THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Shirley C. Robinson, Administrative Law Judge

Appellate Case No. 2012-213186

Jeffrey D. Allen, on behalf of Jane Doe.....Appellant.

v.

South Carolina Public Employee Benefit Authority,
Employee Insurance Program.....Respondent.

FINAL BRIEF OF RESPONDENT

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II. STATEMENT OF THE CASE

Jeffrey Allen ("Appellant") appeals the decision of the Administrative Law Court upholding the denial of $560 in benefits for separately-billed diabetes education training under the Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities ("State Health Plan"). As an employee of Dorchester County School District Two, Appellant participated in the state health benefit program offered through the State of South Carolina Budget and Control Board Employee Insurance Program ("EIP").[1] Appellant specifically covered his daughter, Eva Allen ("Dependent"), on his health coverage through the State Health Plan.

On August 24, 2010, the EIP Appeals Committee issued a decision denying coverage for diabetes education on the basis it was not covered as a separately-billed claim under the State Health Plan. (R.pp. 240-254). Pursuant to S.C. Code Ann. § 1-11-710(C) (2005), Appellant appealed the final determination of the EIP Appeals Committee to the ALC on September 22, 2010. (R.pp. 197-199). By order dated August 13, 2012, the ALC upheld EIP's denial of appellant's claim. (R.pp. 2-13).

[1] Effective July 1, 2012, EIP, a division of the South Carolina Budget and Control Board ("Board"), was transferred from the Board to a newly created agency, The South Carolina Public Employee Benefit Authority pursuant to Act 278 of 2012.

III. STATEMENT OF FACTS

Under S.C. Code Ann. § 1-11-710(A)(1)(2005), the State Budget and Control Board ("the Board") is required to "make available to active and retired employees of this State . . . group health, dental, life, accidental death and dismemberment, and disability insurance plans and benefits in an equitable manner and of maximum benefit to those covered within the available resources." In fulfillment of this mandate, the Board established the Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities ("State Health Plan" or "Plan"). The State Health Plan is a self-funded,[2] non-federal governmental health plan administered by EIP. (R.p. 444). BlueCross BlueShield of South Carolina ("BCBSSC"), a private contractor, is the third-party claims administrator for the State Health Plan. As such, BCBSSC processes and pays the claims for the Plan under the Plan's rules and with the Plan's money, and also provides the first level of review for coverage requests involving the State Health Plan. BCBSSC is not an insurer of the State Health Plan. (R.p. 444).

Appellant and Dependent have been covered by one of the health plan options

[2] The term "self-funded" and its synonym "self-insured" are general terms used to describe, in the realm of health insurance as well as other types of insurance, "a plan under which a business maintains its own special fund to cover any loss. Unlike other forms of insurance, there is no contract with an insurance company." Black's Law Dictionary 664 (8th ed. abr. 2005). In this context, it indicates a self-insurance arrangement in which an employer provides health or disability benefits to employees with its own funds. This term is used to differentiate from fully-insured plans, where the employer contracts an insurance company to cover its employees and their dependents. In self-funded health plans, the employer assumes the direct risk for payment of the claims for benefits, though it may employ an outside administrator to process the claims.

offered through EIP since 2005.[3] Dependent was born July 20, 2005. (R.p. 409). Appellant was hired at Dorchester County effective August 2, 2005, with a benefits effective date of September 1, 2005. Appellant and Dependent were covered under MUSC Options from September 1, 2005, to December 31, 2006. Beginning January 1, 2007, Appellant and Dependent were covered by the Standard Plan.

Dependent was diagnosed with Type I diabetes in November 2007. On August 5, 2008, Appellant, Appellant's spouse, Dependent's grandparents, and two daycare nurses attended a diabetes management educational session in relation to Dependent's new insulin pump for a total cost of $560.00. (R.pp. 401, 418). On August 27, 2008, BCBSSC sent Appellant an Explanation of Benefits ("EOB") showing the claim was denied. (R.pp. 402-403). The explanatory note read, "Your benefit plan does not cover education and/or training for this condition," in accordance with the terms of the Plan.

On February 25, 2009, Appellant's spouse wrote a letter of appeal to BCBSSC. (R.pp. 506-507). Appellant's spouse stated the Medical University of South Carolina ("MUSC") provided training for caregivers on how to properly operate the insulin pump. Appellant's spouse further indicated she, Appellant, their parents (Dependent's grandparents), and two nurses from Dependent's daycare attended the training on August 5, 2008.

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

On April 20, 2009, BCBSSC sent Appellant an adjusted EOB. (R.pp. 402-403). This EOB had no changes except for the explanatory note. Rather than "your benefit plan does not cover education and/or training for this condition," the new EOB indicated that BCBSSC had requested additional medical information from the provider. The updated note explained if the information was received within 45 days, BCBSSC would review it and make a decision within 15 days of receipt. BCBSSC then stated if the information was not received after 45 days, the claim would be considered denied. BCBSSC further indicated that if the information was received after 45 days, but under 225, the appeal would move forward.

On September 30, 2009, Appellant's spouse wrote a letter to BCBSSC in follow-up. (R.pp. 390-391). Appellant's spouse stated she called BCBSSC on August 14, 2009, and was informed the reason for the lack of resolution was BCBSSC had not received Dependent's requested medical records. Appellant's spouse stated she then called MUSC, who stated they had sent the records but agreed to send them to BCBSSC again. She noted this was well within the 225 days in the April 20, 2009, letter. Appellant's spouse then stated, "I am also enclosing a copy [of] the South Carolina statute which requires Diabetes Mellitus coverage in health insurance policies." Appellant's spouse included a photocopy of the text of S.C. Code Ann. § 38-71-46. (R.p. 421).

Subsequently, BCBSSC received Dependent's medical records from MUSC. Dependent's submitted records began with a letter dated July 9, 2008, with a pre-authorization request for Dependent's insulin pump from the manufacturer, Medtronic. (R.p. 408). The items listed on Medtronic's request were an insulin pump with

accompanying equipment, for a total of $5,142.95.[4]

Included in these additional records submitted to BCBSSC was a visit note from Sharon Schwartz, R.N., C.D.E.[5] concerning the August 5, 2008 educational session at issue. (R.pp. 418-420). Nurse Schwarz indicated the content taught included Dependent's care plan, medications, nutrition, food/drug interactions, health promotion, patient safety, and medical equipment. Nurse Schwarz noted Dependent's parents, grandparents, and daycare nurses were "instructed on the Medtronic Paradigm insulin pump. They were instructed on troubleshooting hyper/hypoglycemia on the insulin pump, importance of monitoring, ketone testing, and site rotation." They also were encouraged to practice with saline for a week. The nurse also noted one of the daycare nurses was given a practice pump and saline to practice and would return the pump the following week. A list of instructions was also given, including monitoring for ketones if the blood sugar was elevated, insulin input amounts, and safe glucose levels.

After receipt of the medical records, on March 15, 2010, Ashby Jordan, M.D., a board certified pediatrician and the Medical Director and Vice President of Medical Affairs for BCBSSC, reviewed Dependent's file in its entirety.[6] (R.pp. 392-395). Dr. Jordan noted the services referenced were specifically excluded in the Standard Plan under Article 9, Paragraph O. Dr. Jordan stated Exclusion BB in Article 9 also applied, as there was no mention of these services in the Article 7, Schedule of Benefits section of the Plan. He also noted the statute Appellant's spouse referenced in her appeal document did not apply to the State Health Plan.

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[4] This claim, 8E4953594000, was paid on the actual amount billed of $4,988.40, with the total paid by the Plan at $3,990.72, the normal rate of 80%.
[5] Certified Diabetes Educator.
[6] The CV of Dr. Jordan is in the record at pages 442-443.

On March 19, 2010, Brooks Goodman, Senior Director for State Operations at BCBSSC, sent Appellant a letter indicating the Medical Director had denied Appellant's appeal for the reasons stated above. (R.p. 438). Because the BCBSSC Medical Director did not approve the appeal, the appeal was sent for consideration by the BCBSSC appeals committee.

On April 2, 2010, BCBSSC sent Appellant a letter denying Appellant's appeal for additional benefits for the August 5, 2008 educational session. (R.pp. 439-441). The letter indicated it had reviewed Appellant's spouse's letters from February 25, 2009, and September 30, 2009; a web inquiry from Appellant's spouse dated February 18, 2009; Dependent's medical records, noted above; the claim with EOBs dated August 27, 2008, and April 20, 2009; Dr. Jordan's medical review from March 15, 2010; Article 7 and Article 9, Sections O and BB of the 2008 State Health Plan; the letter from Brooks Goodman on March 19, 2010; and S.C. Code Ann. § 38-71-46. The letter stated the BCBSSC appeals committee observed the Plan specifically excluded educational services in Article 9, Paragraph O, and that Article 9 Paragraph BB excluded services not specifically covered in Article 7. BCBSSC also noted § 38-71-46 did not apply to the self-funded State Health Plan.

On June 30, 2010, Appellant's attorney appealed the denial to the EIP Appeals Committee. (R.pp. 454-455). Appellant's attorney noted, "As you already know the Plaintiffs have brought a putative class action lawsuit against the SCEIP and BCBSSC as it relates to the applicability of S.C. Code Ann. § 38-71-46 to the State Plan."[7] Counsel

[7] On November 25, 2009, while Appellant's administrative appeal was still pending, Appellant filed a putative class action suit against the South Carolina Budget and Control Board, EIP, and BCBSSC in the Court of Common Pleas for the Ninth Judicial Circuit in

for Appellant additionally stated the pleadings were incorporated by reference into the appeals letter, and he enclosed copies of the lawsuit summons and complaint; the memorandum in opposition to EIP's motion to dismiss; Mr. Goodman's denial letter of March 19, 2010; the BCBSSC denial letter dated April 4, 2010; Appellant's motion for class certification; and Appellant's motion to compel and motion to stay decision on EIP's motion for summary judgment. (R.pp. 457-623).

On August 24, 2010, EIP wrote Appellant's counsel that the EIP Appeals Committee had denied the request for reimbursement for Dependent's diabetes education. (R.pp. 240-254). This denial letter concluded that the Plan specifically excluded educational services in Article 9, Paragraph O, and that Article 9, Paragraph BB excluded services not specifically covered in Article 7. It also noted that S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan.

Appellant subsequently appealed this denial to the ALC on September 22, 2010, on the grounds that: "[t]he agency has denied claimant's claim for diabetes education/outpatient self-management training, after the claim was denied by Blue Cross-Blue Shield of South Carolina. This denial is in violation of S.C. Code § 38-71-46(A). The relief sought is payment of claimant's claim." (Emphasis added) (R.p. 197-199). By order dated August 13, 2012, the ALC upheld EIP's denial of Appellant's claim. (R.pp.

Charleston, alleging a violation of S.C. Code Ann. § 38-71-46. By order dated October 15, 2010, the Circuit Court granted EIP's and BCBSSC's motion for summary judgment dismissing Appellant's case with prejudice on the grounds that the administrative remedies under S.C. Code Ann. § 1-11-710(C) were Appellant's exclusive remedy, subject only to appeal to the South Carolina Administrative Law Court pursuant to S.C. Code Ann. § 1-23-600 (D). This decision was upheld by the South Carolina Court of Appeals on July 18, 2012. Allen v. South Carolina Budget and Control Board, Employee Insurance Program, Opinion No. 2012-UP-433 (S.C. Ct. App. filed July 18, 2012).

ARGUMENTS

I. THE ALC'S DECISION TO UPHOLD THE DENIAL OF APPELLANT'S CLAIM FOR SEPARATELY-BILLED DIABETES EDUCATION WAS CORRECT GIVEN THAT THE DECISION WAS RATIONAL AND WAS SUPPORTED BY THE SUBSTANTIAL EVIDENCE IN THE RECORD, APPLICABLE STATE LAW, AND THE TERMS OF THE STATE HEALTH PLAN.

Standard of Review

In S.C. Code Ann. § 1-11-710(C), the General Assembly establishes the Board as the final agency arbiter of disputes under the Plan. Under that section:

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

Under the Board's procedures, which are set forth in Article 12 of the Plan, a claim is reviewed first by the third-party claims processor, in this case BCBSSC, with final agency appeal to the Plan Administrator, in this case EIP in the form of its Appeals Committee. As established in S.C. Code Ann. § 1-11-710(C), the appropriate standard of review is provided in § 1-23-380 of the Administrative Procedures Act ("APA") as follows:

> The Court shall not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact. The Court may affirm the decision of the agency or remand the case for further proceedings. The Court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions or decisions are:
>
> a. in violation of constitutional or statutory provisions;
> b. in excess of the statutory authority of the agency;
> c. made upon unlawful procedures;
> d. affected by other error of law;

e. clearly erroneous in view of the reliable, probative and substantial evidence on the whole record; or

f. arbitrary or capricious as characterized by abuse of discretion or clearly unwarranted exercise of discretion.

S.C. Code Ann. § 1-23-380(5) (2008).[8]

The APA establishes the "substantial evidence" rule as the standard for judicial review of agency decisions. Roper Hosp. v. Bd. of S.C. Dept. of Health and Envtl. Ctrl., 306 S.C. 138, 410 S.E.2d 558 (1991); Lark v. Bi-Lo Inc., 276 S.C. 130, 276 S.E.2d 304 (1981). Under the substantial evidence standard of review, the Court may not substitute its judgment for that of the agency unless the agency's findings are clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record.). See Wilson v. State Budget & Ctrl. Bd. Employee Ins. Program, 374 S.C. 300, 648 S.E.2d 310 (Ct. App. 2007).

Substantial evidence is not a mere scintilla of evidence, but is evidence which, considering the record as a whole, would allow a reasonable mind to reach the conclusion the administrative agency reached to justify its action. Rogers v. Kunja Knitting Mills, Inc., 312 S.C. 377, 440 S.E.2d 401 (Ct.App. 1994). See also Ruocco v. S.C. State Bd. of Registration for Prof'l Eng'rs & Land Surveyors, 314 S.C. 111, 441 S.E.2d 829 (Ct. App. 1994) (when reviewing an agency's decision under the APA to determine if substantial evidence exists, the record must be viewed as a whole to determine whether there is evidence allowing reasonable minds to reach the conclusion of the agency). An abuse of

[8] The Plan itself provides at Paragraphs 6.2 and 12.6 that "any construction or interpretation of the Plan . . . or any other decision arising under the Plan, or exercise of judgment or discretion given to the Plan Administrator . . . shall be binding and conclusive so long as the decision of the Plan Administrator or its duly authorized agent is not arbitrary or capricious or in violation of the applicable statutory law." (R. pp. 136, 182).

discretion occurs when a factual ruling is without evidentiary support. Fontaine v. Peitz, 291 S.C. 536, 354 S.E.2d 565 (1987). The possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's findings from being supported by substantial evidence. Sharp v. Case Produce, Inc., 336 S.C. 154, 519 S.E.2d 102 (1999).

A. S.C. CODE ANN. § 38-71-46 HAS NO APPLICATION TO THE STATE HEALTH PLAN BASED ON A PLAIN READING OF THE STATUTE.

Apparently recognizing that the terms of the State Health Plan specifically exclude standalone educational services like the session at issue, Appellant argues the State Health Plan should be reformed pursuant to S.C. Code Ann. § 38-71-46 to cover diabetes education.[9] However, Appellant's argument fails in that the ALC correctly found S.C. Code Ann. § 38-71-46 had no application to the State Health Plan because the State Health Plan is a self-funded, non-federal governmental plan and is not subject to regulation by the South Carolina Department of Insurance ("SCDOI").

The cardinal rule of statutory construction is to give effect to the intent of the

[9] Appellant's brief fails to make any argument that the ALC erred by finding that express terms of the State Health Plan did not cover separately-billed diabetes management education services. By failing to address this issue in his brief, Appellant waived any argument that the requested services were not covered by express terms of the State Health Plan. State v. Dunbar, 356 S.C. 138, 142, 587 S.E.2d 691, 694 (2003) ("No point will be considered which is not set forth in the statement of issues on appeal."); State v. King, 349 S.C. 142, 157, 561 S.E.2d 640, 648 (Ct. App. 2002) (providing that an argument is abandoned on appeal when conclusory and without supporting authority); ML-Lee Acquisition Fund, L.P. v. Deloitte & Touche, 327 S.C. 238, 489 S.E.2d 470 (1997) (an unchallenged ruling, right or wrong, is the law of the case); Continental Ins. Co. v. Shives, 328 S.C. 470, 492 S.E.2d 808 (Ct. App. 1997) (a lower court's unappealed ruling becomes the law of the case, and the appellate court must assume the ruling was correct).Town of Mt. Pleasant v. Jones, 335 S.C. 295, 516 S.E.2d 468 (Ct.App.1999) (holding an unappealed ruling becomes the law of the case, and the appellate court must assume the ruling was correct).

legislature. S.C. Coastal Conservation League v. S.C. Dep't of Health and Envtl. Control, 390 S.C. 418, 425, 702 S.E.2d 246, 250 (2010); Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000) (citing Charleston County Sch. Dist. v. State Budget and Control Bd., 313 S.C. 1, 437 S.E.2d 6 (1993)). Legislative intent is first and foremost determined by the language of the statute. State v. Pittman, 373 S.C. 527, 561, 647 S.E.2d 144, 161 (2007) (citing Whittler v. State, 328 S.C. 1, 6, 492 S.E.2d 777, 779 (1997)). "When a statute's terms are clear and unambiguous on their face, there is no room for statutory construction and a court must apply the statute according to its literal meaning." S.C. Coastal Conservation League, 390 S.C. at 425-26, 702 S.E.2d at 250; see, also Sloan v. Hardee, 371 S.C. 495, 498, 640 S.E.2d 457, 459 (2007). "Unless there is something in the statute requiring a different interpretation, the words used in a statute must be given their ordinary meaning." Id., 390 S.C. at 425, 702 S.E.2d at 250. The literal language of a statute should be disregarded only when the result is so plainly absurd that it clearly could not have been the intent of the legislature. Kiriakides v. United Artists Commc'ns, Inc., 312 S.C. 271, 275, 440 S.E.2d 364, 366 (1994) (citing Stackhouse v. Rowland, 86 S.C. 419, 68 S.E. 561 (1910)).

"The legislature is presumed to have fully understood the meaning of the words used in a statute and, unless this meaning is vague or indefinite, intended to use them in their ordinary and common meaning or in their well-defined legal sense." Pee v. AVM, Inc., 344 S.C. 162, 168, 543 S.E.2d 232, 235 (Ct. App. 2001). "Where the legislature chooses not to define a term in the statute, courts should interpret the term in accordance with its usual and customary meaning." Id. at 168, 543 S.E.2d at 235 (citing Adoptive Parents v. Biological Parents, 315 S.C. 535, 543, 446 S.E.2d 404, 409 (1994)). "The true

guide to statutory construction is not the phraseology of an isolated section or provision, but the language of the statute as a whole considered in light of its manifest purpose." Floyd v. Nationwide Mut. Ins. Co., 367 S.C. 253, 260, 626 S.E.2d 6, 10 (2005). "Once the Legislature has made [a] choice, there is no room for courts to impose a different judgment based upon their notions of public policy." State Farm Bureau Mut. Ins. Co. v. Mumford, 299 S.C. 14, 20, 382 S.E.2d 11, 14 (Ct. App. 1989).

A plain reading of S.C. Code Ann. § 38-71-46 and the statutes incorporated therein indicates it has no application to the State Health Plan. S.C. Code Ann. § 38-71-46 makes no mention that it applies to the State Health Plan, EIP, the South Carolina Budget and Control Board, or any combination thereof. S.C. Code Ann. § 38-71-46 states:

> (A) On or after January 1, 2000, every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and outpatient self-management training and education for treatment of people with diabetes mellitus, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina.
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> . . .
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> (D) For purposes of this section: "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670 (6)[10] and Section 38-71-840 (14).

Id. (Emphasis added).

[10] S.C. Code Ann. § 38-71-670(6) contains identical language to S.C. Code Ann. § 38-71-840(14) and applies to individual policies. Because the coverage at issue is group coverage, S.C. Code Ann. § 38-71-670(6) is not relevant to the analysis.

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

> (14) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:
>
> (a) coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
> (b) coverage issued as a supplement to liability insurance;
> (c) liability insurance, including general liability insurance and automobile liability insurance;
> (d) workers' compensation or similar insurance;
> (e) automobile medical payment insurance;
> (f) credit-only insurance;
> (g) coverage for on-site medical clinics;
> (h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
> (i) if offered separately;
> (i) limited scope dental or vision benefits;
> (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;
> (iii) other similar, limited benefits as are specified in regulations;
> (j) if offered as independent, noncoordinated benefits;
> (i) coverage only for a specified disease or illness;
> (ii) hospital indemnity or other fixed indemnity insurance;
> (k) if offered as a separate insurance policy;
> (i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
> (ii) coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code; and
> (iii) similar supplemental coverage under a group health plan.

Id. (Emphasis added).

S.C. Code Ann. §38-71-840 (16) defines a "health insurance issuer" as:

> (16) "Health insurance issuer" or "issuer" means any entity that provides health insurance coverage in this State. For purposes of this section, "issuer" includes an insurance company, a health maintenance

> organization, and any other entity providing health insurance coverage which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.

Id. (Emphasis added).

The ALC correctly found that because the State Health Plan is a self-funded plan and not "health insurance coverage" pursuant to S.C. Code Ann. § 38-71-840 (14), and because EIP is not licensed to engage in the business of insurance in this State and not a "health insurance issuer" subject to insurance regulation pursuant to S.C. Code Ann. § 38-71-840(16), S.C. Code Ann. § 38-71-46 has no application to the State Health Plan and EIP. Contrary to Appellant's assertion, the important distinction between a self-funded health plan and a fully-insured health plan is not limited to cases governed by the well-known Employee Retirement Income Security Act (ERISA). As noted above, the dictionary definition of "self-insured" means the employer has assumed the risk obligation, and "there is no contract with an insurance company." Black's Law Dictionary 664 (8th ed. abr. 2005).

As the United States Supreme Court has recognized, self-funded plans generally are not subject to state insurance regulation. See FMC Corporation v. Holliday, 498 U.S. 52 (1990) (self-funded plans usually are not subject to state insurance regulation). The State Health Plan is a self-funded, non-federal, governmental health plan for employees of state agencies, public school districts, and other public entities, administered by EIP, and is not a fully-insured plan. (R.p. 444). EIP is not licensed to engage in the business of insurance in this State and is not subject to insurance regulation by the SCDOI. See S.C. Code Ann. § 1-11-780 (Supp. 2009) ("The State Employee Insurance Program...is not under the jurisdiction of the Department of Insurance"). Because S.C. Code Ann.

§ 38-71-46 is a state insurance statute, it has no application to a self-funded health plan.

Appellant's attempt to rely on the doctrine of "the enumeration of exclusions from the operation of a statute indicates that the statute should apply to all cases not specifically excluded" has no application because S.C. Code Ann. § 38-71-46 and the statutes incorporated therein are not ambiguous. "If a statute's language is plain, unambiguous, and conveys a clear meaning, 'the rules of statutory interpretation are not needed and the court has no right to impose another meaning.'" Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 582 (2000). Simply put, S.C. Code Ann. § 38-71-46 only applies to "health insurance coverage" issued by an "insurance issuer" licensed and regulated by the SCDOI. The State Health Plan is not "health insurance coverage," nor is EIP an "insurance issuer." Accordingly, the State Health Plan does not meet even the preliminary requirements under S.C. Code Ann. § 38-71-840(16). Therefore, any analysis of the exclusions under S.C. Code Ann. § 38-71-840(16) is irrelevant.

B. EVEN ASSUMING FOR THE SAKE OF ARGUMENT THAT S.C. CODE ANN. § 38-71-46 WAS AMBIGUOUS AND RESORT TO THE RULES OF STATUTORY CONSTRUCTION WAS NEEDED, S.C. CODE ANN. § 38-71-46 STILL DID NOT APPLY TO THE STATE HEALTH PLAN.

The ALC correctly found that even assuming for the sake of argument that S.C. Code Ann. § 38-71-46 was ambiguous and resort to the rules of statutory construction was needed, S.C. Code Ann. § 38-71-46 still did not apply to the State Health Plan. (Order, pp. 9-11). The Legislature recently and explicitly recognized the lack of jurisdiction of the SCDOI over EIP as recently as 2005:

> The State Employee Insurance Program shall continue to provide mental health parity in the same manner and with the same management practices as included in the plan beginning in 2002,[11] and is not under the jurisdiction of

[11] The prior coverage beginning in 2002 that is referenced in this statute is from repealed

> the Department of Insurance. The continuation by the State Employee Insurance Program of providing mental health parity in accordance with the plan set forth in 2002 constitutes compliance with this act.

2005 Act No. 76, § 3, codified as S.C. Code Ann. § 1-11-780 (Supp. 2010). (Emphasis added). The remainder of Act 76 created § 38-71-290 separately and distinctly from the portion of the legislation addressing EIP. See 2005 Act. No. 76, § 1, codified as S.C. Code Ann. § 38-71-290 (Supp. 2010). The Legislature was aware it needed to name EIP separately and purposefully outside of a general insurance statute in Title 38, Chapter 71, if it wanted EIP to comply with the contents of that statute. Additionally, the General Assembly plainly ratified its long-term understanding that EIP "is not under the jurisdiction of the Department of Insurance."

In fact, in the 1990s and into the 2000s, the Legislature passed a series of health insurance coverage mandates in Title 38, Chapter 71, Article 1.[12] With the exception of

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

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

§ 38-71-280, regarding autism spectrum disorder, none of these laws or their preceding bills mentioned EIP, the State Health Plan, or the Budget and Control Board. Then in 2007, the Legislature passed § 38-71-280, mandating coverage for autism spectrum disorder care.[13] In § 38-71-280, the Legislature specifically stated it desired the statute apply to EIP: "It includes the State Health Plan. . . . 'State Health Plan' means the employee and retiree insurance program provided for in Article 5, Chapter 11, Title 1." S.C. Code Ann. § 38-71-280(A)(4)-(5). The statute made specific reference to EIP's governing Code sections, again underscoring the General Assembly's knowledge that EIP is governed differently. Accordingly, the Legislature deliberately referenced the State Health Plan and EIP's enabling statutes to make the Legislature's intent clear that § 38-71-280 applied to EIP because simply passing a statute in Title 38, Chapter 71, without a special reference or cross-reference would not do so.

Amidst this series of legislation, the bill that would become § 38-71-46 and mandate the provision of diabetes mellitus coverage by health insurers was introduced and passed in 1999, one session and one year before § 1-11-760 (repealed 2005) would explicitly require EIP to provide mental health coverage. The original diabetes health insurance coverage legislation had no references to EIP in its text. See 1999 S.C. Act No. 98 (codified at S.C. Code Ann. § 38-71-46). Perhaps more importantly, § 38-71-46 was later amended in the same session in which § 1-11-760 (repealed 2005) became law. See 2000 S.C. Act No. 348 (amending coverage mandates for diabetes mellitus); 2000 S.C. Act No. 341 (mandating EIP provide mental health coverage). The Legislature was clearly aware at the time § 38-71-46 was amended in 2000 that for the statute to apply to

[13] Notably, § 38-71-280 mandating State Health Plan autism coverage followed § 1-11-780's acknowledgment of no SCDOI jurisdiction over EIP.

EIP, EIP needed to be identified in the statute. However, the Legislature chose not to do so, and § 38-71-46 makes no mention of its application to the State Health Plan, unlike the contemporaneously and subsequently passed legislation. By Appellant's own admission, "the court should take judicial notice that the members of the South Carolina General Assembly have the option of participating in the State Health Plan themselves, and therefore knowledge of its existence cannot be minimized." (Appellant's Brief p. 13-14).

As the ALC correctly held, the Legislature made it very clear when mandates otherwise restricted to health insurers were to apply to the State Health Plan. When EIP was to be included, the Legislature either: (1) amended EIP's governing statutes in Title 1, Chapter 11, Article 5; (2) made a direct reference to those statutes in its legislation; or (3) at a minimum, identified EIP by name in its legislation. The Legislature was aware EIP was not governed by the SCDOI and specifically stated this fact in 2005 legislation. The Legislature also acknowledged that EIP was not governed by the mandates in Title 38, Chapter 71, Article 1, unless a specific intent to do so was stated in the statute. Finally, § 38-71-46 itself was passed contemporaneously with other legislation specifically indicating application to EIP; yet § 38-71-46 remained silent regarding EIP and the State Health Plan. The ALC did not err in holding, "[i]f the Legislature had intended § 38-71-46 to apply to EIP, it would have indicated that in the statute itself or associated legislation." (R.p. 12).

II. THE ALC DID NOT ERR IN FAILING TO ADDRESS THE AVAILABILITY OF CLASS ACTION RELIEF IN THE ALC.

The ALC did not err in failing to address the availability of class action relief in the ALC in that the ALC's disposition of the prior issue, whether the State Health Plan

covered individually-billed diabetes management education, was dispositive of the entire case. Futch v. McAllister Towing of Georgetown, Inc., 335 S.C. 598, 518 S.E.2d 591 (1999); Whiteside v. Cherokee County Sch. Dist. No. One, 311 S.C. 335, 428 S.E.2d 886 (2003) (appellate court need not address remaining issues when disposition of prior issue is dispositive).

Even assuming that the ALC should have addressed the issue of class action relief, Appellant was not entitled to assert class action relief pursuant to the statutorily provided procedure and remedy. The administrative remedies under S.C. Code Ann. § 1-11-710(C) were Appellant's exclusive remedy. A participant and/or beneficiary challenging an award of benefits under the State Health Plan is limited to the remedies set forth in S.C. Code Ann. § 1-11-710(C), which provides as follows:

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

Id. (Emphasis added). Appellant's appeal to the ALC dated September 22, 2010, stated the relief he was seeking in the following manner: "[t]he agency has denied claimant's claim for diabetes education/outpatient self-management training, after the claim was denied by Blue Cross-Blue Shield of South Carolina. This denial is in violation of S.C. Code § 38-71-46(A). The relief sought is payment of claimant's claim." (Emphasis added) (R.p. 198). Appellant is also requesting the Court interpret the terms of the State Health Plan to include the coverage set out in S.C. Code Ann. § 38-71-46. Appellant further alleges he is entitled to disgorged benefits from the plan for unlawful denials of

coverage and for injunctive relief enjoining further denial of claims for diabetes out-patient self-management training and education. (R.p. 368). The interpretation of the State Health Plan and the resolution of claims for benefits under the Plan are exactly the types of remedies contemplated by § 1-11-710(C).[14]

S.C. Code Ann. § 1-11-710(C) and the appeals procedure set forth in the State Health Plan make no mention of allowing class action relief. The statute provides in pertinent part: "claims for benefits under any self-insured plan of insurance offered by the State . . . must be resolved by procedures established by the board, which shall constitute the exclusive remedy for these claims, subject only to appellate judicial review." (Emphasis added). Those procedures established by the Board are set out specifically in the Plan in Article 12. The request for class certification is inconsistent with the Article 12 provisions and in turn § 1-11-710(C) because the class, as defined by Appellant, does not require any potential class member to have filed written claims or subsequent appeals with the third-party claims processor or with EIP.[15]

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[14] Paragraph 1.3 of the State Health Plan states:

> 1.3 Applicable Law
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> This Plan is established and will be maintained with the intention of meeting the requirements of all applicable federal and state laws. Any provision of this Plan, which is in conflict with the law of any governmental body or agency that has jurisdiction over this Plan, shall be interpreted to conform to the minimum requirements of such laws.

(R.p. 106) (Emphasis added).

[15] See Plan of Benefits Article 12, Paragraph 12.1(B), ("Written notice of care on which a claim is based must be furnished to the Third Party Claims Processor within 90 days of the beginning of care, or as soon thereafter as is reasonably possible. . . ."); Article 12, 12.5(A) ("A Covered Person, after receipt of notification of the Third Party Claims Processor's . . . action on his claim, must request a review of any benefits denied in

In turn, "a statute waiving the State's immunity must be strictly construed, the State can be sued only in the manner and upon the terms and conditions prescribed by the statute." Unisys Corp. v. S.C. Budget & Ctrl. Bd., 346 S.C. 158, 551 S.E.2d 263 (2001) (holding that Unisys' circuit court claims for a jury trial were not appropriate in that Unisys' exclusive remedy was the administrative procedures under the S.C. Procurement Code). Class action relief and damages beyond the amount of a claim for benefits are not specifically allowed by § 1-11-710(C) and the claims procedure set forth in the State Health Plan. To allow the remedy would be a waiver of the State's sovereign immunity. Allowing class action relief with the award requested would exceed the State's liability beyond the terms and conditions prescribed by the statute.

Appellant correctly observes the issue of class-based claims in the ALC has been within the context of the Revenue Procedures Act, which does in fact contain a prohibition against class actions. However, in addition to the prohibition on class action relief, those statutes also state "(A) Except as provided in subsection (B), there is no remedy other than those provided in this chapter in any case involving the illegal or wrongful collection of taxes, or attempt to collect taxes." S.C. Code Ann. § 12-60-80(A). Subsection (B), allowing challenges to the constitutionality of tax laws to be filed in circuit court, and subsection (C), disallowing the class actions, were passed in 2003, amidst the cases Appellant cites. See 2003 Act No. 69, § 3.CC (codified at S.C. Code

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whole or in part within six months of notice of the denial of benefits by the Third Party Claims Processor. . . ."); Article 12, 12.5(B) ("After the review provided in 12.5.A, a Covered Person, who is informed that the claim has been denied in whole or in part, or that benefits will not be paid, and who desires review of that determination, may request from the Plan Administrator's director a review of that decision within 90 days after notice of the denial of benefits after reconsideration.")

Ann. § 12-60-80(B)-(C)); Drummond v. S.C. Dep't of Rev., 378 S.C. 362, 662 S.E.2d 587 (2008); Ward v. State, 343 S.C. 14, 583 S.E. 2d (2000). Three years before subsection (C) was passed, Ward actually addressed whether administrative remedies had to be exhausted when challenging the constitutionality of a statute. 343 S.C. at 18, 538 S.E.2d at 247. In Drummond, the court found the individual relief regarding disgorgement of tax monies to individuals was properly sent to the Administrative Law Court, 378 S.C. at 369, 662 S.E.2d at 590, but a constitutional issue properly went to the circuit court under subsection (B) of the statute. Id. Both cases support the limitation of individual administrative remedies to the statutes at issue, not a broadening of statutory relief to include class actions as a remedy.

Even assuming for the sake of argument that Appellant could request class action relief under S.C. Code Ann. § 1-11-710(C), Appellant is not entitled to class action relief in the present case in that he failed to request it during the course of his administrative claim with BCBSSC and EIP. While it is undisputed that Appellant brought a purported class action in circuit court that was dismissed by summary judgment, Appellant never requested class action relief as part of his administrative claim. Appellant's administrative appeal letters dated February 25, 2009, and September 30, 2009 make no mention of a class action. (R.pp. 506-507, 390-391).

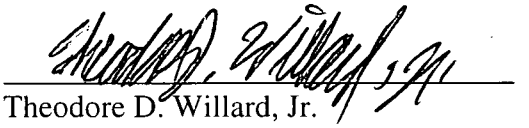
Appellant's appeal letter dated June 30, 2010 stated, "[a]s you already know the Plaintiffs have brought a putative class action lawsuit against SCEIP and BCBSSC as it relates to the applicability of S.C. Code Ann. § 38-71-46 to the State Plan. The legal and factual basis for these claims are (sic) set forth in detail in the attached pleadings in the civil action in Charleston County Court of Common Pleas, and are incorporated into this

appeal letter." (R.p. 452). While this letter and the pleadings submitted with it were submitted for informational purposes that Appellant was seeking a class action in circuit court, Appellant at no time asserted he was entitled to class action relief as part of his administrative claim.

The conclusion is further supported by Appellant's notice of appeal to the ALC dated September 22, 2010, wherein Appellant stated the relief he was seeking as: "[t]he agency has denied claimant's claim for diabetes education/outpatient self-management training, after the claim was denied by Blue Cross-Blue Shield of South Carolina. This denial is in violation of S.C. Code § 38-71-46(A). The relief sought is payment of claimant's claim." (Emphasis added) (R.p. 198). By failing to request class action relief in Appellant's notice of appeal to the ALC, Appellant waived any right to assert class action relief before the ALC. ML-Lee Acquisition Fund, L.P. v. Deloitte & Touche, 327 S.C. 238, 489 S.E.2d 470 (1997) (an unchallenged ruling, right or wrong, is the law of the case).

IV. CONCLUSION

For the foregoing reasons, the decision of the ALC should be affirmed.



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January 3, 2013
Columbia, South Carolina

THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Shirley C. Robinson, Administrative Law Judge

Appellate Case No. 2012-213186

Jeffrey D. Allen, on behalf of Jane Doe.....Appellant.

v.

South Carolina Public Employee Benefit Authority,
Employee Insurance Program.....Respondent.

CERTIFICATE OF COUNSEL

The undersigned certified that this Final Brief complies with Rule 211(b), SCACR.

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PROOF OF SERVICE

I certify that I have served the Final Brief of Respondent on Jeffrey D. Allen, on behalf of Jane Doe by depositing a copy of it in the United States mail, postage prepaid on January 3, 2013, address to his attorneys of record John A. Massalon, Esquire, Post Office Box 859, Charleston, South Carolina 29402; and Terry E. Richardson, Jr., Esquire, Post Office Box 1368, Barnwell, South Carolina 29812.

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