

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC 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

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

v.

Grand Strand Regional, Respondents.
Medical Center, LLC

FINAL BRIEF OF APPELLANT

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STATEMENT OF THE ISSUES ON APPEAL

1. Whether the circuit court erred in finding a Blue Cross member was not an intended third-party beneficiary to a contract between Blue Cross and Grand Strand in which Grand Strand agreed to submit bills for member services to Blue Cross and never seek payment from members.
2. Whether the circuit court erred in finding no fiduciary relationship between a Blue Cross member and Grand Strand, a hospital which touted its Blue Cross PPO provider status and solicited Blue Cross members to seek services at its facility.
3. Whether the circuit court erred in finding it was equitable for Grand Strand to charge a Blue Cross member when it promised not to and for Grand Strand to retain payments at a rate far higher than the agreed upon rate.

STATEMENT OF THE CASE

Appellant Jeanne Beverly filed and served her Complaint on January 6, 2016, alleging claims for (1) breach of contract; (2) bad faith; and (3) unjust enrichment. (R. pp. 23-26). All of Ms. Beverly's claims arise out of an emergency room visit at Respondent Grand Strand Regional Medical Center ("Grand Strand") following an auto accident. The Complaint was filed on behalf of Ms. Beverly and other similarly situated Grand Strand patients. Pursuant to Rule 12(b)(6), SCRCF, Grand Strand filed a motion to dismiss on March 3, 2016, asking the circuit court to dismiss all three of Ms. Beverly's claims. (R. pp. 28-29). Both parties submitted memoranda of law, and the Honorable Benjamin H. Culbertson heard oral arguments on April 26, 2016. The circuit court entered an order granting Grand Strand's motion, and Ms. Beverly filed a Rule 59(e), SCRCF, motion on May 10, 2016. (R. pp. 55-59). The circuit court denied this motion, and Ms. Beverly's counsel received written notice of the order on July 11, 2016. Ms. Beverly filed and served a timely notice of appeal on July 19, 2016. (R. p. 102).

STATEMENT OF THE FACTS

Ms. Beverly was injured in an auto accident caused by another driver on September 6, 2012. (R. p. 20 ¶ 12). On that same day, she presented to Grand Strand's emergency room for diagnosis and treatment of her injuries. (R. p. 20 ¶ 13). Ms. Beverly was evaluated by an emergency room physician, and Grand Strand personnel treated a wound she suffered in the accident. (R. pp. 20-21 ¶¶ 13, 22). A short time later, Grand Strand mailed Ms. Beverly an unexpected \$8,000 bill for emergency room services. (R. p. 21 ¶ 22). The bill was unexpected because Ms. Beverly previously purchased a health insurance policy from Blue Cross Blue Shield of South Carolina ("Blue Cross") that made her a Blue Cross "member" and granted her access to Blue Cross's Preferred Provider Organization ("PPO"). (R. p. 20 ¶ 14). The PPO was a

network of hospitals and medical practices marketed to Blue Cross members as “preferred” providers. (R. pp. 20-24 ¶¶ 16, 41-43; R. p. 116 § 11.2). Ms. Beverly was supposed to benefit from the PPO because PPO providers like Grand Strand were prohibited from billing her. (R. pp. 20-23 ¶¶ 17, 34; R. p. 109 §§ 6.1-6.2).

In the Institutional Agreement, Grand Strand became a PPO provider in exchange for a promise to bill Blue Cross directly for medical services to Blue Cross members. (R. pp. 20-24 ¶¶ 17, 34, 43; R. p. 109 §§ 6.2-6.3). Grand Strand also promised to accept from Blue Cross a discount reimbursement rate for these services. (R. pp. 20-24 ¶¶ 17, 34; R. p. 109 § 6.4). Specifically, the Institutional Agreement¹ prohibited Grand Strand from “solicit[ing] any payment from [Blue Cross] Members” and required Grand Strand to “accept the reimbursement terms and rates” Blue Cross established for the PPO. (R. p. 109 §§ 6.1, 6.4). After signing the Institutional Agreement in 2005, Grand Strand began marketing itself to Blue Cross members as a PPO provider. (R. p. 24 ¶¶ 41-43). Ms. Beverly was aware of Grand Strand’s PPO provider status and expected Grand Strand to function accordingly when she sought out the hospital after her auto accident. (R. p. 24 ¶ 45).

However, the Complaint alleges Grand Strand chose to disregard its contractual duties for Ms. Beverly and similarly situated patients. (R. p. 23 ¶¶ 33-36). Emergency room services for auto accident victims are a poor economic performer for Grand Strand, especially given the discount reimbursement rate Grand Strand agreed to accept from Blue Cross. (R. p. 21 ¶ 19). By charging Ms. Beverly directly and for an amount exceeding the Institutional Agreement’s reimbursement rate, Ms. Beverly alleges Grand Strand acted in its own economic interest and in violation of its contractual duties. (R. pp. 21-25 ¶¶ 21, 22, 24, 46-49). Ms. Beverly demanded

¹ The Complaint alleges Ms. Beverly, as a Blue Cross member, is a third-party beneficiary of the Institutional Agreement. (R. p. 21 ¶ 25).

damages for Grand Strand's breach of contractual and fiduciary duties and, in the alternative, an equitable recovery to remedy Grand Strand's unjust enrichment. (R. pp. 23-26 ¶¶ 36, 50, 56).

STANDARD OF REVIEW

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), SCRC. 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 a complaint merely because the court doubts the plaintiff will prevail. Plyler, 373 S.C. at 645, 647 S.E.2d at 192. An appellate court must apply the same standard. Dawkins v. Union Hosp. Dist., 408 S.C. 171, 176, 758 S.E.2d 501, 503 (2014).

ARGUMENT

In the age of modern medicine and a booming health care industry, a hospital stay is rarely a simple two-party transaction between doctor and patient. Since medical services are costly and unpredictable, it is advisable and now required by federal law² that patients invite a third party to the transaction by procuring health insurance. A patient's relationship with her medical provider is directly affected by the provider's relationship with her insurer since insurers often reach agreements with providers regarding which services the insurer will cover and how the provider will be compensated. Although the provision and payment of health care services is inherently trilateral, the governing contracts often name just two of the participants—e.g. a patient's policy with her insurer or the insurer's reimbursement contract with the provider. When coverage or reimbursement disputes arise, the participants may find themselves seeking relief from a party with whom they lack contractual privity. Medical providers may seek to enforce provisions of their patient's policy with her insurer, and a patient may seek to enforce provisions of her insurer's contract with the provider.

This case asks whether South Carolina contract law and equity principles recognize the core structure of the health insurance market by allowing its participants to enforce duties specifically intended to benefit them even when memorialized in someone else's contract. Several jurisdictions have held that medical providers like Grand Strand may rely on provisions of an insurer-insured contract to demand reimbursement for health care services. Other jurisdictions have also held that patients like Ms. Beverly may rely on provisions within an insurer-provider contract to demand the discount for medical services her provider agreed to accept and to avoid the bill for those services her provider agreed not to send.

² See 26 U.S.C. § 5000A (requiring individuals to “maintain minimum essential coverage” for medical expenses).

South Carolina contract law recognizes the enforcement rights for intended third-party beneficiaries like Ms. Beverly. Yet, the circuit court dismissed Ms. Beverly's contract and equitable claims by concluding she was not a third-party beneficiary and Grand Strand was justified in bypassing her insurer altogether while charging her directly at rates far above what it had agreed to accept. As it stands, Grand Strand's profit-driven decision to ignore its contractual obligation to submit claims is a wrong for which Ms. Beverly lacks a remedy. The circuit court's order should be reversed because it overlooks key provisions of the relevant contract and South Carolina law.

1. Ms. Beverly is an Intended Third-Party Beneficiary of the Institutional Agreement Empowered to Enforce its Claim Submission and Reimbursement Rate Provisions.

While the Institutional Agreement names only Blue Cross and Grand Strand as parties, Blue Cross members like Ms. Beverly are directly benefited by its provisions. Those benefits are not incidental; Grand Strand joined the PPO by entering the Institutional Agreement, an insurance arrangement designed for the purpose of saving Blue Cross members money and the administrative inconvenience inherent to processing medical bills.

Under South Carolina law, it is well-settled that a non-party may enforce contractual terms that intentionally provide her direct benefits. Kingman v. Nationwide Mut. Ins. Co., 243 S.C. 405, 412, 134 S.E.2d 217, 221 (1964). Determining whether a third-party may enforce a contract is a matter of contract interpretation. Touchberry v. City of Florence, 295 S.C. 47, 49, 367 S.E.2d 149, 150 (1988). The circuit court incorrectly interpreted the Institutional Agreement to exclude Ms. Beverly as a third-party beneficiary based on a purported third-party beneficiary disclaimer provision. (R. p. 7) (citing R. p. 123 § 16.16). The court erred because it failed to give effect to the remaining twenty pages of the Institutional Agreement, which imposes requirements on Grand Strand specifically intended to benefit Ms. Beverly and other Blue Cross members.

Additionally, the circuit court failed to give effect to the full language of the purported disclaimer provision which expressly carves out Ms. Beverly's claims.

a. The Institutional Agreement Adds Grand Strand to a PPO Network Structured to Provide Direct Benefits to Blue Cross Members.

The Institutional Agreement's language, structure, and purpose demonstrate its parties' intent to provide direct benefits to Blue Cross members like Ms. Beverly. From its opening provision, the Institutional Agreement acknowledges its core objective is to support a "Preferred Provider Organization" created "for the benefit of [Blue Cross] Members." (R. p. 104 § 1.1). The Institutional Agreement defines PPO as a health insurance network containing "financial incentives for Members." (R. p. 106 § 2.16). Those financial incentives are made explicit later in the contract when Grand Strand agreed to accept reimbursement for its services from Blue Cross at a discount rate. (R. p. 109 § 6.4). Beyond co-pays and deductibles, Grand Strand was prohibited from charging Blue Cross members for Covered Services, not even at the reduced rate. (R. p. 109 § 6.1).³ In clear terms, Grand Strand agreed it would "not solicit any payment from Members." (R. p. 109 § 6.1). Furthermore, the Institutional Agreement also conferred practical benefits on Blue Cross members by placing on Grand Strand the obligation to submit the members' bills to Blue Cross. (R. p. 109 § 6.3) (providing Grand Strand "shall . . . submit all bills as soon as practicable").

Ms. Beverly's third-party beneficiary status is also evident from the PPO's structure—established by the Institutional Agreement. This is significant because the court must consider not only the contract language but the circumstance of the parties and their purpose at the time the contract was formed. M & M Group, Inc. v. Holmes, 379 S.C. 468, 477 666 S.E.2d 262, 266

³ Grand Strand was also prohibited from charging Blue Cross members for Covered Services that were not medically necessary. (R. p. 113 § 7.2).

(Ct. App. 2008) (quoting Ellie, Inc. v. Miccichi, 358 S.C. 78, 94, 594 S.E.2d 485, 493 (Ct. App. 2004)); see also Holden v. Alice Mfg., Inc., 317 S.C. 215, 221, 452 S.E.2d 628, 631 (Ct. App. 1994) (noting that to understand the meaning of the terms chosen for the contract, it is important to consider its “subject matter and purpose”).

The Institutional Agreement was created to further a PPO, a health insurance structure with inherent benefits to insureds. A PPO is a form of health insurance that links an insurance company to a network of medical providers who are granted “preferred” status by the insurer only if they agree to provide discounts to the insurer’s members. As described by South Carolina’s federal district court, a contract adding a hospital to an insurer’s existing PPO is meant to net advantages for the insurer’s members:

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

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

In other words, a PPO is “a network of health care providers organized to offer medical services at discounted rates.” HCA Health Servs. of Ga. Inc. v. Employers Health Ins. Co., 240 F.3d 982 (11th Cir. 2001) *overruled on other grounds by* Doyle v. Liberty Life Assurance Co. of Boston, 542 F.3d 1352 (11th Cir. 2008). A PPO is intended to benefit all three participants. Grand Strand gained access to Blue Cross’s expansive membership along with guaranteed reimbursements from Blue Cross in exchange for accepting reduced payments and taking on the responsibility of submitting members’ claims. See HCA Health Servs. of Va., Inc. v. Aetna Life Ins. Co., 803 F. Supp. 1132, 1134 (E.D. Va. 1992). Blue Cross gained greater cost control in

exchange for promising prompt reimbursements and best efforts to tout Grand Strand's PPO provider status to Blue Cross members.

Grand Strand argues these are the only benefits the Institutional Agreement confers. However, that argument is no more consistent with the contract language cited above than it is with the structure of the PPO that Grand Strand was joining. PPOs directly benefit Blue Cross's members by assuring "a lesser cost than would have been otherwise charged." First Health Group Corp. v. United Payors & United Providers, Inc., 95 F. Supp. 2d 845, 849 (N.D. Ill. 2000) (citing Office of the Inspector General, Office of Personnel Management, Rep. No. 99-00-97-054, Report on the Use of Silent PPOs in the Federal Employees Health Benefits Program 20-23 (1998)); see also Elizabeth S. Rolph et al., *State Laws and Regulations Governing Preferred Provider Organizations*, Rand Corporation (1986), at 3 (noting all PPOs "offer enrollees incentives to limit their care to a panel of 'preferred' providers . . . Typical incentives include lower deductibles and copayments, or coverage of more services when a PPO provider is used").

By refusing its contractual duty to submit Ms. Beverly's bill to Blue Cross and its duty to accept the agreed-upon reimbursement rate, Grand Strand denied Ms. Beverly the fundamental benefits of her participation in the PPO network. Grand Strand was expressly prohibited from sending Ms. Beverly an \$8,000 bill when it had agreed to accept far less and promised not to seek any payment from Ms. Beverly. As the person aggrieved by Grand Strand's conduct and the direct recipient of Grand Strand's contractual obligations, Ms. Beverly is entitled to enforce the Institutional Agreement against Grand Strand. By dismissing Ms. Beverly's breach of contract claim, the circuit court disregarded the Institutional Agreement's language and the core structure of a PPO.

b. Insurance Customers are Recognized as Third-Party Beneficiaries to PPO Provider Contracts in Other Jurisdictions.

The Complaint alleges Grand Strand has a systemic, nefarious billing practice for auto accident victims entering their emergency room with medical insurance coverage. (R. pp. 20-21 ¶¶ 17-24). Grand Strand is not the only hospital defying its contracts with insurers to enhance its profits and harm its patients.⁴ Several other jurisdictions have considered the issue and held that patients like Ms. Beverly are third-party beneficiaries entitled to enforce insurer-provider contracts like the Institutional Agreement. In fact, the Tennessee Supreme Court addressed the issue for **this same Institutional Agreement** between a Tennessee hospital and Blue Cross Blue Shield of Tennessee. Benton v. Vanderbilt Univ., 137 S.W.3d 614 (Tenn. 2004). While the court specifically considered an arbitration dispute, that dispute only arose because the court recognized a Blue Cross insured was a third-party beneficiary of the hospital's Institutional Agreement with the Tennessee Blue Cross affiliate. See also West v. Shelby Cnty. Healthcare Corp., 459 S.W.3d 33, 45 (Tenn. 2014) (citing Benton and noting the court had "already held that persons insured by an insurance company are intended third-party beneficiaries of the contract between their insurance company and a hospital").

In another billing dispute between a Blue Cross insured and a hospital contracting with the insurer, an Arizona court found that a provision requiring the hospital to accept a discount reimbursement rate was "clearly a benefit to the [Blue Cross] subscriber [and] that benefit is both intentional and direct." Nahom v. Blue Cross & Blue Shield of Ariz., Inc., 885 P.2d 1113, 1117

⁴ Evidence suggests the conduct Ms. Beverly alleges is common among medical providers in South Carolina and across the country. See Steve Everly, St. Luke's Hospital Settles Health Insurance Cases with Accident Victims, KANSAS CITY STAR, Apr. 25, 2014, available at <http://www.kansascity.com/news/business/article346893/St.-Luke%E2%80%99s-Hospital-settles-health-insurance-cases-with-accident-victims.html> (noting settlement of claims for similar conduct in Missouri and quoting a South Carolina attorney referring to the practice as "prevalent" in our state).

(Ariz. App. 1994). As further evidence that the insured was an intended third-party beneficiary, Nahom noted the numerous times Blue Cross members were named in the contract. Id. at 1118. This same scenario was addressed in Dorr v. Sacred Heart Hospital, 597 N.W.2d 462, 475 (Wis. App. 1999). Dorr held that a provision in the hospital's provider agreement barring the hospital from billing an insurer's members was "designed specifically for the purpose of protecting" the members and was intended to make each member a third-party beneficiary to the contract. Id.

The South Dakota Supreme Court reached the same conclusion when construing a hospital's contract with a self-insured health plan. Jennings v. Rapid City Reg'l Hosp. Inc., 802 N.W.2d 918 (S.D. 2011). The health plan's members were third-party beneficiaries to the contract because "the contract language clearly expresses intent to benefit" the members. Id. at 922. Jennings made special note of the contract's recitals which, like this case, identified the benefits to members the insurance plan expressly intended to provide. Id. Jennings also rejected the notion that the members could not be a third-party beneficiary because the contract provided direct benefits to its parties—i.e. hospital and insurer. Notwithstanding its benefits to its parties, the contract intended to directly benefit the members, and as such the members must be permitted to protect those benefits by enforcing the contract's terms. Id. at 923 ("We look only at who was directly and primarily benefited. In this case, it is [the insured]"); see also Premovic v. Northshore Univ. Healthcare Sys., 2015 IL App. (1st) 133466-U, 2015 WL 71708, at *1 n. 2 (Ill. App. Jan. 5, 2015) (noting trial court denied a motion to dismiss insured's third-party beneficiary claim).

Thus, the circuit court's order not only fails to account for the Institutional Agreement's language and the PPO's structure, it also overlooks substantial persuasive authority allowing patients like Ms. Beverly to enforce contracts like the Institutional Agreement. These cases

recognize the crucial role an insurer's members play in a PPO provider contract even without being named as parties.

c. The Purported Third-Party Beneficiary Disclaimer Does Not Affect Ms. Beverly's Claims.

After nineteen pages of laying out the intricacies of a three-participant PPO network and its express benefits for Blue Cross members, the Institutional Agreement includes one sentence indicating the contract "is not intended to, and shall not be construed to, make any person or entity a third[-]party beneficiary." (R. p. 123 § 16.16). Construing that sentence in isolation, the circuit court concluded Blue Cross and Grand Strand disclaimed the possibility of any third-party beneficiary claim by Blue Cross members. (R. p. 7). However, the parties' intent must be derived from the Institutional Agreement's language taken as a whole. The Institutional Agreement repeatedly confers benefits on Blue Cross members that one isolated sentence cannot retract. Moreover, the disclaimer provision itself protects Ms. Beverly's right to pursue her current claims. Section 16.16 recognizes a "Member's right[s]" provided by the Institutional Agreement and carves related claims out of any purported third-party beneficiary exclusion.

Interpreting the purported disclaimer provision to bar Ms. Beverly's claims disregards expressions of the parties' intent elsewhere in the Institutional Agreement. As discussed above, the PPO Grand Strand entered was designed for the benefit of Blue Cross members. (R. p. 104 § 1.1). The very first responsibility Grand Strand undertook in the "Institution Services and Responsibilities" section was a duty owed directly to Blue Cross members. (R. p. 107 § 4.1) (stating Grand Strand "will provide Covered Services to any Member"). The benefit of Grand Strand's duty to refrain from billing patients flows not to Blue Cross but directly to its members. (R. p. 109 § 6.1). Blue Cross members are also a direct beneficiary of Grand Strand's promise to accept the negotiated reimbursement rate. (R. p. 109 § 6.4).

One sentence from the purported disclaimer provision cannot displace these numerous substantive provisions granting extensive benefits to Blue Cross members. The substantive provisions must be accepted as the true expression of the parties' intent. By overlooking these provisions, the circuit court violated a crucial South Carolina contract interpretation rule. See Williams v. Government Employees Ins. Co., 409 S.C. 586, 595, 762 S.E.2d 705, 710 (2014) (finding that on insurance question, contract parties' intent must be "determined from examining the entire contract, not by reviewing isolated portions of the contract"). The circuit court was required to examine the Institutional Agreement from the perspective of a "reasonably intelligent person who has examined the entire agreement." Progressive Max Ins. Co. v. Floating Caps, Inc., 405 S.C. 35, 46, 747 S.E.2d 178, 184 (2013). When reviewing in whole, it is evident that through the Institutional Agreement, Grand Strand and Blue Cross did far more to include Blue Cross members than to exclude them.

Significantly, several courts have found that a third-party beneficiary disclaimer may not be applied when the contract as a whole contradicts the purported disclaimer. See e.g., MEA-NEA Local I v. Mount Clemens Cmty. Schools, No. 248794, 2004 WL 2387650, at *7 (Mich. App. Oct. 26, 2004) ("Despite the general clause disclaiming any third party benefit status, the substantive provision of [contract] clearly directly benefit plaintiff"); La Joya Indep. Sch. Dist. v. Villarreal, No. 13-13-00325-CV, 2014 WL 3050484, at *7 (Tex. App. July 3, 2014) (refusing to apply contract's third-party beneficiary exclusion based on other contract language recognizing third party's rights). Several other courts have refused to apply a third-party beneficiary disclaimer to prevent enforcement of health insurance contracts.

In a very similar case, the Wisconsin Court of Appeals held that an insured covered by an health maintenance organization (“HMO”)⁵ was a third-party beneficiary of her insurer’s HMO provider contract with the hospital where she was treated following an auto accident. Dorr, 597 N.W.2d at 475. The contract’s attempt to disclaim third-party beneficiaries was ineffective as to the insured because it was inconsistent with other portions of the same contract directing benefits to her. Id. (finding contract’s terms “are designed specifically for the purpose of protecting HMO subscribers”). Similarly, a federal district court in Pennsylvania recently applied the same principles to reject a third-party beneficiary exclusion offered to prevent a medical provider from enforcing a PPO contract between an insurer and a health insurance network. Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr., Civil Action No. 13-03101, 2015 WL 1954287 (E.D. Pa. Apr. 30, 2015). Since the contract in question purported to exclude third-party beneficiaries while also granting specific benefits to non-parties, the contract was patently ambiguous and the third-party beneficiary claim could not be dismissed on a pre-answer motion. Just like the defendant in Huntingdon Valley, Grand Strand should not be allowed to “have it both ways” by enjoying the benefits of an Institutional Agreement with terms designed to benefit Blue Cross members while also preventing members from enforcing those terms. Id. at * 10.⁶

Even if the third-party beneficiary disclaimer is generally valid, it does not bar Ms. Beverly’s claims because they are specifically carved out. The circuit court misconstrued the provision’s second sentence which indicates that any restriction on potential third-party beneficiaries does not apply to “a Member’s right to receive Covered Services pursuant to the

⁵ An HMO is a medical insurance program that “undertakes to provide or arrange for basic health care services to enrollees for a fixed prepaid premium.” S.C. Code Ann. § 38-33-20(8).

⁶ See also Cates v. Integris Health, Inc., No. CIV-12-0763-F, 2013 WL 3923512, at *6-7 (W.D. Okla. July 29, 2013) (refusing to apply third-party beneficiary disclaimer rendered ambiguous by other provisions in contract).

terms of this Agreement.” (R. p. 123 § 16.16). This crucial phrase is actually a succinct summary of the claims alleged in Ms. Beverly’s Complaint. Along with her equitable claims, Ms. Beverly is suing Grand Strand precisely because its conduct denied her the right to receive Covered Services **pursuant to** the Institutional Agreement’s terms.

Ms. Beverly alleges she presented to Grand Strand as a Blue Cross member to receive Covered Services.⁷ (R. p. 20 ¶¶ 12-14). She alleges she provided clear notice to Grand Strand of her status as a Blue Cross member. (R. p. 20 ¶ 15). She alleges Grand Strand was a PPO provider with an obligation to submit the bill for her treatment to Blue Cross and to accept the resulting discounted reimbursement rate Blue Cross would provide. (R. pp. 20-23 ¶¶ 16-17, 34). She further alleges Grand Strand wrongly sent her an undiscounted bill for treatment qualifying as “covered services.” (R. pp. 21-23 ¶¶ 18, 21-24, 35). Finally, Ms. Beverly alleged Grand Strand’s violation of its contractual duties was an intentional, profit-driven act that damaged Ms. Beverly by denying her the contractual benefits to which she is entitled. (R. pp. 21-23 ¶¶ 19-20, 24, 35, 36).

Grand Strand’s alleged failure to provide Covered Services “pursuant to the terms of” the Institutional Agreement is the Complaint’s overarching theme. Grand Strand’s refusal to submit a bill to Blue Cross is actionable because the Institutional Agreement required it. (R. p. 109 § 6.2) (providing Grand Strand “shall bill” Blue Cross). The same is true for Grand Strand’s submission of a bill to Ms. Beverly and its demand for an undiscounted sum. These acts are

⁷ The Complaint does not specifically reference the contract term “Covered Services” which the Institutional Agreement defines, in pertinent part, as “inpatient and outpatient hospital services . . . to be delivered by or through Institution or Members that are reimbursable under the applicable Member Benefits Contract.” (R. p. 104 § 2.6). However, since “benefits contract” simply refers to Ms. Beverly’s insurance policy with Blue Cross (R. p. 104 § 2.2), the Complaint references “Covered Services” by alleging Grand Strand failed to properly bill for services covered by her policy. (R. pp. 20-23 ¶¶ 14, 17, 18, 21, 33, 35).

improper because, **pursuant to the terms of the Institutional Agreement**, Grand Strand promised to bill only Blue Cross and to accept a discounted reimbursement. (R. p. 109 § 6.1) (Grand Strand “will not solicit any payment from Members”); § 6.4 (Grand Strand “shall accept the reimbursement terms and rates”).

The circuit refused to apply the carve out provision to Ms. Beverly’s claims by finding the provision is limited to “Covered Services” which, as defined in the Institutional Agreement, does not include submission of a patient’s bill or acceptance of discounted reimbursement. (R. p. 9) (concluding Complaint did not relate to a reimbursable service). The circuit court’s conclusion suggests Blue Cross members may only allege claims under the Institutional Agreement when the medical care they received was substandard. However, this interpretation fails to account for the provision’s express intent and the contract’s purpose.

The circuit court’s interpretation fails to account for the phrase that immediately follows “Covered Services” in the carve out provision. Blue Cross members are not excluded as third-party beneficiaries for any claim relating to the provision of Covered Services “**pursuant to the terms of this Agreement.**”⁸ (R. p. 123 § 16.16) (emphasis added). The bolded language expands the carve out provision’s reach by incorporating the contract’s earlier provisions including Grand Strand’s duties to bill Blue Cross only and to accept discounted reimbursements. The Institutional Agreement uses a similar phrase in its recitals where it indicates the entire contract’s purpose is for Grand Strand to become a PPO provider “to provide Covered Services **under the terms of this Agreement.**” (R. p. 104 § 1.2) (emphasis added). In both instances, the highlighted

⁸ The Institutional Agreement does not define “pursuant to,” and the phrase must be given its plain and ordinary meaning. *Bardsley v. Gov’t Employees Ins. Co.*, 405 S.C. 68, 76, 747 S.E.2d 436 (2013). “Pursuant to” means “in compliance with” or “in accordance with.” *Black’s Law Dictionary* 1272 (8th ed. 1999).

language is meant to apply broadly to all of Grand Strand's contractual obligations including the ones referenced in Ms. Beverly's Complaint.

To read the carve out provision otherwise overlooks the contract's purpose. The Institutional Agreement did not just require Grand Strand to bandage Ms. Beverly's wounds and diagnose her injury, it also required Grand Strand to process the bill for those services in a very specific way to a very specific source for a predetermined amount of compensation. In fact, when viewed as a whole, the Institutional Agreement focused heavily on how Covered Services would be paid for and how payment would be processed. Portions of Article IV and Article VIII discuss the quality of medical care Grand Strand provides, but the voluminous provisions of Articles VI and VII are dedicated to the administrative and financial aspects of providing Covered Services.

In sum, the Institutional Agreement's purported third-party beneficiary disclaimer provision does not represent the parties' intent because it is repeatedly contradicted by more specific provisions earlier in the contract. Moreover, the disclaimer provision cannot apply here because it carves out Ms. Beverly's claims. The Complaint alleges Grand Strand provided Ms. Beverly "Covered Services" but not "pursuant to" the Institutional Agreement's terms, which prevented Grand Strand from billing her and required Grand Strand to accept a discount. Ms. Beverly's claims fall squarely within the carve out provision's plain language.

2. The Complaint States a Claim for Breach of Grand Strand's Fiduciary Duty to Bill Blue Cross and to Accept Discount Reimbursements.

When Ms. Beverly purchased her Blue Cross policy, she reasonably expected to receive financial benefits from Blue Cross and all medical providers who contracted to participate in the Blue Cross PPO. When Grand Strand committed to the PPO by entering the Institutional Agreement, it agreed to provide financial benefits to Blue Cross members and to act in members'

best interest by not charging them directly for Covered Services, by submitting bills for those services to Blue Cross, and by accepting the bargained-for discount reimbursement rate. The PPO cannot function effectively unless Blue Cross members can trust medical providers like Grand Strand to honor their Institutional Agreement duties. When Grand Strand ignored these duties by sending Ms. Beverly an undiscounted bill for Covered Services, it violated her trust and provided the basis for her breach of fiduciary duty claim.

The circuit court dismissed the fiduciary duty claim as based on duties arising from a contract Ms. Beverly lacked standing to enforce. (R. pp. 9-10). However, as discussed above, South Carolina law allows a non-party to enforce a contract that intentionally provides her direct benefits. The circuit court also concluded Ms. Beverly and Grand Strand do not have a relationship from which a fiduciary duty arises. (R. pp. 9-10). A fiduciary duty is created when one party places trust or confidence in another's integrity and fidelity. Ellis v. Davison, 358 S.C. 509, 519, 595 S.E.2d 817, 822 (Ct. App. 2004). Ms. Beverly properly states a claim for breach of fiduciary duty if her Complaint alleges (1) the existence of a fiduciary duty; (2) a breach of that duty owed to her by Grand Strand; and (3) damages proximately resulting from Grand Strand's wrongful conduct. Moore v. Moore, 360 S.C. 241, 250-51, 599 S.E.2d 467, 472-73 (Ct. App. 2004).

The Complaint effectively alleges all required elements of a breach of fiduciary duty claim. Grand Strand and Ms. Beverly created a relationship of trust when Grand Strand became a PPO provider bound to the Institutional Agreement's terms, and Ms. Beverly sought out Grand Strand for medical services because it was a Blue Cross PPO provider. (R. pp. 20-24 ¶¶ 17, 39, 45). By presenting to a Blue Cross PPO provider and showing her Blue Cross membership card, Ms. Beverly did all she was required to do to expect Grand Strand to fulfill the duties arising

from this relationship. (R. p. 20 ¶ 15). Grand Strand breached its duty of trust by refusing to submit the bill for Ms. Beverly's services to Blue Cross, and in the process proving that it valued profit maximization over its fiduciary relationship. (R. p. 24 ¶¶ 40, 46). Grand Strand's conduct damaged Ms. Beverly because she paid a bill she did not owe at a rate higher than Grand Strand agreed to charge. (R. p. 21 ¶¶ 22-24).

The circuit court's order incorrectly concluded Ms. Beverly's fiduciary duty claim was based entirely on her actions. Order at 8 (citing Moore, 360 S.C. at 251, 599 S.E.2d at 472). Ms. Beverly acknowledges that a breach of fiduciary duty claim may not be based on unilateral acts. Moore, 360 S.C. at 251, 599 S.E.2d at 472 (citing Regions Bank v. Schmauch, 354 S.C. 648, 670, 582 S.E.2d 432, 444 (Ct. App. 2003)). However, the Complaint alleges both that Ms. Beverly justifiably placed her trust in Grand Strand (R. p. 24 ¶ 45) and that Grand Strand courted and accepted that trust. Specifically, Grand Strand held itself out as a Blue Cross PPO provider to potential patients and represented to Blue Cross members that it would provide medical treatment and seek reimbursement in keeping with its Blue Cross PPO provider status. (R. p. 24 ¶¶ 41-43). In fact, Grand Strand negotiated for the ability to tout its Blue Cross PPO provider status in the Institutional Agreement. Grand Strand bargained for the right to "publically state that it is a provider in [Blue Cross's] provider network" because such declarations were "desirable . . . to [Grand Strand] in the course of its business operations." (R. p. 116 § 11.2). The Complaint allegations reject the notion that Ms. Beverly's fiduciary duty claim relies on unilateral acts.

The circuit court also concluded the fiduciary duty claim was defective because medical providers cannot have a fiduciary duty to submit health insurance claims. (R. p. 11) (citing Wogan v. Kunze, 366 S.C. 583, 605, 623 S.E.2d 107, 119 (Ct. App. 2005), *aff'd as modified*, 379

S.C. 581, 666 S.E.2d 901 (2008)). Yet, the formation of a fiduciary relationship is not as rigid and narrow as the circuit court's ruling suggests. South Carolina law makes every effort to avoid imposing strict limitations on the types of relationships from which a fiduciary duty may arise. Island Car Wash, Inc. v. Norris, 292 S.C. 595, 599, 358 S.E.2d 150, 152 (Ct. App. 1987). Instead, South Carolina courts "broadly construe fiduciary obligations to protect the interests of those placing trust in others." Armstrong v. Sch. Dist. 5 of Lexington & Richland Counties, 26 F. Supp. 2d 789, 797 (D.S.C. 1998). The guiding principles for any fiduciary duty analysis lie in "the particulars of the relationship between the parties." Armstrong v. Collins, 366 S.C. 204, 222, 621 S.E.2d 368, 377 (Ct. App. 2005). This is especially true "with regard to transactions in which the dominant party secures a profit or advantage at the expense of a person under his influence." Island Car Wash, Inc., 292 S.C. at 599, 358 S.E.2d at 152 (citing 36A C.J.S. Fiduciary at 388 (1983)).

Taking the Complaint allegations as true, Grand Strand has devised a scheme to draw Blue Cross members to its facility with the promises inherent in its Blue Cross PPO provider status and then pulled the rug out from beneath them by sending bills for charges Grand Strand knows it may not pursue. Ms. Beverly alleges Grand Strand actively participated in building a relationship of trust with Blue Cross members and exploited that trust for profit. This is a very different situation than Wogan where a doctor did not have a fiduciary duty to seek Medicare reimbursement on a patient's behalf for a costly medication likely not covered by Medicare anyway. 366 S.C. at 588, 623 S.E.2d at 110. For one, the patient in Wogan was explicitly told that the doctor would not file a claim for reimbursement. Id. The opposite is true here as Grand Strand expressly promised to seek reimbursement from Blue Cross on Ms. Beverly's behalf (R.

p. 109 §§ 6.2-6.3) and communicated that promise to Blue Cross members by touting its PPO provider status. (R. p. 24 ¶ 41).

Plus, the Wogan plaintiff's claim was dismissed because the Medicare Act rejected a civil claim for violation of the proposed claim submission duty. 366 S.C. at 601, 623 S.E.2d at 117. There is no corresponding statutory hurdle in this case. In the end, Wogan did not reject a fiduciary duty claim because a medical provider and patient may never form a relationship of trust. To the contrary, Wogan recognized the doctor-patient relationship can create a fiduciary duty. Id. at 605, 623 S.E.2d at 119 (citing McCormick v. England, 328 S.C. 627, 639, 494 S.E.2d 431, 437 (Ct. App. 1997)). Ultimately, it was a federal statute, not a deficient pleading that doomed the fiduciary duty claim in Wogan. 366 S.C. at 606, 623 S.E.2d at 119 (finding that a fiduciary duty claim under these circumstances "would render meaningless our ruling that there is no private right of action arising under the Medicare Act"). Wogan does not apply here and the Complaint alleges all required elements of a fiduciary duty claim.

3. Grand Strand was Unjustly Enriched by Ms. Beverly's Payment for Covered Services.

The Complaint properly alleges a claim for unjust enrichment, an equitable cause of action in no way dependent on a valid contract between the parties. Ms. Beverly alleged an unjust enrichment claim in her Complaint as an alternative cause of action should a factfinder conclude there is no valid contract or that she lacks standing to enforce the Institutional Agreement. See Williams Carpet Contractors, Inc. v. Skelly, 400 S.C. 320, 734 S.E.2d 177, 181 (Ct. App. 2012) (allowing a party to allege an unjust enrichment cause of action as an alternative claim for breach of contract). 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) Ms. Beverly conferred on Grand Strand a benefit; (2) Grand Strand realized that

benefit; and (3) it would be inequitable for Grand Strand to retain the benefit under these circumstances without paying Ms. Beverly 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”).

The circuit court erred in concluding Ms. Beverly’s unjust enrichment 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. The alleged wrong in Pitts was a breach of an alleged “duty of insurer to inform an applicant of the availability of an allegedly superior product.” Id. at 338, 574 S.E.2d at 512. There simply was no duty to provide this notification. Pitts also relied on the fact that the alleged wrongdoing was performed when the plaintiff was a mere insurance applicant. At that point, there was no existing relationship on which to build a fiduciary duty or to impose liability for unjust enrichment. 352 S.C. at 331, 574 S.E.2d at 508 (finding that, at the application stage, “the insurer is in a decidedly different position than after the contract has been entered into”).

Ms. Beverly’s claim is substantially different. Ms. Beverly was not a mere insurance applicant, she was a bona fide Blue Cross member to whom Grand Strand had existing legal obligations. (R. p. 25 ¶ 52). Plus, Ms. Beverly does not allege a failure to inform, she alleges affirmative inequitable conduct that took money away from her. While the Pitts defendant was permitted to refuse to offer a gratuitous discount, Grand Strand is not permitted to collect for its services at a much higher payment rate than it contractually agreed to accept. (R. p. 109 § 6.4). Grand Strand did far more than just refuse to offer a discount. Rather, it agreed to one rather and then maneuvered to charge a higher rate ignoring its very own agreement. (R. p. 25 ¶ 52). All

funds Grand Strand collected from Plaintiff is a benefit that Grand Strand came by inequitably. (R. p. 25 ¶ 53). It is unjust for Grand Strand to retain these funds (R. p. 25 ¶ 54), and Ms. Beverly's unjust enrichment/*quantum meruit* claim is a proper claim to seek a remedy for this wrong.

CONCLUSION

Based on the arguments stated above, Ms. Beverly respectfully requests the Court reverse the circuit court's order granting Grand Strand's motion to dismiss. Ms. Beverly is an intended third-party beneficiary of the Institutional Agreement empowered by South Carolina law to enforce the contract's provisions. If the circuit court's order is permitted to stand, then insurance customers like Ms. Beverly will be barred by law from recovering insurance benefits they paid to receive from the party who authored a scheme to divert those funds for its own use. Moreover, given the relationship of trust Grand Strand fostered with Blue Cross members, the circuit court erred in dismissing Ms. Beverly's breach of fiduciary duty claim. Finally, even if the Court concludes Ms. Beverly lacks standing to enforce the Institutional Agreement's provisions, Grand Strand's blatant abdication of the billing requirements inherent to a PPO is inequitable and all funds Grand Strand obtained from Ms. Beverly must be returned.

Respectfully submitted,

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March __, 2017
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
Appellate Case No. 2016-001499

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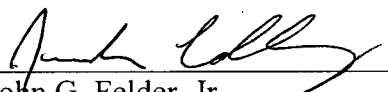
Jeanne Beverly, Individually Appellant
and on behalf of others
similarly situated

v.

Grand Strand Regional, Respondents.
Medical Center, LLC

CERTIFICATE OF COUNSEL

Pursuant to Rule 211, SCACR, Appellant's counsel certifies that the Final Brief of Appellant and Final Reply Brief comply with Rule 211(b), SCACR.


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