

THE STATE OF SOUTH CAROLINA  
In the Supreme Court

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APPEAL FROM THE ADMINISTRATIVE LAW COURT

S.C. Supreme Court

Shirley C. Robinson, Administrative Law Judge

Case No. 2012-213186

Jeffrey D. Allen, on behalf of Jane Doe

Appellant,

v.

South Carolina Public Employee Benefit Authority,  
Employee Insurance Program

Respondents.

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**FINAL BRIEF OF APPELLANT**

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## STATEMENT OF ISSUES ON APPEAL

1. Did the ALJ err in concluding that S.C. Code § 38-71-46 does not apply to the state health plan?
2. Did the ALJ err in considering pronouncements of legislative intent made long after passage of the statute at issue?
3. Did the ALJ err in failing to address the availability of class action relief in the ALC?

## STATEMENT OF THE CASE

Appellant, Jeffrey D. Allen is an employee of a local South Carolina school district and an insured/member of the State Health Plan operated by the South Carolina Employee Insurance Program (EIP). Appellant appealed the denial of an insurance claim for diabetes education for his dependant daughter to the administrator of the EIP State Health Plan on February 25, 2009. In his requests for explanation and reconsideration of the denial, Appellant inquired why the diabetes mandate at S.C. Code Ann. § 38-41-46 did not require coverage. Appellant receive no response from the EIP or its administrator, and on November 25, 2009, (two years less two days from Jane Doe's date of diagnosis), Appellant filed a putative class action complaint seeking declaratory judgment, reformation, disgorgement, injunctive relief, and attorneys fees in the Ninth Circuit Court of Common Pleas against the State of South Carolina and Blue Cross Blue Shield of South Carolina. (R. Vol. II, pp. 457-68). (That case is the subject of a separate

appeal just recently decided by the South Carolina Court of Appeals, and with pending motion for Writ of Certiorari to the South Carolina Supreme Court).

On March 19, 2010, Blue Cross Blue Shield of South Carolina, as administrator for the State Health Plan, upheld its initial denial, and indicated that the appeal file would be sent to the Blue Cross Blue Shield Appeals Review Committee. (R Vol. II, p. 243). Two weeks later, on April 2, 2010, the Blue Cross Blue Shield Appeals Committee issued a denial of the appeal on the basis that education is expressly excluded under the State Health Plan and concluded, without explanation, that S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan. ( R.Vol. II, pp. 362-64). On June 30, 2010, Appellant appealed the denial to the EIP's Appeals Committee, (R. Vol. II pp. 358-59) (R. Vol. II – Vol. III pp. 452-622). By letter dated August 24, 2010, the EIP Appeals Committee wrote Appellant that it was denying his claim and again concluded that S.C. Code § 38-71-46 did not apply to the State Health Plan. (R.Vol. I, pp.200- 213). During the above-referenced “administrative appeal” to the EIP, there was no hearing, meeting, testimony, nor discovery. The EIP Appeals Committee conducts a paper review of EIP's initial coverage determination, which is also made without hearing.

On September 22, 2010, Appellant filed his Notice of Appeal from the EIP decision to the South Carolina Administrative Law Court. That appeal was fully briefed by March 3, 2011; no oral argument or hearing was scheduled. Three and a half years after beginning the “administrative review” and just short of two (2) years from the filing of the appeal to the ALC, on August 13, 2012, the ALJ issued a decision affirming the EIP's denial of benefits and concluding that the diabetes mandate statute did not apply to the

State Health Plan. Said Order was received on August 15, 2012, and that Notice of Appeal filed in this matter on September 14, 2012. This appeal follows.

#### STATEMENT OF THE FACTS

The Appellant, Jeffrey D. Allen is an employee of a local South Carolina school district and an insured/member of the State Health Plan, as administered by the Employee Insurance Program (EIP). His daughter, Jane Doe, a dependant on that plan, was diagnosed with type 1 diabetes<sup>1</sup> in November 2007 at the age of two (2) years old. (R. Vol. I, p. 203). This appeal is about the EIP's failure to comply with a South Carolina statutory mandate for diabetes coverage and whether this matter should be certified as a class action. Appellant alleges that EIP has unlawfully denied Appellant's and other similarly-situated persons' claims for coverage of diabetes-related education on the grounds that the EIP is not subject to the state-wide mandate for diabetes education coverage. S.C. Code Ann. section 38-71-46 provides:

**Diabetes Mellitus coverage in health insurance policies, diabetes education.**

(A) On or after January 1, 2000, *every* health maintenance organization, *individual and group health insurance policy, or contract issued or*

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<sup>1</sup> Type 1 diabetes is an autoimmune disease in which the body's immune system attacks and destroys the insulin-producing cells of the pancreas. Its causes are not yet entirely known. It causes dependence on injected or pumped insulin for life, and carries the constant threat of devastating complications. To stay alive, people with type 1 diabetes must take multiple insulin injections daily or continually infuse insulin through a pump. They must also test their blood sugar by pricking their fingers for blood six or more times a day. While trying to balance insulin doses with their food intake and daily activities, people with this form of diabetes still must always be prepared for serious hypoglycemic (low blood sugar) and hyperglycemic (high blood sugar) reactions, both of which can be life-limiting and life threatening. Each year, more than 15,000 children - 40 per day - are diagnosed with type 1 diabetes in the U.S.

[http://www.jdrf.org/index.cfm?fuseaction=home.viewPage&page\\_id=14AF69BC-BE51-42DA-B1B41955029FBC7F](http://www.jdrf.org/index.cfm?fuseaction=home.viewPage&page_id=14AF69BC-BE51-42DA-B1B41955029FBC7F) (December 28, 2010)

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

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

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

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

(emphasis added).

The denial of benefits arose from an education session attended at MUSC on August 5, 2008. That day, Jane Doe's family and other caregivers, including two Charleston County School District nurses who were to be charged with her care in school

beginning in August 2008, attended a training session set up by MUSC Pediatric Endocrinology to train those caregivers, at home and school, how to operate an insulin pump prescribed by Doe's physician and scheduled to be attached to her body the following week. (R. Vol. III, p. 497). That training session lasted approximately two hours and was taught by a MUSC diabetic educator. Id.

The claim submitted to the State Health Plan was denied on August 27, 2008 on the grounds that the "benefit plan does not cover education and/or training for this condition." (R. Vol. II, pp. 385-86). On February 25, 2009, Appellant submitted a written request for reconsideration to Blue Cross Blue Shield. (R. Vol. III, pp. 506-11). Having received no response, Appellant wrote again on September 30, 2009 and inquired as to why the claim was denied and why S.C. Code § 38-71-46 did not mandate payment of the claim. (R. Vol. III, pp. 525-29). On November 25, 2009, (two years less two days from Jane Doe's date of diagnosis), Appellant filed a putative class action complaint seeking declaratory judgment, reformation, disgorgement, injunctive relief, and attorneys fees in the Ninth Circuit Court of Common Pleas against the State of South Carolina and Blue Cross Blue Shield of South Carolina. (R. Vol. II, pp. 457-68). At the time of that court filing, EIP had yet to respond to Appellant's request for reconsideration.

The State Health Plan provides that it is "established and will be maintained with the intention of meeting the requirements of all applicable federal and state laws. Any provision of the 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 law." (R. Vol. I, p. 106).

On March 23, 2010, over one year after Appellant's initial objection and three weeks after the first hearing in the circuit court case which resulted in a denial of the Respondent's motions to dismiss, Blue Cross Blue Shield first issued its decision dated March 19, 2010 to uphold the original denial dated August 27, 2008, and indicated that the appeal file would be sent to the Blue Cross Blue Shield Appeals Review Committee. (R. Vol. II, p. 361). Two weeks later, on April 2, 2010, the Blue Cross Blue Shield Appeals Committee issued a denial of the appeal on the basis that education is expressly excluded under the State Health Plan and concluded, without explanation, that S.C. Code Ann. § 38-71-46 did not apply to the State Health Plan. (R. Vol. II, pp. 362-64). On June 30, 2010, Appellant appealed the denial to the EIP's Appeals Committee, (R. Vol. II, pp. 358-59), by sending as the basis for appeal a copy of the pleadings as filed in the then-concurrently pending case in the Court of Common Pleas. (R. Vol. II- Vol. III, pp. 452-623).

By letter dated August 24, 2010, the EIP Appeals Committee wrote Appellant that it was denying his claim and again stated that S.C. Code § 38-71-46 did not apply to the State Health Plan. (R. Vol. I, pp. 200-213). The underlying basis for the conclusion that the diabetes coverage mandate did not apply to the State Health Plan was explained (for the first time) as follows:

Lastly, the Committee noted the repeated assertions regarding S.C. Code 38-71-46 and Claimant's attorney's assertion that no one has explained why it does not apply to the State Health Plan. While the Committee noted the alternative methods for obtaining diabetes education noted above, the Committee also observed the Department of Insurance and the General Assembly *historically have acknowledged* the Department [of Insurance] has no jurisdiction over EIP. EIP is not a health insurance issuer under the Code. In the areas on which the General Assembly has

wanted to include EIP in the Accident and Health Insurance provisions of Title 38, Chapter 31, it has specifically said so. Therefore, because 38-71-46 does not refer to EIP or the State Health Plan, it does not apply to the State Health Plan.

(R. Vol. I, p. 213). That explanation contains a single footnote which referenced S.C. Code Ann. §1-11-780 -- a statute addressing mental health coverage -- presumably as the legal justification for the proposition that the South Carolina Department of Insurance has no jurisdiction over the South Carolina State Budget and Control Board's Employee Insurance Program -- an insurance program which admittedly insures over 400,000 South Carolinians. The only support for this underlying legal conclusion appears on the Medical Affairs Review Coordinator's Response in long-hand dated March 15, 2010 and signed by Ashby M. Jordan, MD, V.P. Medical Affairs wherein she writes "the statute referenced in the appeal document does not apply to the State Health Plan." (R. Vol. II, p. 395).

Curiously, in its decision, the EIP also makes very general reference to "alternative methods for obtaining diabetes education," in particular a program entitled "Prevention Partners" and MUSC Options, a separate HMO option for State employee insurance. (R. Vol. I, p. 212). These references, however, do not form the basis for the decision and are, at best, irrelevant, and at worst an attempt to further obfuscate the issue. Prevention Partners is described by the EIP's Insurance Benefit Guide to include services such as preventive worksite screenings for prevention and early detection of chronic disease, spring wellness walk, lifestyle change workshops, worksite program consultation, and volunteer worksite prevention partners. (R. Vol. III, pp. 566-67). Clearly, this program is aimed at adults suffering from chronic and preventable diseases,

such as heart disease and Type 2 Diabetes. The EIP did not and cannot contend that the educational service prescribed by Jane Doe’s physician to assist her caregivers with the operation of her insulin pump would have been paid for or covered by said program. Further, contrary to the EIP’s conclusion that Appellant made no mention of this program, Appellant was contacted, during this legal challenge, presumably about the Prevention Partners’ “wellness program” and then told that Jane Doe was not old enough to participate and that their records indicated (incorrectly) the chronic condition she suffered from was asthma. (R. Vol. III, p. 501). Respondent also referenced in its decision the Appellant could have chosen plans other than the State Health Plan – BlueChoice HMO or MUSC Options as his insurance plan, and that education is covered under those plans. (R. Vol. I, p. 212). However, Respondent fails to recognize that those plans are not the subject of this action, and failed to mention that MUSC Options “option” was discontinued by the EIP in October 2008.

As contained in the Appellant’s Notice of Appeal to the EIP, the claim alleges that the Plaintiff is insured through the State Health Plan, which is a non-ERISA health benefit plan,<sup>2</sup> and that the State Health Plan is in violation of the diabetes mandate by its failure to provide coverage for diabetes education in accordance with the statutory mandate which was enacted in 1999. (R. Vol. II, p. 452). The appeal alleged that over 15,000 State of South Carolina employees have some type of diabetes, and that the exact

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<sup>2</sup> 29 U.S.C.A. § 1003(b)(1) expressly excludes government plans from the broad sweep of ERISA preemption of state laws. Silvera v. Mutual Life Ins. Co. of New York, 884 F.2d 423, 425 (9<sup>th</sup> Cir. 1989). ERISA expressly defines governmental plan as including a plan established by the government of a State or political subdivision 29 U.S.C.A. § 1002 (32).

number of class members affected by the Respondent's unlawful exclusion of coverage for diabetes education is known only to the Respondent and will need to be obtained from the Respondent. (R. Vol. II, pp. 459-60). The appeal to the EIP sought: (1) class action certification; (2) a declaration that the State of South Carolina benefit plan violates the diabetes mandate; (3) a declaration regarding the future rights of the members of the putative class; (4) reformation of the benefit plan to comply with the mandate; (4) disgorgement and return of all profits and/or monies which should have been paid to putative class, (5) an injunction to stop the Respondent from continuing their unlawful actions in the future, and (6) costs and attorneys fees. (R. Vol. II, p. 464).

## ARGUMENT

### A. STANDARD OF REVIEW

The appeal is subject to review pursuant to S.C. Code Ann. § 1-23-380 which provides for judicial review upon exhaustion of administrative remedies. Subsection (A) (5) states, in part, that

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 procedure;
- (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 or characterized by abuse of discretion or

clearly unwarranted exercise of discretion.

B. THE PLAIN AND UNAMBIGUOUS LANGUAGE OF THE DIABETES MANDATE, S.C. CODE ANN. § 38-71-46, APPLIES TO THE STATE HEALTH PLAN.

The ALJ erred by concluding that the State Health Plan was excluded from the diabetes mandate statute. Statutory interpretation is a question of law. City of Newberry v. Newberry Elec. Coop., Inc., 387 S.C. 254, 256, 692 S.E.2d 510, 512 (2010). "The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature." Hardee v. McDowell, 381 S.C. 445, 453, 673 S.E.2d 813, 817 (2009) (internal quotation omitted). Under the plain meaning rule, the court is not permitted to change the meaning of a clear and unambiguous statute. Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000). Where the statute's language is plain, unambiguous, and conveys a clear, definite meaning, the court may not impose a different meaning and need not employ rules of statutory interpretation. Gay v. Ariail, 381 S.C. 341, 345, 673 S.E.2d 418, 420 (2009).

The diabetes mandate statute states that it applies to "*every . . . group health insurance policy, or contract* issued or renewed in this State . . ." S.C. Code Ann. § 38-71-46 (a) (emphasis added). The seminal question in this appeal is whether this language applies to the Employee Insurance Program's State Health Plan, i.e. whether the State Health Plan is a "group health insurance policy, or contract issued or renewed in this State" as defined in the mandate.

Unlike some cases, the legislature did not omit the definition of "health insurance

policy” for the purposes of this mandate. Instead, the General Assembly defined the term “health insurance policy” for this particular statute to mean “a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).” Id. 38-71-46(d).

The ALJ concluded that this statute did not apply to the EIP. Appellant disagrees. Therefore, the question of law for this court is whether the ALJ properly interpreted the language of S.C. Code Ann. §§ 38-71-46; 38-71-670(6); and 38-71-840(14). The entire text of section 38-71-46 is found infra. at pp.1-2. S.C. Code Ann. § 38-71-840 (14) defines “Health insurance coverage” as follows:

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

- (a) coverage only for accident or disability income insurance or any combination of these;
- (b) coverage issued as a supplement to liability insurance;
- (c) liability insurance, including general liability insurance and automobile liability insurance;
- (d) workers' compensation or similar insurance;
- (e) automobile medical payment insurance;
- (f) credit-only insurance;
- (g) coverage for on-site medical clinics;

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

S.C. Code Ann. § 38-71-840 (14) (emphasis added). Similarly, S.C. Code Ann. § 38-71-670 (6) is nearly identical.

The EIP's State Health Plan fits plainly within these broad statutory definitions of "health insurance policy" and "health insurance coverage" in that it provides *benefits, through insurance or reimbursement, or otherwise*, and the State Health Plan is not included within any of the 20+ enumerated exceptions. Therefore, this court should reverse and conclude, as a matter of law, that the State Health Plan is a "Health insurance policy" for purposes of the statutory mandate of S.C. Code Ann. § 38-71-46.

"All rules of statutory construction are subservient to the one that the legislative intent must prevail if it can be reasonably discovered in the language used, and that language must be construed in the light of the intended purpose of the statute."

Broadhurst v. City of Myrtle Beach Election Comm'n, 342 S.C. 373, 380, 537 S.E.2d

543, 546 (2000). Title 38 entitled “The Insurance Law,” S.C. Code Ann. § 38-1-10, defines “accident and health insurance” as “insurance of human beings against death or personal injury . . . against sickness, ailment, and any type of physical disability resulting from accident or disease, and prepaid dental service, but not including coverages required by Workers’ Compensation Law of this State.” *Id.* § 38-1-20 (1).

As illustrated by the title of the statute: “Diabetes Mellitus coverage in health insurance policies, diabetes education,” the plain intent was to mandate insurance coverage for diabetes, and specifically require coverage for diabetes education. Further, the very first clause of section 38-71-46 states: “[o]n or after January 1, 2000, *every* . . . group health insurance policy or contract.” There is no more encompassing word than “every.” The legislature then referenced definitions for what it intended to be deemed and “insurance policy” under the diabetes mandate, and those definitions include the descriptor: “*benefits, through insurance or reimbursement, or otherwise.*” It would have been simple to exclude the State Health Plan from the plain language of the mandate, but the legislature did not. It would have been simple to enact another statute defining diabetes insurance coverage differently for the State Health Plan as the legislature later did regarding mental health coverage, see for example S.C. Code Ann. § 38-71-290 (mandating standards for mental health coverage in “health insurance plans”) and S.C. Code Ann. § 1-11-780 (mandating different standards for mental health coverage for the EIP), both of which were enacted in 2005 with effective dates of June 30, 2006, years after the diabetes mandate at issue, but it did not. Further, there is nothing in section 38-71-46 which limits its applicability to licensed [by the Department of Insurance] health

insurance issuers as suggested by the ALJ's interpretation. Lastly, the court should take judicial notice of the fact that all 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.

The canon of construction "*expressio unius est exclusio alterius*" or "*inclusio unius est exclusio alterius*" holds that "to express or include one thing implies the exclusion of another, or of the alternative." BLACK'S LAW DICTIONARY 602 (7th ed. 1999). Section 38-71-46 does not specifically exempt the EIP's State Health Plan from its operation, nor from the application of the definitional statutes incorporated therein -- sections 38-71-670(6) and 38-71-840(14). "The enumeration of exclusions from the operation of a statute indicates that the statute should apply to all cases not specifically excluded. Exceptions strengthen the force of the general law and enumeration weakens it as to things not expressed." Hodges v. Rainey, 341 S.C. at 87, 533 S.E.2d at 585 (quoting Norman J. Singer, SUTHERLAND STATUTORY CONSTRUCTION § 47.23 at 227 (5th ed. 1992) (citations omitted)).

The language of section 38-71-46 is unambiguous and evidences the General Assembly's intent for the mandate to apply to the EIP's State Health Plan.

C. THE ALJ'S INTERPRETATION OF S.C. CODE ANN. § 38-71-840 (14) IS NOT SUPPORTED BY THE PLAIN MEANING RULE AND IS UNREASONABLE

The ALJ's conclusion that the State Health Plan does not fall within the applicable definition for "group health insurance, policy or contract" relies completely on the inference that the inclusion of the words "offered by a health insurance issuer" in

section 38-71-840 (14) precludes its applicability to the State Health Plan. (R. Vol. I, p. 9). However, the plain language of the section 38-71-46 [the diabetes mandate] at issue and the definitional statute section 38-71-840 (14) simply do not support that interpretation.

“What a legislature says in the text of a statute is considered the best evidence of the legislative intent or will.” Knotts v. S.C. Dept of Natural Resources, 348 S.C. 1, 10, 558 S.E.2d 511, 516 (2002) (quoting Norman J. Singer, SUTHERLAND STATUTORY CONSTRUCTION, §46.03 at 94 (5th Ed. 1992)). The diabetes coverage mandate at issue states plainly that it applies to “every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State,” and then within its own terms, states that for the purposes of this statute, “‘Health insurance policy’ means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in . . . Section 38-71-840(14).” Health insurance “issuer” is defined in 38-71-840(16) as a provider of health insurance coverage “which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.” The General Assembly, however, did not expressly reference or incorporate the definition of “health insurance issuer,” found at section 38-71-840(16) and cited by the ALJ, into the diabetes mandate.

Further and most importantly, the plain language of section 38-71-840(14), which does include the term “health insurance issuer” does not support the ALJ’s conclusion that the presence of the term “health insurance issuer” removes the State Health Plan from application of the diabetes mandate statute. (R. Vol. I, p. 9).

S.C. Code Ann. § 38-71-840 (14) provides:

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

- iii. similar supplemental coverage under a group health plan.

Id. (emphasis added). Broken down into its elements, the first paragraph of section 38-71-840(14) defines health insurance coverage [and therefore determines whether the diabetes mandate applies to the Respondent State Health Plan] to include ‘benefits consisting of medical care’

- (1) provided directly through insurance,
- (2) provided directly through reimbursement, or
- (3) provided otherwise.

Then, the statute expands, by use of the words “and including”, that definition by adding the following specific kinds of “items and services paid for as medical care”:

- (a) under any hospital service policy, certificate, or plan contract,
- (b) under any medical service policy, certificate, or plan contract, or
- (c) under any health maintenance organization contract offered by a health insurance issuer.

Then, the statute specifically excludes, by use of the word “except,” twelve (12) kinds of insurance, which exclusions do not include the State Health Plan in any way. Reading section 38-71-840(14) this way makes sense and, at the same time, illustrates the tortured nature of the ALJ’s interpretation.

“A statute as a whole must receive a practical, reasonable, and fair interpretation consonant with the purpose, design, and policy of the lawmakers.” Browning v. Hartvigsen, 307 S.C. 122, 125, 414 S.E.2d 115, 117 (1992). “The real purpose and intent

of the lawmakers will prevail over the literal import of the words.” Id. “Courts will reject a statutory interpretation which would lead to a result so plainly absurd that it could not have been intended by the legislature or would defeat the plain legislative intention.” Id. (citing Unisun Ins. Co. v. Schmidt, 339 S.C. 362, 368, 529 S.E.2d 280, 283 (2000); Kiriakides v. United Artists Communications, Inc., 312 S.C. 271, 275, 440 S.E.2d 364, 366 (1994)).

The ALJ’s interpretation results in the conclusion that only a “health insurance issuer,” as that term is defined in section 38-71-840(16) can provide “health insurance coverage.” However, in order for that argument to work within the context of the section 38-71-840(14), the clause “offered by a health insurance issuer” would need to modify each subject in the sentence. So, for example, the ALJ’ interpretation would result in the following reading: Health Insurance Coverage means “benefits consisting of medical care”

- (1) provided directly through insurance offered by a health insurance issuer,
- (2) provided directly through reimbursement offered by a health insurance issuer, or
- (3) provided otherwise offered by a health insurance issuer

“and including items and services paid for as medical care”:

- (a ) under any hospital service policy, certificate, or plan contract offered by a health insurance issuer

(b) under any medical service policy, certificate, or plan contract offered by a health insurance issuer, or

(c) under any health maintenance organization contract offered by a health insurance issuer

This interpretation is illogical, and renders most of the language in the definition completely meaningless and unnecessary. If the ALJ's interpretation were correct, then the General Assembly could have simply defined health insurance coverage to mean any benefits consisting of medical care offered by a health insurance issuer. It did not. Whereas, an interpretation where the phrase "offered by a health insurance issuer" only modifies "health maintenance organization contract" has a natural reading, complies with general rules of punctuation, and appears to comport with the purpose of the statute – to broadly define "health insurance coverage." "A court should not consider a particular clause in a statute as being construed in isolation, but should read it in conjunction with the purpose of the whole statute and the policy of the law." Browning, 307 S.C. at 125, 414 S.E.2d at 117. Further, use of this definition to define the scope of the diabetes mandate also comports with the stated intent to apply the diabetes mandate to "every policy or contract issued in the State."

The EIPS's State Health Plan fits plainly within all three general categories of section 38-71-840 (14) in that it provides "benefits consisting of medical care" (1) provided directly through insurance, (2) provided directly through reimbursement, or (3) provided otherwise. The State Health Plan provides benefits directly through insurance

because that is what it calls itself. (R., Vol. III pp. 539-606 – South Carolina Employee Insurance Program’s Employee Insurance Guide). If what is provided is not “directly through insurance” because the State Health Plan is self-funded, then the benefits it provides are provided “directly through reimbursement.” Lastly, if what the State Health Plan provides is not directly through insurance nor directly through reimbursement, the provisions of its benefits certainly fall into the otherwise provided catch-all.

This statutory interpretation issue is not a complicated one. The diabetes mandate is clear that the legislative intent was that it apply to all providers of medical care benefits, and the State Health Plan fits plainly within those definitions.

#### D. THE “SELF-FUNDED” LABEL IS NOT RELEVANT

The ALJ also appears to conclude that because the State Health Plan is self-funded, therefore it is not subject to state regulation. (R. Vol. I, p. 10). This conclusion is too broad to draw, however, from the general statement that within the context of ERISA, self-funded plans are not subject to state regulation. ERISA and the complex relationships it creates between self-funded and fully-insured plans and state and federal regulation have nothing to do with the issues in this appeal. The only case cited in support of said conclusion is FMC Corporation v. Holliday, 498 U.S. 52 (1990), an ERISA case. The terms self-insured are not found in the diabetes mandate, nor in the definitions recited therein, and are not relevant to the issue at bar.

#### E. THERE IS NO EVIDENCE OF LEGISLATIVE INTENT TO EXCLUDE THE STATE HEALTH PLAN FROM THE APPLICABILITY OF THE MANDATE STATUTE

The ALJ’S Order addresses legislative intent through an alternative analysis of

the statute, and finds that there is evidence of legislative history that the intent was to exclude the State Health Plan from the mandate. (R, Vol. I p. 10-12). However, this analysis is flawed because it relies on acts and statements of the legislature made after the passage of the diabetes mandate statute. The Order cites a 2005 mental health parity statute, S.C. Code Ann. §1-11-780, passed into law five (5) years after the diabetes mandate statute. However, nothing in the language of the mental health parity statute expands it to any other subject matter. The court also cites to language in a 2007 autism coverage mandate which specifically included application to the State Health Plan. The terms legislative “history” implies looking backward, and using statements in statutes passed years after the statute at issue to discern the intent of the legislature in 1999 is inherently flawed.

Here, the text of the diabetes mandate statute and the definitions is incorporates by reference are clear—the diabetes mandate applies “every group health insurance policy or contract” as defined by sections 38-71-670(6) and 38-71-840(14). If the legislature’s intent is clearly apparent, the court should not search for intent outside of the statute.

F. THIS COURT SHOULD REVERSE AND MODIFY THE ALJ’S DECISION TO INCLUDE CLASS- BASED RELIEF, REFORMATION, DISGORGEMENT, AND INCLUDE AN AWARD OF ATTORNEYS FEES AND COSTS

The ALJ erred in failing to address the availability of class action relief in the ALC. (R. Vol. I, p. 12). The powers of the ALC allow for modification of the EIP’s decision to include class-based relief. S.C. Code Ann. § 1-23-380(A)(5) provides that the ALC has

the authority to modify a decision of the underlying agency if there has been a violation of state law. Further, ALCR, Rule 68 provides that the court may apply the South Carolina Rules of Civil Procedure and Appellate Court Rules should the ALCRP not address the question. SCRCP, Rule 23 provides for Class Action treatment in a case if the court finds (1) numerosity, (2) commonality of questions of law or fact; (3) typicality of the representative's claim to the class, (4) adequacy of the representative and counsel, and (5) where primary relief is injunctive or declaratory, the amount in controversy exceed one hundred dollars for each member of the class.<sup>3</sup>

Appellant made the issues of class certification and class-wide relief part of the appeal. (R., Vol. II, p. 452). However, the EIP completely failed to address or consider the arguments and grounds submitted to it as the appeal. Instead, the EIP addressed Mr. Allen's singular claim and made the erroneous legal conclusion it was not subject to the diabetes mandate.

As attached to the Notice of Appeal to the EIP, the Appellant submitted all necessary elements of class treatment to the EIP. (R. Vol. II, pp. 459-62). Paragraphs 7-16 of the Complaint alleged:

7. Plaintiff brings this action pursuant to SC Rule of Civil Procedure 23 as a representative of a class of persons who are currently, or since January 1, 2000 have been, employed by the State

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<sup>3</sup> It is important to note that Appellant has attempted to have these claims decided in the Court of Common Pleas- a court of general jurisdiction. The Respondent took the position that the case as filed in Common Pleas (which included a class action complaint) had to be dismissed based on this pending administrative proceeding -- or for failure to fully exhaust administrative remedies. The circuit court granted summary judgment to the Respondent on the failure to exhaust administrative remedies, by final Order dated November 29, 2010. The South Carolina Court of Appeals affirmed said Order on July 18, 2012. Appellant has filed a timely Petition for Writ of Certiorari in that matter.

of South Carolina and who are diabetics or have dependants with diabetes and who have enrolled in the Defendant EIP's standard health benefit plan, as administered by Defendant BCBSSC.

8. Upon information and belief, the proposed class consists of several thousand State of South Carolina current and former employees with diabetes or enrolled dependants with diabetes who have made insurance claims for outpatient self-management training and education for the treatment of people with diabetes, and who have not received the legally-mandated coverage for said services.

9. Upon information and belief in 2008, there were approximately 178,000 current State of South Carolina employees, including K-12 school district employees. According to the South Carolina Department of Health and Environmental Control 2009 published data, approximately 9.6% of the population of South Carolina is affected by diabetes. The exact number of class members is known to the Defendants and will be ascertained in discovery. That number is reasonably anticipated to exceed one thousand persons.

10. There are common questions of law and fact that are common to the Plaintiff and all other members of the proposed class and these questions predominate over issues, if any, that may affect individual class members. The illegal conduct of Defendants is common to all class members as are the claims asserted hereby. Among the issues of law and fact common to all class members are the following :

a. Does the described conduct of the Defendants' – the failure to provide and/or lawfully administer benefits for diabetes outpatient self-management training and education -- violate S.C. Code Section 38-71-46?

b. Are the class members entitled to have the terms of their health benefit plan (dating back to January 1, 2000) reformed to comply with the provisions of S. C. Code Section 38-71-46?

c. Are the class members entitled to a disgorgement of the revenues and other valuable consideration received by the Defendant EIP since January 1, 2000 from the failure to issue health benefit plan coverage for diabetes outpatient self-management training and education?

d. Are the class members entitled to a disgorgement of the revenues and other valuable consideration received by the

Defendant BCBSSC since January 1, 2000 from the failure to lawfully administer said benefit plan in accordance with S. C. Code Section 38-71-46?

e. Are the class members entitled to receive from the Defendants the value those benefits unlawfully issued and/or withheld since January 1, 2000?

f. Are the class members entitled to injunctive relief requiring the Defendants to comply with S.C. Code Section 38-71-46 in the future?

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

12. The interests of the Plaintiff are consistent with the interests of all other members of the putative class and he will represent adequately the interests of the class.

13. Counsel for the Plaintiff and the proposed class is by training and experience qualified to represent them within the context of this litigation.

14. Each member of the proposed class has been damaged in an amount in excess of one hundred (\$100.00) dollars as required by S.C.R.C.P. 23(a); however, as a declaration of rights and privileges of the litigants is sought, as well as injunctive relief, the one hundred (\$100.00) dollar requirement is not applicable, even though met.

15. Class action treatment of the matters and issues in this controversy is superior to the alternative of having thousands of state employees and retirees flooding the dockets of courts across South Carolina resulting from the unlawful actions of Defendants. Class adjudication will also provide the added benefit of permitting the adjudication of relatively narrow question of law – the application of S.C. Code Section 38-71-46 to the Defendants, and will permit the

adjudication of a large number of small claims against a state government and wealthy insurance Defendant against which litigation by individual plaintiffs most likely would not be possible.

16. While the claims and denial records of the Defendants are voluminous and the review and analysis of thousands of documents is anticipated, Plaintiff does not anticipate any difficulty in the overall management of this case.

Id. This court should reverse and remand this matter to require the EIP to disclose all claims made by any insureds from the effective date of section 38-71-46 to the present, identify those insureds and the amount of their claim, and order this case to proceed in the ALC as a class action.

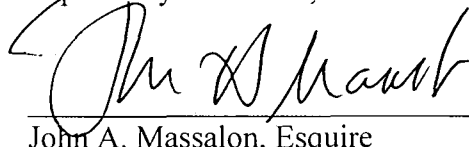
Review of case law related to the availability of class-based claims and relief within the Administrative Law Court illustrates that the issue has arisen only within the context of the South Carolina Revenue Procedures Act, S.C.Code Ann §§ 12-60-10 et seq., a statutory scheme which contains an express prohibition against class actions in claims challenging the imposition of taxes. See, e.g. Drummond v. South Carolina Department of Revenue, 378 S.C. 362, 662 S.E.2d 587 (2008); Ward v. State, 343 S.C. 14, 538 S.E.2d 245 (2000); S.C.Code Ann. § 12-60-80(C) (Supp.2010). No other statute or South Carolina court opinion has addressed class-wide claims related to the Employee Insurance Programs or its claims process. However, unlike the Revenue Procedure Act, there is no prohibition against class-wide relief in either the EIP claims process set forth in its Plan or in the enabling statutes.

#### CONCLUSION

Accordingly, based upon the foregoing, Appellant asks this Court to reverse the

findings and conclusions of ALJ, find that the diabetes mandate applies, as a matter of law, to the EIP, and that the EIP has been in violation of said statute since its effective date of January 1, 2000. This court should remand the case to order the EIP to disclose all claims made by any insureds from the effective date of section 38-71-46 to the present, identify those insureds and the amount of their claim, and order this case to proceed as a class action for a determination of legal and equitable remedies as permitted, including the award of attorneys fees and costs to class counsel.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "John A. Massalon", written over a horizontal line.

John A. Massalon, Esquire

ATTORNEYS FOR APPELLANT

January , 2013

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.  
.....

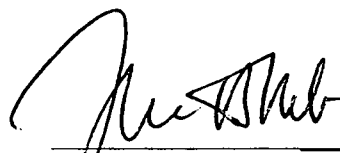
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**CERTIFICATE OF COUNSEL**

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The undersigned hereby certifies that the Appellant's Final Brief complies with Rule 211(b), SCACR.

January 15, 2013



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**PROOF OF SERVICE  
OF FINAL BRIEF**

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I certify that I have served the Final Brief by depositing a copy of it in the United States Mail, postage prepaid, on January 15, 2013, addressed to their attorneys of record, Theodore D. Willard, Jr., Montgomery Willard, LLC, P.O. Box 11886, Columbia, SC, 29211 and Steven Van Camp, South Carolina Public Employee Benefit Employee Insurance Program, State Budget & Control Board, 1201 Main Street, Suite 300, Columbia, SC 29201.



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