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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Paul M. Burch, Circuit Court Judge

Jeffrey D. Allen, individually,
as guardian for Jane Doe, a
minor, and as representative of
other similarly situated State
of South Carolina employees,.....Appellant,

v.

South Carolina Budget and
Control Board Employee
Insurance Program and Blue
Cross and Blue Shield of
South Carolina.....Respondent.

RECORD ON APPEAL

**2009-CP-10-7404
VOLUME 2**

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STATE OF SOUTH CAROLINA)
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS
FOR THE NINTH JUDICIAL CIRCUIT

Jeffrey D. Allen, individually, as guardian)
for Jane Doe, a minor, and as representative)
of other similarly situated State of South)
Carolina employees,)

Civil Action No.: 2009-CP-10-7404

Plaintiffs,)

**MEMORANDUM IN SUPPORT
OF DEFENDANTS' MOTION
FOR SUMMARY JUDGMENT**

v.)

South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)

2010 AUG 26 AM 10:39
FILED
JULIE J. ARMSTRONG
CLERK OF COURT
BY _____

I. BACKGROUND

The Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities ("State Health Plan") is a self-funded, governmental health plan, which is administered by the South Carolina Budget and Control Board, Employee Insurance Program ("EIP"). (Affidavit of Robin Tester, ¶ 3). BCBSSC is the claims administrator for the State Health Plan. BCBSSC is not an insurer of the State Health Plan. (Affidavit of Robin Tester, ¶ 4).

Plaintiff, an employee of a South Carolina School District, brings this purported class action against the State Health Plan and BCBSSC alleging causes of action for declaratory judgment, disgorgement of benefits, reformation of contract and for injunctive relief. Plaintiff alleges that coverage for diabetes outpatient self-management training and education is mandated by S.C. Code Ann. § 38-71-46. Plaintiff's Complaint alleges:

5. This is an action for declaratory judgment arising from Defendants' unlawful issuance and administration of the State of South Carolina EIP Standard

Plan, a plan of health benefits and insurance offered to all current and retired state employees, including public school district employees, for violation of a SC Code Section 38-71-46, for disgorgement of revenues received as a result of the unlawful issuance and administration, and for declaration to determine the value of unlawfully withheld benefits.

11. As the named Plaintiff is an employee of a South Carolina school district, has been enrolled in the EIP Standard Plan, has enrolled his dependent child in said plan who was diagnosed with Diabetes at the age of two years old, and has made multiple claims for his dependent child with a value of approximately One Thousand & 00/100 US Dollars (\$1000.00) for diabetes outpatient self-management training and education which were denied by Defendant BCBSSC as administrator to the EIP, his claim, right and privileges are typical of the proposed class.

19. Plaintiff seeks, individually and as legal guardian for Jane Doe, and on behalf of all class members, a declaration of the rights of the parties hereto: that Defendants are required to issue and administer all health benefit plans offered through the EIP in compliance with the express mandate of South Carolina Code Section 38-71-46.

20. Plaintiff seeks an Order of the Court reforming the terms of the health benefit plan provided to all class members effective January 1, 2000 to provide the mandated diabetes coverage.

21. Plaintiff seeks an Order of the Court requiring the Defendants to disgorge monies received as a result of unlawful denials of the mandatory diabetes coverage, and to pay them to members of the putative class the present value of said unlawfully withheld revenues.

24. The Defendants should be enjoined from the wrongful takings as described above and from further denial of claims for the diabetes outpatient self-management training and education.

Defendants move for summary judgment on the following grounds: (1) the administrative remedies under S.C. Code Ann. § 1-11-710 (c) are Plaintiff's exclusive remedy, subject only to appeal to the South Carolina Administrative Law Court pursuant to S.C. Code Ann. § 1-23-600

(D); and (2) S.C. Code Ann. § 38-71-46 does not apply to the State Health Plan.

II. STANDARD FOR SUMMARY JUDGMENT

The purpose of summary judgment is to "expedite the disposition of cases which do not require the services of a fact finder." Dawkins v. Fields, 354 S.C. 58, 69, 580 S.E.2d 433, 438 (2003) (quoting George v. Fabri, 345 S.C. 440, 452, 548 S.E.2d 868, 874 (2001)); Rumpf v. Massachusetts Mut. Life Ins. Co., 357 S.C. 386, 593 S.E.2d 183 (Ct. App. 2004). When plain, palpable, and indisputable facts exist on which reasonable minds cannot differ, summary judgment should be granted. Pye v. Aycock, 325 S.C. 426, 480 S.E.2d 455 (Ct. App. 1997).

III. DISCUSSION

A. The Administrative Remedies Under S.C. Code Ann. § 1-11-710(C) Are Plaintiff's Exclusive Remedy, Subject Only To Appeal To The South Carolina Administrative Law Court Pursuant To S.C. Code Ann. § 1-23-600 (D).

A participant and/or beneficiary challenging an award of benefits under State Health Plan is limited to the remedies set forth in S.C. Code Ann. § 1-11-710. § 1-11-710(C) provides as follows:

Notwithstanding Sections 1-23-310 and 1-23-320 or any other provision of law, claims for benefits under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board, which shall constitute the exclusive remedy for these claims, subject only to appellate review consistent with standards provided in Section 1-23-380. (Emphasis added).

Id.

Pursuant to the allegations of Plaintiff's Complaint, Plaintiff is requesting that the Court interpret the terms of the State Health Plan to include the coverage set out in S.C. Code Ann. § 38-71-46. Plaintiff further alleges that he is entitled to disgorge benefits from the plan for unlawful denials of coverage, and for injunctive relief enjoining "further denial of claims for

diabetes out-patient self-management training and education.” (Complaint ¶24). The interpretation of the State Health Plan and the resolution of claims for benefits under the Plan are exactly the types of remedies contemplated by § 1-11-710(C).

Interestingly, while the current action was pending, Plaintiff also was availing himself of his administrative remedies under § 1-11-710(C). On September 30, 2009, Plaintiff made a first level appeal to the Blue Cross Blue Shield of South Carolina Appeals Committee regarding the denial of his claim for benefits under the State Health Plan, making the exact same argument he makes here concerning the application of S.C. Code Ann. § 38-71-46 to the State Health Plan. (Affidavit of Robin E. Tester ¶7, Exhibit A). By including this issue as part of his administrative appeal, Plaintiff recognized that EIP had the authority to rule on the application of S.C. Code Ann. § 38-71-46 to the State Health Plan.

On April 2, 2010, The Blue Cross Blue Shield Appeals Committee wrote Plaintiff that it was upholding the denial of Plaintiff’s claim because Plaintiff’s claim was specifically excluded under the terms of the State Health Plan and S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan. (Affidavit of Robin Tester ¶8, Exhibit B). This letter further gave Plaintiff 90 days from April 2, 2010 to appeal this decision to EIP Health Appeal’s Committee.

On June 30, 2010, Plaintiff appealed the denial of his claim to the EIP Health Appeal’s Committee. A true correct copy of this letter is attached hereto as Exhibit A. As can be seen from the contents of this letter, Plaintiff appealed the issue of the applicability of S.C. Code Ann. § 38-71-46 to the State Health Plan to the EIP Health Appeal’s Committee.

By letter dated August 24, 2010, the EIP Health Appeal’s Committee wrote Plaintiff that it was denying his claim for benefits in that S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan. This letter also informed Plaintiff that his next level of appeal was to the South

Carolina Administrative Law Court. A true and correct copy of this letter is attached hereto as Exhibit B.

Appeals involving claims under the State Health Plan are under the exclusive jurisdiction of the Administrative Law Court. Accordingly, this matter should be before the Administrative Law Court.¹ Pursuant to S.C. Code Ann. § 1-11-710(C), the exclusive remedy available to Plaintiff is the administrative review process provided by the Plan, "subject only to appellate judicial review consistent with the standards provided in Section 1-23-380."

S.C. Code Ann. § 1-23-380 provides that "[A] party who has exhausted all administrative remedies available within the agency and who is aggrieved by a final decision in a contested case is entitled to judicial review under this article [the Administrative Procedures Act]." Pursuant to S.C. Code Ann. § 1-23-600 (D), "[a]n administrative law judge also shall preside over all appeals from final decisions of contested cases pursuant to The Administrative Procedures Act...or another law."

Plaintiff argues that based on Drummond v. State of South Carolina, 378 S.C. 362, 662 S.E.2d 587 (2008), the Administrative Law Court cannot rule on whether or not S.C. Code Ann. § 38-71-46 applies to the State Health Plan. However, Drummond stands for the proposition that the Administrative Law Court cannot rule on the validity of a statute in that the Administrative Law Court is a part of the executive branch. The Administrative Law Court is charged with following the law "as written." Video Gaming Consultants, Inc. v. South Carolina Dept. of Revenue, 342 S.C. 34, 535 S.E.2d 642 (2000) ("ALJs are an agency of the executive branch of government and must follow the law as written until its constitutionality is judicially determined;

¹ Prior to July 1, 2006, appeals from EIP went directly to the Circuit Court. After July 1, 2006, pursuant to 2006 S.C. Acts 387, appeals from EIP went directly to the Administrative Law Court.

ALJs have no authority to pass upon the constitutionality of a statute or regulation.”). Here, no one is challenging the validity of S.C. Code Ann. § 38-71-46, merely that S.C. Code Ann. § 38-71-46 does not apply to the State Health Plan. Therefore, rule set forth in Drummond has no application to the present case.

The language of the State Health Plan clearly empowers EIP to take into account applicable state law when resolving benefit claims under the Plan. Because the procedures established by EIP pursuant to § 1-11-710(C) are Plaintiff's exclusive remedy to resolve benefit claims under the plan, subject only to appeal to the South Carolina Administrative Law Court, Defendants' Motion for Summary Judgment should be granted dismissing Plaintiff's Complaint as a matter of law.

B. S.C. Code Ann. § 38-71-46 Has No Application To The State Health Plan In That The State Health Plan Is A Self-Funded, Governmental Plan Not Subject To State Insurance Regulation.

S.C. Code Ann. § 38-71-46 has no application to the State Health Plan in that the State Health Plan is a self-funded, governmental plan that is not subject to regulation by the South Carolina Department of Insurance (“SCDOP”). The primary rule of statutory interpretation is to ascertain and effectuate the intent of the Legislature. See Auto Owners Ins. Co. v. Rollison, 378 S.C. 600, 609, 663 S.E.2d 484, 488 (2008). “The primary rule of statutory construction requires that legislative intent prevail if it can reasonably be discovered in the language used construed in light of the intended purpose. Sections which are part of the same general statutory law of the state should be construed together and each given effect if it can be done by any reasonable construction.” Glover v. Suitt Const. Co., 318 S.C. 465, 469, 458 S.E.2d 535, 537 (1995). “It is proper to consider the title or caption of an act in aid of construction to show the intent of the legislature.” Lindsay v. Southern Farm Bureau Cas. Ins. Co., 258 S.C. 272, 277, 188 S.E.2d 374,

376 (1972). But, "they may not be construed to limit the plain meaning of the text." Gamer v. Houck, 312 S.C. 481, 486, 435 S.E.2d 847, 849 (1993).

S.C. Code Ann. § 38-71-46, the statute that Plaintiff alleges applies to the State Health Plan, makes no mention that it applies to the State Health Plan, EIP and/or the South Carolina Budget and Control Board. S.C. Code Ann. § 38-71-46 states:

(A) On or after January 1, 2000, every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and outpatient self-management training and education for treatment of people with diabetes mellitus, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina.

(D) For purposes of this section: "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670 (6)² and Section 38-71-840 (14). (Emphasis added).

Id.

S.C. Code Ann. §38-71-840 (14), which involves group health insurance, defines health insurance coverage as:

(14) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

- (a) coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
- (b) coverage issued as a supplement to liability insurance;

² S.C. Code Ann. §38-71-670 (6) contains the identical language as S.C. Code Ann. §38-71-840 (14) and applies to individual policies.

- (c) liability insurance, including general liability insurance and automobile liability insurance;
- (d) workers' compensation or similar insurance;
- (e) automobile medical payment insurance;
- (f) credit-only insurance;
- (g) coverage for on-site medical clinics;
- (h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
- (i) if offered separately;
- (i) limited scope dental or vision benefits;
- (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;
- (iii) other similar, limited benefits as are specified in regulations;
- (j) if offered as independent, noncoordinated benefits;
- (i) coverage only for a specified disease or illness;
- (ii) hospital indemnity or other fixed indemnity insurance;
- (k) if offered as a separate insurance policy;
- (i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
- (ii) coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code; and
- (iii) similar supplemental coverage under a group health plan. (Emphasis added).

Id.

S.C. Code Ann. §38-71-940 (16) defines a "health insurance issuer" as:

(16) "Health insurance issuer" or "issuer" means any entity that provides health insurance coverage in this State. For purposes of this section, "issuer" includes an insurance company, a health maintenance organization, and any other entity providing health insurance coverage which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation. (Emphasis added).

Id.

The State Health Plan is a self-funded, governmental health plan for state employees, administered by the South Carolina Budget and Control Board, Employee Insurance Program

("EIP"). (Affidavit of Robin E. Tester ¶ 3). The State Health Plan is not a fully insured plan. EIP is not licensed to engage in the business of insurance in this State and is not subject to insurance regulation by the SCDOI. S.C. Code Ann. §1-11-780 (Supp. 2009) ("The State Employee Insurance Program...is not under the jurisdiction of the South Carolina Department of Insurance.").

The State Health Plan is not "health insurance coverage" pursuant to S.C. Code Ann. §38-71-840 (14), and EIP is not a "health insurance issuer" pursuant to S.C. Code Ann. §38-71-840 (16) in that EIP is not licensed to engage in the business of insurance in this State and is not subject to insurance regulation. Therefore, S.C. Code Ann. § 38-71-46 has no application to the State Health Plan and/or EIP.

This conclusion is further supported by the legislative history of Title 1, Chapter 11 and Title 38, Chapter 71. The Legislature explicitly recognized the lack of jurisdiction of the SCDOI over EIP in South Carolina Code Ann. § 1-11-780 (Supp. 2009). That statute reads in its entirety:

The State Employee Insurance Program shall continue to provide mental health parity in the same manner and with the same management practices as included in the plan beginning in 2002³, and is not under the jurisdiction of the Department of Insurance. The continuation by the State Employee Insurance Program of providing mental health parity in accordance with the plan set forth in 2002 constitutes compliance with this act. (Emphasis added).

Id.

In the 1990s and into the 2000s, the Legislature passed a series of health insurance

³ The prior coverage beginning in 2002 that is referenced in this statute is from repealed § 1-11-760 (repealed 2005), which also pertained to mental health coverage mandates for EIP. See S.C. Code Ann. § 1-11-760 (repealed 2005). The former statute took effect in 2002 with a built-in repeal date effective in 2005. See 2000 S.C. Act No. 341, § 4, codified at S.C. Code Ann. § 1-11-760 (repealed 2005). The former law also specifically defined what entity it applied to: "State Health Insurance Plan means health insurance plans offered or administered by the State Budget and Control Board." S.C. Code Ann. § 1-11-760 (repealed 2005). This statute explicitly set out requirements for mental health coverage by EIP, and by EIP only, as former § 1-11-760 clearly was located in Title 1, Chapter 11, Article 5.

coverage mandates in Title 38, Chapter 71, Article 1.⁴ With the exception of § 38-71-280, regarding autism spectrum disorder, none of these laws or their preceding bills mentioned EIP, the State Health Plan, or the Budget and Control Board.

In 2007, the Legislature passed § 38-71-280, mandating coverage for autism spectrum disorder care.⁵ In § 38-71-280 the Legislature specifically stated that it desired the statute apply to EIP: "It includes the State Health Plan. ... 'State Health Plan' means the employee and retiree insurance program provided for in Article 5, Chapter 11, Title 1." S.C. Code Ann § 38-71-280(A)(4)-(5). Although not in Title 1, Chapter 11, Article 5, the statute made specific reference to EIP's governing Code sections. Accordingly, the Legislature deliberately referenced EIP's enabling statutes to make the Legislature's intent clear that § 38-71-280 applied to EIP.

The bill that would become § 38-71-46 was introduced and passed in 1999, one session and one year before § 1-11-760 (repealed 2005) with no references to EIP in its text. See 1999 S.C. Act No. 98 (codified at S.C. Code Ann. § 38-71-46). It is important to note that § 38-71-46 was amended in the same session in which § 1-11-760 (repealed 2005) became law. See 2000 S.C. Act No. 348 (amending coverage mandates for diabetes mellitus); 2000 S.C. Act No. 341 (mandating EIP provide mental health coverage). The Legislature was clearly aware at the time § 38-71-46 was amended that for the statute to apply to EIP, EIP needed to be identified in the

⁴ Chronologically, these statutes requiring coverage were: § 38-71-240, for cleft lip and palate care (1993 S.C. Act No. 129, § 1); § 38-71-143, for children placed for adoption (1994 S.C. Act No. 481, § 2); § 38-71-135, for postpartum care for mothers and newborns (1996 S.C. Act No. 335, § 1, amended by 1997 S.C. Act No. 5, § 4); § 38-71-125, for mastectomies and related treatment (1998 S.C. Act No. 329, § 3); § 38-71-130, for breast reconstruction following mastectomy (1998 S.C. Act No. 329, § 4); § 38-71-145, for mammograms, pap smears, and prostate cancer examinations (1998 S.C. Act No. 329, § 5); § 38-71-215, for dermatology referrals (1998 S.C. Act No. 353, § 1); § 38-71-46, for diabetes mellitus care, with attendant education and equipment (1999 S.C. Act No. 98, § 5, amended by 2000 Act No. 348, § 1); and § 38-71-280, autism spectrum disorder care (2007 S.C. Act No. 65, § 1).

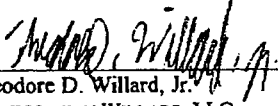
⁵ Notably, § 38-71-280 followed § 1-11-780 in time.

statute. However, the Legislature chose not to do so and § 38-71-46 made no mention of its application to the State Health Plan.

The Legislature made it very clear when health insurance mandates were to apply to the State Health Plan. When EIP was to be included, the legislature either: (1) amended EIP's governing statutes in Title 1, Chapter 11, Article 5; (2) made a direct reference to those statutes in its legislation; or (3) at a minimum, identified EIP by name. The Legislature was aware that EIP was not governed by the SCDOI and specifically stated this fact in 2005 legislation. The Legislature also acknowledged that EIP was not governed by the mandates in Title 38, Chapter 71, Article 1, unless a specific intent to do so was stated in the statute. Finally, § 38-71-46 itself was passed contemporaneously with other legislation that specifically indicated that those statutes applied to EIP; yet § 38-71-46 remained silent in this regard. If the Legislature had intended section § 38-71-46 to apply to EIP, it would have indicated that in the statute itself.

IV. CONCLUSION

For the foregoing reasons, Defendants' Motion for Summary Judgment should be granted and Plaintiffs' complaint should be dismissed as a matter of law.


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August 24, 2010
Columbia, South Carolina

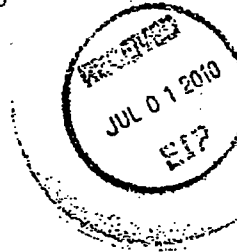


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June 30, 2010

VIA FEDERAL EXPRESS- OVERNIGHT

Appeal Coordinator
Employee Insurance Program
Post Office Box 11661
Columbia, South Carolina 29211
1201 Main Street, Suite 300
Columbia, South Carolina 29201



RE: Jeffrey D. Allen, individually, as guardian for Jane Doe, a minor, and as representative of other similarly situated State of South Carolina employees v. SC Budget & Control Board
Case No.: 09-CP-10-7404
File No.: 595-1

Dear Sir or Madame:

Please allow this letter with attachments to serve as the 90 day written notice of appeal to the EIP from the April 2, 2010 letter authored by BCBSC. As you already know the Plaintiffs have brought a putative class action lawsuit against the SCEIP and BCBSSC as it relates to the applicability of S.C. Code Ann. § 38-71-46 to the State Plan. The legal and factual basis for these claims are set forth in detail in the attached pleadings in the civil action pending in Charleston County Court of Common Pleas, and are hereby incorporated into this appeal letter.

Specifically, I am including the following documents most of which are on file and public record with the Charleston County Court of Common Pleas Clerk of Court:

1. Summons & Complaint
2. Plaintiffs' Memo. in Opp. to Def's Motions to Dismiss
3. Appeal Letter- Goodman, Sr. Director of BCBS dated March 19, 2010
4. Letter from App. Review Committee BCBS dated April 4, 2010
5. Plaintiffs' Motion for Class Certification
6. Plaintiffs' Motion to Compel & Motion to Stay Decision on Def's Motion for Summary Judgment

It is interesting to note that throughout this entire process, which includes the EIP and BCBSSC's Motion to Dismiss, Answer, Motion for Summary Judgment and both underlying administrative decisions to date, neither BCBSSC nor EIP has ever provided any explanation for its legal conclusion that section 38-71-46 does not apply to the State Plan. As our pleadings indicate, we believe that it does in fact apply and intend to continue to pursue this matter to the full extent of the law. Nothing in this letter should be construed as a waiver of any rights or defenses

EX A

under the law.

Thank you.

With kind regards, I am

Sincerely,

WILLS MASSALON & ALLEN, LLC

Smith Irick, Paralegal
for John A. Massalon

Enclosures

cc: (w/out enclosures)
Mr. Jeffrey D. Allen
Terry E. Richardson, Jr., Esquire
Matthew D. Hamrick, Esquire
Theodore D. Willard, Jr., Esquire
Kelly H. Rainsford, Esquire

MARK SANFORD, CHAIRMAN
GOVERNOR

CONVERSE A. CHELLIS, III, CPA
STATE TREASURER

RICHARD ECKSTROM, CPA
COMPTROLLER GENERAL



SC BUDGET AND CONTROL BOARD

EMPLOYEE INSURANCE PROGRAM

(803) 734-0678
FAX: (803) 737-0557

HUGH K. LEATHERMAN, SR.
CHAIRMAN, SENATE FINANCE
COMMITTEE

DANIEL T. COOPER
CHAIRMAN, HOUSE WAYS AND MEANS
COMMITTEE

FRANK W. FUSCO
EXECUTIVE DIRECTOR

August 24, 2010

John A. Massalon, Esquire
Wills Massalon & Allen, LLC
PO Box 859
Charleston, South Carolina 29402

RE: State of South Carolina Group Health Benefits Plan
Subscriber: Jeffrey D. Allen
Patient:
ID#: xxx-xx-1184

Dear Mr. Massalon:

Thank you for your letter to the Employee Insurance Program on behalf of your client, Jeffrey D. Allen, in which you appealed the decision of BlueCross Blue Shield of South Carolina (BCBSSC) to deny the request to cover a claim for diabetes educational training relating to Mr. Allen's daughter. Your client's appeal was considered by the Health Appeals Committee, which consists of five members who have not been involved in any prior decisions to deny this claim. The Committee fully considered the appeal by reviewing the claim file along with the relevant provisions of the State Health Plan (Plan). After the review, the Committee determined that no benefit was payable for the diabetes education training. The Committee's full decision is enclosed for your information.

This determination has been made in good faith under the terms and conditions of the Plan and relevant statutes. Nothing in the decision should be construed as a waiver of any rights or defenses under the Plan or state law, whether or not specifically mentioned in the decision.

Your client's right to appeal through the Employee Insurance Program has been exhausted. In accordance with instruction from the Administrative Law Court (ALC), the next level of appeal is to the ALC in its appellate jurisdiction pursuant to S.C. Code Ann. § 1-23-600(D). The contact information for the ALC is:

1201 MAIN STREET, SUITE 300 • COLUMBIA, SOUTH CAROLINA 29201

EX B

Administrative Law Court
1205 Pendleton Street, Suite 224
Columbia, South Carolina 29201

An appeal is commenced by filing a notice of appeal with the ALC within 30 days of receipt of this letter. If you need any further information regarding your client's appeal, please contact the ALC at (803)734-0550.

If you choose to appeal to the ALC, please note the following address for serving the Employee Insurance Program:

Stephen R. Van Camp, Director
Employee Insurance Program
South Carolina Budget and Control Board
1201 Main Street, Suite 300
Columbia, South Carolina 29201

Thank you for allowing the Employee Insurance Program the opportunity to review your client's claim. Best wishes to your client for good health now and in the future.

Sincerely,



Stephen R. Van Camp
Director, Employee Insurance Program

SRV/ctqc

Enclosure

cc: Theodore Willard, Esquire
Brooks Goodman, BCBSSC
Margie Benson, BCBSSC

**BEFORE THE STATE BUDGET AND CONTROL BOARD,
EMPLOYEE INSURANCE PROGRAM**

Subscriber: Jeffrey D. Allen
Dependent: er)
Plan: South Carolina Group Health
Benefits Plan

**FINAL DECISION OF
THE APPEALS COMMITTEE**

This matter is before the Health Appeals Committee of the Employee Insurance Program (EIP) pursuant to the appeal of John A. Massalon, Esquire, on behalf of his clients Jeffrey Allen (Claimant) and Christie Ford Allen (Claimant's spouse).¹ Claimant is appealing the decision of BlueCross BlueShield of South Carolina (BCBSSC)² to deny reimbursement for diabetes education pertaining to his minor daughter, it).

Findings of Fact

The Appeals Committee carefully considered all evidence contained in the file, including but not limited to Claimant's letters with exhibits, information provided by BCBSSC, and information maintained by EIP. After taking into account the credibility of the evidence, the Appeals Committee made the following findings.

As an employee of Dorchester County School District Two, Claimant participates in the South Carolina Group Health Benefits Plan (Plan or State Health Plan). Claimant and Dependent have been covered by one of the health insurance options offered through EIP since 2005.³ Dependent was born July 20, 2005. Claimant was hired at Dorchester County effective August 2, 2005, with a benefits effective date of September 1, 2005. Claimant and Dependent were covered under MUSC Options from September 1, 2005, to December 31, 2006. Beginning

¹ Claimant's spouse is a partner at the law firm Wills Massalon & Allen, LLC, (formerly known as Wills & Massalon, LLC, until it was given the present name in February 2010) where Claimant's attorney is also a partner. She is not a named plaintiff or counsel of record but, as noted below, handled all the correspondence and research regarding Dependent's coverage until the putative class action lawsuit was filed in November 2009.

² BCBSSC is the third-party claims administrator for the South Carolina Group Health Benefits Plan, which is self-insured. As such, BCBSSC processes and pays the claims for the Plan under the Plan's rules and with the Plan's money. Although the Plan is administered by BCBSSC, it is not a BCBSSC plan.

³ EIP offers several health insurance options. The South Carolina Group Health Benefits Plan consists of the Standard Plan (a preferred provider organization or PPO), the Savings Plan (a high deductible health plan), and the Medicare Supplemental Plan. EIP also offers two health maintenance organization (HMO) options: BlueChoice HealthPlan and CIGNA. EIP offered a third HMO, called MUSC Options, until December 31, 2008. MUSC Options was a region-specific HMO available only in the Charleston area and administered by BlueChoice HealthPlan.

January 1, 2007, Claimant and Dependent have been covered by the Standard Plan.⁴ Claimant's spouse has never been covered under Claimant's health insurance coverage.⁵

Dependent was diagnosed with Type I diabetes⁶ in November 2007. On August 5, 2008, Claimant, Claimant's spouse, Dependent's grandparents, and two daycare nurses attended a diabetes management educational session in relation to Dependent's new insulin pump for a total cost of \$560.00. On August 27, 2008, BCBSSC sent Claimant an Explanation of Benefits (EOB) showing the claim was denied. The explanatory note read, "Your benefit plan does not cover education and/or training for this condition." The EOB indicated Claimant had the right to request reconsideration of the claim in writing within six months of the EOB.

On February 25, 2009, Claimant's spouse wrote a letter of appeal to BCBSSC.⁷ Claimant's spouse stated Claimant and Dependent were "insured under the South Carolina State Insurance Health Plan." Claimant's spouse indicated Dependent was three years old and had been diagnosed with Type I diabetes in November 2007. In August 2008, Dependent had been approved for an insulin pump because Dependent needed continuous insulin therapy. Claimant's spouse stated the Medical University of South Carolina (MUSC) provides training for caregivers on how to properly operate the insulin pump. Claimant's spouse indicated she, Claimant, their parents (Dependent's grandparents), and two nurses from Dependent's daycare attended the training on August 5, 2008.

Claimant's spouse stated she was objecting to the claim denial as a necessary part of insulin pump therapy. She pointed out Dependent was three years old "and as a result of her young age is obviously not able to teach herself how to use the insulin pump." Claimant's spouse also stated the EOB had been mailed to her family's old address even though she had changed it through the website. She then concluded,

Lastly, I also submit this appeal letter to object to the fact that diabetic education is a [sic] item which you indicated is expressly excluded under the policy. I cannot imagine what possible policy, other than one motivated by profit, would support not providing insurance coverage to the education of Type I diabetics about how to better control and manage an intensive, life-long disease which has no cure. While I see no real distinction, does Blue Cross differentiate between its coverage position on education for Type I and Type II diabetes?

⁴ Claimant was covered as an active employee at College of Charleston for August and September 2008, after which he transferred back to Dorchester County with no interruption or change in coverage.

⁵ Claimant's spouse was covered as an active employee by the Standard Plan for six months in 1998 but has not been covered since.

⁶ Type I diabetes is usually diagnosed in childhood and used to be known as juvenile diabetes. In Type I diabetes, the body makes little or no insulin and daily injections of insulin are needed. The exact cause is unknown, though genetics, viruses, and autoimmune problems are suspected to play a role. Type I diabetes can come on suddenly and the symptoms can be severe. Those with Type I diabetes often need injections of insulin one to four times daily, and in more acute cases a continuous insulin pump can be attached to the body for continuous insulin delivery. (Type II diabetes, in which the pancreas does not make enough insulin to regulate blood glucose levels, is far more common than Type I; its frequent causes include obesity, lack of exercise, and age). See The U.S. Nat'l Library of Med. & the Nat'l Insts. of Health, A.D.A.M. Medical Encyclopedia, *Diabetes* (2009), available at <http://www.nlm.nih.gov/medlineplus/ency/article/001214.htm>.

⁷ The letter was on Wills & Massalon's letterhead.

Claimant's spouse included copies of the EOB, and a copy of a screen capture showing she had updated Claimant's address on the BCBSSC website.

On April 20, 2009, BCBSSC sent Claimant an adjusted EOB. It had no changes except for the explanatory note. Rather than "Your benefit plan does not cover education and/or training for this condition," the new EOB indicated BCBSSC had requested additional medical information from the provider. The updated note explained if the information was received within 45 days, they would review their claim and make the decision within 15 days of receipt. It then stated if the information was not received, the claim would be considered denied. Finally, if the information was received after 45 days but under 225, the appeal would move forward.

On September 30, 2009, Claimant's spouse wrote a letter to BCBSSC in follow-up. She indicated her appeal had been pending since February 2009. Claimant's spouse stated she had called BCBSSC on August 14, 2009, and was informed the reason for the lack of resolution was BCBSSC had not received Dependent's requested medical records, which BCBSSC had been unable to describe with particularity. Claimant's spouse stated she then called MUSC, who stated they had sent the records but agreed to send them to BCBSSC again. She noted this was well within the 225 days in the April 20, 2009, letter. Claimant's spouse stated she called BCBSSC again on September 30, 2009, to inquire about the status of the appeal. She said BCBSSC told her they were awaiting "outpatient ER records." Claimant's spouse then stated she had not received any direct request for records "or even that I complete a HIPAA [sic] form." Claimant enclosed the records with the letter. Claimant's spouse then stated, "I am also enclosing a copy [of] the South Carolina statute which requires Diabetes Mellitus coverage in health insurance policies."⁸ She highlighted the provision requiring coverage for outpatient self-management training and education for the treatment of people with diabetes mellitus.

Dependent's records began with a letter dated July 9, 2008, with a pre-authorization request for Dependent's insulin pump from the manufacturer, Medtronic. The items listed on Medtronic's request were an insulin pump with accompanying equipment, for a total of \$5,142.95.⁹ The records also included hemoglobin measurements glucose logs reflecting Dependent's condition, a certificate of medical necessity completed by Dependent's physician for the manufacturer, and Dependent's office visits with endocrinologist Deborah Bowlby, M.D., at MUSC.

Dependent's earliest submitted visit note was from January 2, 2008. The treating physician indicated Dependent had been diagnosed with Type I diabetes six weeks prior after being admitted to the emergency room with diabetic ketoacidosis.¹⁰ Dependent was taking

⁸ S.C. Code Ann. § 38-71-46. The statute is reproduced in the next section.

⁹ This claim, 8E4953594000, was paid on an actual-amount-billed of \$4,988.40, with the total paid by the Plan at \$3,990.72, the normal rate of 80%.

¹⁰ Diabetic ketoacidosis refers to the buildup of ketones in the body. It is a complication of diabetes occurring when the body cannot use blood glucose for fuel because the body has little or no insulin and the body begins using fat instead. Byproducts of fat breakdown, called ketones, build up in the body; in high levels, ketones are poisonous. The liver then produces glucose to try to combat the problem and blood glucose levels rise, often to over 300, when the buildup occurs because the body cannot pull in the glucose without enough insulin.

insulin injections at each meal plus two snack times, with her care providers also checking her glucose levels an average of five to six times per day, "rotating sites over arms, abdomen, and buttock." Dependent was having elevated blood sugars in the afternoon and evening despite this care. Dr. Bowlby stated overall Dependent seemed to be doing okay, adjusted Dependent's insulin, and scheduled follow-up in three months.

A telephone note dated March 11, 2008, indicated Claimant's spouse called the MUSC endocrinology office. She was "concerned with high blood glucose at 9:30 am snack and 11:30 am and was using correction at snacks and meals and was then having hypoglycemia in the afternoon." The responding nurse stated they discussed only using correction at lunch and not the 9:30 snack. Claimant's spouse was concerned when Dependent's glucose was spiking after meals. The responding nurse explained correction was not advised unless it had been three hours since Dependent had a meal or snack. The nurse also noted Claimant's spouse felt the cartridge-based insulin pens leaked with such a small dose of insulin and that the syringes worked better, and she had asked the daycare and those caring for Dependent at home to use the syringes as well. The nurse noted, "Dr. Walsh spoke with mother in great detail regarding above."

Dependent returned to Dr. Bowlby on April 9, 2008. Dr. Bowlby observed Dependent was doing better, with Claimant's spouse reporting Dependent's blood sugars had been more in target range since Dependent's previous visit. Claimant's spouse was feeling better about dealing with elevated or low blood sugars, and Dependent had not had any severe hypoglycemic blood sugar episodes. Dr. Bowles noted Dependent was doing better and recommended an insulin pump, scheduling follow-up with a nurse, Sharon Schwartz, R.N., C.D.E.,¹¹ to discuss the option of an insulin pump.

A visit note from the August 5, 2008, educational session was also included. Nurse Schwarz indicated the content taught included Dependent's care plan, medications, nutrition, food/drug interactions, health promotion, patient safety, and medical equipment. Nurse Schwarz noted Dependent's parents, grandparents, and daycare nurses were "instructed on the Medtronic Paradigm insulin pump. They were instructed on troubleshooting hyper/hypoglycemia on the insulin pump, importance of monitoring, ketone testing, and site rotation." They were encouraged to practice with saline for a week; the nurse also noted one of the daycare nurses was given a practice pump and saline to practice and would return the pump the following week. A list of instructions was also given, including monitoring for ketones if the blood sugar was elevated, insulin input amounts, and safe glucose levels.

On October 15, 2009, Claimant e-mailed a request for a copy of the Plan of benefits to EIP. EIP e-mailed a copy of the Plan document to Claimant's provided gmail account.

Diabetic ketoacidosis may lead to a diagnosis of Type I diabetes because it is often the first symptom that causes a person to see a doctor. It can also be the result of increased insulin needs in someone already diagnosed with Type I diabetes. Infection, trauma, heart attack, or surgery can lead to diabetic ketoacidosis in such cases. Missing doses of insulin can also lead to ketoacidosis in people with diabetes. (People with Type II diabetes can develop ketoacidosis but it is rare and usually triggered by a severe illness). See A.D.A.M. Medical Encyclopedia, *Diabetic Ketoacidosis* (2009), available at <http://www.nlm.nih.gov/medlineplus/ency/article/000320.htm>.

¹¹ Certified Diabetes Educator.

On November 25, 2009, Claimant filed a putative class action suit against the South Carolina Budget and Control Board, EIP, and BCBSSC in the circuit court of the Ninth Judicial Circuit in Charleston, alleging a violation of S.C. Code Ann. § 38-71-46. In response, EIP filed a motion to dismiss, based in part because Claimant had not exhausted the administrative appeals process through EIP and the Administrative Law Court (ALC). Claimant filed a memorandum in opposition to EIP's motions to dismiss on February 26, 2010.

In an affidavit dated February 24, 2010, Claimant stated Claimant's spouse had handled all the appeal activities up to that point. Claimant stated he had gone to the district office, at his wife's direction, in October 2009 to seek a copy of the Plan of Benefits but was told the document was not available. Claimant stated Claimant's spouse had then e-mailed EIP to obtain a copy but they had received no response.

On the same day, Claimant's spouse completed an affidavit. She stated the same things noted above in Claimant's affidavit. She also included recounts of her August 14, 2009, phone call with BCBSSC, the September 30, 2009, phone call with BCBSSC, and stated she had faxed the records on October 5, 2009. Claimant's spouse stated she had obtained and reviewed the *Employee Benefit Guide*¹² after speaking to BCBSSC on September 30, 2009. She stated she noticed the references to the Plan of Benefits Document at the time, which she then attempted to obtain. Claimant's spouse stated she telephoned EIP on October 7, 2009, and was told to have Claimant get a copy at work because the document was large, or else he would have to pay the copying fee. Claimant's spouse stated she had not received a response to her letters dated February 25, 2009, or October 5, 2009, and therefore believed the appeal was still pending within the BCBSSC administrative process. She noted in a footnote a BCBSSC representative had called, offering to enroll Dependent in a diabetes wellness program.¹³ Claimant's spouse stated "after [I] disclosed the pendency of this action, the Blue Cross representative called back to disclose that the program was only for persons 5 years of age and older and therefore Eva would not qualify yet."¹⁴

Copies of e-mails to Dependent's doctor, the medical records and correspondence noted above, and a copy of the entire 2009 IBG were also included with Claimant's memorandum in opposition to dismiss.

On March 15, 2010, Ashby Jordan, M.D., the medical director and vice president of medical affairs for BCBSSC, reviewed Dependent's file in its entirety. He noted the services referenced were specifically excluded in the Standard Plan under Article 9, Paragraph O. Dr. Jordan also stated Exclusion BB in Article 9 also applied, as there was no mention of these services in the Article 7, Schedule of Benefits section of the Plan. He noted the statute referenced in the appeal document does not apply to the State Health Plan.

On March 19, 2010, Brooks Goodman, senior director for state operations at BCBSSC, sent Claimant a letter indicating the medical director had denied Claimant's appeal for the

¹² The Committee understood this to mean the *Insurance Benefits Guide* (IBG), a summary booklet of benefits sent to subscribers annually.

¹³ Claimant's spouse stated the BCBSSC representative initially thought Dependent suffered from asthma.

¹⁴ Dependent turned five in July 2010.

reasons stated above. Because the medical director had not approved the appeal, it would be considered by the BCBSSC appeals committee.

On April 2, 2010, BCBSSC sent Claimant a letter denying Claimant's appeal for additional benefits for the August 5, 2008, educational session. The letter indicated it had reviewed Claimant's spouse's letters from February 25, 2009, and September 30, 2009; a web inquiry dated February 18, 2009; Dependent's medical records, noted above; the claim with EOBs dated August 27, 2008, and April 20, 2009; Dr. Jordan's medical review from March 15, 2010; Article 7 and Article 9, Sections O and BB of the 2008 Plan; the letter from Brooks Goodman on March 19, 2010; and S.C. Code Ann. § 38-71-46. The letter stated the BCBSSC appeals committee observed the Plan specifically excluded educational services in Article 9, and Article 7 excluded services not specifically covered. It also noted § 38-71-46 did not apply to the self-funded State Health Plan. The letter then stated the appeals process through BCBSSC was exhausted, and Claimant had 90 days to appeal in writing to EIP.

On June 30, 2010, Claimant's attorney appealed the denial in the April 2, 2010, to EIP on Claimant's behalf. Claimant's attorney captioned the letter as though it were part of the Claimant's lawsuit. Claimant's attorney noted, "As you already know the Plaintiffs have brought a putative class action lawsuit against the SCEIP [sic] and BCBSSC as it relates to the applicability of S.C. Code Ann. § 38-71-46 to the State Plan." He stated the pleadings were incorporated by reference into the appeals letter, and he enclosed copies of the lawsuit summons and complaint; the memorandum in opposition to EIP's motion to dismiss; Mr. Goodman's denial letter of March 19, 2010; the BCBSSC denial letter dated April 4, 2010; Claimant's motion for class certification; and Claimant's motion to compel and motion to stay decision on EIP's motion for summary judgment. Claimant's attorney noted that throughout the putative class action proceeding, "neither BCBSSC nor EIP has ever provided any explanation for its legal conclusion that section 38-71-46 does not apply to the State Plan." He stated he believed it did apply and intended to pursue the issue to the full extent of the law.

Relevant Statutory, Plan and Policy Provisions

The Appeals Committee considered the relevant statutes in the South Carolina Code of Laws, established by the General Assembly of the State of South Carolina. The statutes read in pertinent part:

Section 38-71-46

(A) On or after January 1, 2000, every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and outpatient self-management training and education for the treatment of people with diabetes mellitus, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina. This subsection does not prohibit a health maintenance organization or an individual

or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.

(B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.

(C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re-credential a provider.

(D) For purposes of this section: "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

Section 38-71-670

As used in this subarticle: . . .

(6) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

a) coverage only for accident or disability income insurance or any combination of these;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for on-site medical clinics;

(h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) if offered separately;

- (i) limited scope dental or vision benefits;
- (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;
- (iii) other similar, limited benefits as are specified in regulations;
- (j) if offered as independent, noncoordinated benefits:
 - (i) coverage only for a specified disease or illness;
 - (ii) hospital indemnity or other fixed indemnity insurance;
- (k) if offered as a separate insurance policy:
 - (i) Medicare supplemental health insurance, as defined under Section 1882(g)(1) of the Social Security Act;
 - (ii) coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code; and
 - (iii) similar supplemental coverage under a group health plan.

Section 38-71-840

As used in this subarticle: . . .

(14) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

- (a) coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
- (b) coverage issued as a supplement to liability insurance;
- (c) liability insurance, including general liability insurance and automobile liability insurance;
- (d) workers' compensation or similar insurance;
- (e) automobile medical payment insurance;
- (f) credit-only insurance;
- (g) coverage for on-site medical clinics;
- (h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
- (i) if offered separately:
 - (i) limited scope dental or vision benefits;
 - (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;
 - (iii) other similar, limited benefits as are specified in regulations;
- (j) if offered as independent, noncoordinated benefits:
 - (i) coverage only for a specified disease or illness;
 - (ii) hospital indemnity or other fixed indemnity insurance;
- (k) if offered as a separate insurance policy:
 - (i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
 - (ii) coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code; and

(iii) similar supplemental coverage under a group health plan.

The Appeals Committee also considered the 2008¹⁵ State Health Plan (Plan), established by the South Carolina Budget and Control Board for state employees and retirees.

Article 7
Schedule of Benefits
[see attached]

Article 9
Exclusions and Limitations

No benefits will be provided under any Article of this Plan for any service, supply or charges for the following:

O. Any medical social services (except for those provided under the Hospice program and Home Health Care Program upon recommendation of the Utilization Review Agency) or vocational, visual, recreational, educational, or milieu therapy;

BB. Benefits will not be provided for services or supplies not specifically listed in Article 7, Schedule of Benefits, inclusive;

The Committee also considered pertinent parts of the 2008 IBG:

General Information

.....
Prevention Partners

Prevention Partners, a unit of the Employee Insurance Program, is designed to help you and your family lead healthier lives. Its activities, programs and services promote good health through disease prevention, early detection of disease and chronic disease education.

.....
Chronic Disease Workshops, another major program, give subscribers and their dependents information they need to help them take better care of themselves. Workshops include: Caregivers, Diabetes, Heart Disease, Asthma, Kidney Evaluation, Women's Reproductive Health, Weight Management, Medications, Men's Health, Cholesterol/Lipids and Gastrointestinal Ailments.¹⁶

State Health Plan

Doctor Visits

Treatments or consultations for an injury or illness are covered, as long as they are medically necessary and not associated with a service excluded by the plan.

¹⁵ Because the claim was incurred in 2008, the Plan provisions from the 2008 Plan would apply. However, the provisions relevant to this claim and appeal were substantially the same in the 2009 Plan.

¹⁶ P. 20.

For mental health and substance abuse services to be covered, you must use a participating provider, and all mental health and substance abuse services must be preauthorized by APS Healthcare. For details on mental health and substance abuse services, see page 58.¹⁷

Exclusions

Services Not Covered by the State Health Plan

There are some medical expenses the State Health Plan does not cover. The Plan of Benefits document (available in your benefits office or through EIP) contains a complete list of the exclusions.¹⁸

BlueChoice HealthPlan

.....

Covered Services

.....

Doctor Visits

Charges from your PCP for office visits, including routine examinations, vision and hearing screenings, preventive care, injections, immunizations, well-child care and health education, are covered. Charges from specialists for treatment or consultation are also covered.¹⁹

MUSC Options

.....

Covered Services

.....

Doctor Visits

Charges from your PCP for office visits, including routine examinations, vision and hearing screenings, preventive care, injections, immunizations, well-child care and health education, are covered. Charges from specialists for treatment or consultation are also covered.²⁰

Determination of Appeals Committee

The Appeals Committee considered all of the evidence in Claimant's file. The Committee then applied all of the reliable and probative evidence to the relevant provisions of the Plan.

The Committee first noted the apparent confusion about the nature of the relationship between EIP and BCBSSC. The South Carolina Budget and Control Board is a state agency charged, in part, with providing a self-insured, non-federal governmental group health benefits plan to employees of the state, public school districts, and other participating entities listed in §

¹⁷ P. 46.

¹⁸ P. 59

¹⁹ P. 66

²⁰ P. 83

1-11-720.²¹ The Board is required to "make available to active and retired employees of this State and its public school districts and their eligible dependents group health, dental, life, accidental death and dismemberment, and disability insurance plans and benefits in an equitable manner and of maximum benefit to those covered within the available resources." The available resources consist of employee contributions, employer contributions (i.e., public funds), and investment income on those contributions. The Board provides coverage to approximately 400,000 lives in South Carolina, and the Plan rules are developed with the purpose of providing affordable quality coverage to all those covered.

EIP is the part of the Budget and Control Board that is responsible for administering the State Health Plan as well as other benefit programs offered to public employees. BCBSSC is a third party claims processor procured by EIP to provide medical reviews, claims processing, and claims payment services for the State Health Plan. With that in mind, the Committee considered the terms of the 2008 Plan applicable to this appeal.

Article 9, Paragraph O of the 2008 Plan excludes educational services, outside of certain programmatically-offered situations. Paragraph BB states those services not enumerated in Article 7 are not covered; diabetes education, as a stand-alone claim, is not covered. Therefore, no more benefits are payable for the educational services received by Claimant, Claimant's spouse, Dependent's grandparents, and two nurses on Dependent's behalf in relation to Dependent's insulin pump on August 5, 2008, under the terms of the Plan. The Plan covered the insulin pump and accessories without issue, but the group's separately-billed educational instruction is not included.

The Committee also observed that, in the Standard Plan, while those diabetes educational services are not covered as a stand-alone claim, wellness and educational programs for chronic diseases including diabetes are available if pursued through EIP's Prevention Partners and other available BCBSSC programs. The Committee noted Claimant's spouse made no mention of having pursued these other avenues, except to state in a footnote someone from BCBSSC had called her regarding one such program.

The Committee also noted other health insurance coverage options were available to Dependent and Claimant which would have covered the in-office, separately-billed educational services they sought. While differences in coverage do exist among the Standard Plan and the HMO options and every subscriber must weigh these options while selecting coverage, if Claimant and his family had decided office-setting, independently-billed educational services were a priority, they could have remained covered under the MUSC Options plan or selected BlueChoice HealthPlan when changing coverage at the beginning of the 2008 Plan year. However, Claimant selected different health insurance coverage for himself and Dependent, and he selected an option that does not cover the desired educational services outside of the wellness programs described above.

Lastly, the Committee noted the repeated assertions regarding S.C. Code Ann. § 38-71-46 and Claimant's attorney's assertion no one has explained why it does not apply to the State Health Plan. While the Committee noted the alternative methods for obtaining diabetes

²¹ S.C. Code Ann. § 1-11-710(A).

education noted above, the Committee also observed the Department of Insurance and the General Assembly historically have acknowledged the Department has no jurisdiction over EIP.²² EIP is not a health insurance issuer under the Code. In the areas in which the General Assembly has wanted to include EIP in the Accident and Health Insurance provisions of Title 38, Chapter 31, it has specifically said so. Therefore, because § 38-71-46 does not refer to EIP or the State Health Plan, it does not apply to the State Health Plan.

The Committee hopes the best for Dependent's well-being in the future. While the particularities regarding Dependent's young age and the severity of her disease are compelling, the Committee must make decisions within the terms of the Plan. The Plan does not cover educational services as a separately billed claim. Therefore, no further benefits are payable for the August 5, 2008, educational session.

Conclusion

Based on all of the evidence in the record, the Committee concluded no benefits are payable for the \$560.00 claim filed for diabetes educational training on August 5, 2008, for Dependent's family and caregivers in conjunction with her covered insulin pump.

²² See, e.g., S.C. Code Ann. § 1-11-780:

The State Employee Insurance Program shall continue to provide mental health parity in the same manner and with the same management practices as included in the plan beginning in 2002, and is not under the jurisdiction of the Department of Insurance. The continuation by the State Employee Insurance Program of providing mental health parity in accordance with the plan set forth in 2002 constitutes compliance with this act.

STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS
FOR THE NINTH JUDICIAL CIRCUIT

Jeffrey D. Allen, individually, as guardian)
for Jane Doe, a minor, and as representative)
of other similarly situated State of South)
Carolina employees,)

Civil Action No.: 2009-CP-10-7404

Plaintiffs,)
)
)

CERTIFICATE OF SERVICE

v.)
)
)

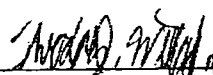
South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)
)
)

I, Theodore D. Willard, Jr., of the law firm of Montgomery Willard, LLC, attorneys for the Defendants do hereby certify that I have served the below named counsel with a copy of *Defendants' Memorandum In Support of Motion For Summary Judgment* by mailing a copy of same by United States mail, proper postage affixed, return address clearly marked, and addressed as follows:

John A. Massalon, Esquire
Wills & Massalon, LLC
Post Office Box 859
Charleston, South Carolina 29402

Terry E. Richardson, Jr., Esquire
Richardson, Patrick, Westbrook & Brickman, LLC
1017 Chuck Dawley Blvd.
Mt. Pleasant, South Carolina 29464



Theodore D. Willard, Jr.

August 24, 2010
Columbia, South Carolina

STATE OF SOUTH CAROLINA)
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS

CASE NO.: 09-CP-10-7404

Jeffrey D. Allen, individually, as Guardian)
For Jane Doe, a minor, and as Representative)
Of other similarly situated State of)
South Carolina employees,)

Plaintiff,)

v.)

South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)

Plaintiff's Notice of Motion and
Motion to Compel Responses to
Plaintiff's First Interrogatories
and First Requests for Production
and Motion to Stay Decision on
Defendant's Motion for Summary
Judgment

2010 JUN 18 PM 2:39
JULIE J. ARMSTRONG
CLERK OF COURT

FILED

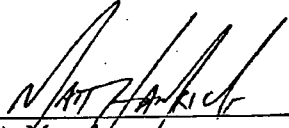
TO: Theodore D. Willard, Jr., Esq. and Kelly H. Rainsford, Esq., counsel for
Defendants.

PLEASE TAKE NOTICE that Plaintiff, by and through his undersigned attorneys, will
move the Court for an order, on the date set by the Court for the hearing of this matter, upon
Plaintiff's motion herein, compelling the Defendants to answer Plaintiff's First Interrogatories
and First Requests for Production (served May 6, 2010, and attached hereto as Exhibits "A,"
"B," "C," and "D") in the above-captioned lawsuit.

Also, as Defendants have moved for (1) a protective order to allow Defendants not to
answer Plaintiff's First Interrogatories and Requests for Production, and (2) summary judgment
prior to any discovery, Plaintiff hereby moves for a stay of decision on Defendants' Motion for
Summary Judgment until after the Court has determined whether Defendants should be required
to respond to Plaintiff's First Interrogatories and Requests for Production.

Counsel for Plaintiff and counsel for Defendants have consulted orally in a good faith
attempt to resolve the matter contained in the foregoing motions.

PLEASE BE PRESENT TO DEFEND IF SO MINDED.


John A. Massalon
Wills Massalon & Allen, LLC
Post Office Box 859
Charleston, SC 29402

(843) 727-1144

-and-

Terry E. Richardson, Jr.

Matthew D. Hamrick

Richardson, Patrick, Westbrook &

Brickman, LLC

1017 Chuck Dawley Blvd.

Mt. Pleasant, SC 29464

(843) 727-6500

ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 17 day of JUNE, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows:

Theodore D. Willard, Jr., Esq.
MONTGOMERY WILLARD, LLC
1002 Calhoun Street
Post Office Box 11886
Columbia, SC 29211

Kelly H. Rainsford, Esq.
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, SC 29211

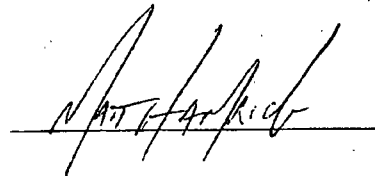
A handwritten signature in black ink, appearing to read "Matt Hamrick", is written over a horizontal line.

EXHIBIT A

STATE OF SOUTH CAROLINA)

IN THE COURT OF COMMON PLEAS

COUNTY OF CHARLESTON)

CASE NO.: 09-CP-10-7404

Jeffrey D. Allen, individually, as Guardian)
For Jane Doe, a minor, and as Representative)
Of other similarly situated State of)
South Carolina employees,)

Plaintiff's First Interrogatories
To Defendant South Carolina Budget
and Control Board Employee Insurance
Program

Plaintiff,)

v.)

South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)

Plaintiff hereby submits the following interrogatories, pursuant to Rules 26 and 33, to
Defendant the South Carolina Budget and Control Board Employee Insurance Program
(hereinafter referred to as the "EIP").

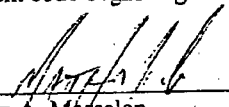
INTERROGATORIES

1. Give the names and addresses of persons known to the EIP or counsel to be witnesses concerning the facts of this case and indicate whether or not written or recorded statements have been taken from the witnesses and indicate who has possession of such statements.
2. Set forth a list of any prepared documents in possession of the EIP or counsel that relate to the claims or defenses in this case.
3. Set forth the names and addresses of all insurance companies which have liability insurance coverage relating to the claim and set forth the number or numbers of the policies involved and the amount or amounts of liability coverage provided in each policy.

4. List the names and addresses of any expert witnesses whom the EIP proposes to use as a witness at the trial of the case.
5. For each person known to the EIP or counsel to be a witness concerning the facts of the case, set forth either a summary sufficient to inform the Plaintiff of the important facts known to or observed by such witness, or provide a copy of any written or recorded statements taken from such witnesses.
6. If the EIP is improperly identified, give the proper identification and state whether counsel will accept service of an amended summons and pleading reflecting the correct information.
7. State the names and addresses of all persons, both entities and individuals, with authority to make decisions regarding coverage or denials of coverage under the EIP Standard Plan (hereinafter referred to as the "Plan"), including but not limited to making the final determination to allow or disallow a claim for benefits, in each calendar year since January 1, 2000.
8. State the names and addresses of all persons, both entities and individuals, who took part in drafting any portion of the Plan, including any revisions or amendments to the Plan.
9. State whether or not the Plan covers self-management training and education for the treatment or maintenance of *any* medical condition(s), and if so identify the condition(s).
10. For each year since January 1, 2000 state the total (by year) number of individuals who were covered by the Plan, including but not limited to any enrolled dependants.
11. State the reason why Plaintiff's claim was disallowed, including an explanation of any relevant policy provisions or exclusions.
12. If the EIP contends that SC Code § 38-71-46 does not apply to the Plan, please explain why.

13. Identify all statutes, regulations, case law and other authority with the force of law which you contend support your contention that S.C. Code § 38-71-46 does not apply to the Plan.
14. State whether the EIP has ever notified the Diabetes Initiative of South Carolina that the Plan does not cover outpatient self-management training and education for the treatment of people with diabetes mellitus because S.C. Code § 38-71-46 does not apply to the Plan.
15. How and when is the EIP able to identify persons covered under the Plan, including but not limited to enrolled dependants, who have diabetes?
16. Provide the total number of claims, by year, of any type processed under the Plan for each calendar year since January 1, 2000.
17. Provide the total number of claims, by year, of any type which were denied under the Plan for each calendar year since January 1, 2000.
18. State the total number of claims, by year, made under the Plan for diabetes education for each calendar year beginning January 1, 2000.
19. Identify all the different types of individuals, employers, state and local governments which are able to participate in the Plan.
20. Identify any other state law insurance mandates EIP contends do not apply to the Plan, and explain why.
21. Describe the flow of the premium monies from the individual and employer to or through the Plan and/or Blue Cross and Blue Shield of South Carolina (hereinafter referred to as "BCBS").
22. Has any entity other than BCBS served in the same or similar capacity for the EIP since January 1, 2000?

23. Is this action similar in whole or in part to any other lawsuit ever filed against the EIP? If so, provide: (1) a short caption and the full case number of the related action; and (2) a statement of the status of the related action. Counsel should disclose any cases which may be related regardless of whether they are still pending.
24. If you contend that some other person or legal entity is a necessary party to this action, identify such person or entity and describe the basis of your claim that the person or entity is a necessary party.
25. If you contend that some other person or legal entity is, in whole or in part, liable to you or the party asserting a claim against you in this matter, identify such person or entity and describe the basis of said liability.
26. Identify any and all diagnosis or treatment codes related to diabetes.
27. For each year since January 1, 2000 state, by year, the total number of individuals, including but not limited to any enrolled dependants, who were covered by the Plan and who received or were assigned the diagnosis code "250" or a treatment code beginning with "250."


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-and-

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Brickman, LLC
1017 Chuck Dawley Blvd.
Mt. Pleasant, SC 29464
(843) 727-6500

ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 60TH day of May, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows:

Theodore D. Willard, Jr., Esq.
MONTGOMERY WILLARD, LLC
1002 Calhoun Street
Post Office Box 11886
Columbia, SC 29211

Kelly H. Rainsford, Esq.
State Budget & Control Board
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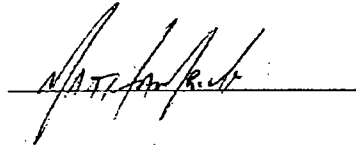
A handwritten signature in black ink, appearing to read "Theodore D. Willard, Jr.", is written over a horizontal line.

EXHIBIT B

STATE OF SOUTH CAROLINA)

IN THE COURT OF COMMON PLEAS

COUNTY OF CHARLESTON)

CASE NO.: 09-CP-10-7404

Jeffrey D. Allen, individually, as Guardian)
For Jane Doe, a minor, and as Representative)
Of other similarly situated State of)
South Carolina employees,)

Plaintiff's First Requests for Production
to Defendant South Carolina Budget and
Control Board Employee Insurance Program

Plaintiff,)

v.)

South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)

Plaintiff hereby submits the following requests for production, pursuant to Rules 26 and 34, to Defendant the South Carolina Budget and Control Board Employee Insurance Program (hereinafter referred to as the "EIP").

REQUESTS FOR PRODUCTION

1. Any and all documents relating to any contracts between the EIP and Blue Cross and Blue Shield of South Carolina (hereinafter referred to as "BCBS"), including but not limited to any records of payment, from 2000 to present.
2. Any and all documents relating to any contracts between the EIP and/or BCBS and/or any diabetic-supply companies, including but not limited to contracts, lists of services and supplies, and terms of payment (both approved and non-approved for payment) from 2000 to present.
3. Any and all documents relating to any contracts between the EIP and/or BCBS and/or any diabetic-related durable medical equipment companies, including but not limited to

contracts, lists of services, durable medical equipment, and terms of payment (both approved and non-approved for payment) from 2000 to present.

4. Any and all indemnity agreements existing between the EIP and BCBS.
5. A listing of the current members of the South Carolina Budget and Control Board.
6. A listing of the current employees of South Carolina Budget and Control Board whose job responsibilities involve the EIP, including their job descriptions.
7. All versions for each policy year, since January 1, 2000, of the provisions of the Plan, to include the Plan Document and the Summary provided to employees.
8. All written inquiries of any type, including but not limited to claims correspondence and documentation, emails, and any other type of inquiry, made to EIP on or after January 1, 2000, regarding S.C. Code § 38-71-46.
9. Any and all communications made by the EIP, on or after January 1, 2000, regarding S.C. Code § 38-71-46.
10. Any and all communications or documents related to the content of or introduction of the legislation which ultimately resulted in the enactment of S.C. Code 38-71-46.
11. Any and all communications made by the EIP containing information about or in any way relating to any type of wellness plan or wellness coverage for people with diabetes.
12. Any and all documents relating to any limitation of authority of claims adjusters for insurance policies, or reflecting any requirement for prior approval for payment of any claim.
13. Produce any electronic communications or representations, including but not limited to emails, blogs, personal homepages, internet message boards, and social networking sites, relating to or referring to coverage or the absence of coverage under the Plan for outpatient self-management training and education for the treatment of people with diabetes mellitus.

14. Produce any and all non-patient-specific information or data the EIP has used since January 1, 2000 to make predictions about the number of diabetes-related claims that would potentially be made by persons covered under the Plan, including but not limited to enrolled dependants.
15. Produce a chart or other similar document showing the organizational structure of the EIP.


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Wills Massalon & Allen, LLC
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-and-

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Brickman, LLC
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Mt. Pleasant, SC 29464
(843) 727-6500

ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 6TH day of May, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows:

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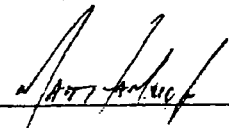


EXHIBIT C

STATE OF SOUTH CAROLINA)

IN THE COURT OF COMMON PLEAS

COUNTY OF CHARLESTON)

CASE NO.: 09-CP-10-7404

Jeffrey D. Allen, individually, as Guardian)
For Jane Doe, a minor, and as Representative)
Of other similarly situated State of)
South Carolina employees,)

Plaintiff's First Interrogatories
To Defendant Blue Cross and Blue
Shield of South Carolina

Plaintiff,)

v.)

South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)

Plaintiff hereby submits the following interrogatories, pursuant to Rules 26 and 33, to
Defendant Blue Cross and Blue Shield of South Carolina (hereinafter referred to as "BCBS").

INTERROGATORIES

1. Give the names and addresses of persons known to BCBS or counsel to be witnesses concerning the facts of this case and indicate whether or not written or recorded statements have been taken from the witnesses and indicate who has possession of such statements.
2. Set forth a list of any prepared documents in possession of BCBS or counsel that relate to the claims or defenses in this case.
3. Set forth the names and addresses of all insurance companies which have liability insurance coverage relating to the claim and set forth the number or numbers of the policies involved and the amount or amounts of liability coverage provided in each policy.
4. List the names and addresses of any expert witnesses whom BCBS proposes to use as a witness at the trial of the case.

5. For each person known to BCBS or counsel to be a witness concerning the facts of the case, set forth either a summary sufficient to inform the Plaintiff of the important facts known to or observed by such witness, or provide a copy of any written or recorded statements taken from such witnesses.
6. If BCBS is improperly identified, give the proper identification and state whether counsel will accept service of an amended summons and pleading reflecting the correct information.
7. State the names and addresses of all persons, both entities and individuals, with authority to make decisions regarding coverage or denials of coverage under the South Carolina Budget and Control Board Employee Insurance Plan (hereinafter referred to as the "EIP") Standard Plan (hereinafter referred to as the "Plan"), including but not limited to making the final determination to allow or disallow a claim for benefits, in each calendar year since January 1, 2000.
8. State the names and addresses of all persons, both entities and individuals, who took part in drafting any portion of the Plan, including any revisions or amendments to the Plan.
9. State whether or not the Plan covers self-management training and education for the treatment or maintenance of any medical condition(s), and if so identify the condition(s).
10. For each year since January 1, 2000 state, by year, the total number of individuals who were covered by the Plan, including but not limited to any enrolled dependants.
11. State the reason why Plaintiff's claim was disallowed, including an explanation of any relevant policy provisions or exclusions.
12. If BCBS contends that SC Code § 38-71-46 does not apply to the Plan, please explain why.
13. Identify all statutes, regulations, case law and other authority with the force of law which you contend support your contention that S.C. Code § 38-71-46 does not apply to the Plan.

14. State whether BCBS has ever notified the Diabetes Initiative of South Carolina that the Plan does not cover outpatient self-management training and education for the treatment of people with diabetes mellitus because S.C. Code § 38-71-46 does not apply to the Plan.
15. State whether or not BCBS covers outpatient self-management training and education under its private health insurance plans (other than the Plan at issue in this case), and identify each plan under which outpatient self-management training and education is covered, and the terms of any such coverage.
16. How and when is BCBS able to identify persons covered under the Plan, including but not limited to enrolled dependants, who have diabetes?
17. Provide the total number of claims, by year, processed under the Plan for each calendar year since January 1, 2000.
18. Provide the total number of claims, by year, which were denied under the Standard Plan for each calendar year since January 1, 2000.
19. State the total number of claims, by year, made for diabetes education for each calendar year beginning January 1, 2000.
20. Set forth the make-up or the formula or method by which BCBS is compensated through its relationship with the EIP, including all years from January 1, 2000 to the present.
21. With regard to any compensation paid to BCBS related in any way to BCBS's services performed for EIP, state whether any portion of the compensation paid to BCBS is based on or related in any way to the number or amount of claims paid or denied.
22. Provide the annual compensation paid to (or revenues collected by) BCBS or any affiliated entities related to the relationship with the EIP.

23. With regard to the annual compensation or revenue referenced in the answer to the preceding Interrogatory, identify for which of the following revenue descriptors compensation or revenue is reported:

- Premiums
- Fee-for-Service
- Risk Revenue
- Net Investment Income Earned
- Net Gain or (Loss) from Agents' or Premium Balances Charged Off
- Other Revenue

24. What percentage of total operating revenue of BCBS is derived from the relationship with the EIP.

25. Does BCBS maintain a separate database of, or have the ability to identify in its databases, diabetes patients, including but not limited to those who have diabetes when they apply for coverage and also those who are diagnosed with diabetes while participants in the Plan?

26. How long has BCBS been serving in its present capacity for the EIP?

27. Is this action similar in whole or in part to any other lawsuit ever filed against BCBS? If so, provide: (1) a short caption and the full case number of the related action; and (2) a statement of the status of the related action. Counsel should disclose any cases which may be related regardless of whether they are still pending.

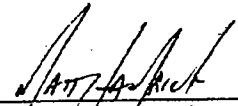
28. If you contend that some other person or legal entity is a necessary party to this action, identify such person or entity and describe the basis of your claim that the person or entity is a necessary party.

29. If you contend that some other person or legal entity is, in whole or in part, liable to you or the party asserting a claim against you in this matter, identify such person or entity and describe the basis of said liability.

30. Set forth all itemized components of diabetes management, including any educational or nutritional component.

31. For each year since January 1, 2000 state, by year, the total number of individuals, including but not limited to any enrolled dependants, who were covered by the Plan and who received or were assigned the diagnosis code "250" or a treatment code beginning with "250."

32. What type of computer system(s), including the data format(s), does BCBS use with regard to submissions of claims?



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(843) 727-1144
-and-
Terry E. Richardson, Jr.
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Mt. Pleasant, SC 29464
(843) 727-6500

ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 6TH day of May, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows:

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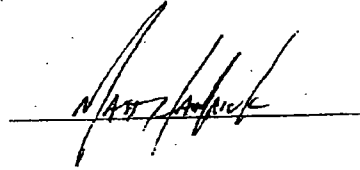
A handwritten signature in black ink, appearing to read "Kelly H. Rainsford", is written over a horizontal line.

EXHIBIT D

STATE OF SOUTH CAROLINA)

COUNTY OF CHARLESTON)

Jeffrey D. Allen, individually, as Guardian)
For Jane Doe, a minor, and as Representative)
Of other similarly situated State of)
South Carolina employees,)

Plaintiff,)

v.)

South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)

IN THE COURT OF COMMON PLEAS

CASE NO.: 09-CP-10-7404

Plaintiff's First Requests for Production
to Defendant Blue Cross and Blue Shield
of South Carolina

Plaintiff hereby submits the following requests for production, pursuant to Rules 26 and 34, to Defendant Blue Cross and Blue Shield of South Carolina (hereinafter referred to as BCBS).

REQUESTS FOR PRODUCTION

1. Any and all documents relating to any contracts between the State of South Carolina Budget and Control Board Employee Insurance Program (hereinafter referred to as the "EIP") and BCBS, including but not limited to any records of payment, from 2000 to present.
2. Any and all documents relating to any contracts between the EIP and/or BCBS and/or any diabetic-supply companies, including but not limited to contracts, lists of services and supplies, and terms of payment (both approved and non-approved for payment) from 2000 to present.
3. Any and all documents relating to any contracts between the EIP and/or BCBS and/or any diabetic-related durable medical equipment companies, including but not limited to

contracts, lists of services, durable medical equipment, and terms of payment (both approved and non-approved for payment) from 2000 to present.

4. Any and all indemnity agreements existing between the EIP and BCBS.
5. A listing of the current employees of BCBS whose job responsibilities involve the EIP, including their job descriptions.
6. All versions for each policy year, since January 1, 2000, of the provisions of the Plan, to include the Plan Document and the Summary provided to employees.
7. All written inquiries of any type, including but not limited to claims correspondence and documentation, emails, and any other type of inquiry, made to BCBS on or after January 1, 2000, regarding S.C. Code § 38-71-46.
8. Any and all communications made by BCBS on or after January 1, 2000, regarding S.C. Code § 38-71-46.
9. Any and all communications or documents related to the content of or introduction of the legislation which ultimately resulted in the enactment of S.C. Code 38-71-46.
10. Any and all communications made by BCBS containing information about or in any way relating to any type of wellness plan or wellness coverage for people with diabetes.
11. Any and all documents relating to any limitation of authority of claims adjusters for insurance policies, or reflecting any requirement for prior approval for payment of any claim.
12. Copies of the annual financial statements, including balance sheets and Profit & Loss Reports, for BCBS for each year beginning January 1, 2000.
13. Training materials, procedure manuals, or other materials used to train employees of BCBS in evaluating claims under the Plan including but not limited to claims for diabetes

related services, and for outpatient self-management training and education for the treatment of people with diabetes mellitus (ICD Code 250).

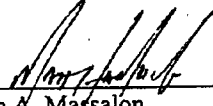
14. Produce any electronic communications or representations, including but not limited to emails, blogs, personal homepages, internet message boards, and social networking sites, relating to or referring to coverage or the absence of coverage under the Plan for outpatient self-management training and education for the treatment of people with diabetes mellitus.

15. Produce any and all non-patient-specific information or data BCBS has used since January 1, 2000 to make predictions about the number of diabetes-related claims that would potentially be made by persons covered under the Plan, including but not limited to enrolled dependants.

16. Produce a chart or other similar document showing the organizational structure of BCBS.

17. Produce documentation of all BCBS claims codes for diabetes (ICD 250)-related services, equipment, drugs, procedures.

18. Produce reimbursement policies for diabetes education and/or nutritional education.


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-and-

Terry E. Richardson, Jr.
Matthew D. Hamrick
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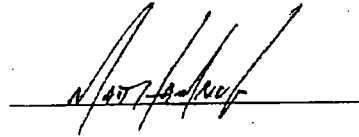
ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 6TH day of May, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows:

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Kelly H. Rainsford, Esq.
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, SC 29211

A handwritten signature in black ink, appearing to read "Kelly H. Rainsford", is written over a horizontal line.

STATE OF SOUTH CAROLINA)
COUNTY OF CHARLESTON)
Jeffrey D. Allen, individually, as Guardian)
For Jane Doe, a minor, and as Representative)
Of other similarly situated State of)
South Carolina employees,)
Plaintiff,)
v.)
South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)
Defendants.)

IN THE COURT OF COMMON PLEAS

CASE NO.: 09-CP-10-7404

Plaintiff's Memorandum in Support of
Motion to Compel Responses to
Plaintiff's First Interrogatories
and First Requests for Production, in
Support of Motion to Stay Decision on
Defendants' Motion for Summary
Judgment or, in the Alternative,
Denial of Defendants' Motion for
Summary Judgment, and in Opposition to
Defendants' Motion for Protective
Order

FILED
CLERK OF COURT
JAN 10 2010

INTRODUCTION

Plaintiff, Jeffrey D. Allen, by and through his undersigned attorneys, submits this memorandum in support of his motion to compel responses to his first interrogatories and requests for production, in support of his motion to stay decision on Defendants' motion for summary judgment or, in the alternative, denial of Defendants' motion for summary judgment, and in opposition to Defendants' motion for protective order.

BACKGROUND AND PERTINENT PROCEDURAL HISTORY

The Plaintiff, Jeffrey D. Allen, is an employee of a local South Carolina school district and an insured/ member of the State Health Plan. His daughter, a dependant covered by that health insurance plan, was diagnosed with Type I Diabetes in November 2007 at the age of two (2) years old. This case is about the Defendants' failure to comply with a South Carolina statutory mandate for coverage of outpatient diabetes training and education, S.C. Code Ann. § 38-71-46 (discussed further below), and whether this case should be certified as a class action.

The Complaint alleges that Defendants have unlawfully denied Plaintiff's and other similarly-situated persons' claims for coverage of diabetes-related education on the grounds that, as set forth in Defendant Blue Cross and Blue Shield of South Carolina's denials of Plaintiff's claims for coverage, the "benefit plan does not cover education and/or training for this condition [diabetes]."

The Defendants have asserted that the above-referenced statutory mandate for coverage of outpatient diabetes education and training does not apply to the State Health Plan, without any explanation or reasoning whatsoever and in direct contradiction to the plain and unambiguous language of the statute.

The Defendants initially moved to dismiss this case, and for judgment on the pleadings, arguing that Plaintiff had failed to exhaust his administrative remedies and that Defendant Blue Cross and Blue Shield of South Carolina is merely the administrator and not the insurer under the State Health Plan. *See* Defendants' Memorandum in Support of Defendants' Motion to Dismiss and for Judgment on the Pleadings.

In response to Defendants' Motion to Dismiss and for Judgment on the Pleadings, Plaintiff submitted a thorough memorandum in opposition and detailed affidavits. *See* Memorandum in Opposition to Defendants' Motion to Dismiss, and exhibits/affidavits attached thereto, all of which are incorporated here in opposition to Defendants' current motion for summary judgment.

A hearing was held before the Honorable Markley Dennis on March 4, 2010 on Defendants' motions to dismiss and for judgment on the pleadings, and Judge Dennis denied the motions. *See* March 8, 2010 and March 10, 2010 Orders, respectively, denying motion to dismiss and denying motion for judgment on the pleadings.

Thereafter, on May 6, 2010 Plaintiff served interrogatories and requests for production upon Defendants. Defendants have refused to respond to Plaintiff's written discovery requests, and instead filed the motion for protective order (to allow Defendants not to respond to Plaintiff's discovery requests) and the motion for summary judgment currently pending before the Court.

Defendants' motion for summary judgment repeats the same grounds regarding the exhaustion of administrative remedies as Defendants' previously-denied motion to dismiss and for judgment on the pleadings, plus the additional ground, without any explanation or reasoning whatsoever, that the above-referenced mandate for coverage of outpatient diabetes education and training does not apply to the State Health Plan.

Thereafter, Plaintiff filed his motion to compel responses to his written discovery requests, and motion to stay decision on Defendants' motion for summary judgment, currently pending before the Court.

Defendants' motion for protective order should be denied and discovery in this case should be allowed to proceed. Defendants' motion for summary judgment should either be stayed until the parties have had a full opportunity to conduct discovery, or, alternatively, should be denied because no discovery has taken place in this case, Defendants' unexplained and unreasoned assertion that the above-referenced statutory mandate does not apply to the State Insurance Plan is completely without basis and in direct contradiction to the plain and unambiguous language of the statute and is a novel question, and the application of the law to the facts is in dispute.

In addition to Plaintiff's Memorandum in Opposition to Defendants' Motion to Dismiss, and the exhibits/affidavits attached thereto, all of which are incorporated here in opposition to

Defendants' current motion for summary judgment, Plaintiff also submits the Affidavit of Matthew D. Hamrick, counsel for Plaintiff, pursuant to Rule 56(f), SCRCP (attached hereto as Exhibit "A").

THE STATUTORY MANDATE FOR COVERAGE OF DIABETES EDUCATION

S.C. Code Ann. § 38-71-46 provides:

Diabetes Mellitus coverage in health insurance policies, diabetes education.

(A) On or after January 1, 2000, *every* health maintenance organization, *individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for* the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and *outpatient self-management training and education for the treatment of people with diabetes mellitus*, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina. This subsection does not prohibit a health maintenance organization or an individual or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.

(B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.

(C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re-credential a provider.

(D) For purposes of this section: "*Health insurance policy*" means a *health benefit plan*, contract, or evidence of coverage providing health insurance

coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

S.C. Code Ann. § 38-71-46 (emphasis added).

As noted above, the mandate statute states that "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14). S.C. Code § 38-71-670(6) defines "Health insurance coverage" as follows:

(6) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

(a) coverage only for accident or disability income insurance or any combination of these;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for on-site medical clinics;

(h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) if offered separately:

(i) limited scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;

(iii) other similar, limited benefits as are specified in regulations;

(j) if offered as independent, noncoordinated benefits:

(i) coverage only for a specified disease or illness;

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy:

(i) Medicare supplemental health insurance, as defined under Section 1882(g)(1) of the Social Security Act;

(ii) coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code; and

(iii) similar supplemental coverage under a group health plan.

S.C. Code § 38-71-670(6). Similarly, S.C. Code § 38-71-840(14) is nearly identical and defines

"Health insurance coverage" as follows:

(14) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

(a) coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for on-site medical clinics;

(h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) if offered separately:

(i) limited scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;

(iii) other similar, limited benefits as are specified in regulations;

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(ii) hospital indemnity or other fixed indemnity insurance;

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(i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(ii) coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code; and

(iii) similar supplemental coverage under a group health plan.

S.C. Code § 38-71-840(14). The State Health Plan obviously meets these statutory definitions of "health insurance coverage" and is not included within any of the enumerated exceptions. Therefore, the State Health Plan is a "Health insurance policy" for purposes of the statutory mandate of S.C. Code Ann. § 38-71-46. See *Riverwoods, LLC v. County of Charleston*, 349 S.C. 378, 384, 563 S.E.2d 651, 655 (2002) ("The canon of construction '*expressio unius est exclusio alterius*' or '*inclusio unius est exclusio alterius*' holds that 'to express or include one thing implies the exclusion of another, or of the alternative. The enumeration of exclusions from the operation of a statute indicates that the statute should apply to all cases not specifically excluded. Exceptions strengthen the force of the general law and enumeration weakens it as to things not

expressed.' ") (citations omitted); *W. Va. Pulp & Paper Co. v. Riddock*, 225 S.C. 283, 288, 82 S.E.2d 189, 190 (1954) (" The inclusion in the statute of certain specified exclusions leaves the inference that the Legislature intended no other exclusions from the exemption.").

The Defendants have asserted that the above-referenced statutory mandate for coverage of outpatient diabetes education and training does not apply to the State Health Plan, without any explanation or reasoning whatsoever and in direct contradiction to the plain and unambiguous language of the statute. The statutory mandate should be held to apply to the State Health Plan. "The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature." *Hardee v. McDowell*, 381 S.C. 445, 453, 673 S.E.2d 813, 817 (2009) (internal quotation omitted). Under the plain meaning rule, the court is not permitted to change the meaning of a clear and unambiguous statute. *Hodges v. Rainey*, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000). Where the statute's language is plain, unambiguous, and conveys a clear, definite meaning, the court may not impose a different meaning and need not employ rules of statutory interpretation. *Gay v. Ariail*, 381 S.C. 341, 345, 673 S.E.2d 418, 420 (2009).

**DEFENDANTS' MOTIONS FOR A PROTECTIVE ORDER AND SUMMARY JUDGMENT
SHOULD BE DENIED, AND DISCOVERY SHOULD BE ALLOWED TO PROCEED**

The Defendants' motions for a protective order (that they be permitted to not respond to Plaintiff's written discovery requests) and for summary judgment should be denied. Discovery should be allowed to proceed. At the very least, a decision on the motion for summary judgment should be stayed until the parties have had a full opportunity to conduct discovery. The Court of Appeals of South Carolina has explained that:

summary judgment is a "drastic remedy" which should be cautiously invoked so no person will be improperly deprived of a trial of the disputed factual issues. *Cunningham v. Helping Hands, Inc.*, 352 S.C. 485, 575 S.E.2d 549 (2003); *Lanham v. Blue Cross & Blue Shield*, 349 S.C. 356, 563 S.E.2d 331 (2002); *Comner v. City of Forest Acres*, 348 S.C. 454, 560 S.E.2d 606 (2002); *Redwend*

Ltd. P'ship v. Edwards, 354 S.C. 459, 581 S.E.2d 496 (Ct.App.2003); *Baril v. Aiken Reg'l Med. Ctrs.*, 352 S.C. 271, 573 S.E.2d 830 (Ct.App.2002); *Trivelas v. South Carolina Dep't of Transp.*, 348 S.C. 125, 558 S.E.2d 271 (Ct.App.2001); *Murray v. Holnam, Inc.*, 344 S.C. 129, 542 S.E.2d 743 (Ct.App.2001); *McNair v. Rainsford*, 330 S.C. 332, 499 S.E.2d 488 (Ct.App.1998). Because summary judgment is a drastic remedy, it **must not be granted until the opposing party has had a "full and fair opportunity to complete discovery."** *Dawkins v. Fields*, 354 S.C. 58, 69, 580 S.E.2d 433, 439 (2003); *Lanham*, 349 S.C. at 363, 563 S.E.2d at 334; *Doe v. Batson*, 345 S.C. 316, 322, 548 S.E.2d 854, 857 (2001); *Baird v. Charleston County*, 333 S.C. 519, 529, 511 S.E.2d 69, 74 (1999); *Baughman v. American Tel. & Tel. Co.*, 306 S.C. 101, 112, 410 S.E.2d 537, 543 (1991).

Schmidt v. Courtney, 357 S.C. 310, 592 S.E.2d 326, 331 (Ct. App. 2003) (emphasis added). The court in *Schmidt* went on to explain:

Summary judgment is not appropriate where further inquiry into the facts of the case is desirable to clarify the application of the law. *Lanham*, 349 S.C. at 362, 563 S.E.2d at 333; *Moriarty v. Garden Sanctuary Church of God*, 341 S.C. 320, 534 S.E.2d 672 (2000); *Mosteller v. County of Lexington*, 336 S.C. 360, 520 S.E.2d 620 (1999); *Redwend Ltd. P'ship*, 354 S.C. at 468, 581 S.E.2d at 501; *Baril*, 352 S.C. at 280, 573 S.E.2d at 835; *Trivelas*, 348 S.C. at 130, 558 S.E.2d at 273; *Hall v. Fedor*, 349 S.C. 169, 561 S.E.2d 654 (Ct.App.2002); *Hedgepath v. American Tel. & Tel. Co.*, 348 S.C. 340, 559 S.E.2d 327 (Ct.App.2001); *Bayle v. South Carolina Dep't of Transp.*, 344 S.C. 115, 542 S.E.2d 736 (Ct.App.2001); *Vermeer Carolina's, Inc. v. Wood/Chuck Chipper Corp.*, 336 S.C. 53, 518 S.E.2d 301 (Ct.App.1999); *Middleborough Horizontal Prop. Regime Council v. Montedison*, 320 S.C. 470, 465 S.E.2d 765 (Ct.App.1995). "Summary judgment is inappropriate when further development of the facts is desirable to clarify the application of the law." *Lee v. Kelley*, 298 S.C. 155, 158, 378 S.E.2d 616, 617 (Ct.App.1989). Even when there is no dispute as to evidentiary facts, but only as to the conclusions or inferences to be drawn from them, summary judgment should be denied. *Redwend Ltd. P'ship*, 354 S.C. at 468, 581 S.E.2d at 501; *Baril*, 352 S.C. at 280, 573 S.E.2d at 835; *Hall*, 349 S.C. at 173-74, 561 S.E.2d at 656; *Glasscock, Inc. v. United States Fid. & Guar. Co.*, 348 S.C. 76, 557 S.E.2d 689 (Ct.App.2001); *Stewart v. State Farm Mut. Auto. Ins. Co.*, 341 S.C. 143, 533 S.E.2d 597 (Ct.App.2000); see also *Laurens Emergency Med. Specialists v. M.S. Bailey & Sons Bankers*, 355 S.C. 104, 584 S.E.2d 375 (2003) (noting that summary judgment should not be granted even when there is no dispute as to evidentiary facts, if there is dispute as to conclusions to be drawn therefrom).

Schmidt v. Courtney, 357 S.C. 310, 592 S.E.2d 326, 331 (Ct. App. 2003). The Court of Appeals held that summary judgment should have been denied in the *Schmidt* case because the question

of law in that case was a novel one, and the application of the law to the facts was in dispute. As in the *Schmidt* case, the question of law in this case (whether the above-referenced statutory mandate applies to the State Health Plan) is a novel question, and the application of the statute to the facts of this case is in dispute. Additionally, further inquiry into the facts is necessary to clarify the application of the law. Therefore, summary judgment is inappropriate and should be denied, as should Defendants' motion for a protective order allowing them not to answer Plaintiff's discovery requests. At a minimum, the decision on Defendants' motion for summary judgment should be stayed until the parties have had a full opportunity to conduct discovery.

PLAINTIFF IS NOT REQUIRED TO EXHAUST ADMINISTRATIVE REMEDIES

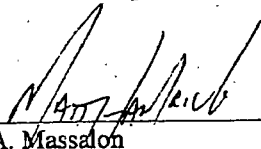
The issue of exhaustion of administrative remedies, which Defendants assert is a basis for summary judgment, was fully briefed and argued pursuant to Defendants' motion to dismiss and for judgment on the pleadings, which, as mentioned above, were denied. Defendant is now attempting a second bite at the apple by again asserting the issue of exhaustion of administrative remedies as a purported basis for summary judgment. Plaintiff incorporates by reference Plaintiff's Memorandum in Opposition to Defendants' Motion to Dismiss, and the exhibits/affidavits attached thereto, in opposition to this purported basis for summary judgment. Additionally, Plaintiff respectfully directs the Court's attention to *Drummond v. State of South Carolina*, 378 S.C. 362, 662 S.E.2d 587 (2008), wherein the court recently affirmed that the Administrative Law Court and judges formerly known as ALJs "are an agency of the executive branch of government" and cannot rule on the validity of a statute or regulation. While this case is not a direct challenge of the constitutionality of the subject statutory coverage mandate, the South Carolina Budget and Control Board is a state agency and it has promulgated its "decision" that its State Health Plan does not provide coverage for diabetic education. It is the validity of

that state agency's decision which is being challenged in this case. In *Drummond*, the court held that although the appellant was not challenging the constitutionality of the regulation, he was challenging its validity under state law. Because the Administrative Law Court is part of the executive branch, as stated in *Video Gaming Consultants, Inc. v. South Carolina Dep't of Revenue*, 342 S.C. 34, 38, 535 S.E.2d 642, 644 (2000), it has no authority to rule on the validity of the regulation.

CONCLUSION

For the reasons discussed above, Plaintiff respectfully requests that the Court issue an order as follows:

1. Granting Plaintiff's motion to compel Defendants to fully respond to Plaintiff's first interrogatories and requests for production;
2. Denying Defendant's motion for a protective order; and
3. Denying Defendant's motion for summary judgment, or, alternatively, staying the decision on Defendant's motion for summary judgment until the parties have had a full and fair opportunity to complete discovery.


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-and-

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Matthew D. Hamrick
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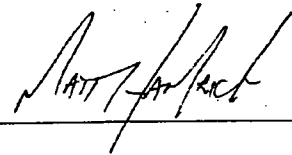
ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 23RD day of AUGUST, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows, and also by email transmission as follows:

Theodore D. Willard, Jr., Esq.
MONTGOMERY WILLARD, LLC
1002 Calhoun Street
Post Office Box 11886
Columbia, SC 29211
tdw@montgomerywillard.com

Kelly H. Rainsford, Esq.
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, SC 29211
krainsford@digs.sc.gov



2010 AUG 24 PM 3:15
JULIE J. AUSTIN
CLERK OF COURT

FILED

EXHIBIT A

STATE OF SOUTH CAROLINA

) IN THE COURT OF COMMON PLEAS

COUNTY OF CHARLESTON

) CASE NO.: 09-CP-10-7404

Jeffrey D. Allen, individually, as Guardian
For Jane Doe, a minor, and as Representative
Of other similarly situated State of
South Carolina employees,

Plaintiff,

v.

South Carolina Budget and Control Board
Employee Insurance Program and Blue
Cross and Blue Shield of South Carolina,

Defendants.

) AFFIDAVIT OF
) MATTHEW D. HAMRICK, ESQ.

APPEARED BEFORE ME Matthew D. Hamrick, Esq., who, after being first duly sworn,
deposed and said the following:

1. My name is Matthew D. Hamrick. I am over the age of eighteen (18) years. I am a citizen and resident of South Carolina, and I am one of the attorneys of record for the Plaintiff in the above-captioned lawsuit.
2. My statements herein are made upon my oath, are based upon my own personal knowledge, are true and correct, and I make them voluntarily and under penalty of perjury.
3. I make this affidavit pursuant to Rule 56(f), SCRCF in opposition to Defendants' motion for summary judgment.
4. This case is about the Defendants' failure to comply with a South Carolina statutory mandate for coverage of outpatient diabetes training and education, S.C. Code Ann. § 38-71-46, to an insured covered by the State Health Plan and whether this case should be certified as a class action.
5. Defendant Blue Cross and Blue Shield of South Carolina has asserted, in its denials of Plaintiff's claims for coverage, that the "benefit plan does not cover education and/or training for this condition [diabetes]."
6. The question of whether S.C. Code Ann. § 38-71-46 applies to the State Health Plan appears to be a novel question of law. Plaintiff's counsel has not found any case or other authority on this particular question.

7. On May 6, 2010 Plaintiff served interrogatories and requests for production upon Defendants. Defendants have refused to respond to Plaintiff's written discovery requests, and instead filed the motion for protective order (to allow Defendants not to respond to Plaintiff's discovery requests) and motion for summary judgment currently pending before the Court.

8. It is necessary for Plaintiff to have a full and fair opportunity to conduct discovery in this case, beginning with Plaintiff's first interrogatories and requests for production, so that Plaintiff can discover additional factual evidence to offer in opposition to Defendants' motion for summary judgment.

9. In their motion for summary judgment, Defendants have asserted that S.C. Code Ann. § 38-71-46 does not apply to the State Health Plan, but Defendants have not given any explanation or reason for this assertion.

10. In Plaintiff's first interrogatories to Defendant the South Carolina Budget and Control Board Employee Insurance Program, Plaintiff inquired, among other things:

....

9. State whether or not the Plan covers self-management training and education for the treatment or maintenance of *any* medical condition(s), and if so identify the condition(s).

....

11. State the reason why Plaintiff's claim was disallowed, including an explanation of any relevant policy provisions or exclusions.

12. If the EIP contends that SC Code § 38-71-46 does not apply to the Plan, please explain why.

13. Identify all statutes, regulations, case law and other authority with the force of law which you contend support your contention that S.C. Code § 38-71-46 does not apply to the Plan.

14. State whether the EIP has ever notified the Diabetes Initiative of South Carolina that the Plan does not cover outpatient self-management training and education for the treatment of people with diabetes mellitus because S.C. Code § 38-71-46 does not apply to the Plan.

....

23. Is this action similar in whole or in part to any other lawsuit ever filed against the EIP? If so, provide: (1) a short caption and the full case number of the related action; and (2) a statement of the status of the related action. Counsel should disclose any cases which may be related regardless of whether they are *still* pending.

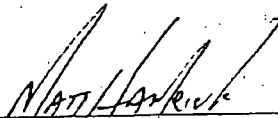
11. In Plaintiff's first requests for production to the South Carolina Budget and Control Board Employee Insurance Program, Plaintiff requests, among other things:

-
7. All versions for each policy year, since January 1, 2000, of the provisions of the Plan, to include the Plan Document and the Summary provided to employees.
 8. All written inquiries of any type, including but not limited to claims correspondence and documentation, emails, and any other type of inquiry, made to EIP on or after January 1, 2000, regarding S.C. Code § 38-71-46.
 9. Any and all communications made by the EIP, on or after January 1, 2000, regarding S.C. Code § 38-71-46.
 10. Any and all communications or documents related to the content of or introduction of the legislation which ultimately resulted in the enactment of S.C. Code 38-71-46.
 11. Any and all communications made by the EIP containing information about or in any way relating to any type of wellness plan or wellness coverage for people with diabetes.
-
13. Produce any electronic communications or representations, including but not limited to emails, blogs, personal homepages, internet message boards, and social networking sites, relating to or referring to coverage or the absence of coverage under the Plan for outpatient self-management training and education for the treatment of people with diabetes mellitus.

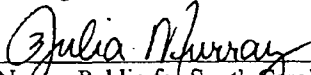
12. In Plaintiff's first interrogatories and requests for production to Defendant Blue Cross and Blue Shield of South Carolina Plaintiff made inquiries and requests similar or essentially identical to those listed above.

13. The Defendants' answers and responses to all of the above-listed interrogatories and requests for production are necessary and would be highly relevant to the Defendants' assertion as a basis for summary judgment that S.C. Code Ann. § 38-71-46 does not apply to the State Health Plan.

FURTHER AFFIANT SAYETH NAUGHT.


Matthew D. Hamrick (SC Bar #: 16853)

Sworn to before me this 23rd day
of August, 2010.


Notary Public for South Carolina
My commission expires: 6/4/17

STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS

CASE NO.: 09-CP-10-7404

Jeffrey D. Allen, individually, as Guardian)
For Jane Doe, a minor, and as Representative)
Of other similarly situated State of)
South Carolina employees,)

Plaintiff,)

v.)

South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)

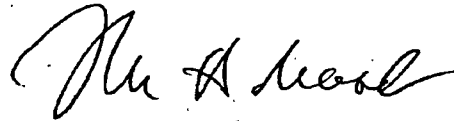
NOTICE OF AND MOTION TO ALTER
OR AMEND PURSAUNT TO SCRCF,
RULE 59(e)

2010 NOV -8 PM 1: 06
JULIE J. ARMSTRONG
CLERK OF COURT

FILED

PLEASE TAKE NOTICE that Plaintiffs, by and through his undersigned counsel, will move before the Hon. Paul M. Burch, Judge of the Charleston County Court of Common Pleas, at the Charleston County Courthouse, Charleston, South Carolina ten (10) days from the filing of this motion, for an order altering or amending the summary judgment order entered in this case pursuant to SCRCF, Rule 59(e). Said entry of judgment was received by the undersigned on October 27, 2010. The grounds for this motion are fully explained in the memorandum filed herewith, and are based on the South Carolina Rules of Civil Procedure, any other applicable law, any memorandum of law filed prior to the hearing, and argument of counsel at a hearing on this matter.

PLEASE BE PRESENT TO DEFEND IF SO MINDED.



John A. Massalon
Wills Massalon & Allen, LLC
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(843) 727-1144

-and-

Terry E. Richardson, Jr.
Matthew D. Hamrick
Richardson, Patrick, Westbrook &
Brickman, LLC
1017 Chuck Dawley Blvd.
Mt. Pleasant, SC 29464
(843) 727-6500

ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 8th day of November, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage prepaid, addressed as follows, and also by email transmission as follows:

Theodore D. Willard, Jr., Esq.
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tdw@montgomerywillard.com

Kelly H. Rainsford, Esq.
State Budget & Control Board
1201 Main Street, Ste. 300
Columbia, SC 29211
krainsford@digs.sc.gov

Jaith Irick

STATE OF SOUTH CAROLINA)
COUNTY OF CHARLESTON)
Jeffrey D. Allen, individually, as Guardian)
For Jane Doe, a minor, and as Representative)
Of other similarly situated State of)
South Carolina employees,)
Plaintiff,)
v.)
South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)
Defendants.)

IN THE COURT OF COMMON PLEAS

CASE NO.: 09-CP-10-7404

2010 NOV -8 PM 4: 05
JULIE J. ARMSTRONG
CLERK OF COURT

FILED

MEMORANDUM IN SUPPORT OF
MOTION TO ALTER OR AMEND
PURSUANT TO SCRCP, RULE 59(e)

This memorandum is submitted in support of the Motion to Alter or Amend filed herewith. This motion to alter or amend the court's order granting summary judgment is based on the court's failure to rule on the following matters raised by the Plaintiff:

1. The court's order fails to discuss why it is not exercising its discretion to stay the civil action pending the outcome of the administrative case. This court has broad discretion in its supervision over the progression and disposition of a circuit court case in the interests of justice and judicial economy. See *Williams v. Bordon's Inc.*, 262 S.E.2d 881, 883 (S.C. 1980). "A party should not be required to 'roll the dice' on whether a collateral administrative proceeding will conclude prior to the running of an applicable statute of limitations in order to preserve a claim properly within the jurisdiction of the circuit court." *Capital City Ins. Co. v. BP Staff, Inc.*, 674 S.E.2d 524, 531 (S.C. Ct. App. 2009).

was first diagnosed with Type I diabetes on November 27, 2007 at the age of two, and diabetic education and training was provided during her initial 3-day hospital stay. In

reviewing all claims for diabetic education made by Allen, Defendants have denied three other such claims dating back to December 17, 2007. In light of the State of South Carolina board/agency being named as a Defendant, the undersigned made the determination to commence this action within two (2) years of the date of diagnosis, so as not to risk a possible statute of limitation defense related to the two (2) year statute of limitation in the South Carolina Tort Claims Act. Plaintiff should not be prejudiced by a decision to protect himself against all statute of limitations defenses, particularly when there is no guidance in the law of whether the Administrative Law Court has the power to grant the relief requested by the Plaintiffs, and that legal issue has not been ruled upon by this court.

While the parties to this case were awaiting the court's ruling in this matter, the South Carolina Court of Appeals issued an opinion in *South Carolina Dept. of Consumer Affairs v. Foreclosure Specialists, Inc.* Op. No. 4749 (S.C. Ct. App. Filed Sept. 29, 2010). That case is instructive because, although addressing a different statutory scheme -- the Consumer Credit Counseling Act, the court found that, under the more general Administrative Law Court statutes, also relied upon by the Defendants in this case, that the ALC did not in fact have the power to grant the Dept. a refund of fees collected in violation of the Act, and that any action for such relief should have been brought in circuit court. While not substantively on point, the case illustrates that risk and difficulty of predicting where the lines fall between the jurisdiction of the ALC and the circuit court.

The court in *Capital City* held that where a party would be harmed by the running of the statute of limitations or otherwise prejudiced if its claim is dismissed on exhaustion of administrative remedies, and the court has determined that resolution of the administrative proceeding would impact the circuit court case, then the circuit court should properly consider a

stay or continuance of the judicial action until the administrative proceedings have concluded. *Id.* at 531. While the outcome of the administrative proceeding could moot this case; another possible outcome is that the ALC (or South Carolina Court of Appeals) determines it does not have the power to grant the relief requested and that the plaintiffs should be in circuit court. This is the classic *catch-22* for a plaintiff, and this court should vacate its order granting summary judgment and enter an order staying this circuit case could pending the final outcome of the administrative proceeding.

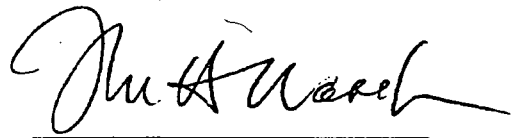
2. The court's order does not address the differences between what is "pending" in the administrative process and the claims made in this Complaint. The claims in this Complaint are not "claims for benefits" within the meaning of section 1-11-710(C), and continuing with the administrative appeal would not provide Plaintiff with an adequate remedy. The only result possible from the administrative proceeding underway would not provide the relief sought by Allen and the potential class members.

If the denial of the subject claim were reversed, Allen would receive coverage for a single \$560 diabetes education claim. However, neither the Allen benefit plan nor the putative class members' benefit plans would necessarily be reformed to provide the statutorily mandated insurance coverage for diabetes education. Allen prevailing in the administrative process would not require the Defendants to review all denials made in violation of the diabetes mandate since its enactment in 2000. Allen prevailing in the administrative process would not enjoin the Defendants from violating the diabetes mandate in the future, nor force disgorgement of revenues and profits related to the illegal conduct.

Generally, "[w]hen an administrative remedy is available to *determine a question of fact*, one must seek the administrative remedy or be precluded from pursuing relief in the courts."

Stinney v. Sumter School Dist. 17, 675 S.E.2d 760, 763 (S. C. Ct. App. 2009) (citing *Hyde v. Dept. of Mental Health*, 442 S.E.2d 582, 583 (S.C. 1994)) (emphasis added). "A party is not required to exhaust administrative remedies if the issue is one that cannot be ruled upon by the administrative body." *Capital City Ins. Co. v. BP Staff, Inc.*, 674 S.E.2d 524, 529 (S.C. Ct. App. 2009) quoting *Charleston Trident Home Builders, Inc. v. Town Council of Town of Summerville*, 632 S.E.2d 864, 867 (S.C. 2006) (citing *Ward v. State*, 538 S.E.2d 245 (S.C. 2000); see also *Stinney*, 675 S.E.2d at 763 (recognizing that inadequacy of the administrative appeal is an exception to the general rule requiring exhaustion).

The purpose of the exhaustion requirement, to allow the agency to render a final decision and set forth its reason for denying the diabetes education claim, would not assist the court in this case. The alleged wrong – violation of the statutory mandate as to an entire class of persons—is not one which the administrative process was designed to address.



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ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify that I have this 8th day of November, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage prepaid, addressed as follows, and also by email transmission as follows:

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tdw@montgomerywillard.com

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Jaith Trunk

FILED
2010 NOV -8 PM 4:06
JULIE J. ARMSTRONG
CLERK OF COURT
BY _____

STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS
FOR THE NINTH JUDICIAL CIRCUIT

Jeffrey D. Allen, individually, as guardian)
for Jane Doe, a minor, and as representative)
of other similarly situated State of South)
Carolina employees,)

Civil Action No.: 2009-CP-10-7404

Plaintiffs,)

**DEFENDANTS' RESPONSE TO
PLAINTIFF'S RULE 59(e) MOTION
TO ALTER OR AMEND JUDGMENT**

v.)

South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)

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JULIE J. ARMSTRONG
CLERK OF COURT

Defendants, South Carolina Budget and Control Board Employee Insurance Program
("EIP") and Blue Cross and Blue Shield of South Carolina ("BCBSSC"), Respond to Plaintiff's
SCRCP 59(e) Motion To Alter or Amend Judgment as follows:

I. DISCUSSION

**A. Plaintiff's Rule 59(e) Motion Fails In That Plaintiff Cannot Use Rule 59(e) To Raise
Issues He Could have Raised Prior To Judgment.**

Plaintiff's Rule 59(e) motion fails as a matter of law in that Plaintiff is attempting to use
Rule 59(e) to present issues that he failed to present prior to judgment. "A party cannot use Rule
59(e) to present to the court an issue the party could have raised prior to judgment, but did not."
C.A.H. v. L.H., 315 S.C. 389, 434 S.E.2d 268 (1993). Here, Plaintiff argues that a stay of the
case pending a resolution of the administrative appeal was more appropriate than a dismissal.
However, Plaintiff never raised this issue prior to entry of judgment in favor of Defendant.
Accordingly, Plaintiff's Rule 59(e) motion fails with respect to this issue. Even assuming,

arguendo, that the Plaintiff did assert this position prior to judgment, his argument would fail as discussed fully in I. B.

B. Dismissal Was Proper In That The Administrative Remedies Under S.C. Code Ann. § 1-11-710 (C) Were Plaintiff's Exclusive Remedy, Subject Only To Appellate Review To The South Carolina Administrative Law Court ("ALC") Pursuant To S.C. Code Ann. § 1-23-600 (D).

Even assuming that Plaintiff properly preserved the issue, Plaintiff's argument that this action should be stayed rather than dismissed "pending resolution of a collateral administrative proceeding" is misplaced in that the administrative proceeding was not collateral, but, in fact, was Plaintiff's exclusive remedy as a matter of law. A participant and/or beneficiary challenging an award of benefits under the State Health Plan is limited to the remedies set forth in S.C. Code Ann. § 1-11-710(C), which provides as follows:

Notwithstanding Sections 1-23-310 and 1-23-320 or any other provision of law, claims for benefits under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board, which shall constitute the exclusive remedy for these claims, subject only to appellate review consistent with standards provided in Section 1-23-380.

Id. (Emphasis added).

Pursuant to the allegations of Plaintiff's Complaint, Plaintiff is requesting the Court interpret the terms of the State Health Plan to include the coverage set out in S.C. Code Ann. § 38-71-46. Plaintiff further alleges he is entitled to disgorge benefits from the plan for unlawful denials of coverage and for injunctive relief enjoining "further denial of claims for diabetes outpatient self-management training and education." (Complaint ¶24). The interpretation of the State Health Plan and the resolution of claims for benefits under the Plan are exactly the types of remedies contemplated by § 1-11-710(C).¹

¹ Paragraph 1.3 of the State Health Plan states:

In Unisys v. The S.C. Budget and control Board, 346 S.C. 158, 551 S.E.2d 263 (2001), the South Carolina Supreme Court upheld the dismissal of the plaintiff's complaint on the grounds that exhausting plaintiff's administrative remedies under the S.C. procurement Code was the exclusive remedy. The Court went on to hold that the term "exclusive remedy" indicates "exclusivity of jurisdiction." Id. at 269. The Court also found that "because a statute waiving the State's immunity must be strictly construed, the State can be sued only in the manner and upon the terms and conditions prescribed by the statute." Id. at 266. Finally, the Court held that dismissal was an appropriate remedy. The Court stated:

Since Unisys is required to exhaust its administrative remedies as a matter of law, dismissal under Rule 12(b)(6) for failure to state a claim was proper. Further, because an action was pending pursuant to the Procurement Code as required when this action was brought, dismissal was also proper under Rule 12(b)(8). See Southern Ry. Co. v. Order of Ry. Conductors, 210 S.C. 121, 41 S.E.2d 774 (1947) (exhaustion of remedies will preclude original resort to courts where statute by express terms gives exclusive jurisdiction to administrative agency).

Id. at 273.

Contrary to Plaintiff's argument, Capital City Insurance Company v. B.P. Staff, Inc., 382 S.C. 92, 674 S.E.2d 524 (Ct. App. 2009) does not stand for the blanket proposition that a stay is more appropriate than a dismissal. In fact, the Court of Appeals in Capital City, relying on the holding in Unisys, acknowledged that:

The South Carolina Supreme Court has instructed that dismissal may be proper under Rule 12 (b)(6) SCRPC where the opposing party is required to exhaust administrative remedies as a matter of law, but failed to do so. See Unisys Corp. v. S.C. Budget & Control Bd., 346 S.C. 158, 176, 551 S.E.2d 263, 273 (2001)

1.3. Applicable Law

This Plan is established and will be maintained with the intention of meeting the requirements of all applicable federal and state laws. Any provision of this Plan, which is in conflict with the law of any governmental body or agency that has jurisdiction over this Plan, shall be interpreted to conform to the minimum requirements of such laws.

(Affidavit of Robin E. Tester, Exhibit C, p.1) (Emphasis added).

(stating that exhaustion of remedies precludes original resort to courts where an administrative agency is granted exclusive jurisdiction by the express terms of a statute). Thus, we must determine whether exhaustion of administrative remedies was required as a matter of law; if not, we next determine whether the court abused its discretion in dismissing the case until exhaustion of the administrative process is complete in order to assist in the disposition of the circuit court proceeding.

Capital City, at 529.

Simply put, the rule relied upon by Plaintiff that an action should be stayed rather than dismissed, does not apply where the administrative agency has exclusive jurisdiction to consider the complaint initially brought in the court. U.S. v. Michigan National Corp., 419 U.S. 1, N. 2 (1974); Pan American World Airways v. U.S., 371 U.S. 296 (1963). In the present case, because a participant and/or beneficiary challenging an award of benefits under the State Health Plan is limited to the administrative remedies set forth in S.C. Code Ann. § 1-11-710(C), dismissal was appropriate.

Finally, Plaintiff's argument that he should not be forced to "roll the dice" with respect to the statute of limitations has no application. Plaintiff's administrative remedies under S.C. Code Ann. § 1-11-710 (C) were Plaintiff's exclusive remedy, subject only to appellate review to the ALC under S.C. Code Ann. § 1-23-600 (D). It is undisputed that Plaintiff timely availed himself of these remedies. Because Plaintiff appealed to the ALC on a timely basis, Plaintiff was not threatened by the statute of limitations. Accordingly, Plaintiff will suffer no prejudice as a result of the dismissal.

C. Plaintiff's Complaint Is A Claim For Benefits Under The State Health Plan.

Plaintiff's argument that his complaint is not a claim for benefits under the State Health Plan is incorrect and is not supported by the allegations of his pleadings. Plaintiff's Complaint alleges:

5. This is an action for declaratory judgment arising from Defendants' unlawful issuance and administration of the State of South Carolina EIP Standard Plan, a plan of health benefits and insurance offered to all current and retired state employees, including public school district employees, for violation of a SC Code Section 38-71-46, for disgorgement of revenues received as a result of the unlawful issuance and administration, and for declaration to determine the value of unlawfully withheld benefits.

11. As the named Plaintiff is an employee of a South Carolina school district, has been enrolled in the EIP Standard Plan, has enrolled his dependent child in said plan who was diagnosed with Diabetes at the age of two years old, and has made multiple claims for his dependent child with a value of approximately One Thousand & 00/100 US Dollars (\$1000.00) for diabetes outpatient self-management training and education which were denied by Defendant BCBSSC as administrator to the EIP, his claim, right and privileges are typical of the proposed class.

19. Plaintiff seeks, individually and as legal guardian for Jane Doe, and on behalf of all class members, a declaration of the rights of the parties hereto: that Defendants are required to issue and administer all health benefit plans offered through the EIP in compliance with the express mandate of South Carolina Code Section 38-71-46.

20. Plaintiff seeks an Order of the Court reforming the terms of the health benefit plan provided to all class members effective January 1, 2000 to provide the mandated diabetes coverage.

21. Plaintiff seeks an Order of the Court requiring the Defendants to disgorge monies received as a result of unlawful denials of the mandatory diabetes coverage, and to pay them to members of the putative class the present value of said unlawfully withheld revenues.

24. The Defendants should be enjoined from the wrongful takings as described above and from further denial of claims for the diabetes outpatient self-management training and education.

(Plaintiff's Complaint).

As the Court correctly found in its order,

Pursuant to the allegations of Plaintiff's Complaint, Plaintiff is requesting the Court interpret the terms of the State Health Plan to include the coverage set out in S.C. Code Ann. § 38-71-46. Plaintiff further alleges he is entitled to disgorge benefits from the plan for unlawful denials of coverage and for injunctive relief enjoining "further denial of claims for diabetes out-patient self-management training and education." (Complaint ¶24). The interpretation of the State Health Plan and the resolution of claims for benefits under the Plan are exactly the types of remedies contemplated by § 1-11-710(C).

(Order at 4 -5).

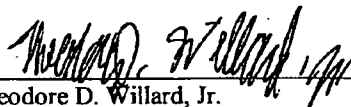
Plaintiff's attempt to circumvent the statutory requirements of § 1-11-710(C) by alleging a purported class action and/or a declaratory judgment action is of no avail. The administrative remedies under S.C. Code Ann. § 1-11-710 (C) were Plaintiff's exclusive remedy, subject only to appellate review to the ALC pursuant to S.C. Code Ann. § 1-23-600 (D). Accordingly, all of Plaintiff's causes of action are preempted by S.C. Code Ann. § 1-11-710 (C). As was previously stated: "because a statute waiving the State's immunity must be strictly construed, the State can be sued only in the manner and upon the terms and conditions prescribed by the statute." Unisys, at 266.

Additionally, it is well settled a court ordinarily will refuse to grant a declaratory judgment where a special statutory remedy has been provided. "Gratuitous interference" in the administrative process should be avoided. Williams Furniture Corp. v. Southern Coatings & Chemical Co., 216 S.C. 1, 7-8, 56 S.E.2d 576, 579 (1949); Smith v. The South Carolina Retirement System, 336 S.C. 505, 520 S.E.2d 339 (Ct. App. 1999). The Court, therefore, should not serve as a substitute for "a tribunal of original jurisdiction in issues that are ripe for litigation by the usual processes." Williams Furniture Corp., at 579; see also Garris v. Governing Bd. of South Carolina Reinsurance Facility, 319 S.C. 388, 390, 461 S.E.2d 819, 821 (1995) ("Declaratory relief will ordinarily be refused where another remedy will be more effective or appropriate under the circumstances," as "relief is not generally available to one who has not

exhausted administrative remedies.”). In general, judicial review is appropriate only when appeal is from a final agency order. *Id.* at 821 (citing S.C. Code Ann. § 1-23-380 (A)). Accordingly, Plaintiff’s complaint was properly dismissed.

II. CONCLUSION

For the foregoing reasons, Plaintiff’s SCRCP 59 (e) Motion To Alter or Amend Judgment should be denied.


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ATTORNEYS FOR DEFENDANTS

November 16, 2010
Columbia, South Carolina

STATE OF SOUTH CAROLINA)
)
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS
FOR THE NINTH JUDICIAL CIRCUIT

Jeffrey D. Allen, individually, as guardian)
for Jane Doe, a minor, and as representative)
of other similarly situated State of South)
Carolina employees,)

Civil Action No.: 2009-CP-10-7404

Plaintiffs,)

CERTIFICATE OF SERVICE

v.)

South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)

Defendants.)

2010 NOV 17 AM 11:33
JULIE J. ARMSTRONG
CLERK OF COURT

FILED

I, Tracey D. Smith, an employee of the law firm of Montgomery Willard, LLC, attorneys for the Defendants do hereby certify that I have served the below named counsel with copies of *Defendants' Response to Plaintiff's Rule 59(e) Motion to Alter or Amend Judgment* by mailing copies of same by United States mail, proper postage affixed, return address clearly marked, and addressed as follows:

John A. Massalon, Esquire
Willis Massalon & Allen LLC
Post Office Box 859
Charleston, South Carolina 29402


Tracey D. Smith

November 16, 2010
Columbia, South Carolina

STATE OF SOUTH CAROLINA)
COUNTY OF CHARLESTON)
Jeffrey D. Allen, individually, as Guardian)
For Jane Doe, a minor, and as Representative)
Of other similarly situated State of)
South Carolina employees,)
Plaintiff,)
v.)
South Carolina Budget and Control Board)
Employee Insurance Program and Blue)
Cross and Blue Shield of South Carolina,)
Defendants.)

IN THE COURT OF COMMON PLEAS

CASE NO.: 09-CP-10-7404

2010 NOV 29 PM 1:55
JULIE J. ARMSTRONG
CLERK OF COURT

FILED

PLAINTIFF'S REPLY TO
DEFENDANTS' OPPOSITION TO
MOTION TO ALTER OR AMEND
PURSUANT TO SCRCP, RULE 59(e)

As one basis for their opposition to Plaintiff's Motion to Alter or Amend the court's order granting summary judgment, Defendants assert that the Plaintiff's request that the court stay this case pending the administrative appeal action was not raised during the briefing and argument before this court and as such was not the proper subject of a motion to alter or amend. However, Plaintiff did, in fact, raise the issue and possibility of a stay in briefing on the motions heard and ruled upon by this court, and therefore such request is proper under SCRCP, Rule 59(e).

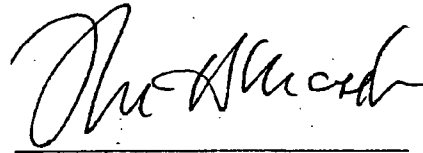
The issue of exhaustion was first raised by the Defendants in a motion to dismiss and denied by Judge M. Dennis, and then, while refusing to conduct any discovery, Defendants filed the subject motion raising that identical ground. Page 10 of "Plaintiff's Memorandum in Support of Motion to Compel Responses to Plaintiff's First Interrogatories and First Requests for Production, in Support of Motion to Stay Decision on Defendants' Motion for Summary Judgment or, in the Alternative, Denial of Defendants' Motion for Summary Judgment, and in Opposition to Defendants' Motion for Protective Order" stated:

The issue of exhaustion of administrative remedies, which Defendants assert is a basis for summary judgment, was fully briefed and argued pursuant to Defendants' motion to dismiss and for judgment on the pleadings, which, as mentioned above, were denied. Defendant is now attempting a second bite at the apple by again asserting the issue of exhaustion of administrative remedies as a purported basis for summary judgment. Plaintiff incorporates by reference Plaintiff's Memorandum in Opposition to Defendants' Motion to Dismiss, and the exhibits/affidavits attached thereto, in opposition to this purported basis for summary judgment.

Said Memorandum in Opposition to Defendants' Motion to Dismiss raised and briefed the South Carolina Court of Appeals' decision in *Capital City Ins. Co. v. BP Staff, Inc.*, 674 S.E.2d 524, 529 (S.C. Ct. App. 2009), where the court held that where a party would be harmed by the running of the statute of limitations or otherwise prejudiced if its claim is dismissed on exhaustion of administrative remedies, and the court has determined that resolution of the administrative proceeding would impact the circuit court case, then the circuit court should properly consider a stay or continuance of the judicial action until the administrative proceedings have concluded. *Id.* at 531. (See Exhibit A, Plaintiff's Memorandum in Opposition to Defendants' Motion to Dismiss at pp. 11-12). This issue was raised at both the Defendant's motion to dismiss and motions for summary judgment, and has been sufficiently preserved for inclusion into this request to alter or amend.

Based on this Reply and Motion to Alter or Amend and Memorandum in Support, Plaintiff's request that the court alter or amend its judgment.

Respectfully submitted,



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ATTORNEYS FOR PLAINTIFF

EXHIBIT "A"

In light of the effort of the Plaintiff and unexplainable delays and confusion, the Defendants should be deemed to have waived any further reliance on the defense of exhaustion. The Plaintiff and his wife made numerous efforts to navigate the "claims procedure" prior to discovering the statutory mandate for diabetes education coverage. Finally, Plaintiff should not be forced to await a decision from Blue Cross on his appeal so that he can then submit it to the EIP for further review because of a possible statute of limitations deadline. This court has broad discretion in its supervision over the progression and disposition of a circuit court case in the interests of justice and judicial economy. See *Williams v. Bordon's Inc.*, 262 S.E.2d 881, 883 (S.C. 1980). "A party should not be required to 'roll the dice' on whether a collateral administrative proceeding will conclude prior to the running of an applicable statute of limitations in order to preserve a claim properly within the jurisdiction of the circuit court." *Capital-City Ins. Co. v. BP Staff, Inc.*, 674 S.E.2d 524, 531 (S.C. Ct. App. 2009).

was first diagnosed with Type I diabetes on November 27, 2007 at the age of two, and diabetic education and training was provided during her initial 3-day hospital stay. In reviewing all claims for diabetic education made by Allen, Defendants have denied three other such claims dating back to December 17, 2007. See Exhibit C (C. Allen Aff. ¶ 22). In light of the State of South Carolina board/agency being named as a Defendant, the undersigned made the determination to commence this action within two (2) years of the date of diagnosis, so as not to risk a possible statute of limitation defense related to the two (2) year statute of limitation in the South Carolina Tort Claims Act. Plaintiff should not be prejudiced by a decision to protect himself against all statute of limitations defenses. The court in *Capital City* held that where a party would be harmed by the running of the statute of limitations or otherwise prejudiced if its

claim is dismissed on exhaustion of administrative remedies, and the court has determined that resolution of the administrative proceeding would impact the circuit court case, then the circuit court should properly consider a stay or continuance of the judicial action until the administrative proceedings have concluded. *Id.* at 531.

4. *The Complaint States a Claim for Reformation, Disgorgement, and Injunctive Relief*

Defendants have moved to dismiss the claims for reformation, disgorgement and injunctive relief on the grounds that the Complaint fails to state a claim for relief. An action to reform an insurance policy is an action in equity. *Elias v. Fireman's Ins. Co. of Newark, New Jersey*, 420 S.E.2d 504, 505 (S.C. 1992). The Complaint in this case alleges that the State Health Plan, an insurance policy within the express terms of 38-71-46(D), violates the diabetes mandate. The freedom of parties to contract is not absolute, and insurance coverage required by law may not be omitted because statutory provisions relating to an insurance contract are part of the contract. *See Bovain v. Canal Ins.*, 678 S.E.2d 422, 429 (S.C. 2009) (citing *Jordan v. Aetna Cas. & Sur. Co.*, 214 S.E.2d 818, 820 (S.C. 1975)). The reformation claims should be permitted to forward at this early stage.

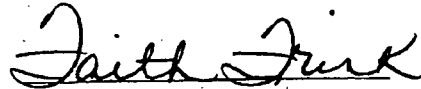
The equitable remedies of restitution and disgorgement require payment of the defendant's ill-gotten gain. *Ellett Brothers, Inc. v. USF&G Co.*, 275 F.3d 384, 388 (4th Cir. 2001) (interpreting South Carolina law). The Plaintiff's class action Complaint sufficiently contains allegations of ill-gotten gain by one or both of the Defendants – that of the retention of monies which should have been paid to the Plaintiff and others similarly situated for claims made for diabetes education. For example, with regard to the named Plaintiff alone, the four

CERTIFICATE OF SERVICE

I hereby certify that I have this 23rd day of November, 2010 served the foregoing pleading or paper by depositing a copy of it in the US Mail, first class, postage pre-paid, addressed as follows, and also by email transmission as follows:

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State Budget & Control Board
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Columbia, SC 29211
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STATE OF SOUTH CAROLINA	)	
	)	COURT OF COMMON PLEAS
COUNTY OF CHARLESTON	)	
Jeffrey D. Allen, as guardian ad litem	)	
for Jane Doe,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No. 09-CP-10-7404
	)	
South Carolina Budget & Control	)	
Board Insurance Program, and Blue	)	
Cross-Blue Shield of S.C.	)	
	)	
Defendant.	)	

TRANSCRIPT OF HEARING

The within Hearing was held in the above-captioned action on March 4, 2010, before The Honorable R. Markley Dennis, Jr. in Courtroom 4B of the Charleston County Courthouse, 100 Broad Street, Charleston, South Carolina; attended by Counsel, as follows:

APPEARANCES:

John Massalon, Esq.
Appearing for Plaintiff

Theodore Williard, Esq.
Kelly H. Rainsford, Esq.
S.C. Budget & Control Board
Appearing for Defendant

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Jeffrey Allen v S.C. Budget & Control Board et al
09-CP-10-7404
Hearing of March 4, 2010
Before The Honorable R. Markley Dennis, Jr.

2

1 MARCH 4, 2010 2:00 P.M.

2

3 THE COURT: Good afternoon, ladies
4 and gentlemen. If you would, please, identify
5 yourself and the parties that you are
6 representing, please.

7 MR. MASSALON: Good afternoon.
8 I'm John Massalon, Your Honor. I'm here for
9 the plaintiffs.

10 THE COURT: Thank you.

11 MR. WILLARD: Ted Willard and
12 Kelly Rainsford on behalf of the defendants.

13 THE COURT: Thank you. This is a
14 Motion to dismiss, is that correct?

15 MR. WILLARD: Yes, sir.

16 THE COURT: I'll be happy to hear
17 from you.

18 MR. WILLARD: Your Honor, may it
19 please the Court, this case involves a claim
20 for benefits from the South Carolina State
21 Health Insurance Plan. That plan is a self-
22 insured plan and is administered by the South
23 Carolina Budget and Control Board, a fully
24 insurance program.

25 The claims administrator for that

1 plan is Blue Cross-Blue Shield. Your Honor,
2 we're moving to dismiss on the grounds that,
3 one, plaintiff's causes of action are
4 prohibited by South Carolina Code 1-11-17(c).

5 And that Code Section, Your Honor,
6 I've handed up a copy and provided the
7 plaintiffs a copy -- states, (reading):
8 "Notwithstanding ..." -- and it cites two Code
9 Sections, " ...or any other provision of law
10 has claims for benefits under any self-insured
11 plan of insurance offered by the state to
12 state and public school district employees and
13 other eligible individuals must be resolved by
14 procedures established by the Board, but shall
15 constitute the exclusive remedy for these
16 claims, subject only to appellate judicial
17 review consistent with the standards provided
18 in Section 1-23-3(a)."

19 Your Honor, if we examine the
20 allegations in plaintiff's Complaint -- and
21 I will point Your Honor to, for instance,
22 allegations in Paragraph 5 of the Complaint
23 where the plaintiff states, "This is an action
24 for a declaratory judgment arising from the
25 defendants' unlawful issuance and

1 administration of the State of South Carolina
2 to the standard plan, a plan of health
3 benefits and insurance offered to all current
4 and retired state employees, including public
5 school district employees, in violation of
6 South Carolina Code Section 38-71-46."

7 Your Honor, I've provided you a copy
8 of that statute. That is an insurance statute
9 for disgorgement of revenue received as an
10 unlawful issuance and administration and for
11 declaration to determine the value of any
12 unlawful withheld benefits.

13 We turn, Your Honor, to Paragraph 11
14 of the Complaint. It sets out the standing
15 the plaintiff has. "As the main plaintiff who
16 is an employee of a South Carolina school
17 district, he has been enrolled in the EIP
18 standard plan and enrolled his dependent child
19 in the said plan who was diagnosed with
20 diabetes at the age of two years old and has
21 made multiple claims for his dependent child
22 for the value of approximately a thousand
23 dollars for diabetes out-patient treatment and
24 for training and education, which were denied
25 by Defendant Blue Cross-Blue Shield, as

1 administrator, to the EIP whose claim is
2 typical of those of its proposed clients.

3 Plaintiff goes on to allege, Your
4 Honor, in Paragraph 19 asking for a declara-
5 tion of the rights of the parties herein.
6 The defendants are required to issue and
7 administer all health plan documents and PIP
8 in compliance with that Code Section.

9 Paragraph 20 goes on to seek an
10 Order reforming the terms of the health
11 benefit plan provided by its members to
12 provide the mandated diabetes coverage.

13 Paragraph 21 ---

14 THE COURT: You don't need to go
15 through all that on the record, please. I
16 have it. It's in the record for purposes of
17 review. *Why am I not entitled to this benefit*
18 *based on this Section*, is what you're saying.

19 I mean, it's a declaratory judgment.
20 It's not asking for anything other than
21 somebody to look at the statute. And I assume
22 the justiciable controversy, in theory, could
23 be all the things that may have to be brought
24 under the Administrative Procedures Act. But,
25 clearly, you're not saying that the agency has

Jeffrey Allen v S.C. Budget & Control Board et al
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Before The Honorable R. Markley Dennis, Jr.

6

1 to declare law? How does an agency have a
2 right to do that?

3 MR. WILLARD: And, Your Honor, if I
4 may, in Paragraph 21 they ask for -

5 THE COURT: Let's don't talk about
6 the Complaint. Let's talk about how a
7 declaratory judgment action has to first be
8 brought and determined by an agency. What
9 authority does an agency have to declare law?

10 MR. WILLARD: Your Honor, the agency
11 can determine law.

12 THE COURT: In making applications,
13 yes, under the Act. But I don't think they
14 have the right to review the law and then make
15 a determination from a legal perspective, do
16 they?

17 MR. WILLARD: Absolutely, Your Honor.

18 THE COURT: What case says that?

19 MR. WILLARD: Your Honor, the case
20 is ---

21 THE COURT: I'll need to look at
22 that.

23 MR. WILLARD: Yes, sir. It talks
24 about what a state agency cannot do is

1 interpret constitutionality. That it cannot
2 do because of another act.

3 I call your attention, Your Honor, to the
4 case of *Smith v. South Carolina Retirement*
5 *System*. I believe I've handed that up.

6 THE COURT: Do you know what the
7 cite is on that?

8 MR. WILLARD: It's 520 S.E.2d 339.

9 THE COURT: Thank you.

10 MR. WILLARD: Your Honor, that case
11 -- is a case involving an action against the
12 South Carolina Retirement System for a
13 declaratory judgment, and a constructive trust
14 of benefits under a requirement. This is a
15 Court of Appeals case.

16 THE COURT: Uh-hum.

17 MR. WILLARD: Held that the
18 plaintiffs had to exhaust administrative
19 remedies under the South Carolina Retirement
20 System. And it says "a Court should
21 ordinarily refuse to grant a declaratory
22 judgment where special statutory remedies have
23 been provided." So that's an example.

1 If you read these cases about when a
2 DJ action is appropriate and when it is not,
3 an agency can interpret the law.

4 Here, if you read the provision of
5 the state health plan, the applicable law is
6 incorporated under the terms of the plan.

7 And, Your Honor, I believe in
8 Paragraph 1.3 of the plan that I've handed up,
9 it clearly states that. If you'll look at the
10 enforcement provision of the Insurance Code
11 that applies to the insurance statute that
12 they say applies, it says, "those terms are
13 incorporated into the plan." The plan has
14 language that matches the code, that the terms
15 and is considered a part of the plan.

16 Here, statutorily -- PIP Budget and
17 Control Board is charged with interpretation
18 of the plan and the payment of benefits. The
19 allegations the plaintiff makes are
20 disgorgement of benefits -- clearly alleged.

21 Can a state agency interpret the
22 law? Absolutely, Your Honor. What a state
23 agency cannot do is interpret the constitu-
24 tionality of the law.

25 THE COURT: Okay.

1 MR. WILLARD: And, Your Honor,
2 on that basis we feel that we are entitled for
3 the action to be dismissed.

4 THE COURT: All right.

5 MR. WILLARD: Your Honor,
6 there's a further argument concerning
7 the -- what I would say the exhaustion of
8 administrative benefits. In this case there's
9 no allegation by the Plaintiff that the
10 administrative remedies have been exhausted.

11 The Plaintiff did submit an
12 affidavit contending that there's still a
13 pending administrative review. Your Honor,
14 concerning -- taking the facts in the light
15 most favorable to the plaintiff, there's still
16 a pending administrative appeal. One of the
17 grounds, Your Honor, mentioned in that appeal
18 by the plaintiffs is the application of this
19 statute to the state health plan. So that has
20 not been decided in this appeal.

21 Your Honor, as a part of the
22 administrative appeal, there is a two-level
23 layer of internal appeals. This is only at
24 the first level. The second level goes to the
25 state EIP. Then after that, Your Honor, the

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10

1 case is appealed to the ALJ who has exclusive
2 jurisdiction over the appeal.

3 Now, the next part of the argument
4 is, Your Honor, assuming that they did have
5 the exhaustion of administrative appeals,
6 we're in the wrong Court. And that statute
7 was amended in 2006.

8 THE COURT: Okay.

9 MR. WILLARD: Finally, Your
10 Honor, not to burden the Court too much but
11 there are some additional grounds.

12 One is they sued Blue Cross-Blue
13 Shield. Blue Cross-Blue Shield is the claims
14 administrator. There's no privity of
15 contract. This contract has been alleged with
16 Blue Cross. Blue Cross-Blue Shield is not the
17 insurer.

18 THE COURT: You're getting into the
19 area now of in the motion to dismiss that I
20 don't think I can go. Thank you. I thank
21 you. Let me hear from Mr. Massalon. I don't
22 want to hear any more about issues that are
23 outside the pleadings.

24 MR. WILLARD: One issue that is
25 absolutely within the pleadings ---

1 THE COURT: Okay.

2 MR. WILLARD: The plaintiff has
3 alleged three technical causes of action,
4 injunction, reformation and, I believe,
5 disgorgement. Your Honor, the plaintiffs have
6 not plead an essential element to an equitable
7 cause of action, no active remedy at law. So
8 based on that, Your Honor, that would be our
9 position.

10 THE COURT: Thank you. Mr.
11 Massalon.

12 MR. MASSALON: Thank you, Your
13 Honor. We submitted our memo ahead of the
14 hearing and it I'm prepared to recite some of
15 the facts.

16 THE COURT: You can. All the
17 materials filed, of course, in conjunction
18 with the motion are incorporated fully for the
19 purposes of review. And I assume that all
20 this has been submitted -- has been filed with
21 the Court as well?

22 MR. MASSALON: Yes, sir. So I
23 will go straight to the legal issues and throw
24 in a few facts here and there.

25 THE COURT: Thank you.

1 MR. MASSALON: First of all, Your
2 Honor, on the argument that the suit must be
3 dismissed because it's just a claim for
4 benefits, this case is not just a claim for
5 benefits. My opposing counsel cited several
6 sections of the Complaint. But what we've
7 alleged in this lawsuit is basically this.
8 The policy that was issued to my client
9 contained an exclusion for diabetes-related
10 incidents. There is a state statute that we
11 cited in our brief that mandates that this
12 policy include that. And so what we're
13 seeking in this lawsuit is not benefits under
14 the policy. We are seeking a declaration that
15 the policy violates state law and seeking
16 reformation of the policy to be conformed in
17 accordance with state law. We've alleged
18 class action claims that not just this policy
19 but all the ones like it would be reformed in
20 accordance with state law. And we are also
21 seeking a declaration that the monies that
22 have been wrongfully withheld or not paid as
23 benefits must be restored.
24 Those aren't claims for benefits under
25 the policy, Judge. What we're looking for

1 here is something that we cannot get in the
2 agency process. Because regardless of what
3 the *Smith* case says and these other cases say,
4 what we cannot get by going back to Blue
5 Cross-Blue Shield or going through the
6 administrative process is somebody telling us,
7 "you're right, this policy doesn't comply with
8 state law. We're going to rewrite an all new
9 policy." We believe that under the law, this
10 is the only place that we can get that remedy.
11 The first point, Your Honor, is ---

12 THE COURT: Why?

13 MR. MASSALON: Because, Your
14 Honor, the remedies provided under the
15 Administrative Procedure Act in the cases
16 pertaining to exhaustion, I believe, fairly
17 read really deal with issues of policy
18 interpretation. And an example might be if
19 this claim was submitted and denied as not
20 being medically necessary. That's really kind
21 of a facts-and-circumstances determination.
22 And exhaustion would really deal with whether
23 there's a *prima facie* decision under the
24 policy. And in those circumstances I think,
25 fairly read, you could go back to the people

1 that made the decision and ask them to take
2 another look at it in light of some additional
3 facts.

4 What we're alleging in this case is
5 this policy violates the law.

6 THE COURT: I understand that. But
7 wouldn't that be something an Administrative
8 Law Judge should hear?

9 MR. MASSALON: We don't think so,
10 Your Honor, because we haven't been able to
11 come up with any authority that vests the
12 Administrative Law Judge with jurisdiction to
13 rewrite policies under these circumstances.
14 We believe this Court, under the declaratory
15 judgment act ---

16 THE COURT: But if your argument is
17 that it violates the law, assuming counsel's
18 argument that the agency has the right to
19 interpret and apply the law, they could make
20 a finding that yes, it does or no, it doesn't.
21 That frames the issue, does it not?

22 MR. MASSALON: I guess what I
23 would say, Your Honor, is it's possibly.
24 Here's where I part company with Mr. Willard.
25 The argument he's essentially making is that

1 Court has got exclusive jurisdiction over it.
2 So there's a change, and we've cited it on
3 appeal in *Capital City*. It was recently
4 decided. And it says exactly the opposite.
5 It says that this is not an adoption of
6 jurisdiction. It's adoption of policy. And
7 that's where I think Mr. Willard's wrong and
8 we're correct. He's saying it's the only
9 place you can go. We are saying, and based on
10 the *Capital City* case which I think is on all
11 fours with these issues, that this is not
12 jurisdictional. It is discretionary. It's a
13 matter of policy. And it's really a doctrine
14 that's designed to promote efficiency and have
15 these cases resolved quickly and as
16 efficiently as possible and by the people who
17 know the most about them.

18 So I think if you read that case,
19 what it says is that we don't have to go
20 there. We can come here.

21 THE COURT: I see.

22 MR. MASSALON: Now, on the
23 exhaustion requirement, Your Honor, I've got
24 three main points about that particular issue.
25 First of all, as far as whether exhaustion is

1 mandated -- the other thing the *Capital City*
2 case says is it's a discretionary matter and
3 you are supposed to look at this and exercise
4 your discretion about whether going back to
5 the people who had denied this benefit so far
6 is an additional appropriate thing to do, and
7 should not require us to do it.

8 The second thing is if you look at
9 the facts of this case, Your Honor, my clients
10 have gone above and beyond what anybody should
11 be expected to do in an attempt to get these
12 issues resolved. And I won't rehash all the
13 facts to you, but simply give you a sense of
14 what they've done.

15 THE COURT: Well, with all due
16 respect, that's really more for another day,
17 because this one is really technical. It's
18 based on the pleadings, as I understand the
19 motion. So all these things -- just as I
20 stopped Mr. Willard -- I really don't need
21 to hear that part of it. The issue is whether
22 or not on the pleadings, on its face, does it
23 withstand scrutiny of the Court?

24 Now, if I do deny it and there's
25 another motion to dismiss based on some other

1 grounds, now we're getting into an area where
2 I probably need to be consider that, or a
3 judge should.

4 MR. MASSALON: Thank you. I'll
5 skip that for now.

6 The other issue that I'd like to
7 raise with you is the issue that we think is
8 material and say that even if you disagree
9 with me and agree that exhaustion is required,
10 we don't have to exhaust it.

11 Again, without going into the facts
12 of it, I think that under this circumstance,
13 the reason - and there's a case cited where
14 it's been decided, and the Court found well,
15 if you don't even attempt and just say it's
16 going to be hard or difficult for them to do
17 it.

18 But what we've got here, Your Honor,
19 is a situation where we've been trying to get
20 this resolved as we've alleged in the
21 Complaint for over a year. And you heard Mr.
22 Willard say it - we have no response. And so
23 he argues on the fact that we haven't told him
24 no means that we haven't exhausted it.

1 But the point I'd like to make, Your
2 Honor, is the fact that we've been waiting
3 over a year for an answer is proof positive
4 that we're doing what he wants us to do and
5 it's getting us nowhere. Because otherwise
6 they could never answer any prevent anybody
7 from suing, just by not giving the answer.

8 THE COURT: Okay.

9 MR. MASSALON: Finally, Your
10 Honor, on the issue of the other defendant,
11 and I'll just touch on it briefly, I think
12 that -- again, because this is a motion to
13 dismiss and we're entitled to an inference
14 that we can prove what we allege and all
15 inferences that flow from that, we've alleged
16 plenty to keep Blue Cross-Blue Shield in,
17 mostly because somebody, and we don't know who
18 yet because we haven't gotten into discovery,
19 made the determination to deny the claim. We
20 allege that it violates state law. And this
21 is the claims administrator, which is Blue
22 Cross-Blue Shield and the other defendant
23 which actually issued the policy. Again,
24 taking the facts in the light most favorable
25 to us, we've alleged enough against them to

1 entitle us to get a declaratory judgment based
2 on the proof of the facts. And also the same
3 is true for the equitable causes of action
4 that we've alleged. Again, on the motion to
5 dismiss, in the light most favorable to us we
6 believe we've alleged sufficient facts here to
7 make our causes of action. And again, what I
8 think Mr. Willard urges the Court to do is to
9 anticipate defenses in our pleadings. Again,
10 I don't think in a well-plead Complaint we're
11 required to not only plead the elements of our
12 causes of action, but also we anticipate
13 defenses that are going to be raised and
14 allege facts that would respond to them.
15 Thank you.

16 THE COURT: Hold on just one
17 second. Ladies and gentlemen, we've got a
18 jury that's reached a verdict. And we're
19 going to recess this for a minute so I can get
20 those people in and out. I'll be happy to
21 hear from you in response, Mr. Willard, when
22 we come back. Thank you. I'm sorry to hold
23 y'all up.

24 (RECESS)

25 THE COURT: Thank you very much.

1 Mr. Willard, I'll be happy to hear from you
2 MR. WILLARD: Yes, Your Honor. One thing,
3 Your Honor, I have handed up the case of
4 *Unisys v. South Carolina Budget and Control*
5 *Board.*

6 THE COURT: Yes, sir.

7 MR. WILLARD: And that is a case
8 concerning the exclusivity of a remedy.

9 THE COURT: Yes.

10 MR. WILLARD: Your Honor, the
11 language under the South Carolina Code
12 regarding exclusivity is very similar to the
13 language here. The exclusion remedy for
14 claims and benefits from the state health plan
15 is governed by that.

16 Your Honor, if we just keep in mind
17 two things, futility has not been plead.
18 Certainly, there's some arguments concerning
19 futility. But the test of futility is very
20 high. In fact, it has to be such that an
21 agency authority made up its mind.
22 And that is simply not the case here, because
23 the issue has not been determined.

24 THE COURT: My question is what's a
25 person to do if they've tried to find out an

1 answer and can't get one? What are you
2 supposed to do? Why isn't that futility?

3 MR. WILLARD: Your Honor, our Courts
4 determine futility.

5 THE COURT: I'm asking you a
6 question. Assuming everything you've said is
7 correct, and they're trying to do something
8 and find out something and can't get an
9 answer, why they should be held ---

10 MR. WILLARD: They're at round one.

11 THE COURT: I don't know where they
12 are.

13 MR. WILLARD: Stage two is the second
14 internal step, and they go to the next step.

15 THE COURT: But my question is
16 round one is dead in the water, from what I'm
17 hearing.

18 MR. WILLARD: That's what they're
19 alleging.

20 THE COURT: Well, that's what you
21 said too.

22 MR. WILLARD: There is intentional
23 dealing.

24 THE COURT: I understand that.

1 MR. WILLARD: And the thing is, this
2 issue was made part of that opinion. And
3 we've got some determination here.

4 THE COURT: I understand that. But
5 don't you think somebody's entitled to have an
6 answer to when it's coming? I mean you can't
7 sit there and tell them, "Well, let's just
8 wait around."

9 MR. WILLARD: I understand, Your
10 Honor.

11 THE COURT: I tell you what I'm
12 going to do because I, really - that concerns
13 me. I hear what you're saying. And I really
14 don't have any problem, at least at this
15 juncture, thinking through this process and
16 coming up with a conclusion that really the
17 ultimate determination to get - the ultimate
18 determination of this case obviously isn't
19 going to be in a lower court. It's going to
20 be in the Court in Columbia.

21 And what route is the quickest way
22 and the best way and the proper way to get
23 there, I think, is through the administrative
24 law judge now that it's in direct appeal,
25 which it should have been. I'm delighted they

1 changed that, because that's the way it needs
2 to go. And I think this issue ultimately will
3 get there once they rule.

4 But the problem we have is these -
5 it's like they're holding these people
6 hostage. Because you say we're the only way
7 you can go, but we haven't decided and we
8 don't know when we're going to decide. That's
9 what I'm hearing. And so that's the problem I
10 have.

11 So the motion to dismiss based on
12 the pleadings is denied, given all the
13 circumstances in this case.

14 MR. WILLARD: Thank you, Your
15 Honor.

16 THE COURT: Thank you. But,
17 obviously, there may be another day when we
18 hear motions for summary judgment and dismiss
19 it because it's not -- it's a matter of law
20 and doesn't belong in here. But that's when
21 we can get to some other things outside the
22 pleadings, which is where is this process.
23 And I can't do that right now. That's my
24 problem. Okay.

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24

1 MR. WILLARD: Judge, would you like
2 me to submit an Order?

3 THE COURT: I'm going to do a form
4 order that just simply says motion to dismiss
5 on the pleadings is denied. So it will be
6 clearly on the pleadings which doesn't
7 prejudice you from filing a subsequent motion
8 for summary judgment. Thank you.

9 Thank you very much.

10 (HEARING CONCLUDED)

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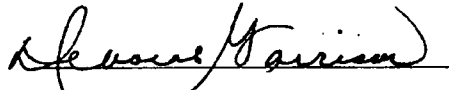
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CERTIFICATE OF REPORTER

I, the undersigned, Deborah Garrison,
official court reporter for the 9th Judicial
Circuit of the State of South Carolina, do
hereby certify that the foregoing is a true,
accurate and complete transcript of the
hearing held before The Honorable R. Markley
Dennis, Jr., on March 4, 2010;

I further certify that I am neither kin
nor counsel to any of the parties and have no
interest in the outcome of this action.



Deborah Garrison

Circuit Court Reporter

9th Judicial Circuit

Charleston, South Carolina

February 6, 2011

2-15-11

COUNTY OF CHARLESTON

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REPORTED BY: H. EUGENE BUCKNER, CVR

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Index of Testimony

NO SWORN TESTIMONY WAS OFFERED IN THESE PROCEEDINGS.

Index of Exhibits

NO EXHIBITS WERE MARKED BY THE COURT REPORTER FOR THIS
HEARING

1 CLERK:

2 Jeffrey Allen versus South Carolina

3 Budget and Control:

4 UNIDENTIFIED SPEAKER:

5 Your Honor, may I approach?

6 THE COURT:

7 (Nods in the affirmative.)

8 MR. WILLARD:

9 Those are some briefs and
10 authorities I will be referring to.

11 THE COURT:

12 All right.

13 MR. WILLARD:

14 May it please The Court, Your
15 Honor; Bo Willard, for the Defendants, the State Health Plan
16 and Blue Cross Blue Shield.

17 Your Honor, this is Defendant's
18 Motion of Summary Judgment.

19 Uh -- There are two rifle-shot
20 legal issues in this case, Your Honor.

21 And, Your Honor, this case will be
22 in English (laughs) unlike Dutch in the previous hearing.

23 Your Honor, the first issue -- and
24 again, this is the State Health Plan.

25 And, Your Honor, the State Health

1 Plan is a self-funded health plan for by the State of South
2 Carolina.

3 And it's not an insured plan.

4 The claim administrator of the self
5 -- excuse me -- of the State's health plan is Blue Cross
6 Blue Shield.

7 Blue Cross Blue Shield is not the
8 insurer of the plan.

9 In this case Your Honor, the
10 Plaintiff alleges in the Complaint that:

11 He was an employee with the School
12 District of South Carolina covered by the State's Health
13 Plan.

14 And that he made a claim of
15 benefits for his daughter for diabetic education and
16 training, out-patient, that should have been covered by the
17 State Health Plan.

18 And that claim was denied.

19 Plaintiff, then, alleges that:

20 Pursuant to 38 71 46, that should
21 -- a -- which is a coverage mandate, that that coverage
22 should have been covered by the State's Health Plan.

23 He asks that the State's Health
24 Plan -- first for a Declaratory Judgment Action that this
25 claim be paid.

1 He asks for reformation of the
2 State's Health Plan.

3 And he asks for disgorgement of
4 benefits from the State's Health Plan, which he alleges were
5 wrongfully denied.

6 Now, Your Honor, the problem with
7 Plaintiff's Complaint -- I'd ask you to turn to Tab 2 of the
8 information I handed up.

9 Pursuant to section 111 710 C, claims
10 for benefits under any self-insured plan of insurance
11 offered by the State to State and public school district
12 employees must be resolved by procedures established by The
13 Court, which shall constitute the exclusive remedy for these
14 claims, subject only to appellate review pursuant to the
15 standards provided in 123 380.

16 123 380 is The Administrative
17 Procedures Act..

18 So, Your Honor, what we have is that:

19 By statute, the Plaintiff's exclusive
20 remedy is his administrative remedies under the APA, subject
21 to appeal -- and as I'll talk about later -- to the
22 Administrative Law Court.

23 So, again, Your Honor, we're in the
24 wrong court.

25 Plaintiff needs to be before the

1 Administrative Law Court.

2 And interesting, the Plaintiff, while
3 he filed this action, was going through the administrative
4 process.

5 I call your attention to Tab 1, which
6 is a Final Denial Order by the South Carolina Budget and
7 Control Board, which denied the Plaintiff's claim.

8 And if you'll notice, Your Honor, the
9 first page refers the Plaintiff to his appellate rights to
10 the Administrative Law Court

11 So, again, this exact issue, that has
12 been brought in this case, was a Section 38 71 46, a finding
13 for the State's Health Plan, was ruled on by the Budget and
14 Control Board and denied.

15 Now, Plaintiff's exclusive remedy by
16 statute is an appeal to the Administrative Law Court, not
17 the Circuit Court.

18 I'd ask Your Honor look at Tab 3,
19 which is Section 120 3 380 that says:

20 A party who has exhausted all
21 administrative remedies within an agency is entitled to have
22 his case for judicial review.

23 If you look at Tab 4, Section 123 600
24 (b) says that:

25 An Administrative Law Judge shall

1 preside over all appeals from final decisions of contested
2 cases pursuant to The Administrative Procedures Act or
3 another law.

4 So again, Your Honor, by statute, the
5 exclusive remedy the Plaintiff has, and which he has in
6 fight gone through the administrative process, is through
7 the ALC, not the Circuit Court.

8 Now according to Spike's -- uh --
9 case in his briefing, Drummond versus State of South
10 Carolina.

11 And that case is located at Tab 5.

12 And Drummond stands for the position
13 that:

14 The Administrative Law Court is an
15 executive body and may not rule on the validity or
16 constitutionality of a statute.

17 And that's exactly right. They
18 can't.

19 That is not the issue here.

20 The validity of the statute is not at
21 issue. It is whether or not the statute applies to the
22 State's Health Plan.

23 And again, there's another case at
24 Tab 6, Video Gaming Consultants, that again expands on the
25 authority of the ALJ.

1 And in fact, it says:

2 The ALJ must follow the law as
3 written and can't challenge the constitutionality.

4 So again, Your Honor, this claim for
5 benefits, that is brought in Circuit Court, needs to be
6 before the ALJ.

7 So, Your Honor, that's ground number
8 one of our motion -- uh -- that:

9 The Plaintiff is in the wrong court.

10 He needs to go to the ALJ, which has
11 exclusive jurisdiction over appeals of denials.

12 Your Honor, issue number two really
13 goes to the ultimate issue in this case.

14 And that is:

15 Does the Section 38 71 46 even apply
16 to the State's Health Plan?

17 Again, Your Honor, the State's Health
18 Plan is not a fully insured plan. It is a self-funded plan.

19 If the Plaintiff's claim is paid by
20 state money, again, no insurance companies are involved.

21 Section 38 71 46 says that:

22 After January 1st, 2000, any health
23 insurance policy sold or reviewed in this state, has to
24 cover diabetes self-management and education.

25 If you look at Section D -- and

1 again, Your Honor, this is a Tab 7.

2 It talks about defining what is
3 health insurance?

4 For purposes of this section, health
5 insurance means -- and it goes down -- as it is defined --
6 and it gives two code sections.

7 Section 38 71 676 involves individual
8 insurance. So that would not, certainly, apply.

9 On Section 38 71 840 14, which is
10 group insurance:

11 If we look at that Section, which is
12 at Tab 14 -- or excuse me -- Tab 8 of the materials, it
13 defines what health insurance coverage is.

14 It means benefits consisting of
15 medical care provided directly, through insurance
16 reimbursement or otherwise, and including items and services
17 paid for as medical care under any office, hospital, or
18 medical service policy or certificate, top civil, medical
19 and service plan contract, or health maintenance
20 organization contract, offered by a self-issuer.

21 And again, Your Honor, you have to
22 look up:

23 What is a health issuer?

24 You turn to Tab 9:

25 A health issue is defined -- and it

1 goes on to say -- for purposes of the section, issuer
2 includes an insurance company, a health maintenance
3 organization, and any other entity providing health
4 insurance coverage which is licensed to engage in the
5 business of insurance in the state, and which is subject to
6 state insurance regulation.

7 Now, Your Honor, the State's Health
8 Plan is not subject to state insurance regulation.

9 And in fact, at Tab 10, there is a
10 statute that specifically says:

11 The state employee insurance program
12 is not under the jurisdiction of the South Carolina
13 Department of Insurance.

14 So, Your Honor, because the State's
15 Health Plan is a -- not a health insurance issuer, and
16 therefore, it is not health insurance, this code section has
17 no application.

18 If you were to look at these mandated
19 coded, Your Honor?

20 For instance, if you look at Tab 10,
21 1 11 78 does apply to the State's Health Plan and it is in
22 Title 1, Chapter 11, where the State's Health Plan mandates
23 are included.

24 Now, there were several mandates
25 during this period of time that talked about the coverages

1 that insurance policies had to offer.

2 They are silent as to apply to the
3 State's Health Plan with the exception -- if you look at --
4 uh -- Tab 11.

5 Tab 11 was a health mandate in Title
6 38 that specifically says:

7 It applies to the State's Health
8 Plan.

9 So, Your Honor, the code section at
10 issue here, 38 71 46, is silence on its application of the
11 State's Health Plan.

12 So again, Your Honor, the State's
13 Health Plan is self-funded. It is not insurance.

14 Your Honor, that's our second ground.

15 The statute that the Plaintiff hangs
16 his hat on simply does not apply to the State's Health Plan.

17 Thank Your Honor.

18 THE COURT:

19 Council?

20 MR. HAMRICK:

21 Thank Your Honor.

22 Matt Hamrick, from Richardson,
23 Patrick, Westbrook and Brickman -- uh -- along with -- uh --
24 Christy Ford Allen.

25 Uh -- Wills, Massalon, and Allen, is

1 our co-counsel in this case, Your Honor.

2 Uh -- Several points to address in
3 response to counsel's argument:

4 Uh -- But first of all, Your Honor,
5 if I may, just give you a little bit of background on the
6 procedural history of this case, because I believe it's
7 important -- uh -- to understand where we are today.

8 Your Honor -- uh -- this case began
9 when Jeffrey Allen -- uh -- who is a school district
10 employee -- uh -- brought a claim, all the way back in
11 December of 2007, Your Honor -- uh -- for education related
12 to diabetic -- uh -- treatment -- uh -- for his daughter,
13 who was two years old -- uh -- in November of 2007, just
14 before he made his claim, when she was diagnosed with type I
15 diabetes.

16 The claim was denied.

17 And follow-up claims and -- uh --
18 procedure began. That's what this all started.

19 And every time, Your Honor, Blue
20 Cross Blue Shield issued a -- uh -- Explanation of Benefits
21 and said on the bottom of the form, simply, that:

22 Your coverage does not include
23 coverage for this -- for this diabetes education; no
24 explanation.

25 So, that process did begin, long ago.

1 In fact, it's been over two and a
2 half years, Your Honor.

3 And the letter that Defense Counsel
4 referenced, which is at Tab 1, if you'll notice, Your Honor,
5 it was issued two days ago, the same day that Counsel served
6 us his brief -- uh -- pursuant to this hearing.

7 The is the very first time, Your
8 Honor, two days ago, after two and a half -- over two and a
9 half years -- that anyone has ever explained why they say
10 that:

11 The mandate for the education doesn't
12 apply to the State Health Plan; two days ago, Your Honor.

13 Before that, never had an
14 explanation.

15 And I'll get back to that in a
16 moment, but -- about the explanation, and why is so tortured
17 -- and such a tortured reading of the -- uh -- statute.

18 But first of all, let me just also
19 point out to Your Honor, that:

20 This case was filed -- this lawsuit
21 -- in November of 2009, November 25th.

22 Out of -- Out of an abundance of
23 caution -- because the administrative procedure -- that
24 process has been lollygagging, and delayed through no fault
25 of the Plaintiff.

1 And there's -- there's plenty in the
2 record, because we've already had a motion about the
3 exhaustion requirement, Your Honor, after we filed the
4 lawsuit, because the statute of limitations was potentially
5 coming up and the administrative process was going along,
6 but slowly.

7 The Defendant moved to dismiss the
8 case on the grounds that the statute of limit -- I mean, I'm
9 sorry exhaustion of administrative remedies had not been
10 done -- uh -- and also that Blue Cross was an improper
11 party.

12 Judge Dennis -- uh -- in this very
13 courtroom, I believe, back in March, heard those motions and
14 them; the same exact exhaustion motion that we heard today.

15 After that, the Defendant answered.
16 And we then served our initial discovery requests.

17 May 5th, we served discovery;
18 Interrogatories, Requests for Production to both client --
19 uh -- both Defendants.

20 Instead of answering our initial
21 discovery, the Defendant filed a Motion for Summary Judgment
22 and a Protect Order motion to be allowed not to answer any
23 of the discovery in the case; and just have the case -- uh
24 -- Dismissed on Summary Judgment.

25 So what is pending before Your Honor

1 today, is:

2 The Defendant's Motion for Summary
3 Judgment.

4 Their motion that they not have to
5 answer discovery.

6 And then, we filed a motion to compel
7 discovery. Uh -- So it's our motion to have our discovery
8 answered.

9 And we also filed a motion, Your
10 Honor, that the Summary Judgment decision be stayed -- uh --
11 until it's determined whether or not we get discovery in the
12 case, or not.

13 However, after understanding, now,
14 their argument about Summary Judgment:

15 In the alternative, Your Honor, we
16 would ask you to go ahead and on Summary Judgment, if Your
17 Honor is so inclined.

18 And it should be denied.

19 And here's why:

20 I'd like to come back to the
21 exhaustion argument, because, again, we've already argued
22 that.

23 It was dismissed.

24 And there's nothing new there, except
25 for one thing. I will point this out now.

1 Back when that motion was heard in
2 May, Your Honor, again, the administrative process was going
3 on.

4 The Allen's were back and forth with
5 Blue Cross Blue Shield -- uh -- and not getting any
6 explanation for why it was denied; why the mandate doesn't
7 apply to the insurance coverage.

8 And the Defense made the -- the -- We
9 made the argument of two titles.

10 One of our arguments on the
11 exhaustion issue is:

12 It was futile to try to do this in
13 the administrative process.

14 And Defendant -- uh -- objected or
15 they -- they disagreed with that; and said:

16 It's not futile because the Agency
17 has not made a hard and fast -- taken a hard and fast
18 position -- uh -- which makes an adverse ruling appropriate.

19 Well, the futility has now been borne
20 out. Two day's it was borne out.

21 Because, finally, as this motion was
22 coming up for a hearing, the Agency, the Budget and Control
23 Board Insurance Program -- uh -- Committee or Board -- uh --
24 went ahead and -- and reviewed the case; and then, as I
25 said, two days ago issued a letter that:

1 Uh -- If I may submit, probably not
2 coincidentally, tracks the language of Defendant's brief to
3 Your Honor on their Motion for Summary Judgment, and was
4 issued on the same day.

5 But in any event, the futility
6 argument has now been borne out.

7 They've ruled that:

8 This mandate does not apply to the
9 Plaintiff.

10 And the other argument for
11 exhaustion, I'd like for us to come back and to touch on,
12 because they are the same as have already been argued.

13 But, Your Honor, on a Motion for
14 Summary Judgment on a case where there is a novel question
15 of law -- and this is a novel question of law -- I submit
16 that:

17 If there were any cases, or any other
18 authorities out there, to determine whether this diabetes
19 education mandate applies to the employee's insurance
20 claims, we would have heard about it.

21 We haven't found it.

22 Defense obviously hasn't found it.

23 It's a novel issue.

24 And, there's abundant case law; we
25 cite it in our brief -- uh -- in particular the Schmidt

1 versus Courtney case -- uh -- and -- uh -- and the cases
2 cited therein, which, Your Honor, states that:

3 A Motion for Summary Judgment should
4 not be granted when the issue is a novel issue.

5 This is certainly a novel issue.

6 And Motion for Summary Judgment also
7 should not be granted, Your Honor, when -- uh -- when
8 discovery has not even begun.

9 I mean, the cases say:

10 When the parties haven't had a full
11 and fair opportunity to complete discovery..

12 We haven't even had the opportunity
13 to start discovery, other than our serving discovery.

14 Uh -- The Defense won't answer.

15 And discovery is important, Your
16 Honor.

17 We -- We need the discovery so we can
18 understand how to apply this law to the facts.

19 And then, now, based on the new
20 arguments about that the -- the -- not only the mandate
21 doesn't apply to the insurance plan, but none of the
22 insurance regulations apply to insurance plan, we've got to
23 do discovery on that.

24 Uh -- And that's another reason the
25 motion should not be granted.

1 But, on the actual question of
2 whether or not, as -- as Counsel put it -- the ultimate
3 issue:

4 Does this diabetes education mandate
5 apply?

6 Your Honor, it was -- it was gone
7 over fairly quickly. And I'm not going to belabor it, but
8 I just want you to understand:

9 Defendant's argument, how they get to
10 this short-hearing proposition that:

11 The South Carolina Insurance
12 Regulation under Title 38 and the Department of Insurance do
13 not apply to the over 400,000 South Carolina citizens that
14 are insured under these state plans.

15 That's how many people have this type
16 of insurance, Your Honor.

17 And the Defense wants to now say that
18 -- that:

19 The regulations in our state for
20 insurance is on what -- for all those peoples insurance.

21 But let me say for sure how they get
22 there, Your Honor, and it's -- it's extremely tortured -- uh
23 -- reading of the statute.

24 Your Honor, was cited to -- uh --
25 Section 38 71 46, which is the Mandate Statute, which says:

1 Every -- and I'm going to paraphrase,
2 because some of it doesn't apply.

3 You can read it for -- for yourself,
4 Your Honor, but -- but:

5 Every health maintenance
6 organization, individual, group health insurance policy, or
7 contract issued or renewed in the state, must provide
8 coverage for equipment -- and it goes on.

9 And it says also:

10 Out-patient self-management training
11 and education for the treatment of people with diabetes
12 mellitus.

13 And then it goes on.

14 And it says:

15 Health insurance policy means: A
16 health benefit plan, contract, or evidence of coverage
17 providing health insurance as defined in the section that
18 Counsel -- uh -- for the Defense cited, 38 71 840, Sub 14,
19 which applies to these three plans.

20 Your Honor, that -- that code section
21 says:

22 Health insurance means:

23 Benefits consisting of medical care
24 provided directly through insurance reimbursement.

25 I believe this, Your Honor, is the

1 Tab -- 9 -- uh -- or rather 8 -- of what Counsel handed up.

2 Health insurance coverage means:

3 Benefits consisting of medical care
4 provided directly, comma, through insurance or
5 reimbursement, comma, or otherwise; and including items or
6 services paid for, or medical care, under any hospital or
7 medical service policy or a certificate, comma, hospital or
8 medical service plan contract, comma, or health maintenance
9 organization contract offered by the health insurance
10 issuer.

11 All right.

12 Now, first of all:

13 That first part of the statute, the
14 definition of what health insurance coverage is -- and if I
15 might just pause, Your Honor?

16 It -- Every time I -- I think about
17 the Defense argument, it just amazes me that, ultimately,
18 your argument is that:

19 The Plaintiff's health insurance
20 policy is not health insurance coverage; all right.

21 But in any event, the very last part
22 of that first part of the health insurance coverage
23 definition says:

24 Comma, or health maintenance
25 organization contract offered by a health insurance issuer.

1 And -- And they -- they then go --
2 all right -- they then go to the health insurance issuer --
3 uh -- definition.

4 But, before I go there, I just want
5 Your Honor to -- to see that:

6 This is not a health maintenance
7 organization contractor we're talking about.

8 The plan that Mr. -- uh -- Allen has
9 is not an HMO-type insurance contract.

10 So, it may be that that part of the
11 statute's definition does not even apply, the part that
12 says:

13 Or health maintenance organization
14 contract offered by a health insurance issuer.

15 It's not -- It's not an HMO policy.

16 But in any event, then it lists
17 several exceptions.

18 A through -- A through J -- K --
19 through K, and subsections of K:

20 Exceptions to that definition of
21 health insurance coverage.

22 And this plan is not in it; in any of
23 the exceptions.

24 The employee insurance plan is not
25 within any of the enumerated exceptions to that definition

1 of health insurance coverage.

2 And, as Your Honor, I'm sure, is well
3 aware:

4 The doctrine of *expressio unius est*
5 *exclusio alterius* -- and I'm sorry about my Latin -- but if
6 there are exceptions to a statute, and something is not
7 included in the exceptions, then that means the Statute
8 doesn't apply -- the exceptions don't apply to it.

9 There -- There is no exception for
10 this employee insurance plan.

11 But in any event, Your Honor, that's
12 where the mandate statute direction for how to figure out if
13 the mandate statute applies -- what insurance policies the
14 mandate statute applies to.

15 But that's where it stops.

16 All it says is:

17 Look to the definition of health
18 insurance coverage that I just spent a great deal of time
19 going over; and that's all it says.

20 It doesn't say:

21 And then, go and look up the
22 definition in Title 38 for health insurance issuer, which
23 again, is related in this sentence to an HMO-type policy.

24 But even if it did apply to this
25 type of policy, here's what the Defendants then do:

1 Then, they wanted to go over to a
2 different part of Title 38, that has a definition for health
3 insurance issuer, 38 71 840.

4 And that definition, Your Honor,
5 after very broadly saying that:

6 A health insurance issuer or issuer
7 in any entity that provides health insurance coverage in
8 this state is a health insurance issuer.

9 And then, you go on to:

10 For the purposes of the section,
11 issuer includes -- and very broad -- insurance company -- uh
12 -- health maintenance organization, and any other entity
13 providing health insurance coverage which is licensed to
14 engage the business of insurance in this state and which is
15 subject to state insurance regulation.

16 Because of the last part of that
17 definition -- a definition that is not even mentioned in the
18 mandate statute, or the definition that the mandate statute
19 says to go and see, they come up with the argument that:

20 The EIP -- the insurance -- The
21 Employee Insurance Plan and the -- the State Budget and
22 Control Board Insurance Program is not a health insurance
23 issuer.

24 It doesn't say that anywhere in Title
25 38, dealing with insurance.

1 It doesn't say that anywhere in the
2 Mandate Statute for this type of diabetes education.

3 It doesn't say that -- doesn't even
4 say that where they say to go and see that that's the case.

5 They then cited Your Honor to a
6 totally different code section -- a totally different title
7 of the code -- Title 1 -- 1 dash 11 780, and thus what they
8 say is -- in their brief -- uh -- explicit recognition of
9 the lack of application of -- of these insurance
10 regulations, including the mandates for this policy.

11 1 11 780, Your Honor, which is in --
12 what they handed up at Tab 10, if Your Honor looks, the
13 title of it is "Mental Health Insurance."

14 They cite you a mental health
15 insurance statute that has nothing to do with diabetes or
16 diabetes education, or anything close to anything this case
17 is about.

18 And that is the silver of their
19 argument.

20 And where we get full-circle, if you
21 take their argument to its logical conclusion, Your Honor,
22 is that:

23 Because this mental health statute
24 says that:

25 The employee insurance program -- and

1 it goes on -- and then they want you to just skip to the
2 end, that says:

3 It's not under the jurisdiction of
4 Department of Insurance.

5 They made the extraordinary argument
6 then, that:

7 Therefore, not only does this
8 diabetes mandate education statute not apply, none of the
9 insurance regulations in our state apply for 400 -- over
10 400,000 people's health insurance, Your Honor, for any type
11 of insurance that they get through the state.

12 And that just can't be so.

13 And if -- if The Court's reading of
14 the statute -- they make -- they try to make a point that:

15 You've got to read -- uh -- the same
16 general -- uh -- the statutory law -- you know -- to -- to
17 harmonize it, and all that.

18 It's not even the same general
19 statutory law.

20 They have to jump to a totally
21 different title of the code to get there.

22 And it's a novel question.

23 And it's really fairly extraordinary,
24 Your Honor, I mean, that -- that that is what -- It really
25 boggles my mind to think that:

1 If you carry that to its logical
2 conclusion, that there is no regulation of these over
3 400,000 people's insurance in the state, except for by the
4 Budget and Control Board, which is an agency of the state.

5 So anyway, that brings again, Your
6 Honor, to the exhaustion -- uh -- Although, real quick, Your
7 Honor, also in the definition of insurer in Title 38 -- uh
8 -- which is now at 38 120:

9 It does not exclude the employee
10 insurance program.

11 Uh -- The insurance licensing law at
12 38 510:

13 There's no exclusion for it.

14 It doesn't even mention any of this
15 stuff that the Defendant is arguing, that it's not -- uh --
16 regulated by the regulations in Title 38 and the Department
17 of Insurance.

18 But in any event, Your Honor, this
19 case cannot be decided in the Administrative Law Court.

20 And -- And here's why. o

21 And, of course, that's the process
22 that -- where it began -- because they made an insurance
23 claim that was denied.

24 And they did an appeal.

25 And it's gone for two and a half

1 years or more.

2 But in any event, Your Honor, this
3 case is a class-action case.

4 Uh -- That can't be heard in the
5 Administrative Law Court.

6 It's a case for -- They want to try
7 to make this just a simple old claim for coverage.

8 But it's also -- It's a case about
9 enforcement of the Defendant's profits on -- both
10 Defendant's profits -- uh -- for denying these claims -- uh
11 -- in violation of -- uh -- the mandate.

12 It's a case providing an injunction
13 going forward, that they not deny them anymore.

14 And -- And those -- those are not
15 appropriate, Your Honor for an Administrative Law Court --
16 uh -- action.

17 Even though the Plaintiff has -- you
18 know -- gone through that process in abundance of caution --
19 uh -- and as the cases that we've cited, Your Honor, say:

20 That is appropriate.

21 Uh -- The Capital City case that is
22 cited in our -- uh -- that was cited in our brief when this
23 exhaustion argument was already denied by a judge then --
24 says that:

25 Uh -- It's not a jurisdictional

1 issue.

2 That the exhaustion requirement is
3 about -- uh -- policy -- convenient discretion -- uh -- that
4 goes to the prematurity of the case.

5 It's not subject matter jurisdiction
6 that's being decided on exhaustion -- uh -- question.

7 And Your Honor, in the Drummond case,
8 Counsel for Defendant -- uh -- with all due respect,
9 misunderstands our -- our citing of the Drummond case.

10 The Drummond case says that:

11 Administrative Law Judges can not
12 pass upon the validity of the statute or regulations.

13 And I understand the Defense -- uh --
14 thinks that only went to this mandate statute; that the ALJ
15 -- We -- We're not saying they the ALJ can't pass on the
16 validity of the mandate statute.

17 But what we've got is:

18 The Budget and Control Board Employee
19 Insurance Program has now issued a rule -- two days ago --
20 but still -- have now issued a rule -- a policy -- a
21 regulation that:

22 The mandate statute does not apply.

23 In fact, that none of Title 38, or
24 the Department of Insurance Regulations apply to these.

25 For the first time that we know of,

1 they've made that argument.

2 But the Administrative Law Judge
3 can't pass on the validity of that policy -- of that
4 regulation.

5 Uh -- So, it's not appropriate to be
6 heard in the Administrative Law Court.

7 I've gone on for a long time, Your
8 Honor.

9 I'd be happy to answer any questions;
10 but that's our argument.

11 We'd ask you to:
12 Deny the Motion for Summary Judgment.

13 Uh -- And deny the Motion for a
14 Protective Order, so we can get some discovery, and get on
15 with this case.

16 Thank Your Honor.

17 MR. WILLARD:

18 Your Honor, just -- just briefly.

19 That is not a regulation.

20 That is merely a decision by the
21 state health insurance plan that was denied.

22 The exclusive remedy is appeal to the
23 ALJ.

24 The Plaintiff and purposely availed
25 themselves of that procedure; and in fact, went through the

1 process.

2 Certainly an Administrative Law Judge
3 can determine whether not that statute applies.

4 One other issue I'd like to address
5 is this argument that -- uh -- we're saying:

6 Nothing in Title 38 applies to the
7 state contract.

8 If the legislature intended it to
9 apply, mandates for coverage, they'd put them in Title 1,
10 like we pointed out in Section 10.

11 And there have been incidences in
12 Title 38 where it does say it applies to the State's Health
13 Plan; and it specifically says -- I'm looking at Tab 11:

14 It applies to the State's Health
15 Plan, and it defines it:

16 As provided for in Article 5, Chapter
17 11, Title I.

18 So again, Your Honor, this is a clear
19 -- two clear questions of law.

20 One is:

21 What court should the Plaintiff be
22 in?

23 They purposely availed themselves of
24 the administrative process; and the statute says:

25 Their exclusive remedy.

1 Now, there is -- there were
2 allegations of class-action and things of that nature.

3 But again, no class has been
4 certified.

5 Right now, we have one case with one
6 Plaintiff with a claim that they admit was denied under the
7 State's Health Plan.

8 And again:

9 Claims under the State's Health Plan:
10 The exclusive remedy is with the ALJ.

11 With respect to this -- this argument
12 about discovery.

13 Your Honor, no amount of discovery in
14 the world is going to change this with anything other than a
15 statutory interpretation case.

16 And in fact, the Plaintiff even asked
17 Your Honor to go ahead and move on it.

18 So, Your Honor, either the ALJ will
19 move it, or we'll get a ruling here.

20 That's a strict -- straight question
21 of law; both those issues.

22 Your Honor, there is no need for
23 discovery.

24 There's no need to drag this out to
25 tie up more time and money, particularly in this budget

1 year, with class-action discovery that's not needed to clear
2 up this question.

3 Thank Your Honor.

4 MR. HAMRICK:

5 Just briefly, Your Honor; very
6 briefly, I promise.

7 Uh -- Counsel mention of the -- uh --
8 class-action allegations, in fact, reminds me that our
9 motion for class certification was actually filed months
10 ago.

11 We filed it because Judge Dennis had
12 just had a bench bar meeting and told us that it was taking
13 -- you know -- 4 and 5 months to get a motion heard.

14 So we went ahead and filed it.

15 Really, at the beginning of the case,
16 it really is not ripe to be heard, Your Honor.

17 We'd ask that it either be continued
18 to another motion -- uh -- another motion day -- uh -- or
19 just postponed in some way until we get some discovery.

20 You know, obviously we cannot have a
21 class-action motion -- uh -- heard without considerable
22 discovery. And we haven't even begun to get any.

23 Uh -- Your Honor, the -- you know --
24 when we hear that:

25 We don't want to drag this out.

1 It's a little difficult to hear,
2 because, as I've said several times, the administrative
3 process has been drug out for over two and a half years.

4 And until two days ago, there was no
5 good explanation -- there's still no good explanation, but
6 it was no explanation at all until then.

7 And just briefly, the argument that:

8 If the legislature had wanted to say
9 that the mandate applies to the employee plan, it could
10 have.

11 And Counsel points to a statute
12 regarding autism that -- uh -- in Title 1 that -- that does
13 -- in Title 1 that does specifically -- uh -- say it applies
14 to the -- uh -- to the employee insurance plan.

15 Your Honor, that statute was passed
16 in 2007.

17 And Counsel makes the argument in
18 their brief that -- you know:

19 The legislature knew, as shown by
20 that statue, that it had to specifically say -- uh -- that
21 the mandate applies to employee insurance plan, when it has
22 to.

23 But it -- the -- the (not
24 understandable word) mandate was passed in 2000.

25 But it doesn't work.

1 You can't -- It's not -- It's not
2 that -- uh -- they passed the diabetes mandate after they'd
3 already passed the mandate where they specifically said:

4 It applies to the employee insurance
5 plan.

6 It was the other way around -- uh --
7 and that was the 38 71 280. And that was an autism -- uh --
8 mandates about autism coverage.

9 In any event, Your Honor -- uh --
10 we'd ask that:

11 You deny the Motion for Summary
12 Judgment.

13 Allow us to proceed.

14 And allow us to get discovery.

15 Thank you, Your Honor.

16 THE COURT:

17 All right.

18 I need proposed orders within 10 days
19 on this. And let me take a look at it.

20 And those other matters are
21 continued.

22 MR. HAMRICK:

23 Thank Your Honor.

24 MR. WILLARD:

25 Thank Your Honor.

1 THE COURT:

2 Thank you.

3 WHEREUPON: There being nothing

4 further in this particular matter, this hearing was closed

5 at 12:42 PM, August, 26, 2010.

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CERTIFICATE

I, the undersigned, H. Eugene Buckner, CVR, Official Court Reporter at Large in and for the State of South Carolina, do hereby certify that the foregoing proceeding was taken on the 26th day of August, 2010;

That the within judicial proceedings are, to the best of my ability, an accurate and verbatim transcription of the hearing;

I further certify that I'm neither Counsel nor Solicitor to any of the parties in said suit, nor interested in the event of the cause.

IN WITNESS WHEREOF, I've hereunto set my hand and seal this 14th day of February, 2011.

H. Eugene Buckner

H. EUGENE BUCKNER, CVR
OFFICIAL COURT REPORTER AT LARGE
15TH JUDICIAL DISTRICT
STATE OF South Carolina

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

31st day of August, 2011



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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Paul M. Burch, Circuit Court Judge

Jeffrey D. Allen, individually,
as guardian for Jane Doe, a
minor, and as representative of
other similarly situated State
of South Carolina employees,

Appellant,

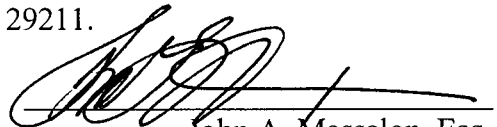
v.

South Carolina Budget and
Control Board Employee
Insurance Program and Blue
Cross and Blue Shield of
South Carolina.

Respondent,

PROOF OF SERVICE

I certify that I have served the Record on Appeal on South Carolina Budget and Control Board Employee Insurance Program, and Blue Cross and Blue Shield of South Carolina, by depositing a copy of it in the United States Mail, postage prepaid, on August 12, 2011, addressed to their attorneys of record, Theodore D. Willard, Jr., Esquire, 1002 Calhoun Street, Post Office Box 11886, Columbia, SC 29211; and Kelly H. Rainsford, Esquire, 1201 Main Street, Ste. 300, Columbia, SC 29211.



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AUG 15 2011

SC Court of Appeals

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