

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

Benjamin H. Culbertson, Circuit Court Judge

Case No. 2016-CP-26-0166
Appellate Case No. 2016-001499

RECEIVED

FEB 13 2017

SC Court of Appeals

Jeanne Beverly, Individually Appellant
and on behalf of others
similarly situated

v.

Grand Strand Regional, Respondents.
Medical Center, LLC

**APPELLANT'S MEMORANDUM IN OPPOSITION
TO RESPONDENT'S MOTION TO STRIKE**

Appellant Jeanne Beverly, through her attorneys, respectfully submits her memorandum in opposition to Respondent Grand Strand Regional Medical Center's ("Grand Strand") Motion to Strike.

This appeal is taken from a circuit court's order dismissing Ms. Beverly's Complaint that alleged breach of contract, bad faith, and unjust enrichment claims against Grand Strand, the hospital in which Ms. Beverly was treated following an auto collision in September 2012. Ms. Beverly alleged Grand Strand ignored her status as a Blue Cross Blue Shield of South Carolina ("Blue Cross") insured and billed her rather than Blue Cross and at an amount greater than the discount rate Grand Strand agreed to accept. Ms. Beverly alleges Grand Strand's conduct violates its contractual promises, contradicts other promises made directly to Ms. Beverly and

the putative class, and defies basic notions of equity. In many ways, Grand Strand's brief attempts a systematic retreat from its contractual promises to bill Blue Cross, not bill Blue Cross insureds, and to accept a discount reimbursement rate.¹

Now, with briefing completed, Grand Strand seeks to retreat *from its own words* by asking the Court to strike from Appellant's reply brief references to Grand Strand's unambiguous promises to insured customers that it will bill their insurers and not the customers directly. To support its motion, Grand Strand asserts Ms. Beverly raises new arguments in her reply brief. However, Ms. Beverly's arguments have remained the same from the circuit court until now. Ms. Beverly has consistently argued Grand Strand violated promises to Ms. Beverly made both within and without its contract with Blue Cross and that Grand Strand must return her money as either a measure of contract damages or equitable relief. Respondent's motion should be denied.

Grand Strand argues Ms. Beverly raises new arguments in her reply brief by referencing Grand Strand's allegedly false promises regarding insurance claim submission and patient billing. Resp't Mot. at 2 (citing Jackson v. Bi-Lo Stores, Inc., 313 S.C. 272, 277, 437 S.E.2d 168, 171 (Ct. App. 1993)). Jackson does not apply here because Ms. Beverly's reply brief does not raise any new arguments. Ms. Beverly's Complaint specifically alleged Grand Strand made false contractual and extra-contractual promises, she supported those arguments to the circuit court, and she raised those arguments in her initial brief to this Court. There is no issue preservation

¹ Compare Resp. Br. at 19 ("Grand Strand does not have any obligation to file for insurance benefits") with Institutional Agreement at 6 § 6.2 ("Institution shall bill Plan . . ."); compare Resp. Br. at 25 ("It is not inequitable for Grand Strand to charge Beverly non-discounted rates") with Institutional Agreement at 6 § 6.1 ("Institution will not solicit any payment from Members . . .") and § 6.4 (stating Grand Strand's duty to accept discount reimbursement rates).

concern here and, therefore, no basis to exclude Grand Strand's promises from the Court's consideration.

In her Complaint, Ms. Beverly alleges Grand Strand acted in bad faith by billing her at a non-discount rate rather than her insurer at an agreed upon discount rate. (Compl. ¶¶ 37-50), attached as Exhibit 1. The direct promises Grand Strand makes to potential customers are a crucial component of Ms. Beverly's bad faith claim. She alleged Grand Strand "actively sought out patients' trust" and "represented to . . . [Blue Cross] insureds that it would provide treatment and care as a preferred provider" in Blue Cross's Preferred Provider Organization. (Compl. ¶¶ 41-42). Ms. Beverly also alleged Grand Strand obtained the business of Blue Cross insureds using false promises. Specifically, Ms. Beverly alleged Grand Strand "actively sought [Blue Cross's] insureds as patients" and "mischaracterize[ed]" its relationship with Blue Cross to do so. (Compl. ¶ 43).

Ms. Beverly asserted arguments based on these Complaint allegations in opposing Grand Strand's motion to dismiss. Pla. Mem. in Opp. to Mot. to Dismiss at 7-8 (arguing Grand Strand "held itself out" as hospital that would bill insurers and "actively sought out" Blue Cross insureds using such promises), attached as Exhibit 2. These same arguments were instrumental to her initial brief. App. Br. at (v) (identifying second issue on appeal as whether a fiduciary relationship was formed when Grand Strand "touted its Blue Cross PPO provider status and solicited Blue Cross" insureds). Ms. Beverly returned to these arguments as proof of the fiduciary relationship Grand Strand formed with her and other Blue Cross insureds. App. Br. at 18. Ms. Beverly noted Grand Strand obtained the right to "publically state" its Blue Cross PPO status and took advantage of that right by making promises to patients like her. *Id.* In light of these consistent references to Grand Strand's unfulfilled promises throughout this litigation, the

court should reject Grand Strand's argument that the reply brief contains a new argument by referencing Grand Strand's public statements about insurance claim submission and patient billing.

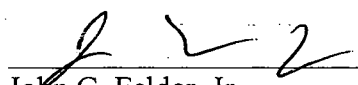
Finally, the Court should reject Grand Strand argument that Ms. Beverly raised a new argument by referencing the Emergency Medical Treatment and Labor Act. Resp. Mot. at 3-4 (citing Reply Br. at 9). This is not a new argument but rather a direct response to arguments raised in the respondent's brief. The reply brief even specifically identifies that portion of Grand Strand's argument to which the federal statutory reference refers. (Reply Br. at 9) (citing Resp. Br. at 17, 19). By faulting Ms. Beverly for responding to its argument, Grand Strand misunderstands the core function of the reply brief. Moreover, the Court should deny Grand Strand's motion on this issue because Grand Strand improperly seeks to add a response to Ms. Beverly's reply brief. Instead of limiting itself to an inaccurate issue preservation argument, Grand Strand goes on to challenge the merits of Ms. Beverly's reply argument. Resp. Mot. at 4 ("In addition . . . Beverly's application of the Act is erroneous"). In essence, Grand Strand here attempts a sur-reply brief even though no such filing is permitted by the rules. See Rule 208(a)(1)-(3), SCACR (authorizing only an appellant, respondent, and reply brief).

CONCLUSION

Based on the arguments stated above, Ms. Beverly respectfully requests the Court deny Grand Strand's Motion to Strike. Since they are so far at odds with the contractual duties, Grand Strand perhaps has an interest in retreating from its public statements regarding insurance claim submission and patient billing. However, Ms. Beverly's reply brief raises no new arguments, and

Grand Strand should not be permitted to prevent the Court's consideration of these statements under the guise of the appellate courts' issue preservation rules.²

Respectfully submitted,


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² Grand Strand's motion also asks the Court to strike the reply brief's reference to documents promulgated by the South Carolina Department of Insurance. While Ms. Beverly disagrees with Grand Strand's arguments for the reasons stated above, she will remove reference to these documents in her final reply brief.

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February 13, 2017
Columbia, South Carolina

STATE OF SOUTH CAROLINA
COUNTY OF HORRY

IN THE COURT OF COMMON PLEAS
FOR THE FIFTEENTH JUDICIAL CIRCUIT

Civil Action No. 2016-CP-26-

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

Plaintiff,

v.

Grand Strand Regional Medical Center,
LLC,

Defendant.

**CLASS ACTION COMPLAINT
JURY TRIAL DEMANDED**

2016 JAN 11 PM 2:40
HORRY COUNTY
CLERK OF COURT

Plaintiff Jeanne Beverly, individually and on behalf of others similarly situated, alleges and states the following claims for relief against Defendant Grand Strand Regional Medical Center, LLC.

NATURE OF THE ACTION

1. Plaintiff Jeanne Beverly and those similarly situated were patients at Defendant's hospital who sought medical treatment arising from motor vehicle accidents. At the time of treatment, Defendant refused to process or submit bills to Plaintiff's health insurance provider and required Plaintiff and similarly situated patients to pay medical bills out of pocket.
2. Ms. Beverly and the class she seeks to represent were named "insureds" under existing insurance policies with Blue Cross Blue Shield Insurance Company ("BCBS").
3. Defendant is a preferred provider in the BCBS network and previously agreed, pursuant to a contract, to scheduled rates of payment for BCBS's insureds as a condition of being a preferred provider.

4. Ms. Beverly and the class she seeks to represent are third party beneficiaries to the contract between Defendant and BCBS, and have a right to enforce the contract between Defendant and BCBS.
5. Defendant's decision to not submit claims was based on monetary gain. By not submitting claims through BCBS, Defendant was able to increase its cash flow by charging insureds the full price of services instead of at the reduced price previously negotiated with BCBS for BCBS's insureds. Defendant's actions ignored its contractual obligations to both BCBS, Plaintiff, and other class members.
6. Defendant's conduct deprived Ms. Beverly and other class members of the benefit of their insurance coverage.

PARTIES

Plaintiff:

7. Plaintiff Jeanne Beverly is a citizen and resident of Myrtle Beach, South Carolina. Plaintiff was a patient of Defendant Grand Strand Regional Medical Center who, like the class members she seeks to represent, was denied the right to have her claims processed and submitted to her insurance carrier by Defendant.

Defendant:

8. Defendant Grand Strand Regional Medical Center, LLC is a limited liability company organized under the laws of the state of Delaware that provides medical services in South Carolina, maintains a registered agent in Richland County, South Carolina, and transacts significant business in South Carolina.

JURISDICTION AND VENUE

9. The jurisdiction of this Court is founded upon S.C. Const. art. V § 11, which grants the circuit court general jurisdiction over civil actions.
10. This Court has personal jurisdiction over Defendant because Defendant conducts business in South Carolina and/or has the requisite minimum contacts with South Carolina necessary to constitutionally permit the Court to exercise jurisdiction, with such jurisdiction also being within the contemplation of the South Carolina “long arm” statute, S.C. Code Ann. § 36-2-803 (2003).
11. Venue in this Court is proper pursuant to the Rules of the South Carolina Supreme Court and the South Carolina Code.

GENERAL FACTUAL ALLEGATIONS APPLICABLE TO ALL CLAIMS

12. Upon information and belief, Ms. Beverly was involved in a motor vehicle collision on September 6, 2012, in which she sustained serious injuries.
13. Ms. Beverly received treatment at Defendant’s hospital for those injuries.
14. At the time of the collision and treatment, Ms. Beverly was covered by a health insurance policy issued by BCBS. Ms. Beverly obtained this health insurance coverage for the purpose of defraying medical expenses.
15. Ms. Beverly’s insurance information was provided to Defendant at the time of her admission and treatment.
16. At all relevant times, Defendant was a preferred provider in the BCBS network.
17. As a preferred provider, Defendant agreed to accept BCBS insurance and provide services for BCBS’s insureds at reduced cost.

18. Despite these contractual relationships and Ms. Beverly's presentment of her insurance coverage, Defendant and its representatives refused to submit Ms. Beverly's bills related to the vehicle collision to BCBS for payment.
19. Medical claims of motor vehicle victims in a hospital's emergency room represent the worst performing revenue streams for a hospital.
20. By refusing to accept insurance coverage for motor vehicle accidents, Defendant can generate a significant increase in cash flow by receiving payment immediately and in an amount that far exceeds the negotiated rate with BCBS.
21. Defendant demanded payment in full from Ms. Beverly despite her insurance coverage.
22. Defendant claimed an amount due of \$7,031.25 for initial medical treatment and an additional \$ 968.75 for the removal of staples.
23. Ms. Beverly was not aware at the time of treatment of Defendant's systematic refusal to honor its contractual obligations regarding emergency room bills for insured patients and did not learn of this information until a later date.
24. Defendant ignored its contractual arrangement with BCBS in an attempt to avoid the discounts it voluntarily negotiated and agreed to in order to become a preferred provider for BCBS. By not submitting Ms. Beverly's bills, BCBS unfairly profited from Ms. Beverly and others similarly situated.
25. Ms. Beverly is a third party beneficiary of the agreements between Defendant and BCBS.

CLASS ACTION ALLEGATIONS

26. Plaintiffs reallege and incorporate by reference the allegations set forth above.
27. Pursuant to Rule 23, SCRPC, Plaintiffs bring this action on behalf of herself and all other similarly situated persons. Plaintiffs seek to represent the class defined as follows:

All persons (or estates of persons) in South Carolina or persons (or estates of person) who have jurisdiction with a South Carolina Court under the Door Closing Statute) insured by BCBS receiving services in Defendant's emergency department from September 6, 2009 to present for whom Defendant failed to submit the bill for medical services to BCBS and instead obtained recovery from the person.

28. On information and belief, the class includes a substantial number of Defendant's patients and is so numerous that joinder of all members is impractical.
29. There are questions of fact or law common to the class predominating over questions affecting only individual class members, including without limitation:
 - a. Whether Defendant's contract with BCBS requires submission of emergency room claims for payment by the insurer rather than the patient;
 - b. Whether Defendant's pursuit of payment from class members rather than from class members' insurer was permitted by law;
 - c. Whether Defendant acted in good faith by pursuing medical expenses from class members despite Defendant's contractual obligations; and
 - d. Whether Defendant's retention of money for medical expenses paid by class members is just.
30. Plaintiffs' claims are typical of the absent class members in that all allege financial losses and other damages attributable to Defendant's process of charging and collecting medical expenses from insured emergency room patients.
31. Plaintiffs will fairly and adequately protect the interests of the other class members. Plaintiffs' counsel is experienced in handling class action claims. Neither Plaintiff nor Plaintiffs' counsel has any interests adverse to or in conflict with the absent class members.
32. The amount in controversy for all class members exceeds one hundred dollars.

COUNT I
BREACH OF CONTRACT

33. Plaintiff and the other class members entered into a contractual agreement with BCBS, whereby Plaintiff and the other class members agreed to pay monthly premiums to BCBS for the benefit of health insurance.
34. BCBS as a part of its service to Plaintiff and other class members, contracted with Defendant to provide payments for their insureds' services. Specifically, Defendant bargained and contracted with BCBS for discounted payments as satisfaction of patient's accounts. This arrangement entitled Defendant to a preferred provider status within the BCBS network and generated business for Defendant.
35. Defendant breached its contract with BCBS, Plaintiff, and the other class members, as third party beneficiaries, by refusing to submit claims to BCBS. Defendant deprived Ms. Beverly of the benefits of the discounts and other provisions negotiated between BCBS and Defendant.
36. As a direct and proximate result of Defendant's breach, Plaintiff and the other class members have suffered damages, which include all payments collected by Defendant from Plaintiff and the other class members together with prejudgment interest.

COUNT II
BAD FAITH

37. The aforementioned paragraphs are hereby incorporated by reference as if fully set forth herein.
38. Plaintiff and other class members were patients at Defendant's hospital from 2012 until present.

39. Defendant created a special relationship with Plaintiff and the other similarly situated class members by contracting with BCBS, thereby making Plaintiff and the other class members third party beneficiaries to its contract with BCBS.
40. Defendant breached the fiduciary duties owed to Plaintiff and the other class members by refusing to submit her insurance claims.
41. Defendant held itself out to be a BCBS preferred provider, with a guaranteed acceptance of BCBS insurance.
42. Defendant actively sought patients' trust for providing medical treatment and care, both as a corporate entity and as a medical facility.
43. Defendant represented to both BCBS and BCBS's insureds that it would provide treatment and care as a preferred provider, which was memorialized in the contract signed by Defendant and BCBS.
44. Defendant actively sought BCBS's insureds as patients, not to ensure that they were provided appropriate medical care, but rather so they could profit off its mischaracterization of its relationship with BCBS.
45. Plaintiff and other similarly situated class members reasonably placed a level of trust in Defendant by choosing to seek medical care and treatment from Defendant based on Defendant's status as a preferred provider.
46. Defendant breached its fiduciary duty to Plaintiff and other class members by choosing to prioritize its revenue stream over the fiduciary relationship it created with BCBS and its insureds.
47. Defendant's goal to maximize its revenue stream was achieved at the monetary expense of patients, like Plaintiff and other class member involved in motor vehicle accidents.

48. Defendant failed to act with fairness and good faith in its dealings with Plaintiff and other class members, and instead used its position to the detriment of BCBS's insureds involved in motor vehicle accidents.
49. The breach of fiduciary duty is believed to be outrageous, willful, wanton, and with reckless disregard of Plaintiff and other similarly situated class members.
50. By the above-referenced conduct, breaches, violations, and failures, it is believed that Defendant failed to discharge its professional and fiduciary duties with the care, skill, prudence, and diligence under the circumstances as required by a prudent person or entity, acting in a like capacity and familiar with such matters.

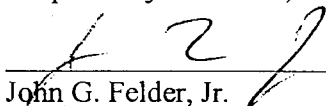
COUNT III
UNJUST ENRICHMENT

51. The aforementioned paragraphs are hereby incorporated by reference as if they were set forth fully herein.
52. Defendant was unjustly enriched through the collection of additional payments from Plaintiff and the other class members for payment of services at a higher value than contracted for with BCBS.
53. This conduct constitutes an unjust retention of a benefit to the detriment of Plaintiff and class members, and Defendant's retention of money is against the fundamental principles of justice and good conscience and is patently unfair.
54. It would be unconscionable for Defendant to retain the payments made by Plaintiff and other class members because those funds were received with complete disregard of available insurance coverage and in contradiction to the agreed upon price for services bargained for between Defendant and BCBS.
55. Equity demands that Defendant be compelled to return its ill-gotten gains.

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

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

Respectfully submitted,



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January 6, 2016.
Columbia, South Carolina.

STATE OF SOUTH CAROLINA

COUNTY OF Horry

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

Plaintiff,

v.

Grand Strand Regional Medical Center,
LLC,

Defendant.

IN THE COURT OF COMMON PLEAS

FOR THE FIFTEENTH JUDICIAL CIRCUIT

Civil Action No. 2016-CP-26-0166

**PLAINTIFF'S MEMORANDUM OF
LAW IN OPPOSITION TO
DEFENDANTS' MOTION TO DISMISS**

FILED
HORRY COUNTY
2016 APR 13 PM 2:08
MELANIE HUGGINS-WARD
CLERK OF COURT

Plaintiff Jeanne Beverly, individually and on behalf of others similarly situated, respectfully submits Plaintiff's Memorandum of Law in Opposition to Defendant Grand Strand Regional Medical Center, LLC's ("GSRMC") Motion to Dismiss.

FACTS

Plaintiff Jeanne Beverly was injured in a car accident on September 6, 2012 and was treated at GSRMC the same day. (Compl. ¶¶ 12-13). Plaintiff had health insurance through Blue Cross Blue Shield of South Carolina ("BCBS"). She sought treatment at GSRMC because it is a BCBS Preferred Provider Organization ("PPO") provider. (Compl. ¶ 16). To become a BCBS PPO provider, GSRMC entered a contract with BCBS known as an "Institutional Agreement," which imposes several requirements on prospective PPO providers "for the benefit of [BCBS] members" like Plaintiff. Institutional Agreement § 1.1. GSRMC agreed to (1) submit all BCBS members' bills to BCBS as soon as practicable¹; (2) seek payment for those services "solely

¹ Institutional Agreement § 6.3

copy

EXHIBIT 2

from” BCBS²; (3) accept the discounted reimbursement rate outlined in the Agreement³; and (4) refrain from charging BCBS members directly except for coinsurance, copays, and deductibles⁴.

Even though Plaintiff is a BCBS member and the services GSRMC provided her are covered by the Institutional Agreement, GSRMC charged the full amount for those services and sought payment from Plaintiff rather than BCBS. (Compl. ¶ 21). GSRMC disregarded the agreed upon reimbursement rate and sent Plaintiff a \$7,031.25 bill for emergency room services and an additional \$968.75 bill for staple removal. (Compl. ¶ 22). Upon information and belief, GSRMC routinely chooses to disregard the reimbursement rate to which it agreed and routinely charges BCBS members directly for medical service costs that grossly exceed the reimbursement rate. See (Compl. ¶¶ 27-32). Accordingly, Plaintiff, individually and on behalf of similarly situated BCBS members, filed a Class Action Complaint against GSRMC alleging claims for (1) breach of contract; (2) bad faith; and (3) unjust enrichment. GSRMC filed the current Motion to Dismiss on March 3, 2016.

LEGAL STANDARD

A defending party may assert in its answer or in a pre-answer motion a defense alleging the complaint against the defending party fails to state facts sufficient to constitute a cause of action. Rule 12(b)(6), SCRPC. When reviewing a 12(b)(6) motion, a court must view a complaint in the light most favorable to the plaintiff and every doubt must be resolved in the plaintiff’s favor. Plyler v. Burns, 373 S.C. 637, 645, 647 S.E.2d 188, 192 (2007). If the “facts alleged and inferences reasonably deducible therefrom would entitle the plaintiff to any relief on any theory of the case,” then the court may not grant a 12(b)(6) motion. Sloan Constr. Co. v. Southco Grassing Co., 377 S.C. 108, 113, 659 S.E.2d 158, 161 (2008). A court may not dismiss

² Institutional Agreement § 6.1

³ Institutional Agreement § 6.4

⁴ Institutional Agreement § 6.1 (a)-(d)

a complaint merely because the court doubts the plaintiff will prevail. Plyler, 373 S.C. at 645, 647 S.E.2d at 192.

ARGUMENT

1. Plaintiff may allege a breach of contract claim as a third-party beneficiary.

The Institutional Agreement expressly acknowledges its terms are intended to benefit not just the parties (i.e. GSRMC and BCBS) but also BCBS members. Even in the provision purporting to exclude third-party beneficiaries, the Institutional Agreement acknowledges benefits the contract confers on BCBS members like Plaintiff. By choosing to enter the Institutional Agreement, GSRMC chose to forgo the full cost of Covered Services and the right to look to patients directly for payment in exchange for access to BCBS's members and the guaranteed payment the Institutional Agreement provides. In both its structure and terms, the Institutional Agreement intended to directly benefit Plaintiff and she is entitled to enforce it.

Generally, a contract may be enforced only by those who objectively manifest assent to its terms and enter the contract as parties. Hardaway Concrete Co. v. Hall Contracting Co., 374 S.C. 216, 225, 647 S.E.2d 488, 492 (Ct. App. 2007). As an exception to this rule, a person that contract parties "intended to directly benefit" may be a third-party beneficiary who may then assert a breach of contract claim. Helms Realty, Inc. v. Gibson-Wall Co., 363 S.C. 334, 340, 611 S.E.2d 485, 488 (2005). A contract's language is the first point of reference for determining the parties' intent. Wallace v. Day, 390 S.C. 69, 74-75 700 S.E.2d 446, 449 (Ct. App. 2010) (citing C.A.N. Enters., Inc. v. S.C. Health & Human Servs. Fin. Comm'n, 296 S.C. 373, 377, 373 S.E.2d 584, 586 (1988)). When the contract language is capable of two or more meanings, the contract is ambiguous, creating a question of fact on the parties' intent. Id.

The Institutional Agreement clearly intended to provide direct benefits to BCBS members like Plaintiff. The contract's express purpose was for GSRMC to become a provider for a PPO created "for the benefit of [BCBS] members." Institutional Agreement at §§ 1.1-1.2; Cf. M & M Group Inc. v. Holmes, 379 S.C. 468, 476-77, 666 S.E.2d 262, 266 (Ct. App. 2008) (using recital provision to determine parties' intent). Benefitting BCBS members inheres to the PPO concept, which the Institutional Agreement defines as a "network of providers" that "contain[s] financial incentives for Members." Institutional Agreement § 2.16. Plaintiffs contracted with BCBS to become PPO members so they could reap the financial and medical benefits of the PPO network outlined in the Institutional Agreements between BCBS and each PPO provider. Given the PPO structure GSRMC signed on to and the clearly expressed language in the Institutional Agreement, it is not reasonable for GSRMC to argue the Institutional Agreement was not intended to benefit Plaintiff.

GSRMC contends the Institutional Agreement expressly excluded the possibility of third-party beneficiaries. Def.'s Mem. in Supp. of Mot. to Dismiss at 5-6 (citing Institutional Agreement § 16.16). GSRMC's memorandum provided the Court only a portion of this provision. Section 16.16 reads in full:

This Agreement is not intended to, and shall not be construed to, make any person or entity a third party beneficiary. Notwithstanding the preceding, nothing in this section shall affect Plans rights under Article XV, or **a Member's right to receive Covered Services pursuant to the terms of this Agreement.**

(Emphasis added).

The highlighted language is crucial for two reasons. First, it provides further proof the Institutional Agreement contemplated Plaintiff and intended to directly benefit her. The provision acknowledges a "Member's rights" under the Institutional Agreement. Second, even if this section is construed as a general exclusion of third-party beneficiary rights, it clearly

includes carve outs for certain scenarios including a BCBS member seeking to ensure receipt of Covered Services. Plaintiff's breach of contract claim is simply an attempt to enforce the Institutional Agreement's terms on the provision of Covered Services.

As alleged in the Complaint, Plaintiff's did not "receive Covered Services pursuant to the terms of the Agreement." The Institutional Agreement required GSRMC to provide Plaintiff's the Covered Services their medical conditions required. Institutional Agreement § 4.1. Except for Plaintiff's coinsurance, copayment, and deductible obligations, GSRMC was then required to seek payment for Covered Services "solely from" BCBS. Institutional Agreement § 6.1. To provide Covered Services "pursuant to the terms of the Agreement," GSRMC was required to "bill [BCBS] in a manner acceptable to and as prescribed by [BCBS]" and to "exercise reasonable efforts to submit all bills" to BCBS "as soon as practicable after Covered Services are rendered." Institutional Agreement §§ 6.2-6.3. Finally, the Institutional Agreement provides that GSRMC "shall accept the reimbursement terms and rates for Covered Services" stated in the Agreement and its attachments. Institutional Agreement § 6.4.

This is not how GSRMC provided Covered Services to Plaintiff. Plaintiff was treated in GSRMC's emergency department (Compl. ¶¶ 13, 27) but almost nothing related to the submission or payment of bills for her treatments was consistent with GSRMC's contractual obligations. The bills were not submitted to BCBS (Compl. ¶ 18) even though GSRMC was required to do so. Institutional Agreement § 6.2. GSRMC sought payment from Plaintiff (Compl. ¶ 21) rather than BCBS even though the Agreement expressly prohibits this practice. Institutional Agreement § 6.1. GSRMC then sought and obtained for Covered Services more than the contractually-established reimbursement rate. (Compl. ¶ 24); Institutional Agreement § 6.4. Thus, even if Section 16.16 generally excludes third-party beneficiaries, Plaintiff falls

within the provision's exception because her claim relates to her "right to receive Covered Services pursuant to the terms of this Agreement."

Plus, GSRMC's argument has been rejected by other jurisdictions considering a nearly identical Institutional Agreement. In Benton v. Vanderbilt Univ., 118 F. Supp. 2d 877 (M.D. Tenn. 2000), a patient injured in an auto accident and treated at the defendant hospital sued the hospital for breach of contract when the hospital refused to submit bills to BCBS of Tennessee and instead asserted a lien against the victim's potential tort recovery. The patient alleged a breach of contract claim and argued he was a third party beneficiary to the hospital's Institutional Agreement with BCBS of Tennessee. Id. at 879; see also Benton v. Vanderbilt Univ., 137 S.W.3d 614 (Tenn. 2004) (holding on remand that patient is third-party beneficiary to her insurer's contract with hospital). The Tennessee Supreme Court reaffirmed this holding in 2014 in another case construing a BCBS of Tennessee-hospital Institutional Agreement. West v. Shelby County Healthcare Corp., 459 S.W.3d 33, 45 (Tenn. 2014) ("We have already held that persons insured by an insurance company are intended third-party beneficiaries of the contract between their insurance company and a hospital" (citing Benton, 137 S.W.3d at 620)).⁵

Thus, under South Carolina law, Plaintiff is a third-party beneficiary to the Institutional Agreement between BCBS and GSRMC and is entitled to enforce its provisions. Defendants' motion to dismiss Plaintiff's breach of contract claim should be denied.

2. Plaintiff properly alleges a breach of fiduciary duty claim.

The Complaint properly states a cause of action for breach of fiduciary duty. This claim requires proof of (1) the existence of a fiduciary duty; (2) breach of that duty owed to the

⁵ See also Cates v. Integris Health, Inc., No. CIV-12-0763-F, 2013 WL 3923512 (W.D. Okla. July 29, 2013); Dorr v. Sacred Heart Hosp., 597 N.W.2d 462, 475 (Wis. Ct. App. 1999) (finding insured was third-party beneficiary to hospital-insurer contract despite contract provision purporting to exclude third-party beneficiaries).

plaintiff by the defendant; and (3) damages proximate resulting from the wrongful conduct of the defendant; Turpin v. Lowther, 404 S.C. 581, 589, 745 S.E.2d 397, 401 (Ct. App. 2013) (citing RFT Mgmt. Co. v. Tinsley & Adams, L.L.P., 399 S.C. 322, 335-36, 732 S.E.2d 166, 173 (2012)). A fiduciary relationship is formed when one party places a “special confidence” in another so that the other must “act in good faith and with due regard to the interests of the one imposing the confidence.” Hendricks v. Clemson Univ., 353 S.C. 449, 458, 578 S.E.2d 711, 715 (2003). To demonstrate a fiduciary relationship, Plaintiff must only show the facts and circumstances surrounding her claim provided a foundation for believing GSRMC would act in Plaintiff’s interest and that GSRMC either accepted or induced the confidence Plaintiff placed in it. Moore v. Moore, 360 S.C. 241, 251, 599 S.E.2d 467, 472 (Ct. App. 2004) (citing Burwell v. S.C. Nat’l Bank, 288 S.C. 34, 41, 340 S.E.2d 786, 790 (1986); Regions Bank v. Schmauch, 354 S.C. 648, 671, 582 S.E.2d 432, 444 (Ct. App. 2003)).

Through the facts and circumstances surrounding Plaintiff’s treatment at GSRMC, including the Institutional Agreement’s terms, Plaintiffs have properly pled the existence and breach of a fiduciary duty. As a BCBS insured in need of emergency room services, Plaintiff sought out GSRMC, an entity that entered the Institutional Agreement to become a BCBS PPO provider. (Compl. ¶¶ 39, 45); Institutional Agreement § 1.2. Plaintiff “placed a level of trust” that GSRMC would function as a BCBS PPO provided by offering emergency room services to BCBS members, submitting bills for those services to BCBS as soon as practicable after the services were provided, accepting the established reimbursement rate for those services, and never looking to Plaintiff for payment except for coinsurance, copayments, and deductibles. (Compl. ¶ 45); Institutional Agreement § 6.1-6.4. GSRMC “held itself out” as a BCBS PPO provider and “actively sought” patients to trust GSRMC would act as a BCBS PPO provider

(Compl. ¶¶ 42, 44). Plaintiff further alleges GSRMC breached this trust by choosing not to submit bills to BCBS as it had agreed and by seeking payment at levels above the reimbursement rate and from someone other than BCBS. (Compl. ¶¶ 46-48).

GSRMC argues Plaintiff's claim fails because (1) Plaintiff was not a third-party beneficiary to the Institutional Agreement; (2) GSRMC owed Plaintiff no fiduciary duty; and (3) even if GSRMC owed a fiduciary duty, claim submission is not a part of the duty. None of these arguments are consistent with South Carolina law or the Institutional Agreement GSRMC entered. As discussed above, Plaintiff was an intended third-party beneficiary of the Institutional Agreement. GSRMC is also wrong to conclude it owed Plaintiff no fiduciary duty. It is true that a fiduciary duty may not be created by unilateral action. Def. Mem. in Supp. of Mot. to Dismiss at 7 (Moore, 360 S.C. at 251, 599 S.E.2d at 472). However, Plaintiff's fiduciary claim is based on both Plaintiff placing trust in GSRMC (Compl. ¶ 45) and GSRMC's actions to induce and accept that trust. (Compl. ¶¶ 41-44).

Finally, Plaintiff's fiduciary duty claim is not precluded by Wogan v. Kunze, 366 S.C. 585, 605, 623 S.E.2d 107, 119 (Ct. App. 2005). In fact, the medical provider-patient relationship is recognized as a confidential relationship in South Carolina. Id. (citing McCormick v. England, 328 S.C. 627, 639, 494 S.E.2d 431, 437 (Ct. App. 1997)). Wogan affirmed summary judgment on a breach of fiduciary duty claim related to Medicare claim submission because the claim was essentially a repackaged medical malpractice claim and because the Medicare Act does not permit a statutory claim for relief. 366 S.C. at 606, 623 S.E.2d at 606. Plaintiffs' claim is significantly different. Plaintiff's claim is not dependent on the Medicare Act and does not conflict in any way with federal law. Plus, the Institutional Agreement is substantially different than the contract considered in Wogan where the Court of Appeals specifically noted that the

contract did not specify a claim submission requirement. 366 S.C. at 604, 623 S.E.2d at 119. Here, however, the Institutional Agreement expressly states GSRMC “shall bill” BCBS and “shall exercise reasonable efforts to submit all bills as soon as practicable.” Institutional Agreement at §§ 6.2, 6.3.

In short, GSRMC wanted to be a BCBS PPO provider to gain access to BCBS’s extensive membership and guaranteed revenue sources from BCBS. (Compl. ¶¶ 43-44). To do so, GSRMC agreed to abide by the PPO’s rules explicitly intended to benefit BCBS members like Plaintiff. Those rules include a limited reimbursement rate, claim submission mandate, and a requirement that GSRMC look only to BCBS for payment. By agreeing to these terms, GSRMC was able to hold itself out as a BCBS preferred provider which induced Plaintiff to trust that GSRMC would follow the rules. GSRMC breached that trust causing Plaintiff to incur medical expenses and other damages. (Compl. ¶¶ 46-49). These allegations properly state a claim for breach of fiduciary duty and Defendant’s motion should be denied.

3. Plaintiff may allege an unjust enrichment claim based on GSRMC’s collection of medical expenses beyond the reimbursement rate established in the Institutional Agreement.

GSRMC only became a PPO provider by agreeing to accept the established reimbursement rate for Covered Services provided to BCBS members like Plaintiff. Institutional Agreement § 6.4 (GSRMC “shall accept the reimbursement terms and rates for Covered Services”). In complete disregard of that duty, GSRMC unjustly charged Plaintiff and collected from her significantly more than the reimbursement rate. (Compl. ¶¶ 21-22; 52). Under these circumstances it is proper for Plaintiff to allege a claim for unjust enrichment or *quantum meruit*. These claims are one and the same and require proof that (1) Plaintiff conferred on GSRMC a benefit; (2) GSRMC realized that benefit; and (3) it would be inequitable for GSRMC to retain

the benefit under these circumstances without paying Plaintiff for its value. Gignilliat v. Gignilliat, Savitz & Bettis, 385 S.C. 452, 684 S.E.2d 756 (2009); Clyde v. Johnson, 402 S.C. 458, 466, 742 S.E.2d 6, 10 (Ct. App. 2013) (“*quantum meruit* is a remedy for unjust enrichment”).

Unjust enrichment is similar to restitution and both terms are simply “modern designations for the older doctrine of quasi-contracts.” JASDIP Props. SC, LLC v. Estate of Richardson, 395 S.C. 633, 640, 720 S.E.2d 485, 489 (Ct. App. 2011) (quoting Ellis v. Smith Grading & Paving, Inc., 294 S.C. 470, 473, 366 S.E.2d 12, 14 (Ct. App. 1988)). Contrary to GSRMC’s argument (Def.’s Mem. at 8), it is proper for Plaintiff to allege both an unjust enrichment/*quantum meruit* and a breach of contract claim. While a plaintiff may not be able to recover for both claims in some circumstances, the claims are not mutually exclusive and Plaintiff may plead both. See Williams Carpet Contractors, Inc. v. Skelly, 400 S.C. 320, 734 S.E.2d 177, 181 (Ct. App. 2012) (“A breach of contract claim and *quantum meruit* claim can be alternative rather than inconsistent remedies”).

As to the merits of Plaintiff’s unjust enrichment claim, GSRMC argues only that the claim is foreclosed by Pitts v. Jackson National Life Insurance Co., 352 S.C. 319, 574 S.E.2d 502 (Ct. App. 2002). Pitts held that it was not inequitable for an insurer to retain the price of an insurance policy even though the insurer could have offered a policy with similar coverage at a lesser price. 352 S.C. at 339, 574 S.E.2d at 512. Plaintiff’s claim is substantially different. While the Pitts defendant was permitted to refuse to offer a gratuitous discount, GSRMC is not permitted to collect for its services a much higher payment rate than it had agreed to accept. GSRMC did far more than just refuse to offer a discount. Instead, it agreed to one and then maneuvered to charge a higher rate anyway. All funds GSRMC collected from Plaintiff above

the reimbursement rate is a benefit that GSRMC came by inequitably. It is unjust for GSRMC to retain these funds, and Plaintiff's unjust enrichment/*quantum meruit* claim is a proper claim to seek a remedy for this wrong.

4. Plaintiff is not bound to arbitrate her claims against GSRMC.

Even though it has moved under Rule 12(b)(6), SCRPC⁶, GSRMC asks the Court to compel Plaintiff to arbitrate her claims based on a provision in the Institutional Agreement. However, "a party cannot be required to submit to arbitration any dispute which he has not agreed so to submit." Landers v. Fed. Deposit Ins. Corp., 402 S.C. 100, 108, 739 S.E.2d 209, 213 (2013) (quoting United Steelworkers v. Warrior & Gulf Navigation Co., 363 U.S. 574, 582 (1960)). GSRMC has not pointed to any document where Plaintiffs agreed to arbitrate her claims.

The Institutional Agreement's arbitration provision specifically excludes Plaintiffs' claims from its reach. GSRMC argues the provision requires arbitration for "any problem or dispute." Def.'s Mem. in Supp. of Mot. to Dismiss at 9 (citing Institutional Agreement § 12.2). Yet again, GSRMC does not provide all of the crucial language. Section 12.2's states:

In the event that **the parties** through mutual negotiation are not able to satisfactorily resolve any problem or dispute (other than a Utilization Management Program decision, which shall be governed by the terms of Article VII), **Plan and Institution agree to arbitrate** such problem or dispute using a single arbitrator.

(Emphasis added). Thus, while the Institutional Agreement recognizes BCBS members' rights and the PPO to which GSRMC gained access was created for the benefit of BCBS members, the Agreement specifically limits arbitration to "the parties." The arbitration provision goes a step

⁶ Rule 12(b)(6), SCRPC allows a defending party to move for dismissal for "failure to state facts sufficient to constitute a cause of action." A 12(b)(6) motion tests only "the factual and legal sufficiency of the complaint." Woodell v. Marion School Dist. One, 307 S.C. 297, 298, 414 S.E.2d 794, 794 (Ct. App. 1992).

further by stating arbitration applies only to claims between "Plan and Institution," i.e. BCBS and GSRMC. When an insurer-health care provider contract specifically limits arbitration to its parties, a third-party beneficiary's claims are not subject to arbitration. For example, in Rath v. Managed Health Network, Inc., 844 P.2d 12 (Idaho 1992), the court refused to submit a third-party beneficiary's claim to arbitration when the contract specifically limited arbitration to disputes "between the parties to this Agreement." GSRMC is bound by the contract language it chose. Since language clearly does not include Plaintiffs' claims within its arbitration provision, GSRMC cannot compel Plaintiff to arbitrate.

5. Forcing Arbitration in this case would be unconscionable.

The Institutional Agreement contemplates the marketing of the PPO advantages to members and the member communications state charges will be at network rate. This is one of the major advantages to a consumer of purchasing this particular plan. Accordingly, the PPO network is published to consumers and plan members as advantages of doing business with the health care providers "in the network".


It would be unconscionable and unforeseeable by the consumer that an undisclosed, confidential provision in the agreement would foreclose suit when A hospital violates the published facts of agreement to consumers and then bills patients in excess of the rate agreed upon by member's insurance plan (BCBS). It would be unconscionable to entice consumers to use the medical providers in the network, based on promises of the network price discounts, and then then, in a secret provision, remove the consumer's ability to do anything about it. See, Aiken v. World Fin. Corp. of S.C., 373 S.C. 144, 644 S.E.2d 705 (2007); Simpson v. World Fin. Corp. of S.C., 373 S.C. 178, 644 S.E.2d 723 (2007); Simpson v. MSA of Myrtle Beach, Inc., 373 S.C. 14, 644 S.E.2d 663 (2007); Chassereau v. Global-Sun Pools, Inc., 373 S.C. 168, 644 S.E.2d

718 (2007). South Carolina Supreme Court has raised issue of whether an arbitration agreement is unconscionable and narrows the applicability of arbitration provisions to claims for "outrageous torts that are unforeseeable to a reasonable consumer in the context of normal business dealings." Aiken v. World Fin. Corp. of S.C., 373 S.C. 144, 151, 644 S.E.2d 705, 709 (2007).

CONCLUSION

Based on the arguments stated above, Plaintiff respectfully requests an order denying GSRMC's motion to dismiss. Plaintiff is a third-party beneficiary to the Institutional Agreement and may allege a breach of contract claim to enforce its terms. Plus, the Complaint properly alleges all elements of a breach of fiduciary duty claim. Finally, the Institutional Agreement specifically excludes Plaintiff's claims from its arbitration provision, and GSRMC may not compel arbitration.

Respectfully submitted,



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April 11, 2016.
Columbia, South Carolina.

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

Benjamin H. Culbertson, Circuit Court Judge

Case No. 2016-CP-26-0166

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SC Court of Appeals

Jeanne Beverly, Individually Appellant
and on behalf of others
similarly situated

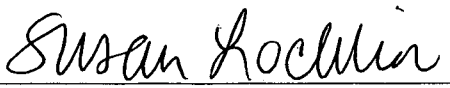
v.

Grand Strand Regional, Respondents.
Medical Center, LLC

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 13th day of February, 2017, she served counsel for the Defendants with a copy of the Appellant's Memorandum in Opposition to Respondent's Motion to Strike in this matter by mailing a copy of the same by the United States Mail with first class postage prepaid to the following address:

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February 13, 2017

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SC Court of Appeals

Via Hand Delivery

The Honorable Jenny Abbott Kitchings
Clerk, South Carolina Court of Appeals
1205 Pendleton St.
Columbia, SC 29201

**Re: Jeanne Beverly v. Grand Strand Regional Medical Center
Civil Action No. 16-CP-26-0166**

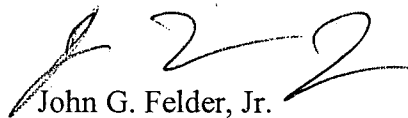
Dear Ms. Kitchings:

Enclosed please find the original and seven copies of Appellant's Memorandum in Opposition to Respondent's Motion to Strike. Please file the same in your customary manner and return a copy to me.

By copy of this letter, I am serving all counsel of record.

With kind regards,

Sincerely,


John G. Felder, Jr.

JGFjr/sll

Enclosures

cc: James Lynn Werner, Esquire