STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM FLORENCE COUNTY
Court of Common Pleas

The Honorable William H. Seals, Circuit Court Judge

RECEIVED
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SC Court of Appeals

SAMUEL BARR, on behalf of himself and all others similarly situated,

APPELLANT,

v.

QHG of South Carolina, Inc., d/b/a Carolinas Hospital System,

RESPONDENT,

Appellate Case no. 2017-000065

INITIAL BRIEF OF APPELLANT

STROM LAW FIRM, LLC
J. Preston Strom, Jr.
Jessica L. Fickling
Mario A. Pacella
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ATTORNEYS FOR APPELLANT

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STATEMENT OF ISSUES ON APPEAL

1. THE COURT ERRED IN COMPELLING TO ARBITRATION APPELLANT'S CLAIMS ARISING OUT OF RESPONDENT'S INTENTIONAL INTERFERENCE WITH APPELLANT'S INSURANCE POLICY WITH BLUE CROSS BLUE SHIELD

2. THE COURT ERRED IN RULING THAT MCCARRAN-FERGUSON REVERSE PREEMPTION DOES NOT APPLY IN THIS MATTER WHERE THE INSTITUTIONAL AGREEMENT BY AND BETWEEN RESPONDENT AND BLUE CROSS BLUE SHIELD CONSTITUTES "THE BUSINESS OF INSURANCE"

3. THE COURT ERRRED IN RULING THAT S.C. CODE ANN. § 15-48-10(b)(4) DID NOT APPLY IN A CONTROVERSY INVOLVING A CONTRACT OF INSURANCE AND THE BENEFICIARY OF AN INSURANCE POLICY

STATEMENT OF THE CASE

This matter was initially heard by the Honorable Williams Seals on September 13, 2016 on Respondent's Motion to Stay and/or Compel Arbitration, and Appellant's Motion to Assign the Case to Clifton Newman as complex hospital billing litigation. Appellant has pled this case as a class action involving two (2) contracts, the first by and between the Appellant Class and their respective private health insurers, along with a second contract known as the "Institutional Agreement" by and between Respondent, a for-profit hospital, and Blue Cross Blue Shield.

As alleged by Appellant in his Amended Complaint, Respondent wrongfully engaged in fraudulent billing practices for emergency patients involved in motor vehicle accidents by directly billing the injured person, rather than submitting the billing to the injured person's private health insurance. In the case of Appellant, this resulted in significant cost to Appellant when his minor daughters were injured in a motor vehicle accident and presented to Respondent's emergency room for treatment. Rather than submitting the girls' hospital bills to Blue Cross Blue Shield, where Appellant was a preferred member-beneficiary, Respondent made Appellant the guarantor of the entire amount of the bill. Ultimately Appellant paid Respondent in excess of the negotiated rate agreed upon by Blue Cross Blue Shield to satisfy the accounts of the girls.

In his complaint, Appellant alleged seven causes of action: (1) breach of contract; (2) breach of the duty of good faith and fair dealing; (3) tortious interference with contract/economic relations; (4) unjust enrichment; (5) conversion; (6) quantum meruit; and (7) declaratory relief under S.C. Code Ann. § 15-53-30.

The two contracts at issue in this matter collectively set forth how the Appellant Class will receive services from Respondent, and how Respondent agrees to bill Appellant's insurer for

those services. In particular, the Institutional Agreement expressly states that: "Institution shall seek payment for Services solely from [Blue Cross Blue Shield]. Institution will not solicit payment from Members[.]" (Institutional Agreement, Article VI: Compensation and Billing, 6.1).

However, the Institutional Agreement entered into between Respondent and Blue Cross Blue Shield also contains a number of specific provisions regarding marketing, advertising and publicity. As set forth in the plain language of the Institutional Agreement, Respondent recognized that its name would be used for, and was essential for, marketing and increasing the number of Preferred Blue Member Contracts. Thus, the Institutional Agreement contains very clear provisions for cross marketing, and states quite plainly that the Agreement is "essential" for increasing the number of member-beneficiaries in the Blue Cross Blue Shield Preferred network. (Institutional Agreement: XI, Marketing Advertising & Publicity, 11.1, "Accordingly [Respondent] agrees that Plan shall have the right to inform Members of the existence of this Agreement and to use the name of [Respondent] in Plan's marketing efforts.")

At the hearing on Respondent's Motion to Dismiss and/or Compel Arbitration, and in Appellant's briefing, Appellant argued that the claims arising out of Respondent's intentional interference with the contract between Appellant and Blue Cross Blue Shield did not "arise out of" the Institutional Agreement such that they could be compelled to arbitration. (Plt. Memo. In Opposition to Def. Motion to Compel Arbitration) Instead, Appellant argued that these claims arose out of Appellant's own contract with Blue Cross Blue Shield, which Respondent knowingly interfered with so that Respondent would receive in excess of the negotiated rate for service. (Plt. Memo. In Opposition to Def. Mtn. to Compel, ps. 5-9); (Plt. Motion to Alter or Amend, ps. 7-8).

In addition, Appellant argued that the Institutional Agreement entered into between Respondent and Blue Cross Blue Shield constituted the "business of insurance," such that S.C. Code Ann. § 15-48-10(b)(4) and McCarran-Ferguson preemption precluded arbitration of the controversy. (Plt. Memo in Opposition to Def. Motion to Compel, ps. 9-13); (Plt. Motion to Alter or Amend, p. 4-7). Appellant further argued that this matter, including the decision on Respondent's Motion to Compel Arbitration should be assigned to the honorable Clifton Newman under the 2010 Order of the South Carolina Supreme Court vesting Judge Newman with jurisdiction in complex business matters involving hospital billing.

The Court, however, granted Respondent's Motion to Compel Arbitration. The Court held that Respondent's claims either derived from the Institutional Agreement between Respondent and Blue Cross, or bore a significant relationship to this Agreement, such that all of Appellant's claims were governed by the Institutional Agreement's arbitration provision. (Order Compelling Arbitration, p. 6). The Court further found that the exemption against arbitration set forth in S.C. Code Ann. § 15-48-10(b)(4) was inapplicable, narrowly construing this provision to apply only in controversies involving an insured against an insurer. (Order to Compel Arbitration, p. 8). The Court found that the McCarran-Ferguson Act reverse preemption was inapplicable because the Institutional Agreement did not involve the "business of insurance," under the interpretation set forth in *Group Life & Health Insurance Company v. Royal Drug Company*, 440 U.S. 205, 99 S.Ct. 1067 (1979). (Order to Compel Arbitration, p. 13). Finally, the Court declined to rule on whether the case should be assigned to Judge Newman, because, having found that arbitration was proper as to all claims, the Court ruled it divested itself of jurisdiction as to the controversy. (Order to Compel Arbitration, FN. 1)

Appellant timely filed a Motion to Reconsider, pursuant to the above listed grounds. The Court declined Appellant's motion. This appeal follows.

STANDARD

"The question of arbitrability of a claim is an issue for judicial determination, unless the parties provide otherwise." *Wilson v. Willis*, 416 S.C. 395, 786 S.E.2d 571 (Ct.App. 2016), quoting *Zabinski v. Bright Acres Assoc.*, 346 S.C. 580, 596, 553 S.E.2d 110, 118 (2001). "Arbitrability determinations are subject to *de novo* review." *Wilson* at 408-409, 786 S.E.2d 571 at 578, quoting *Dean v. Heritage Healthcare of Ridgeway, LLC*, 408 S.C. 371, 379, 759 S.E.2d 727, 751 (2014). Where the party arguing against arbitration demonstrates that no evidentiary basis exists to support the circuit court's ruling, arbitration must not be compelled. *Wilson, supra. See Gissel v. Hart*, 382 S.C. 235, 240, 676 S.E.2d 320, 323 (2009).

ARGUMENT

I. THE COURT ERRED IN COMPELLING TO ARBITRATION APPELLANT'S CLAIMS ARISING OUT OF RESPONDENT'S INTENTIONAL INTERFERENCE WITH APPELLANT'S CONTRACT OF INSURANCE WITH BLUE CROSS BLUE SHIELD

In Appellant's underlying complaint, Appellant alleged that Respondent intentionally interfered with Appellant's independent Contract with Blue Cross Blue Shield, thereby procuring a breach of Appellant's contract with Blue Cross Blue Shield and deprivation of the contract's benefit (i.e. covered healthcare services.) (*See* Plaintiff's Amended Complaint, Count III). Moreover, Appellant alleged that Respondent's conduct of willfully failing to submit billing to Appellant's health insurer resulted in unjust enrichment to Respondent where Appellant had to pay in excess of the negotiated rate for services for care. (*See* Plaintiff's Amended Complaint, Count IV and V).

In ruling that these causes of action were subject to the Institutional Agreement's arbitration provision, however, the Court found that "[a]ll of [Appellant's] claims either arose out of the Institutional Agreement, or have a significant relationship to the Institutional Agreement. Therefore, the Court finds that [Appellant] must be compelled to arbitrate his claims against [Respondent] as provided under the Agreement." [1]

[1] In a Footnote the Court found that "[a]though [Appellant] is a nonsignatory to the Institutional Agreement, he is bound by its valid and enforceable arbitration clause. When a signatory seeks to enforce an arbitration agreement against a non-signatory, the doctrine of equitable estoppel prevents the non-signatory from claiming they are not bound by the arbitration agreement when they received a direct benefit from a contract containing an arbitration clause." *See Wilson v. Willis*, at 416-17, 789 S.E.2d at 582. *See also Pearson v. Hilton Head Hospital*, 400 S.C. 281, 295-96, 733 S.E.2d 597, 604 (Ct.App. 2012) However, the Court's argument is in applicable where the claimed benefit derives not as a result of the Institutional Agreement entered into by Respondent, but instead by the Appellant's status as a member-beneficiary of an insurer, and Respondent's interference with Appellant's contractual rights.

The policy of the United States and of South Carolina is to favor arbitration of disputes. *Parsons v. John Wieland Homes and Neighborhoods of the Carolinas, Inc.*, 418 S.C. 1, 791 S.E.2d 128 (S.C. 2016), citing *Zabinski v. Bright Acres Associates*, 346 S.C. 580, 553 S.E.2d 110, 115 (S.C. 2001). However, "[a]rbitration is a matter of contract law and general principles of state law apply to a court's evaluation of the enforceability of an arbitration clause." *JWH* at 6, 791 S.E.2d at 130-131.

In *JWH*, the South Carolina Supreme Court was asked to determine the scope of an arbitration clause contained within a warranty for the purchase of a new home. *Id.* At 6, 791 S.E.2d at 130. The circuit court denied JWH's motion to compel arbitration finding that, because the arbitration clause was contained within the warranty booklet, the scope was limited to claims under the warranty. *Id.* The circuit court further found that because the warranty was limited to defects and deficient design, the allegations, which involved fraudulent concealment of a hazardous substance upon the property, were outside the scope of the arbitration clause. *Id.* The Court of Appeals affirmed. The Supreme Court granted JWH's petition for writ of certiorari.

On petition for cert, the Supreme Court first recognized that "[t]o determine whether an arbitration clause applies to a dispute, a court must determine whether the factual allegations underlying the claim are within the scope of the arbitration clause." *JWH* at 7, 791 S.E.2d at 131, citing *Zabinski* at 597, 553 S.E.2d at 118 (where the Court declined to extend the reach of an arbitration clause against all of the claims set forth because, after an in depth factual review, the Court found a significant relationship did not exist between the claims and the partnership agreement containing the arbitration clause.)

The JWH Court then engaged in a review of the breadth and scope of the arbitration clause in comparison with the claims alleged. *JWH* at 8-9, 791 S.E.2d at 131. The Court

thereafter found that, "[t]he plain and unambiguous language of the arbitration clause provides that all claims, including ones based in warranty, be subject to arbitration." *Id.* As a result, the Court reversed the Court of Appeals determination limiting the scope of the clause. *Id.*

Unlike the cases in *Zabinksi* and *JWH,* the instant case involves two contracts: the Institutional Agreement between Respondent and Blue Cross Blue Shield, and the contract of insurance between Appellant and Blue Cross Blue Shield.[2] In a later section of its underlying opinion compelling arbitration, the circuit court found that "an insurance policy and an agreement to provide a good or a service for a set rate are readily distinguishable contracts. Plaintiff's insurance policy with BCBS insures against the risk that Plaintiff will be unable to pay for medical treatment during the period of coverage." (Order to Compel Arbitration, p. 13)

While Appellant maintains that the contract between Respondent and Blue Cross does constitute the "business of insurance," the court clearly recognized that Appellant had a contract with Blue Cross Blue Shield, which conferred upon Appellant certain rights. The circuit court ignored this contract, however, in deciding that <u>ALL</u> of Appellant's claims arose out of the Institutional Agreement or bore a significant relationship to this Agreement.

As alleged by Appellant, Respondent interfered with Appellant's legitimate contractual relationship with BCBS, and then retained a monetary benefit arising out of this interference. The circuit court failed to provide any analysis on which it based its decision that all of Appellant's claims either arose out of the Institutional Agreement between Respondent and Blue Cross Blue Shield, or bore a significant relationship to this Institutional Agreement (Order to Compel Arbitration, ps. 5-6). The circuit court also ignored Appellant's separate contract of insurance with Blue Cross Blue Shield, and the rights that arose thereunder. Without any factual

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or precedential support for the court's determination, the court's ruling that all of Appellant's claims were subject to the Institutional Agreement's arbitration clause is not supported by any evidence and must be reversed.

II. THE COURT ERRED IN RULING THAT MCCARRAN-FERGUSON REVERSE PREEMPTION DOES NOT APPLY IN THIS MATTER BECAUSE THE INSTITUTIONAL AGREEMENT BY AND BETWEEN RESPONENT AND BLUE CROSS BLUE SHIELD DOES NOT CONSTITUTE "THE BUSINESS OF INSURANCE"

Certain of Appellant's underlying causes of action are based upon Appellant's status as an intended third-party beneficiary of the Institutional Agreement between Respondent and Blue Cross Blue Shield. Article I, Section 1.1 of the Institutional Agreement provides: "WHEREAS Plan has established a preferred provider arrangement *for the benefit of its Members*[.]" (emphasis added). Therefore it is clear from the plain language of the Agreement that the members are at the heart of the agreement, and were expressly contemplated regarding the benefit these members would derive from this agreement.

Article XII sets forth Dispute Resolution for controversies arising under the Institutional Agreement and provides: "12.1: Except for decisions made pursuant to the Utilization Management Program, Plan and Institution agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement." Section 12.2 then provides:

> "[i]n 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. A single arbitrator shall conduct the arbitration under the then current commercial rules of the American Arbitration Association. The American Arbitration Association shall appoint an arbitrator who is knowledgeable in the health care management field. The arbitration shall be held and any award shall be made in Columbia, South Carolina. Subject to the terms of the Uniform Arbitration Act, the arbitrator's determination shall be final and binding upon the parties."

In general the Federal Arbitration Act preempts any state law that might invalidate an agreement to arbitrate. *Zabinksi v. Bright Acres Assocs.*, 346 S.C. 580, 592, 553 S.E.2d 110, 116 (2001). However, the McCarran-Ferguson Act, 15 U.S.C. § 1012(b) allows a state law to reverse preempt a federal law when the state law relates to the business of insurance.

Under S.C. Code Ann. § 15-48-10(a), "[a] written agreement to submit any existing controversy to arbitration or a provision in a written contract to submit to arbitration any controversy thereafter arising between the parties is valid, enforceable, and irrevocable, save upon such grounds as exist at law or in equity for the revocation of a contract[.]" Notwithstanding this provision, S.C. Code Ann. § 15-48-10(b)(4) exempts from arbitration "[a]ny claim arising out of personal injury, based on contract or tort, or to any insured or beneficiary under any insurance policy or annuity contract."

South Carolina has determined that S.C. Code Ann. § 15-48-10(b)(4) is a law enacted for the purpose of regulating the business of insurance, and specifically exempts from arbitration "any insured or beneficiary under any insurance policy or annuity contract." *Cox v. Woodmen of the World Insurance, Co.*, 347 S.C. 461, 556 S.E.2d 397 (Ct.App. 2001). Thus, under McCarran-Ferguson, S.C. Code Ann. § 15-48-10(b)(4) reverse preempts the Federal Arbitration Provision to the extent that the controversy involves the business of insurance.

The United States Supreme Court has held, and our courts have recognized, that the primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk. *Group Life & Health Insurance Company v. Royal Drug*, 440 U.S. 205, 99 S.Ct. 1067 (1979). While emphasis begins with focus on the relationship between an insurance company and its policyholders, "other activities of insurance companies [can] relate so closely to their

status as reliable insurers that they too must be placed in the same class." *Id* at 216, 99 S.Ct. at 1075 (1979).

In *Royal Drug*, the respondents, 18 owners of independent pharmacies, initially filed suit against the petitioner, Group Life and Health Insurance, Co., known as Blue Shield of Texas, alleging violations of the Sherman Act. *Id.* at 207, 99 S.Ct. at 1071. The complaint alleged that petitioner, Group Life, had entered into certain price fixing agreements that resulted in petitioner's policyholders choosing to use other pharmacies. *Id.* The trial court granted summary judgment on behalf of the petitioner, finding that the agreements were exempt from antitrust regulation under §2(b) of the McCarran-Ferguson Act, because the agreements constituted the "business of insurance," and were thus subject to state law. *Id.* at 208, 99 S.Ct. at 1071-1072. The Court of Appeals reversed and remanded, holding that the agreements were *not* the "business of insurance." The Supreme Court then granted certiorari based on the intercircuit conflicts as to the meaning of the phrase "business of insurance." *Id.*

According to the Court's opinion in *Royal Drug*, "[r]eferences to the meaning of the 'business of insurance' in the legislative history of the McCarran-Ferguson Act strongly suggest that Congress understood the business of insurance to be the underwriting and spreading of risk." The Court thereafter concluded that the contracts between the pharmacies and Blue Shield[3] were not the "business of insurance," because the contracts themselves did not involve underwriting or spreading of risk, and were instead, "merely arrangements for the purchase of goods and services."

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[3] Of note, at the time *Royal Drug* was decided in 1979, corporations organized for the purpose of providing their members with medical services and hospitalization were not considered to be engaged in the insurance business at all. *Id.* at 225-226, 99 S.Ct. 1079-1080. This idea underlies how outdated the court's decision in *Royal Drug* has become in today's context. It could hardly be said today that Blue Cross Blue Shield is not engaged in the business of insurance.

Several years after *Royal Drug*, the Supreme Court was again asked to interpret "the business of insurance." In *United Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 102 S.Ct. 3002 (1982), the Supreme Court created three non-exhaustive factors for courts to consider when asked to determine whether a statute, or an activity constitutes the "business of insurance. *Id.* at 134, 102 S.Ct. at 3011. Under *Pireno*, courts are first to consider "whether the practice has the effect of transferring or spreading the policyholder's risk; second, whether the practice is an integral party of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Id.* at 129, 102 S.Ct. at 3008. The purpose of *Pireno* and *Royal Drug* was not to limit the business of insurance to the four corners of an insurance contract. *United States Department of Treasury v. Fabe*, 508 U.S. 491, 113 S.Ct. 2202 (1993). Rather, "*Pireno* and *Royal Drug* held only that 'ancillary activities' that do not affect performance of the insurance contract or enforcement of contractual obligations do not enjoy the antitrust exemption for laws regulating the 'business of insurance.'" *Fabe* at 502-503, 113 S.Ct. at 2209.

In *United States Department of Treasury v. Fabe*, the United States Supreme Court was asked to determine whether a state statute prioritizing first-party claims against a defunct insurance company over claims of the Federal Government fell under McCarran-Ferguson reverse preemption. *Id.* at 493, 113 S.Ct. at 2204. *Fabe* included an extensive examination of both *Royal Drug* and *Pireno*. The Court concluded:

> "[t]here can be no doubt that the actual performance of an insurance contract falls within the 'business of insurance,' as we understood that phrase in *Pireno* and *Royal Drug*. To hold otherwise would be mere formalism. The Court's statement in *Pireno* that the 'transfer of risk from insured to insurer is effected by means of the contract between the parties… and… is complete at the time that the contract is entered,' (internal quotations omitted) presumes that the insurance contract in fact will be enforced. **Without performance of the terms of the insurance policy, there is no risk to transfer at all. Moreover, performance of an**

insurance contract also satisfies the remaining prongs of the *Pireno* test: It is central to the policy relationship between insurer and insured and is confined to entities within the insurance industry." (emphasis added). *Id.* at 503-504, 113 S.Ct. at 2209.

The *Fabe* Court then held that "[t]he Ohio priority statute is designed to carry out the enforcement of insurance contracts by ensuring the payment of policyholders' claims despite the insurance company's intervening bankruptcy." *Id.* As such, the Court concluded the statute was integrally related to the performance of an insurance contract. *Id.*

The *Fabe* Court noted that both *Pireno* and *Royal Drug* involved the anti-trust immunity located in the second clause of the McCarran-Ferguson Act. *Id.* at 504, 113 S.Ct. at 2209. The Court found that the second clause must be construed to carve out only a "narrow exemption" for the "business of insurance" from anti-trust regulation, whereas the first clause, which provides protection for laws enacted for the purpose of regulating the "business of insurance," encompasses a much broader scope. *Id.*

In finding that McCarran-Ferguson did not apply in the instant case, the circuit court did not consider the *Pireno* factors, which the South Carolina Supreme Court recognized in *Cox*[4]. Rather, the circuit court found that "[t]he instant case is overwhelmingly analogous to *Royal Drug*." (Order to Compel Arbitration, p. 13). "As noted in *Royal Drug*, an insurance policy and an agreement to provide a good or service for a set rate are readily distinguishable contracts. Plaintiff's insurance policy with BCBS insures against the risk that Plaintiff will be unable to pay

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[4] In *Cox v. Woodmen of World Ins., Co.*, 374 S.C. 460, 556 S.E.2d 397 (2001), the South Carolina Supreme Court, recognizing and in light of the *Pireno* factors, determined that S.C. Code Ann. § 15-48-10(b)(4) is a law specifically enacted for the purpose of regulating the business of insurance. Therefore, where a contract encompasses the business of insurance, S.C. Code Ann. § 15-48-10b)(4) precludes application of an arbitration provision, and McCarran-Ferguson reverse preempts application of the Federal Arbitration Act.

for medical treatment during the period of coverage. The Institutional Agreement does not insure Plaintiff against any risk *or spread the risk* of any BCBS policyholder." *Id.* (emphasis added.)

Contrary to the circuit court's ruling, however, the Institutional Agreement *must* be enforced in order for Appellant to receive any benefit from his contract with Blue Cross Blue Shield. Moreover, unlike the contract in *Royal Drug*, the Institutional Agreement between Respondent and Blue Cross contains an express Article dedicated to marketing, advertising and publicitiy.[5]

Article XI: Marketing Advertising and Publicity, provides as follows:

> 11.1 Institution recognizes that the use of Institution's name by Plan is essential for: informing Members that Institution participates in Preferred Blue; and marketing Preferred Blue Benefits Contracts. Additionally, Institution acknowledges that it has an interest in the effective marketing of Preferred Blue Contracts. Accordingly, Institution agrees that Plan shall have the right to inform members of the existence of this Agreement and to use the name of Institution in Plan's marketing efforts. The use of Institution's name in advertising by radio, television, newspaper, billboards or other mass media means is subject to prior approval of Institution, which approval shall not be unreasonably held.
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> 11.2 Plan recognizes that the use of Plan's name by Institution may be desirable from time to time to Institution in the course of its business operations. Plan agrees that Institution shall have the right to use Plan's name in communications by mail and other communications disseminated within Institution. The use of Plan's name in advertising by radio, television, newspaper, billboards or other mass media means is subject to prior approval of Plan, which approval shall not be unreasonably withheld.
>
> 11.3 Plan and Institution each reserve the right to control the use of their respective registered symbols, trademarks, and service marks presently existing or hereafter established. Except as may be otherwise provided in 11.1 and 11.2, Plan and Institution will not use the registered symbols, trademarks, and service marks of the other without prior approval for such use, which approval shall not be unreasonably withheld.

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[5] *See Sec. & Exchange Comm'n v. Nat'l. Sec, Inc.*, 393 U.S. 453, 460, 89 S.Ct. 564 (1969), holding that **advertising constitutes the business of insurance.** (emphasis added)

The purpose of this provision is the marketing of Blue Cross contracts, and the expansion of the Blue Cross network, thereby spreading risk. As discussed above, another fundamental tenet of the Institutional Agreement is the clause where Respondent has agreed in exchange for a guarantee of payment from Blue Cross, that it shall seek payment for Services solely from Plan, and will not solicit payment directly from beneficiaries such as the Appellant.

This agreement is more than a simple agreement on *who* Respondent will bill. This is an agreement on *how* Respondent will bill. Pursuant to this agreement, Respondent is responsible to beneficiaries, such as the Appellant, to insure that bills associated with Respondent's provision of care are submitted to Blue Cross. Appellant alleges that Respondent is knowingly in violation of this agreement, and as such, Appellant is deprived of the performance of his own contract of insurance by and through Blue Cross. The performance of Respondent's responsibilities under the Institutional Agreement is thus a prerequisite to the performance of a contract of insurance, and constitutes the "business of insurance."

The circuit court's holding that the Institutional Agreement does not constitute the "business of insurance," and is therefore not entitled to exemption from the arbitration provision ignores the distinctions between the Institutional Agreement and the Contracts at issue in *Royal Drug*, and further ignores the violation of the Institutional Agreement by Respondent, which thwarts the performance of a contract of insurance. As a result, the circuit court's ruling constitutes an error as a matter of law and must be reversed.

III. THE COURT ERRRED IN RULING THAT S.C. CODE ANN. § 15-48-10(b)(4) DID NOT APPLY IN A CONTROVERSY INVOLVING A CONTRACT OF INSURANCE AND THE BENEFICIARY OF AN INSURANCE POLICY

S.C. Code Ann. § 15-48-10(b)(4) provides that the South Carolina Uniform Abritration Act "shall not apply to...[a]ny claim arising out of personal injury, based on contract or tort, or

to any insured or beneficiary under any insurance policy or annuity contract." In *Wilson v. Willis*, 416 S.C. 395, 786 S.E.2d 571 (Ct.App. 2016), the Court of Appeals affirmed that this section was enacted for the purpose of regulating the business of insurance, and reverse preempts the Federal Arbitration Act to the extent a litigant seeks to enforce an arbitration agreement contained in an insurance contract. *Id.* at 426-27, 786 S.E.2d at 587.

In *Walden v Harrelson Nissan, Inc.*, 399 S.C. 205, 731 S.E.2d 324 (Ct.App. 2015), the Court of Appeals concluded that S.C. Code Ann. § 15-48-10(b)(4) was not intended to apply to an automobile lease agreement, which contained an option to purchase life insurance, because the primary contract had only a tangential connection to an insurance policy. *Id.* at 209-10, 731 S.E.2d at 326. The Court of Appeals determined that the statute was intended to apply directly to an insurance contract.[6]

In the instant case, the circuit court found S.C. Code Ann. § 15-48-10(b)(4) inapplicable, determining that the Institutional Agreement was neither an insurance policy nor an annuity contract. (Order to Compel Arbitration, p. 8) In its conclusion, the circuit court ignored the marketing and advertising provision of the Institutional Agreement, whose whole purpose is to increase the number of Preferred Blue member-beneficiaries, thereby spreading risk. The circuit court also ignored the fact that enforcement of the Institutional Agreement is a prerequisite to performance of Appellant's insurance policy. Finally, the circuit court ignored the basis of Appellant's claims arising out of his own insurance policy with Blue Cross, which arose out of Respondent's intentional interference with that contract, rather than from Respondent's breach of its contract with Blue Cross. Appellant's contract with Blue Cross is without question exempt

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[6] *See United States Dept. of Treasury v. Fabe*, 508 U.S. 491, 501, 113 S.Ct. 2202, 2208 (1993) (The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement, these were the core of the "business of insurance." Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class.) (internal citations omitted).

from arbitration pursuant to S.C. Code Ann. § 15-48-10(b)(4). As a result, the circuit court's decision to compel arbitration is not supported by any evidence, constitutes an error as a matter of law, and must be reversed.

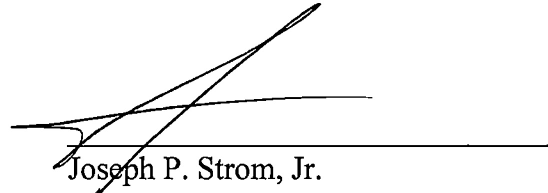
CONCLUSION

The circuit court erred in concluding that all of the allegations of Appellant's complaint were substantially related to the Institutional Agreement such that they were encompassed within the Institutional Agreement's arbitration clause, and this ruling must be reversed. Moreover, the circuit court erred in concluding that the Institutional Agreement did not constitute the business of insurance for purposes of McCarran-Ferguson preemption, and exemption under S.C. Code Ann. § 15-48-10(b)(4), because the Institutional Agreement expressly contemplates the spreading of risk, and is fundamental to the performance of Appellant's contract with Blue Cross Blue Shield. Finally, the circuit court erred in compelling Appellant's claims to arbitration, where those claims arose out of Appellant's insurance contract with Blue Cross Blue Shield.

For the reasons set forth above, the circuit court must be reversed, and this Court should Order that the pending matter is exempt from arbitration, and remand.

Respectfully Submitted this 17 day of May, 2017.

STROM LAW FIRM, LLC



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STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM FLORENCE COUNTY
Court of Common Pleas

The Honorable William H. Seals, Circuit Court Judge

RECEIVED
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SC Court of Appeals

SAMUEL BARR, on behalf of himself and all others similarly situated,

APPELLANT,

V.

QHG of South Carolina, Inc., d/b/a Carolinas Hospital System,

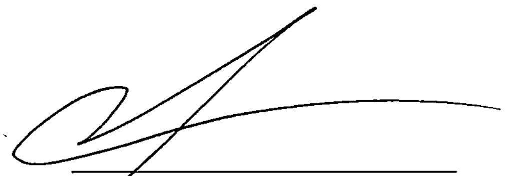
RESPONDENT,

Appellate Case no. 2017-000065

CERTIFICATE OF SERVICE

I certify that I have served Appellant's Initial Brief upon counsel for Respondent, James L. Werner, of Parker Poe Adams and Bernstein, by forwarding a copy via United States mail to Mr. Werner at the following address: Parker Poe Adams & Bernsetin, LLP, P.O. Box 1509, Columbia, SC 29202.

This 17th day of May, 2017.



AND SWORN TO ME
This 17th day of May, 2017
_______________ (M.J.)
Notary Public for South Carolina
My Commission Expires: 8-26-25

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