S.E.2d 505, 510 (2006) (quoting *Arnold v. State*, 309 S.C. 157, 172, 420 S.E.2d 834, 842 (1992)). “[I]t is proper to view a Rule 59(e) motion not only as a vehicle to request the trial court ‘alter or amend the judgment,’ but also as a vehicle to seek ‘reconsideration’ of issues and arguments. A motion under Rule 59(e) long has been viewed as ‘motion for reconsideration’ despite the absence of those words from the rule.” *Elam v. S.C. Dept. of Transp.*, 361 S.C. 9, 21, 602 S.E.2d 772, 778–779 (2004). Additionally, where a movant fails to identify any issue raised, but not ruled upon in a prior motion, a motion for reconsideration is properly denied. *See Collins Music Co. v. IGT*, 353 S.C. 559, 579 S.E.2d 524 (Ct. App. 2002).

ANALYSIS

1. Plaintiff Owens should not be compelled to arbitrate his claims against Defendants.

The Court previously rejected Defendants’ assertion that this case should be stayed and Plaintiff Owens should be compelled to arbitrate his claims against Defendants due to an agreement between CIGNA and Defendant Mary Black. Defendants’ Motion to Alter or Amend

has not convinced the Court that it should change its prior conclusion. In asking the Court to reconsider its decision on the arbitration issue, Defendants have argued the issues of equitable estoppel, whether the elective nature of the arbitration provision in the CIGNA agreement affects the analysis, and whether a disclaimer of third parties and class arbitration in that agreement renders the arbitration provision unenforceable against Plaintiff Owens.

The Court finds it significant that Plaintiff Owens is not a party to the CIGNA agreement. Under the facts and circumstances of this case, the Court concludes that the decisions of the Court of Appeals in *Weaver v. Brookdale Senior Living, Inc.*, 431 S.C. 223, 847 S.E.2d 268 (Ct. App. 2020), and of the South Carolina Supreme Court in *Wilson v. Willis*, 426 S.C. 326, 827 S.E.2d 167 (2019), are applicable and controlling. Indeed, the facts of the present case are even more compelling than those in *Weaver* or in *Wilson*. Neither direct benefits estoppel nor equitable estoppel apply to this case, and Defendants' remaining arguments for compelling arbitration are rejected.

2. Plaintiffs' Amended Complaint sufficiently pled facts against Defendants.

The Court also rejects Defendants' argument that Plaintiffs have improperly pled their claims against them because some of those claims were pled collectively. The Court agrees with Plaintiffs' arguments that Defendants misconstrue either the effect of Plaintiffs' allegations or applicable South Carolina pleading standards, and concludes that, under the standards of Rule 8 and Rule 12(b)(6), SCRCF, the allegations of Plaintiffs' Amended Complaint are sufficient.

Although Defendants suggest Plaintiffs' pleadings improperly attempt to attach liability to each defendant, Plaintiffs have not alleged any defendant is vicariously liable for the actions of another, nor have Plaintiffs attempted to pierce the corporate veil of any defendant. Plaintiffs'

Amended Complaint instead alleges that these Defendants acted in concert and that each Defendant is liable for its own conduct. For these reasons, the Court concludes that Defendants' authorities are inapposite.

The Court also finds Defendants' alternative suggestion that collective pleading is prohibited or improper in South Carolina is incorrect. The Court is unaware of any case law, statute, or rule in the South Carolina Rules of Civil Procedure that prohibits "collective pleading" or somehow requires Plaintiffs to repeat allegations against individual defendants when those defendants allegedly acted in concert. Again, the Court finds that the cases Defendants cite on this point are not dispositive, and in fact, *Pro Slab, Inc. v. Argos USA Corp.*, C.A. No. 2:17-3185-BHH, 2018 WL 6985008 (D.S.C. June 28, 2018), supports Plaintiffs' position.

In *Pro Slab*, the district court cited *Connor v. Honeywell Int'l Inc.*, C.A. No. 2:12-1421-CWH, 2012 WL 6135193 (D.S.C. Nov. 13, 2012), which found collective Pleading to be proper:

In *Connor*, affiliated corporate defendants sought dismissal of the plaintiff's claims . . . by claiming that it was not clear which defendant or defendants were alleged to have committed which wrong. The court stated that it was "initially inclined to allow the plaintiff an opportunity to amend the complaint to clarify which conduct was attributable to which defendant." *Id.* at *1. However, after the plaintiff represented that it was his view that the defendants were acting in concert . . . , the court found the complaint adequate. . . . Thus, the factual allegations in the plaintiffs' complaint in *Connor* supported the assertion that the defendants acted together. In contrast, here, Plaintiffs' amended complaint merely alleges the legal conclusion that the affiliated corporate entities were agents and/or alter egos and operated as one company, but the amended complaint contains *no factual allegations* to support that legal conclusion.

Pro Slab, Inc., 2018 WL 6985008, at *5. Additionally, the Court has considered Defendants' other cited authority and concludes it offers no support for their position. See *Scurmont LLC v. Firehouse Rest. Grp., Inc.*, C.A. No. 4:09-CV-00618-RBH, 2010 WL 11433199, at *15 (D.S.C. May 19, 2010) (finding a lack of specific personal jurisdiction over an individual defendant because the plaintiff failed to plead facts demonstrating the defendant committed wrongful acts within South

Carolina). Accordingly, the Court did not err by finding Plaintiffs sufficiently pled the allegations in their Amended Complaint.

3. Other provisions of the Court's September 4 Order do not require alteration.

Defendants' remaining arguments regarding the statute of limitations, the voluntary payment doctrine, unjust enrichment, and the Med-Cost Agreement's alleged disclaimer are also rejected. The Court has fully considered those arguments and found Plaintiffs' responses to be persuasive and appropriate.

CONCLUSION

For all the foregoing reasons, Defendants have not convinced the Court that it should alter or amend its order denying Defendants' Motions to Dismiss or Compel Arbitration. Defendants' Motion to Alter or Amend is accordingly **DENIED**.

IT IS SO ORDERED.

Judge's electronic signature page follows.



Spartanburg Common Pleas

Case Caption: Jo Ann Blackwell , plaintiff, et al VS Mary Black Health System, Llc
, defendant, et al

Case Number: 2017CP4200219

Type: Order/Other

IT IS SO ORDERED

s/ J. Mark Hayes, II #2132

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

**DEFENDANT'S ANSWERS TO
PLAINTIFF'S FIRST SET OF
REQUESTS TO ADMIT****TO: WILLIAM C. LEWIS, ESQ. AND CHRISTOPHER MOORE, ESQ., ATTORNEYS
FOR PLAINTIFF**

Defendant ACS Primary Care Physicians-Southeast P.C. ("Defendant") hereby responds to Plaintiff's First Set of Requests to Admit pursuant to the provisions of Rules 26 and 36 of the South Carolina Rules of Civil Procedure.

PRELIMINARY STATEMENT AND RESERVATION OF RIGHTS

Defendant has filed a Motion for Protective Order seeking an order that no discovery be conducted during the pendency of Defendant's Motion to Dismiss and Compel Arbitration. As set forth in the Motion for Protective Order, Defendant objects to Plaintiff's discovery and maintains that it is premature and improper because this matter should be dismissed and compelled to arbitration. Accordingly, any discovery proceedings should be governed by the applicable rules applicable to discovery in arbitration. Defendant is providing these Answers to Plaintiff's First Set of Requests to Admit out of an abundance of caution only to avoid any argument that the Requests to Admit must be deemed admitted. By providing these Answers to Plaintiff's First Set of Requests to Admit, Defendant is not waiving its right to compel arbitration, and these Answers

to Plaintiff's First Set of Requests may not be used as evidence of Defendant's voluntary participation in this litigation.

Further, Defendant reserves the right to object to future discovery on the same or related matters and does not waive any objections by providing the information reflected in these responses. Defendant objects and further reserves the right to object to the admissibility of any of these answers, in whole or in part, at trial in this action, on any grounds, including, but not limited to, materiality, relevancy, and privilege. Defendant's responses to these Requests to Admit are made to the best of its present knowledge, information and belief. Said responses are at all times subject to additional or different information that discovery or further investigation may disclose.

ANSWERS TO REQUESTS FOR ADMISSION

1. Please admit that you charged Plaintiff different prices for your services rendered on December 16, 2018 than what you would have been paid by BCBS under plaintiff's health insurance agreement for the same services.

ANSWER: Denied. Defendant does not know what amount, if any, BCBS would have paid had the charges been billed to it.

2. Please admit that you charged Plaintiff different prices for your services rendered on December 16, 2018 than what you would have been paid by Blue Cross Blue Shield under plaintiff's health insurance agreement for the same services.

ANSWER: Denied. Defendant does not know what amount, if any, Blue Cross Blue Shield would have paid had the charges been billed to it.

3. Please admit that you did not submit your charges for services rendered to plaintiff on December 16, 2018 to BCBS.

ANSWER: Admit.

4. Please admit that you have an internal practice of identifying patients whose injuries are potentially a result of an event for which there could be third party liability insurance.

ANSWER: Denied as stated. By way of further response, Defendant had a practice of attempting to determine whether patients' injuries were the result of a motor vehicle accident.

5. Please admit that you have an internal practice of not submitting your bills to health insurers of patients that you identify as having injuries that are potentially a result of an event for which there could be third party liability insurance.

ANSWER: Denied.

6. Please admit this practice may result in more revenue to you than if you submitted those patients' claims to their health insurers, like BCBS.

ANSWER: Denied. Defendant does not have such an internal practice.

Dated: October 30, 2020

GORDON & REES LLP

By



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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-South P.C.,

)

Defendant.

)

**RULE 59(e) MOTION FOR
RECONSIDERATION OF DENIAL OF
MOTION TO COMPEL ARBITRATION
AND DISMISS OR STAY**

Pursuant to Rule 59(e), SCRPC, Defendant ACS Primary Care Physicians-Southeast P.C. (“ACS”) hereby moves the Court to reconsider its order (the “Denial Order”) denying ACS’s Motion to Compel Arbitration pursuant to Rules 12(b)(1), 12(b)(3) and 12(b)(6), SCRPC, 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”). By its motion to compel arbitration, ACS sought to have the Court compel Plaintiff to pursue her claims against ACS by way of bilateral arbitration (*i.e.*, arbitration on a non-classwide basis) and to dismiss this matter, or, in the alternative to dismissal, to stay this case pending the arbitration. For the reasons set forth below, the Court should grant this motion, reconsider its Denial Order, vacate the Denial Order, and enter a new order granting ACS’s motion to compel arbitration.

INTRODUCTION

In the Denial Order, the Court denied ACS’s motion to compel arbitration because it concluded that Plaintiff, who did not sign the Provider Agreement between ACS and Blue Cross Blue Shield of South Carolina (“BCBSSC”), should not be estopped from denying that the arbitration clause in the Provider Agreement applied to her. Specifically, the Court concluded that,

in order for Plaintiff to be estopped under the “direct benefits” test, which ACS argued applied here, Plaintiff must either have “actively exploit[ed]” the Provider Agreement or “mislead[] [the other party] to [her] injury[.]” (Denial Order at 3.) The Court further concluded that, because “Plaintiff was completely unaware that the [Provider Agreement] existed when she received her medical treatment,” she could not have “actively exploit[ed]” the Provider Agreement. (*Id.*)

As ACS explains in Section I of this motion, respectfully, the Denial Order is erroneous as a matter of law. Under South Carolina law, Plaintiff should be estopped from denying the arbitration clause in the Provider Agreement applies to her because she has brought a claim against ACS for breach of the Provider Agreement alleging that she is a third-party beneficiary of that agreement. **By this claim, Plaintiff is seeking to actively exploit the Provider Agreement.** Thus, Plaintiff’s claim for breach of the Provider Agreement is itself sufficient to establish the “direct benefit” required under the law to estop Plaintiff from denying that the arbitration clause applies to her. Moreover, holding that the “direct benefits” test does not apply here would be preempted by the FAA. Under background principles of contract law, a defendant in a third-party beneficiary claim retains all defenses under the contract, and denying application of the “direct benefits” test here would impermissibly subject arbitration to suspect status.

In addition, even independent of the fact that Plaintiff brought a claim for breach of the Provider Agreement, Plaintiff herself alleges that she received a “direct benefit” under the Provider Agreement. This allegation is sufficient to estop Plaintiff from denying the arbitration clause in the Provider Agreement applies to her.

Finally, as ACS explains in Sections II-VIII of this motion, arbitration is otherwise proper for the same reasons that ACS has explained in its prior briefing on the motion to compel 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 BCBSSC. (*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**.¹

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

¹ ACS has previously filed all exhibits to this motion in connection with its motion to compel arbitration. ACS attaches them again here for the Court’s convenience.

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.)

Based on the arbitration clause in the Provider Agreement, ACS filed a motion to compel arbitration. Plaintiff opposed that motion, and the Court denied it in the Denial Order. For the reasons below, the Court should reconsider the Denial Order, vacate the Denial Order, and enter a new order granting ACS’s motion to compel arbitration.

DISCUSSION

I. PLAINTIFF IS ESTOPPED FROM DENYING THAT THE ARBITRATION CLAUSE APPLIES TO HER.

As set forth in more detail in Sections II-VIII below, Plaintiff’s claims are subject to bilateral arbitration under the FAA and the SCUAA. In this Section I, ACS explains why the Court’s conclusion in the Denial Order that direct benefits estoppel does not apply here was erroneous.

A. Plaintiff seeks a “direct benefit” under the Provider Agreement because she has brought a claim for breach of the Provider Agreement alleging that she is a third-party beneficiary under that agreement.

“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.* As with the FAA, “[t]he policy of [] South Carolina is to favor arbitration of disputes.” *Parsons v. John Wieland Homes & Neighborhoods of the Carolinas*, 418 S.C. 1, 6, 791 S.E.2d 128 (2016); *see also Zabinski v. Bright Acres Assocs.*, 346 S.C. 480, 596, 553 S.E. 2d 110, 118 (2001); *Damico v. Lennar Carolinas, LLC*, 884 S.E.2d 66, 430 S.C. 188 (Ct. App. 2020).

It is undisputed that Plaintiff is not a signatory to the Provider Agreement. This fact, however, does not undermine the conclusion that she is bound by the arbitration agreement in the Provider Agreement. Rather, Plaintiff should be estopped from denying that the arbitration clause applies to her because she seeks the direct benefits of other provisions of the same contract.

“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, 29f5, 733 S.E.2d 597, 604 (Ct. App. 2012); *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 (emphasis added); *see also Am. Bankers Ins. Group v. Long*, 453 F.3d 623, 628 (4th Cir. 2006). A nonsignatory seeks a “direct benefit” under a contract when, among other things, she asserts a claim based on her alleged status as a third-party beneficiary of the contract. *Wilson v. Willis*, 426 S.C. 326, 344, 827 S.E.2d 167, 177 (2019) (noting that “direct benefits” estoppel applies “where plaintiffs sue and seek relief based on contracts containing arbitration clauses”); *see also Am. Bankers*, 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.*²

Here, Plaintiff seeks a “direct benefit” under 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 agreement under a third-party beneficiary theory. (Compl. ¶ 63) Because Plaintiff is relying on the Provider Agreement as the foundation for her breach of contract claim, she is estopped from denying she is a signatory to that agreement and that the arbitration agreement applies to her under the “direct benefits” test. *Wilson*, 426 S.C. at 344, 827 S.E.2d at 177.

B. The Denial Order erroneously concluded that Plaintiff’s third-party beneficiary claim did not satisfy the “direct benefits” test.

1. Plaintiff “actively exploited” the Provider Agreement by alleging a claim for breach of contract alleging that she is a third-party beneficiary of that agreement.

In its Denial Order, the Court concluded that estoppel does not apply here because “estoppel is reserved for instances where a beneficiary of a contract ‘actively exploits’ the agreement or ‘mislead[s] [the other party] to his injury.’” (Denial Order at 3 (quoting *Weaver v. Brookdale Senior Living*, 431 S.C. 223, 232, 847 S.E. 2d 268, 274 (Ct. App. 2020)). According

² In her briefing in opposition to the motion to compel arbitration, Plaintiff argued that South Carolina courts have not adopted the “direct benefits” test but, instead, would apply estoppel in the arbitration context only where the traditional elements of equitable estoppel were met. As ACS demonstrated, however, this argument is incorrect. To be sure, a party seeking to estop another from denying that an arbitration clause applies *may* invoke the traditional elements of equitable estoppel. But that is not the only means under which equitable estoppel can apply. A party may *also* prevail on an estoppel argument under the direct benefits test. *See, e.g., Wilson*, 426 S.C. at 344, 827 S.E.2d at 177 (noting that “direct benefits” estoppel applies “where plaintiffs sue and seek relief based on contracts containing arbitration clauses”). Indeed, the United States District Court for the District of South Carolina has subsequently interpreted *Wilson* to mean that the direct benefits test is available under South Carolina law. *See Kiawah Island Util., Inc. v. Westport Ins. Corp.*, No. 2:19-cv-1359-DCN, 2019 U.S. Dist. LEXIS 182220, at *8-9 (D.S.C. Oct. 2, 2019) (applying the direct benefits test and holding that arbitration agreement was enforceable against a non-signatory). Accordingly, South Carolina courts have adopted the direct benefits test.

to the Denial Order, Plaintiff cannot be estopped from denying the arbitration clause applies to her because she “was completely unaware that the [Provider Agreement] existed when she received her medical treatment.” (*Id.*)

Respectfully, this conclusion is erroneous. As the South Carolina Supreme Court observed in *Wilson*, direct benefits estoppel applies “where plaintiffs sue and seek relief based on contracts containing arbitration clause.” 326 S.C. at 344, 827 S.E.2d at 177. In support of this statement, the court in *Wilson* cited *International Paper Co. v. Schwabedissen Maschinen & Anlagen GMBH*, 206 F.3d 411, 418 (4th Cir. 2000). In *International Paper*, the plaintiff purchased an industrial saw from a distributor. *Id.* at 414. The plaintiff was not satisfied with the saw, and sued the manufacturer. *Id.* The warranty agreement—which was between the manufacturer and distributor only (and not the plaintiff)—contained an arbitration clause, and the manufacturer sought to compel the plaintiff’s claims against it to arbitration. *Id.* at 415. The plaintiff argued that it could not be bound by the arbitration clause in the warranty agreement because “it had no knowledge of, and so could not be bound by” the arbitration clause. *Id.* Despite this fact, the court held that the plaintiff was bound by the arbitration clause because the plaintiff’s claims were based on the warranty agreement. Specifically, the court held:

In its amended complaint, [the plaintiff] alleges that [the manufacturer] failed to honor the warranties in the [contract between the manufacturer and distributor], and it seeks damages, revocation, and rejection “in accordance with” that contract. [The plaintiff’s] entire case hinges on its asserted rights under the [contract between the manufacturer and distributor]; it cannot seek to enforce those contractual rights and avoid the contract’s requirement that “any dispute arising out of” the contract be arbitrated.

Id. at 418. In other words, as the Court in *Wilson* described *International Paper*, that case stands for the proposition that the “nonsignatory plaintiff could not bring claims to enforce the guarantees

and warranties issued by the defendant in a contract with another party without complying with an arbitration provision contained in that contract.” *Wilson*, 326 S.C. at 344, 827 S.E.2d at 177.

Applying *International Paper* and *Wilson* here, it does not matter whether Plaintiff had knowledge of or actively exploited the Provider Agreement at the time she received the medical treatment at issue. The crucial point is that Plaintiff is now asserting a claim against ACS alleging that she is the third-party beneficiary of a contract containing an arbitration clause. Phrased differently, **Plaintiff is seeking to actively exploit the Provider Agreement by asserting a claim for breach of the Provider Agreement based on her allegation that she is a third-party beneficiary of that Agreement.** Accordingly, the direct benefits test applies in this situation. Indeed, this is textbook direct benefits case. *Wilson*, 426 S.C. at 344, 827 S.E.2d at 178; *International Paper*, 206 F.3d at 418; see also *See Kiawah Island Util., Inc. v. Westport Ins. Corp.*, No. 2:19-cv-1359-DCN, 2019 U.S. Dist. WL 5394200, at *8-9 (D.S.C. Oct. 2, 2019); *Osborne v. Marina Inn @ Grand Dunes, LLC*, No. 4:08-cv-0490, 2009 U.S. Dist. WL 2009 WL 3152044, at *9 (D.S.C. Sept. 23, 2009). The Court erred in concluding otherwise.³

ACS respectfully suggests that the reason for the Denial Order’s error in in this regard is because the Court relied on a case—*Weaver v. Brookdale Senior Living, Inc.*—where the defendant argued that the direct benefit at issue arose in the *course and scope of the parties’ underlying dealings with one another*. Here, by contrast, Plaintiff satisfies the direct benefits test because *she is alleging that she is a third-party beneficiary under the Provider Agreement*. In the latter situation, whether Plaintiff knew of or actively exploited the Provider Agreement at the time she

³ The Denial Order also erred in finding that Plaintiff was “unaware that the [Provider Agreement] existed when she received her medical treatment.” (Denial Order at 3.) There is no evidence in the record to support that finding. In any event, Plaintiff was aware of the Provider Agreement at the time she filed her lawsuit and, in so doing, she actively exploited the Provider Agreement and thereby satisfied the “direct benefits” test.

received medical services is simply irrelevant. Instead, Plaintiff is actively exploiting the Provider Agreement via her claim for breach of contract because it is based on the allegation that she is a third-party beneficiary of that agreement.

In *Weaver*, the plaintiff sued a residential care facility for negligence and other torts arising out of her grandmother's death. 431 S.C. at 228, 847 S.E. 2d at 270. The residential care contract, to which the plaintiff was not a signatory, contained an arbitration clause, and the facility argued that the plaintiff received a direct benefit from that contract, in part, because the facility's standard of care vis-à-vis the plaintiff's grandmother was set forth in the contract. *Id.* at 230, 847 S.E. 2d at 272. The court disagreed, holding that the facility's standard of care was set forth in the background law of negligence and, because the plaintiff had only brought tort claims, she did not seek a direct benefit under the residential care contract. *Id.* at 232-34, 847 S.E. 2d at 273-74. In *Weaver*, however, the plaintiff did not allege a claim for breach of contract based on the contention that she was a third-party beneficiary under the residential care contract. Instead, she brought only tort claims. Here, because Plaintiff has sued for breach of the Provider Agreement, *Weaver* is inapposite.

Indeed, the Court in *Kiawah Island* explicitly rejected the notion that the direct benefits test is limited to an examination of the course and scope of the parties' underlying dealings with one another. 2019 U.S. Dist. LEXIS 182220, at *9-11. In *Kiawah Island*, the court explained that the nonsignatory's knowledge and exploitation of the agreement containing the arbitration clause can be a factor when the alleged direct benefit arises in the course and scope of the parties' underlying dealings with one another, but that an inquiry into knowledge and exploitation is not required when the party to be estopped is claiming to be a third-party beneficiary of the contract containing the arbitration clause. *Id.* Thus, the court in *Kiawah Island* held that it "need not

examine whether [the plaintiff] knew about the Arbitration Clause because that factual question only relates to whether [the plaintiff] is seeking a benefit from the [policy agreement], and [the plaintiff] is clearly seeking a benefit by seeking coverage.” *Id.* at 11.

Unlike the non-signatory in *Weaver*—and like the plaintiff in *Kiawah Island*—Plaintiff here is seeking a direct benefit from the Provider Agreement through her claim for breach of that agreement as a third-party beneficiary. Thus, Plaintiff should be estopped from denying the arbitration clause in the Provider Agreement applies to her.⁴

2. A holding that the “direct benefit” test does not apply here would be preempted by the FAA.

Moreover, the Denial Order’s conclusion that the “direct benefits” test is not satisfied here is preempted by the FAA because it would subject arbitration agreements to special rules that apply only to contracts containing arbitration agreements and not to contracts generally.

⁴ In her briefing in opposition to the motion to compel arbitration, Plaintiff argues that the fact the arbitration clause states that it applies to the “parties” to the Provider Agreement—and not to her—means that the arbitration clause does not apply to her. This argument, however, misapprehends the scope of the equitable estoppel doctrine. That doctrine does not simply preclude Plaintiff from arguing that she is a signatory to the Provider Agreement; rather, it also precludes Plaintiff from arguing that the Provider Agreement’s arbitration clause *applies to her*. *Swane Co. v. Berkeley Cnty. S.C.*, No. 2:15-cv-2586, 2015 U.S. Dist. LEXIS 147235, at *17 n.4 (D.S.C. Oct. 30, 2015) (holding, in a case involving arbitration agreement that applied only to the “parties” to the agreement, that a non-signatory was nevertheless bound by it under the theory of equitable estoppel). If the law were otherwise, because contracts generally only bind the parties thereto, the equitable estoppel doctrine would only apply in a narrow set of cases in which the language of the arbitration clause did not specify who was bound by it. That is not the state of the law.

Moreover, the Provider Agreement does not contain any language providing that the arbitration agreement does not apply to third parties. Thus, the language of the arbitration clause is not, by its terms, limited to the parties thereto.

In any event, this argument ignores the header on the first page of the Provider Agreement, which states in bold, capitalized, and underlined letters that “**THIS . . . AGREEMENT IS SUBJECT TO ARBITRATION.**” That header contains no limitation whatsoever on the parties who are bound by the arbitration provision. Thus, the arbitration provision applies to Plaintiff.

Under 9 U.S.C. § 2, arbitration agreements “shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.” Under this provision, “Congress precluded States from singling out arbitration provisions for suspect status, requiring instead that such provisions be placed upon the same footing as other contracts.” *Doctor’s Associates, Inc. v. Casarotto*, 517 U.S. 681, 682 (1996). Thus, “[c]ourts may not . . . invalidate arbitration agreements under state laws applicable only to arbitration provisions.” *Id.*; see also *AT&T Mobility LLC v. Concepcion*, 463 U.S. 333, 343 (2011) (holding the FAA does not “preserve state-law rules that stand as an obstacle to the accomplishment of the FAA’s objectives”). Applying this rule, the South Carolina Supreme Court has held that S.C. Code Ann. § 15-48-10(a)—the statutory provision that requires agreements containing an arbitration clause to contain a header on the first page of the agreement—is preempted by the FAA. *Soil Remediation Co. v. Nu-Way Env’t, Inc.*, 323 S.C. 454, 459, 476 S.E.2d 149, 151–52 (1996).

Under general principles of South Carolina contract law, third parties to a contract may sue to enforce the contract if they can demonstrate they were “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). In such a situation, however, the third-party beneficiary’s claim is subject to any defenses that might exist under the contract. See Restatement (Second) of Contracts § 309 (Defenses Against the Beneficiary), cmt. c (“The position of a [third-party] beneficiary is comparable to that of an assignee after knowledge of the assignment by the obligor. *His right, like that of an assignee, is subject to limitations inherent in the contract*, and to supervening defenses arising by virtue of its terms.” (emphasis added)); 13 Williston, Contracts § 37:57 (4th ed. May 2021 Update) (“[A] third party beneficiary’s rights are subject to any contract defense that the promisor could assert against the promisee if the promisee were suing on the contract.”); see also *Bakery & Confectionery Union*

& *Indus. Int'l Pension Fund v. Ralph's Grocery Co.*, 118 F.3d 1018, 1021 (4th Cir. 1997) (“Although a third party beneficiary can enforce the terms of a contract that inure to its benefit, it is subject to defenses that the promisor could assert against the original party to the contract.”).

Here, as noted, Plaintiff has alleged a claim for breach of contract against ACS on the theory that it is a third-party beneficiary of the Provider Agreement. In light of this allegation, the Denial Order is tantamount to a ruling that arbitration—unlike all other defenses ACS may have to Plaintiff’s third-party beneficiary claim—is unavailable to ACS. Such a ruling, however, is in contravention of the background common law rule that a third-party beneficiary’s claim is subject to all defenses that might exist under the contract. In other words, the Denial Order singles out arbitration for suspect status. As such, the Denial Order is preempted by the FAA.⁵

C. The Denial Order erred in failing to recognize that Plaintiff’s own Complaint alleges she received a “direct benefit” under the Provider Agreement.

Even putting aside the fact that Plaintiff is asserting a third-party beneficiary claim based on the Provider Agreement, Plaintiff’s own factual allegations establish that the direct benefits test is satisfied here. Specifically, the Complaint alleges that Plaintiff “received *direct benefits* from the Provider Agreement” in the form of lowered health care costs from ACS.” (Compl. ¶ 20, 14 (emphasis added)). These allegations are conclusive on the point, and Plaintiff should not be permitted to speak out of both sides of her mouth in arguing otherwise. The Denial Order erred in failing to hold Plaintiff to this allegation.

⁵ In her briefing on the motion to compel arbitration, Plaintiff argued that there is a presumption against arbitration when a signatory to an arbitration agreement seeks to compel a non-signatory to arbitration. For the reasons set forth in the text, however, any such presumption would be preempted by the FAA. Moreover, even if such a presumption existed (and it does not), as noted, this is a prototypical direct benefit case. Thus, any presumption against arbitration would be overcome.

II. PLAINTIFF'S CLAIMS ARE SUBJECT TO 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 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.⁶ The arbitration clause provides that the parties "agree to arbitrate [any] problem or dispute" that "arises under the agreement," (Provider Agreement at 11). Plaintiff's claim for breach of contract—*i.e.*, breach of the Provider Agreement—is plainly a claim that "arises under" that agreement. In other words, because Plaintiff has brought a claim for breach of the Provider Agreement, that claim "arises under" the Provider Agreement. *See, e.g., Fleetwood Transp. Corp. v. Packaging Corp. of Am.*, No. 6:10-0129-JMC, 2012 U.S. Dist. LEXIS 31421, at *15 (D.S.C.

⁶ In addition, as discussed in Section 1, Plaintiff should be estopped from denying that the arbitration agreement applies to her.

Mar. 8, 2012) (compelling claim for breach of contract to arbitration under arbitration clause that applies to disputes “arising under the agreement”); *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 because they have a “significant relationship” to 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, 437 S.E. 2d at 23 (“Any doubts concerning the scope of arbitration should be resolved in favor of arbitration”).

Third. The transaction at issue here 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 and 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 cross 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.

III. PLAINTIFF’S CLAIMS ARE SUBJECT TO ARBITRATION UNDER THE SCUAA.

Even if the Provider Agreement did not involve interstate commerce (and it 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 also subject to arbitration under the SCUAA. Specifically, Plaintiff’s claims “arise under” the Provider

Agreement and, thus, are subject to its arbitration clause. *See Fleetwood Transp. Corp.*, 2012 U.S. Dist. LEXIS 31421, at *15; *Great W. Coal*, 312 S.C. at 563, 437 S.E.2d at 23.

Further, under the SCUAA, “[n]otice that 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. Accordingly, the Court should also compel arbitration under the SCUAA.

IV. THE ARBITRATION MUST BE ON A BILATERAL BASIS.

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.

V. QUESTIONS REGARDING THE EXISTENCE AND SATISFACTION OF CONDITIONS PRECEDENT TO AN ARBITRATION CLAUSE ARE FOR THE ARBITRATOR, NOT THE COURT, TO DECIDE.

In her briefing in opposition to the motion to compel arbitration, Plaintiff contended that the fact the arbitration clause requires a pre-arbitration meet-and-confer means that the dispute may not be arbitrated. This contention is incorrect.

As an initial matter, the issues of (1) whether a contractual provision is, in fact, a condition precedent to arbitration and (2) if a condition precedent, whether it is fulfilled, are questions for the arbitrator, not the court, to decide. As the Fourth Circuit recently held, “arbitrators—not courts—must decide whether a condition precedent to arbitrability has been fulfilled.” *Chorley Enters. v. Dickey’s Barbecue Rests., Inc.*, 807 F.3d 553, 565 (4th Cir. 2015) (citing *BG Group PLC v. Republic of Arg.*, ___ U.S. ___, 134 S. Ct. 1198, 1207-1208 (2014)). Notably, in *Chorley*, the Fourth Circuit noted that **every single case** that Plaintiff cites in support of her argument otherwise has been overruled by the Supreme Court of the United States. *Id.* at 565 n.14 (noting that *Perdue Farms, Inc. v. Design Build Contr. Corp.*, No. 07-1056, 2008 U.S. App. LEXIS 2861 (4th Cir. Feb. 8, 2008), *HIM Portland LLC v. Devito Builders Inc.*, 317 F.3d 41 (1st Cir. 2003), and *Kemiron-Atl. Inc. v. Aguakem Int’l Inc.*, 290 F.3d 1287, 1291 (11th Cir. 2002), have all been overruled). Accordingly, Plaintiff’s argument regarding the alleged existence of a condition precedent is for the arbitrator—not the Court—to resolve.

Moreover, Plaintiff may not openly violate the arbitration provision—an arbitration provision she is estopped from denying she is party to—and then claim, **based on her own violation of the contract**, that her claim may not be arbitrated. The law does not aid parties in

their own breaches of contract. *See, e.g., Champion v. Whaley*, 280 S.C. 116, 121, 311 S.E.2d 404, 407 (Ct. App. 1984) (“Where a party’s repudiation contributes materially to the nonoccurrence of a condition precedent to his duty of performance, the nonoccurrence of the condition is excused.”).

VI. THE AAA IS AVAILABLE TO RESOLVE THIS DISPUTE.

In her briefing in opposition to the motion to compel arbitration, Plaintiff argued that the arbitration clause here is not enforceable because the AAA will refuse to arbitrate the dispute. This argument, however, misreads just how narrow the AAA pronouncement on this point actually is, and ignores the fact that the AAA will arbitrate (1) disputes between providers and their patients involving billing issues and (2) disputes that are compelled to arbitration pursuant to a court order.

It is true, as Plaintiff claims, that the AAA announced in 2003 that it would not voluntarily “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.” *See* AAA Healthcare Policy Statement, American Arbitration Association, https://www.adr.org/sites/default/files/document_repository/AAA_Healthcare_Policy_Statement.pdf (last visited July 1, 2021), attached hereto as **Exhibit B**). As the text of this provision reveals, however, the pronouncement applies only to disputes that “relate to **medical services**, such as **negligence and medical malpractice disputes**.” *Id.* (emphases added). To make this limitation clear, the AAA further specified that it “will continue to administer arbitrations that involve solely **billing or collections matters** between an individual and a . . . healthcare provider.” *Id.* (emphasis added). Moreover, the AAA also clarified that it “will administer disputes between patients and healthcare providers to the extent a **court order directs such a dispute to arbitration** where the parties’ agreement provides for the AAA’s rules or AAA administration.” *Id.* (emphasis added).

This case falls squarely within both exceptions noted by the AAA in the Healthcare Policy Statement. For one thing, this is a dispute between an individual (Plaintiff) and a healthcare provider (ACS) that “involve[s] solely billing or collections matters.” Plaintiff does not allege a medical malpractice or related negligence claim against ACS; instead, the crux of Plaintiff’s Complaint is allegations that ACS improperly billed her. Thus, this is indisputably a “billing . . . matter.” In addition, the AAA will arbitrate any case that is compelled to them by a court, as this case should be. Therefore, the AAA policy provides no impediment to arbitration.

Moreover, even if the AAA were actually unavailable (and it is not), the proper remedy is not to hold the arbitration clause unenforceable. Instead, the Court should simply appoint a substitute arbitrator. Indeed, the FAA specifically provides for the manner in which to name an arbitrator in this situation. Section 5 of the FAA provides in relevant part:

[i]f in the agreement provision be made for a method of naming or appointing an arbitrator or arbitrators or an umpire, such method shall be followed; but if no method be provided therein, or if a method be provided and any party thereto shall fail to avail himself of such method, or if for any other reason there shall be a lapse in the naming of an arbitrator or arbitrators or umpire, or in filling a vacancy, then upon the application of either party to the controversy, the court shall designate and appoint an arbitrator or arbitrators or umpire, as the case may require...

9 U.S.C. § 5. Thus, even if the AAA were unavailable, the remedy would simply be for the Court to appoint a substitute arbitrator.

Plaintiff argues that *Grant v. Magnolia Manor-Greenwood, Inc.*, is analogous to this case, but that case is easily distinguishable. In *Grant*, the arbitration provision provided in relevant part: “any action, dispute, claim, or controversy of any kind . . . shall be resolved by binding arbitration **administered by** the National Health Lawyers Association (the “NHLA”).” 383 S.C. 125, 128, 578 S.E.2d 435, 436-37 (2009) (emphasis added). After the parties entered into the arbitration agreement, but before the dispute arose, the NHLA amended its rules to provide that it would only

honor arbitration agreements entered into after the dispute arose. *Id.* The Court denied enforcement of the arbitration provision, reasoning that, because the parties' agreed-upon exclusive forum was unavailable, section 5 of the FAA did not permit the court to enforce the arbitration provision by appointing a substitute arbitrator. *Id.* at 132.

Here, by contrast, the arbitration provision invokes the AAA—not the NHLA—and, as noted, the AAA Healthcare Policy Statement does not apply to billing disputes or to cases compelled to arbitration by a court. For this reason alone, *Grant* is inapposite. Moreover, the arbitration provision at issue here does not state that the arbitration will be “administered” by the AAA, as was the case in *Grant*. Instead, the Provider Agreement provides only that the AAA will “appoint” an arbitrator and that the AAA “commercial rules” will apply. (Provider Agreement at 11.) Thus, even if the AAA were unavailable to appoint an arbitrator (and it is not), the Court should appoint a substitute arbitrator under section 5 of the FAA, and the parties can arbitrate under the AAA rules. Indeed, the Supreme Court of South Carolina has held exactly that. *See Dean v. Heritage Healthcare of Ridgeway, LLC*, 408 S.C. 371, 384, 729 S.E.2d 727, 734 (2014) (holding that arbitration service is integral to arbitration clauses that provide the arbitration service shall be “administered by” a particular arbitration service, and, conversely, arbitration service is not integral to arbitration clauses that provide the arbitration shall be conducted “in accordance with” the selected arbitration service’s rules).

For these reasons, the fact that the arbitration clause here provides that the AAA will select an arbitrator and that the AAA commercial rules apply is not an impediment to arbitration.

VII. THE SCUAA DOES NOT PRECLUDE ARBITRATION HERE AND, THUS, THE SCUAA DOES NOT REVERSE PREEMPT THE FAA.

In her briefing in opposition to the motion to compel arbitration, Plaintiff also argues that the arbitration provision at issue here is unenforceable under SCUAA because it calls for

arbitration of a claim involving insurance benefits and, further, that the SCUAA reverse preempts the FAA under the McCarran-Ferguson Act. Plaintiff's argument is fatally flawed, however, because the arbitration here is not located in an insurance policy and ACS is not an insurance company.

It is true, as Plaintiff argues, that the SCUAA provides that arbitration clauses are unenforceable insofar as they apply to "any insured or beneficiary under any insurance policy or annuity contract." S.C. Code Ann. § 15-48-10(b)(4). The problem for Plaintiff is that this provision only applies "when a litigant seeks to enforce an arbitration agreement contained *in an insurance policy* governed by South Carolina law." *Walden v. Harrelson Nissan Inc.*, 399 S.C. 205, 210, 731 S.E. 2d 324, 326 (Ct. App. 2012) (emphasis added). In *Walden*, the plaintiff urged the Court to read § 15-48-10(b)(4) to include contracts related to insurance policies, but the Court rejected this expansive reading of the statute. *Id.* at 209, 731 S.E.2d at 326. Instead, the Court held that the contract at issue—a lease agreement containing a provision that the defendant would secure insurance for the plaintiff—was not exempt from arbitration because it itself was not an insurance policy. *Id.* at 210, 731 S.E.2d at 327; *see also Cox v. Woodmen of World Ins. Co.*, 347 S.C. 460, 468, 556 S.E.2d at 402 (Ct. App. 2001) (holding that S.C. Code. Ann. § 15-48-10(b)(4) is a "specific exemption limited to entities *within the insurance industry*") (emphasis added). For these reasons, the court in *Walden* held:

we reject [the plaintiff's] expansive interpretation of the statute and conclude the General Assembly did not intend for the arbitration exception of section 15-48-10(b)(4) to apply to automobile lease agreements that have only a tangential relationship to an insurance policy, but was instead *intended to apply directly to an insurance contract*.

399 S.C. at 210, 731 S.E. 2d at 326 (emphasis added); *see also Blue Ridge Emergency Physicians, P.A. v. Emergency Physicians Ins. Co.*, RRG C/A no. 6:10-cv-00428-JMC, at *5-6 (D.S.C. Mar.

15, 2011) (noting that “S.C. Code Ann. § 15-48-10(b)(4) prohibits the enforcement of arbitration clause in **insurance policies** under South Carolina law” (emphasis added)).

By her argument, Plaintiff asks the Court to make the same mistake the plaintiff in *Walden* made—she asks the Court to expand § 15-48-10(b)(4) to preclude the arbitration of claims that are merely **related to** a contract for insurance (and tangentially so, at that). This argument is as unpersuasive here as it was in *Walden* for the simple reason that the Provider Agreement is not an insurance policy.

In support of her argument, Plaintiff cites *Rock v. Atl. Specialty Ins. Co.*, for the proposition that § 15-48-10(b)(4) applies to more than insurance policies themselves, but *Rock* does not help Plaintiff. In *Rock*, the court—applying the law of the District of Columbia—held that an arbitration clause contained in a certificate of insurance was unenforceable. No. 4-19-cv-01433-SAL, 2020 U.S. Dist. LEXIS 66641, at *8 (D.S.C. April 16, 2020). The District of Columbia statute at issue provided that arbitration clauses in insurance policies are unenforceable. See D.C. Code § 16-4403(c)(1). The court, noting that the certificate of insurance “describes the main features of the Policy,” held that the District of Columbia statute precluded application of the arbitration clause. *Id.* at *3. In a footnote, the court stated, in *dicta*, and without any reasoning or explanation, that the arbitration clause would also be unenforceable under § 15-48-10(b)(4). *Id.* at * 7 n.4.

Plaintiff’s reliance on the district court’s order in *Rock* is misplaced for multiple reasons—the Fourth Circuit directed that the order be vacated, the order contains dicta, and the order is inapposite in any event. First, on appeal, the Fourth Circuit remanded the case to the district court with directions to **vacate the very order** cited by Plaintiff, in part because “it is arguably incorrect.”

See Order, *Rock v. Atlanta Specialty Ins. Co.*, No. 20-1569 (4th Cir. Oct. 6, 2020), attached hereto as **Exhibit C**.

Second, as noted, the court in *Rock* applied the law of the District of Columbia, and the footnoted statement regarding § 15-48-10(b)(4) was pure *dicta*.

Third, the facts in *Rock* are materially different from the facts in this case in any event. In *Rock*, the document at issue was a *certificate of insurance* issued by an *insurance company* that described the benefits available to the policyholder under a policy of insurance. *Id.* at *2-4. Thus, the certificate had a direct relationship with the insurance policy it was evidencing and the contract at issue was with an insurance company. *Id.* at 3 (noting that the certificate of insurance “describes the main features of the Policy”). Here, by contrast, the Provider Agreement is only tangentially related to Plaintiff’s insurance policy with BCBSSC; it governs certain aspects of the relationship between BCBSSC and ACS regarding ACS’s provision of medical care to participants under certain BCBSSC medical plans. Unlike a certificate of insurance, the Provider Agreement does not describe the benefits available under any insurance policy that Plaintiff has, nor does it bestow any benefits on any beneficiary or participant of any insurance policy. Moreover, unlike the situation in *Rock*, Plaintiff here is not suing her insurance company. Instead, she is suing her medical provider, which is a type of lawsuit that falls outside of the situations contemplated under § 15-48-10(b)(4). (See Pl. Mot. to Remand at 2 (Plaintiff “is not alleging a denial of benefits under her ERISA plan. Indeed, she makes no claim whatsoever under her ERISA plan or against its administrators.... She is suing Defendant for its billing practices and alleges those practices violate the contractual duties contained in the Provider Agreement between Defendant and BCBS.”), attached hereto as **Exhibit D**.) Accordingly, even if *Rock* were good law (and it is not) or held any precedential value (and it does not), it has no bearing whatsoever on this case.

For all of these reasons, § 15-48-10(b)(4) does not render the arbitration provision at issue in this case unenforceable and, therefore, it does not reverse preempt the FAA.

VIII. PLAINTIFF’S CLAIMS SHOULD BE DISMISSED.

Finally, assuming the Court compels this case to arbitration (as it should), Plaintiff’s claims should be dismissed, rather than stayed, because all of her claims are subject to arbitration. 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 grant this motion, reconsider its Denial Order, vacate the Denial Order, and enter a new order granting ACS’s motion to compel arbitration and dismissing this case. In the alternative to dismissal, the Court’s order should stay this matter pending the arbitration.⁷

Dated: July 1, 2021

GORDON & REES LLP

⁷ It is worth noting that, in her briefing in opposition to the motion to compel arbitration, Plaintiff does not argue either (1) that the FAA does not apply or (2) that, if the case is compelled to arbitration, the arbitration should be on a bilateral basis only.

By s/Josh Dixon

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Physicians-Southeast P.C.

EXHIBIT A

) IN THE COURT OF COMMON PLEAS

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

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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

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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 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 - 2021 Jul 01 9:17 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)

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.

EXHIBIT B



AAA® Healthcare Policy Statement

In 2003, the American Arbitration Association® (“AAA”) announced that 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. This policy is consistent with the *American Arbitration Association/American Bar Association/American Medical Association Due Process Protocol for the Mediation and Arbitration of Health Care Disputes*.

However, the AAA will administer disputes between patients and healthcare providers to the extent a court order directs such a dispute to arbitration where the parties’ agreement provides for the AAA’s rules or AAA administration. In addition, the AAA will continue to administer arbitrations that involve solely billing or collections matters between an individual and a doctor or healthcare provider, although such billing or collections disputes may be governed by the AAA’s *Consumer Rules and Consumer Due Process Protocol*.

The AAA notes that this policy does not relate to or impact the administration of all other types of disputes in the healthcare field, such as disputes among providers, healthcare companies, insurance carriers and related entities. For more information on the AAA’s administration of these types of cases and the AAA’s *Healthcare Payor Provider Arbitration Rules*, please visit www.adr.org.

EXHIBIT C

FILED: October 6, 2020

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 20-1569
(4:19-cv-01433-SAL)

LINDA ROCK, as the Personal Representative for the Estate of Gerald Lindsay

Plaintiff - Appellee

v.

ATLANTIC SPECIALTY INSURANCE COMPANY; MICHAEL KLUG;
BRENTWOOD SERVICES ADMINISTRATORS, INC.

Defendants - Appellants

and

BRENTWOOD SERVICES, INC.

Defendant

O R D E R

Upon consideration of the joint motion for a limited remand, the court grants the motion and remands this case to the district court for the limited purpose of reconsidering its order entered on April 16, 2020.

The clerk shall forward a copy of this order, accompanied by a copy of the motion to remand, to the district court. This appeal shall remain on the active docket of this court and the parties shall file a status report on November 5, 2020, and every 30 days thereafter, and shall immediately notify this court when the district court proceedings have concluded.

For the Court

/s/ Patricia S. Connor, Clerk

No. 20-1569

**United States Court of Appeals
for the Fourth Circuit****LINDA ROCK, as the Personal Representative for the Estate of Gerald
Lindsay,**

Plaintiff – Appellee

v.

**ATLANTIC SPECIALTY INSURANCE COMPANY; MICHAEL KLUG;
BRENTWOOD SERVICES ADMINISTRATORS, INC.**

Defendants – Appellants

On Appeal from the United States District Court,
District of South Carolina, Florence Division
Civil Action No. 4:19-cv-01433-SAL
District Judge Sherri A. Lydon

JOINT MOTION FOR LIMITED REMAND

All parties in this case jointly move this Court, pursuant to Rule 12.1 of the Federal Rules of Appellate Procedure, for a limited remand of this case to the United States District of South Carolina for the purpose of issuing an order vacating its order entered on April 16, 2020, which is the order that is the subject of this appeal. The grounds for this motion are as follows.

1. Plaintiff-Appellee, Linda Rock, filed this lawsuit to recover benefits under an insurance policy issued by Atlantic Specialty Insurance Company after Gerald Lindsay was involved in a motor vehicle accident while

he was driving as a courier for Sun Logistics. Defendants-Appellants, Atlantic Specialty Insurance Company, Brentwood Services Administrators, Inc., and Michael Klug (collectively referred to as “Atlantic Specialty”), filed a motion to stay litigation and to compel arbitration because there is an arbitration clause in the insurance policy.

2. On April 16, 2020, the district court denied the motion, finding that the arbitration clause is void because a D.C. statute provides that any provision in an insurance policy with a consumer that requires binding arbitration is void. Atlantic Specialty appealed to this Court from that order to argue that the D.C. statute does not apply because this is not an insurance policy with a consumer, but instead is a policy that provides coverage to a courier who is under dispatch as a part of the courier’s occupation. This is that appeal.

3. On June 3, 2020, this Court sent the parties a Notice of Scheduled Mediation, pursuant to Fourth Circuit Local Rule 33, requiring the parties to participate in a mediation with Fourth Circuit Mediator Cynthia Mabry-King. At that time, there were no on-going settlement negotiations between the

parties, but all parties participated in the mediation in compliance with the Fourth Circuit's directive. The mediation occurred on June 15, 2020.

4. Under the guidance of Ms. Mabry-King, the parties were successful in negotiating a conditional settlement agreement that would resolve all disputes in this litigation. A mandatory condition of the settlement is the vacatur of district court's April 16, 2020, Order, so the parties filed with the district court a joint motion to vacate the April 16, 2020, Order pursuant to Fed. R. Civ. Pro. 60(b).

5. The procedure governing a district court's ability to grant a Rule 60(b) motion while the case is on appeal is well-settled and was explained in *Fobian v. Storage Technology Corp.*, [164 F.3d 887](#) (4th Cir. 1999). After the parties file a Rule 60(b) motion with the district court, "[i]f the district court is inclined to grant the motion, it should issue a short memorandum so stating." *Id.* Second, the litigants are to provide to this Court the district court's memorandum to advise this Court that the district court is inclined to grant the Rule 60(b) motion. Third, this Court grants a limited remand so that the district court has jurisdiction to grant the Rule 60(b) motion. *Id.* "By saving judicial resources and avoiding expense and delay, this procedure accords with the overarching mandate in the Federal Rules of Civil Procedure that the rules 'shall be construed to secure the just, speedy, and inexpensive

determination of every action.” *Id.* (quoting Fed. R. Civ. Pro. 1). This Court has followed the procedure set forth in *Fobian* numerous times, some of which are published in the Federal Appendix. *See, e.g., Herriott v. McCabe*, 813 F. App’x 897 (4th Cir. 2020); *Howard v. Red Lobster Operated by Darden Restaurants, Inc.*, 693 F. App’x 270 (4th Cir. 2017); *Boyd v. South Carolina*, 475 F. App’x 909 (4th Cir. 2012); *Stevenson v. Shoup*, 390 F. App’x 286 (4th Cir. 2010); *Stepney v. Beckwith*, 360 F. App’x 418 (4th Cir. 2010); *Sindram v. Sengel*, 108 F. App’x 745 (4th Cir. 2004); *Columbia Gas Transmission Corp. v. Burdette Realty Improvement, Inc.*, 48 F. App’x 910 (4th Cir. 2002); *Davis v. City of Jacksonville*, 22 F. App’x 316 (4th Cir. 2001).

6. Following the procedure set forth in *Fobian*, on September 23, 2020, the district court in this case entered a short memorandum to state that it is inclined to grant the joint motion to vacate and to request that this Court grant a limited remand for that purpose. The district court’s memorandum is attached as Exhibit A.

7. All parties agree—and the district court agrees as well, as Exhibit A demonstrates—that a limited remand from this Court so that the district court can vacate its April 16, 2020, order is appropriate in light of the “exceptional circumstances” in this case. *Valero Terrestrial Corp. v. Paige*, 211

E.3d 112, 121 (4th Cir. 2000) (quoting *U.S. Bancorp Mortgage Co. v. Bonner Mall P'ship*, 513 U.S. 18, 29 (1994)).

8. Specifically, exceptional circumstances exist to vacate the April 16 Order for three independent reasons: (1) the April 16 Order is at least arguably wrong; (2) the April 16 Order concerns the important issue of arbitration, which is favored both under federal and D.C. law; and (3) the circumstances surrounding the conditional settlement. Plaintiff-Appellee Linda Rock does not join in paragraphs 9 to 11 of this joint motion so as to preserve her arguments in the event that this Court were to deny this motion for limited remand.

9. ***Exceptional circumstances exist because the April 16 Order is arguably incorrect.*** Exceptional circumstances justifying a vacatur of the April 16, 2020, Order exist in this case because that the order is arguably incorrect. *See, e.g., In re Gen. Motors Corp.*, No. 94-2435, 1995 WL 940063, at *1 (4th Cir. Feb. 17, 1995) (*U.S. Bancorp* requirements satisfied for an incorrect district court order).

10. The D.C. statute that forms the basis of the April 16, 2020, Order states: “Any provision in an insurance policy with a consumer that requires binding arbitration is void and unenforceable.” D.C. Code § 16-4403(C)(1)). However, the Atlantic Specialty insurance policy is not an insurance policy

with a consumer, so this provision does not apply. This insurance policy instead provides insurance to a courier who is under dispatch as a part of the courier's occupation. When someone obtains insurance as a part of their work, they are not acting a consumer. The D.C. Code itself makes that clear. The same chapter of the D.C. Code that contains § 16-4403 also defines a "consumer" as "a party to an arbitration agreement who, in the context of that arbitration agreement, is an individual, not a business, who seeks or acquires, including by lease, any goods or services primarily for personal, family, or household purposes including, but not limited to, financial services, healthcare services, or real property." D.C. Code § 16-4401(3). Here, Gerald Lindsay obtained insurance that would provide coverage when he was working, not when he was acting for personal, family, or household purposes. This is clear from the title of the policy itself—an "Occupational Accident" policy. It is also clear from the requirements for coverage under the occupational policy, which provide coverage only when someone is acting as a courier under dispatch. And jurisprudence in other contexts confirms that someone is not acting as a consumer when they are working. *See, e.g., In re Runski*, [102 F.3d 744, 747](#) (4th Cir. 1996) (under the Bankruptcy Code, "courts have concluded uniformly that debt incurred for a business venture or with a profit motive does not fall into the category of" consumer debt); *Am. Exp. Co. v.*

Koerner, [452 U.S. 233, 245](#) (1981) (transaction relating to the purchase of airline tickets was not an extension of “consumer credit” because the tickets were purchased for business trips). Because the April 16, 2020, Order is arguably incorrect when it fails to enforce an arbitration clause, exceptional circumstances exist to justify the district court’s decision to vacate its prior interlocutory order.

11. ***Exceptional circumstances exist because federal and D.C. law strongly support upholding arbitration.*** The April 16, 2020, Order not only declined to enforce a binding arbitration provision in a contract, but it did so on a basis that may be argued in later cases to effectively read the provision out of the contract. This is inconsistent with federal and D.C. law, both of which overwhelmingly favor upholding binding arbitration provisions. *Moses H. Cone Mem’l Hosp. v. Mercury Constr. Corp.*, [460 U.S. 1, 24](#) (1983) (noting the “liberal federal policy favoring arbitration agreements”); *Hill v. Peoplesoft USA, Inc.*, [412 F.3d 540, 543](#) (4th Cir. 2005) (same); *TRG Customer Sols., Inc. v. Smith*, [226 A.3d 751, 755](#) (D.C. 2020) (“Our case law has expressed a strong preference favoring arbitration when a contract contains an arbitration clause.”). By not enforcing an arbitration clause, the April 16, 2020, Order is contrary to this public policy, and this is another reason that exceptional

circumstances justify the district court's decision to vacate its prior interlocutory order.

12. ***Exceptional circumstances exist because of the circumstances surrounding the conditional settlement.*** When a settlement results from a court referring a case to mediation, when that settlement is expressly contingent upon vacatur, when the order to be vacated is being challenged on appeal at the time of the conditional settlement, and when the order to be vacated is a federal court interpretation of state court law, then exceptional circumstances exist and vacatur is warranted. The Eleventh Circuit addressed this exact situation in *Hartford Cas. Ins. Co. v. Crum & Forster Specialty Ins. Co.*, [828 F.3d 1331](#) (11th Cir. 2016). In that case, which involved an insurance policy, the district court applied state law and granted summary judgment on an issue regarding the scope of the insurance policy. The losing insurance company appealed, and the Eleventh Circuit ordered the parties to attempt to resolve the dispute through mediation. The mediation resulted in a conditional settlement agreement whereby the parties were willing to settle their differences, but that was contingent upon a court of competent jurisdiction vacating the order that was being appealed. *Id.* at 1333. The Eleventh Circuit stayed the appeal so that the parties could file a Rule 60(b) motion with the district court. They did so, but the district court did not

believe that exceptional circumstances existed. *Id.* The Eleventh Circuit reversed, explaining that vacatur was appropriate because exceptional circumstances did exist.

13. First, the court noted that it had referred the parties to the mediation, and thus it was not a case in which one party voluntarily forfeited a legal remedy. *Id.* at 1336. Second, the court noted that the settlement was conditioned upon there being a vacatur, and thus without a vacatur, settlement would be impossible. *Id.* “Taken together, these considerations weigh heavily in favor of vacating the District Court’s orders. The parties’ interests are best served through the voluntary disposition of this case, and further proceedings are curtailed, conserving judicial resources.” *Id.* The court also noted that there is only “slight value” in preserving a district court opinion on an issue of state law, and explained that any such value was “outweighed by the direct and substantial benefit of settling this case to [the parties] and to the judicial system (and thus to the public as well).” *Id.* The court explained that its decision was consistent with prior decisions from the First Circuit (*Motta v. Dist. Dir. of I.N.S.*, 61 F.3d 117 (1st Cir. 1995)) and the

Second Circuit (*Major League Baseball Properties, Inc. v. Pac. Trading Cards, Inc.*, [150 F.3d 149](#) (2d Cir. 1998)). *Id.* at 1334-35.

14. Similarly, the productive settlement negotiations in this case were the result of a court-ordered mediation with a Fourth Circuit mediator. And just like *Hartford*, a condition of the settlement is vacatur of the April 16, 2020, Order that is on appeal. The only solution that avoids the necessity of Atlantic Specialty's appeal of the April 16 Order is a vacatur of that decision. And just like *Hartford*, where the opinion sought to be vacated was an interpretation of state court law, here, the opinion sought to be vacated is a federal court interpretation of District of Columbia law. *Hartford*, [828 F.3d at 1336](#); *see also Microsoft Corp. v. Bristol Tech., Inc.*, [250 F.3d 152, 155](#) (2d Cir. 2001) (exceptional circumstances exist and vacatur is warranted when a federal court opinion concerns an issue of state law).

15. Accordingly, all parties in this case jointly move this Court to grant a limited remand of this case to the district court so that the district court can vacate its April 16, 2020, Order. Once the district court vacates its prior order, Defendants-Appellants will notify this Court and will move to voluntarily dismiss their appeal at that time.

WHEREFORE, Plaintiff-Appellee, Linda Rock, and Defendants-Appellants, Atlantic Specialty Insurance Company, Brentwood Services

Administrators, Inc., and Michael Klug, move this Court for a limited remand so that the district court can rule on the pending Fed. R. Civ. Pro. 60(b) motion.

Respectfully submitted:

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*Attorneys for Plaintiffs-Appellees Linda
Rock as Personal Representative for the
Estate of Gerald Lindsay*

Certificate of Service

On September 30, 2020, I caused this joint motion to be filed electronically with the Clerk of the Fourth Circuit Court of Appeal through ECF, which constitutes services on all parties through their counsel pursuant to Fourth Circuit Local Rule 25(a)(4).

s/ Jeffrey E. Richardson

Jeffrey E. Richardson

Certificate of Compliance with Type-Volume Limit, Typeface Requirements, and Type-Style Requirements

1. This motion complies with type-volume limits of Fed. R. App. P. 27(d)(2)(A) and Fed. R. App. P. 32(c)(1) because, excluding the parts of this document exempted by Fed. R. App. P. 32(f), this motion contains 2,200 words.
2. This document complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this document has been prepared in a proportionally-spaced typeface using Microsoft Word 2016 (16.0.5017.1000) in Cambria 14-point.

s/ Jeffrey E. Richardson

Jeffrey E. Richardson

Dated: September 30, 2020

EXHIBIT D

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 ERISA¹ 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

¹ 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.² 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,³ 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).⁴

² 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 Stand Reg'l Med. Ctr. LLC*, 839 S.E.2d 468, 471-473 (S.C. Ct. App. 2020) (holding that insured patient is a third-party beneficiary of a provider agreement).

³ 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).

⁴ 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.L.A. 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. ¶ 4.⁵ 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.

⁵ 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 ERISA⁶— 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

⁶ 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 provision⁷: “[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).⁸ 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).

⁷ 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).

⁸ 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 action⁹ 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.¹⁰ The Court addressed the first prong of *Davila*, noting:

⁹ She also alleges related equitable remedies. Comp ¶¶ 69-79.

¹⁰ *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:¹¹

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).¹²

¹¹ *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).

¹² 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,¹³ 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.¹⁴ 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

¹³ 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.”).

¹⁴ *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,

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ATTORNEYS FOR THE PLAINTIFF

Dated: May 18, 2020

STATE OF SOUTH CAROLINA

COUNTY OF HORRY

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

Plaintiff,

v.

ACS Primary Care Physicians-Southeast
P.C.,

Defendant.

IN THE COURT OF COMMON PLEAS
FIFTEENTH JUDICIAL CIRCUIT

C/A No.: 2020-CP-26-01982

**PLAINTIFF'S RESPONSE IN OPPOSITION TO DEFENDANT'S
MOTION FOR RECONSIDERATION**

For the reasons previously submitted to the Court in extensive briefing, Plaintiff opposes the Defendant's attempt to compel arbitration. Because Defendant's motion is primarily a retread of its prior arguments, Plaintiff respectfully incorporates her prior briefing on those issues in response to the motion. To the extent Defendant's motion is read to raise new arguments, those must be rejected. See *Stevens & Wilkinson of S.C., Inc. v. City of Columbia*, 409 S.C. 563, 567, 762 S.E.2d 693, 695 (2014) ("[A] party cannot use a Rule 59(e) motion to advance an issue the party could have raised to the court prior to judgment, but did not."). The Court correctly denied the motion to compel arbitration and, for the same reasons, should deny Defendant's motion for reconsideration.

There are, however, a few points in Defendant's brief with which Plaintiff takes exception. They are as follows:

1. Plaintiff has not actively exploited the provider agreement

The Court correctly found that Plaintiff did not actively exploit the provider agreement. See Order at 4 (filed Jun. 18, 2021). Defendant persists in its contention that Plaintiff did. However, Defendant misconstrues active exploitation.

As alleged here, the benefit Plaintiff seeks in this action is the insurance benefits for which she paid BCBS *under her health insurance agreement*. She is **not** seeking to receive wages under an locum tenens agreement (like the doctor in *Pearson v. Hilton Head Hosp.*, 400 S.C. 281, 297, 733 S.E.2d 597, 605 (Ct. App. 2012)) or seeking insurance benefits on a policy under which she is an additional insured (like the plaintiff in *Kiawah Island Util., Inc. v. Westport Ins. Corp.*, No. 2:19-CV-1359-DCN, 2019 WL 5394200, at *1 (D.S.C. Oct. 22, 2019)). To the contrary, she claims Defendant's actions are depriving her of her right to receive health benefits under her agreement **with BCBS**. Benefits for which she paid BCBS. Plaintiff simply asks that Defendant comply with its contractual obligations with BCBS under the provider agreement so as not to interfere with her right to receive her benefits under the separate agreement with BCBS. Those cases cited by defendant in support of direct benefits estoppel are clearly distinguishable and do not control here. Plaintiff's health insurance benefits arise under her separate agreement with BCBS; they do **not** flow directly from the Provider Agreement. See *Wilson v. Willis*, 426 S.C. 326, 343, 827 S.E.2d 167, 176 (2019). Absent her independent health insurance agreement with BCBS, plaintiff would have no claim, as she derives no direct benefit from the Provider Agreement absent those which flow to her as a BCBS insured through her health insurance agreement.

More importantly, the court correctly notes that our appellate courts hold equitable estoppel in this context should only be used in rare circumstances "to prevent injustice."

Weaver v. Brookdale Senior Living, 431 S.C. 223, 231, 847 S.E.2d 268, 272 (Ct. App. 2020). Where, as here, Plaintiff never received any benefit from defendant and the Provider Agreement, Defendant's actions seek to deprive Plaintiff the benefit of her health benefits, and Plaintiff has done nothing to mislead defendant to any injury, equitable estoppel is not appropriate. Under these circumstances its application would promote – not prevent – injustice by denying plaintiff her day in court by enforcing an arbitration provision for which she received no notice or consideration.

2. A finding that equitable estoppel does not compel arbitration under state law is not a decision preempted by the FAA

Defendant wrongly claims that the Court's decision that direct benefits estoppel does not apply is preempted by the FAA. That is plainly incorrect.

Our supreme court's holding in *Wilson v. Willis*, 426 S.C. 326, 337–38, 827 S.E.2d 167, 173–74 (2019), a case cited throughout the briefs in this matter, dispatches the argument. In *Wilson*, the Court held unanimously that “[w]hether an arbitration agreement may be enforced against nonsignatories, and under what circumstances, is an issue controlled by state law.” *Wilson*, 426 S.C. 338, 827 S.E.2d at 174 (citing *Arthur Andersen LLP v. Carlisle*, 556 U.S. 624, 630–31, 630 n.5 (2009) and its holding that under the FAA traditional principles of state law determine whether a contract provision may be enforced under an estoppel theory).

Just because Defendant disagrees with this Court's order, or South Carolina's presumption against arbitration as to nonsignatories, does not mean it runs afoul of the FAA. The FAA does not preempt the Court's finding that under South Carolina law defendant is not entitled to estoppel. Nor does it preempt our state decisions finding a presumption against arbitration exists as to nonsignatories.

3. Plaintiff's allegations do not compel a different result

Last, Defendant makes much ado about the phrasing of a portion of Plaintiff's allegations. But Defendant's point is merely semantic, not substantive.

Under the totality of the allegations in the complaint it is clear that Plaintiff is alleging that Defendant's conduct deprived her the benefit of her own health insurance. See Compl. ¶¶ 14, 66. Plaintiff's complaint is clear that the benefit she seeks is the one "she paid for through [her] health insurance with BCBS." *Id.* at 66. Plaintiff never received anything directly from defendant other than medical services and an invoice. The benefit she was supposed to receive under her health insurance – her copayment and health coverage – was denied her due to the defendant's scheme to extract more money from her.

CONCLUSION

The Court was correct to deny Defendant's motion and to find Defendant is not entitled to estoppel under the circumstances. Defendant's motion to reconsider should also be denied.

Respectfully submitted,

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July 14, 2021

Attorneys for Jessica Bennett

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,

)

)

)

NOTICE OF APPEAL

Plaintiff,

)

)

v.

)

)

ACS Primary Care Physicians-Southeast P.C.,

)

)

Defendant.

)

)

Notice is hereby given that ACS Primary Care Physicians-Southeast P.C., defendant in the above-named case, hereby appeals to the Court of Appeals for the State of South Carolina from the Court's Order denying Defendant's Motion to Compel Arbitration and Dismiss or Stay Plaintiff's Claims, entered in this action on June 21, 2021. Motion for Reconsideration was denied on November 5, 2021.

Respectfully submitted,

Dated: November 12, 2021

GORDON & REES LLP

By s/Julianne Farnsworth

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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,

)

)

)

CERTIFICATE OF SERVICE

Plaintiff,

)

)

v.

)

)

ACS Primary Care Physicians-Southeast P.C.,

)

)

Defendant

)

)

I certify that a copy of DEFENDANT ACS PRIMARY CARE PHYSICIANS-SOUTHEAST P.C.'S NOTICE OF APPEAL, has been served upon the following counsel of record by way of the court's electronic filing system and by US Certified Mail, addressed as shown below this 12th day of November, 2021:

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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 other)
similarly situated,)

Plaintiffs,)

v.)

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

Defendant.)
_____)**NOTICE OF APPEAL****RECEIVED****Dec 03 2021****SC Court of Appeals**

Notice is hereby given that ACS Primary Care Physicians-Southeast P.C., defendant in the above-named case, hereby appeals to the Court of Appeals for the State of South Carolina from the Court's Order denying Defendant's Motion to Compel Arbitration and Dismiss or Stay Plaintiff's Claims, entered in this action on November 23, 2021.

Dated: December 3, 2021

GORDON REES SCULLY MANSUKHANI

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RECEIVED**Dec 03 2021****SC Court of Appeals**

ELECTRONICALLY FILED - 2021 Dec 03 3:49 PM - Horry - COMMON PLEAS - CASE#2020CP2603169

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Steven H. John, Circuit Court Judge

Case No.: 2020-CP-26-03169

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

v.

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

PROOF OF SERVICE

I certify that I have served the Notice of Appeal on the Respondent Thuy N. Gasser, individually and on behalf of those similarly situated, via E-mail and U.S. Mail upon their respective attorneys of record as properly addressed below this 3rd day of December, 2021:

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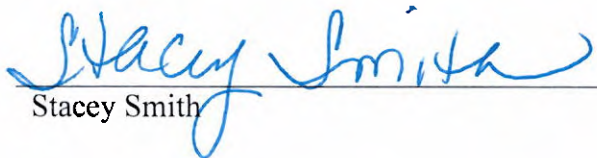
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Dated: December 3, 2021

GORDON REES SCULLY MANSUKHANI

By 
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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

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SC Court of Appeals

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

v.

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

CERTIFICATE OF COUNSEL

The undersigned certifies that this Record on Appeal contains all material proposed to be
included by any of the parties and no other material.

Dated: June 1, 2022

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