

IN THE STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)

IN THE COURT OF COMMON PLEAS
FOR THE 5TH JUDICIAL CIRCUIT
CASE NO: 2019-CP-40-00341

LISA BEATTIE as Personal
Representative for the ESTATE OF
BRANCH BEATTIE, Individually and as
the Representative of a Class of Similarly
Situated Persons,

Plaintiffs,

v.

BLUE CROSS BLUE SHIELD OF
SOUTH CAROLINA, and COMPANION
BENEFIT ALTERNATIVES, INC.,

Defendants.

**ORDER DENYING DEFENDANTS'
MOTION TO DISMISS AND MOTION
TO STRIKE**

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INTRODUCTION

This matter came before this Court on May 9, 2019 on Defendant Blue Cross Blue Shield of South Carolina (“BCBSSC”), and Defendant Companion Benefit Alternatives, Inc.’s (“CBA”) (herein “Defendants”) Motion to Dismiss and/or Motion to Strike. Counsel for Plaintiff and Defendants were present. Counsel provided memoranda and attachments to the Court in support of their respective arguments. After considering the pleadings, memoranda, other matters in the record, and the arguments of counsel at the hearing, the Court finds and concludes as follows:

For the reasons set forth below, Defendants’ Motion to Dismiss pursuant to SCRCP 12(b)(1) and 12(b)(6) is **DENIED**, and Defendants’ Motion to Strike pursuant to SCRCP 12(f) is **DENIED**.

STATEMENT OF FACTS

Plaintiff’s Decedent, Branch Ellis Beattie (“Branch”) died of a drug overdose on August 17, 2017 at the age of 23. (Complaint ¶ 78). In the months leading up to his death, Plaintiff

claims that Defendants continually denied health insurance coverage for inpatient and outpatient medical treatment for drug and alcohol abuse. (Complaint ¶ 51, 55, 59, 71, 76). Plaintiff alleges that Defendants' repeated failures and ultimate denial for outpatient treatment at MUSC lead to Branch's untimely death.

Plaintiff alleges that Branch was covered under the health plan of his mother, Plaintiff Lisa Beattie, called the MUSC Group Health Benefits Plan ("MUSC Health Plan"). (Complaint ¶ 15 – 17). The MUSC Health Plan was based on Plaintiff's employment with the Medical University of South Carolina ("MUSC"). In support of their motion and prior to the hearing on this matter, Defendants BCBSSC and CBA filed with the Court a copy of the Group Health Plan. (Ex. A to Def. MTD).

The Plan document is a comprehensive contractual agreement identifying the duties and responsibilities of the "plan sponsor" the "claims administrator," and "manager" of the mental health behavioral benefits facets of the plan. (See Ex. A to Def. MTD). Defendants' stated in its Motion to Dismiss that BCBSSC was the Third-Party Claims Processor for the MUSC Health Plan and CBA was the Behavioral Health Manager and a Utilization Review Agency for the MUSC Health Plan. (See Def. MTD). Defendants argue that neither Defendants were insurers of the MUSC Health Plan and Plaintiff, as such, does not have privity with either Defendant. Defendant next states that this Court lacks subject matter jurisdiction because Plaintiff failed to exhaust her administrative remedies in a timely manner prior to commencing her lawsuit, but after her son, Branch, died. Finally, Defendants take issue with the class certification based on Rule 23(a), SCRCP.

LAW/ANALYSIS

Defendants' Motion to Dismiss is denied as (I) the "exclusive remedies" outlined in § 1-11-710(C) and the terms of the MUSC Health Plan do not apply to the case at hand as Plaintiff is not claiming health insurance benefits from the MUSC Health Plan, Plaintiff did begin the appeals process as outlined in the plan, and any additional appeals would be moot; (II) Defendants were parties and insurers of the MUSC Health Plan; and (III) Plaintiff's Class Action allegations meet the requirements of SCRCP 23(a).

I. Administrative Remedies and Jurisdiction do not apply.

"Subject matter jurisdiction is the power to hear and determine cases of the general class to which the proceedings in question belong." *Dove v. Gold Kist, Inc.*, 314 S.C. 235, 237-38, 442 S.E.2d 598, 600 (1994) (internal quotations omitted). The question of subject matter jurisdiction is a question of law for the court. *Capital City Ins. Co. v. BP Staff, Inc.*, 382 S.C. 92, 99, 674 S.E.2d 524, 528 (Ct. App. 2009).

Defendants contend the Administrative Law Court has exclusive jurisdiction over appeals from decisions of the MUSC Health Plan pursuant to S.C. Code Ann. § 1-23-600 (D) and the language of the MUSC Health Plan. Defendants assert in their Motion to Dismiss, "[b]ecause Plaintiff is claiming health insurance benefits from the MUSC Health Plan . . . Plaintiff is limited to the exclusive administrative remedies set forth § 1-11-710(C) and the terms of the MUSC Health Plan." [Def. MTD at 7].

Plaintiff has not claimed she is entitled to those back dated health insurance benefits from the MUSC Health Plan. Plaintiff is claiming bad faith refusal to pay health insurance benefits under the MUSC Health Plan. These are two separate claims.

Plaintiff is properly within the subject matter jurisdiction of this Court as there are simply no administrative remedies left to exhaust since Branch is dead.

The MUSC Health Plan ¶ 12.10 (A)(4) states:

Request for Reconsideration Deadline. The Request for Reconsideration of an adverse benefit decision must be filed within 180 days following the Covered Person's receipt of the notification of adverse benefit decision, except that the appeal of a decision by the Third Party Claims Processor or Utilization Review Agency to reduce or terminate an initially approved course of treatment (see the definition of Concurrent Care decision) must be filed within 30 days of the Covered Person's receipt of the notification of the decision of the Third Party Claims Processor or Utilization Review Agency to reduce or terminate. Failure to comply with this deadline will cause the Covered Person to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

In fact, Plaintiff alleges she has not failed to exhaust her administrative remedies under the MUSC Health Plan in a timely manner pursuant to S.C. Code Ann. § 1-11-710(C), § 1-23-380 and the language of the MUSC Health Plan. [Def. MTD at 8-10]. Plaintiff alleges she received notice of an adverse benefit decision as it related to CDAP on July 6, 2017. (Complaint ¶ 76). Plaintiff alleges that the very same day, Branch's doctor from MUSC, Dr. Gregory Cain, faxed a request to CBA Appeals requesting that his care be approved because of his "remarkable medical history regarding substance abuse." Plaintiff alleges she received additional denials after Branch's death. Plaintiff alleges she followed the appropriate appeals process *while her son was still living*, but coverage was continually denied until – and even after – her son's death. Essentially, Defendants are saying that despite the fact that Branch died in August 2017, Plaintiff was expected to continue to follow their prescribed appeals process in order to get approval for alcohol and drug treatment for a dead person. The Court does not find that argument convincing.

Once again, Defendants state that Plaintiff should have acted as though her son had not died, followed their appeals process, and either have (1) coverage denied again or (2) have

coverage granted that was no longer needed. This Court is not swayed by those arguments as Defendants' remedies that require the Administrative Law Court are procedures to seek benefits.

Our Courts ordinarily will refuse to review a decision of an administrative body where the application for review shows that the question presented is abstract or moot, or where it has become moot under the circumstances of the case. 73A C.J.S. Public Administrative Law and Procedure § 207, at 247 (1983); *Food Mart v. S.C. Dep't of Health & Envtl. Control*, 318 S.C. 384, 387, 458 S.E.2d 47, 48–49 (Ct. App. 1995), *aff'd in part, vacated in part*, 322 S.C. 232, 471 S.E.2d 688 (1996).

An insured has a valid tort claim where he “can demonstrate bad faith or unreasonable action by the insurer in processing a claim under their mutually binding insurance contract....” *Id.* at 619. *Estate of Anderson by Brown v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA.*, No. CV 3:17-00032-MGL, 2018 WL 1428497, at *4 (D.S.C. Mar. 22, 2018).

The elements of an action for bad faith refusal to pay benefits under an insurance contract include: “(1) the existence of a mutually binding contract of insurance between the plaintiff and the defendant; (2) refusal by the insurer to pay benefits due under the contract; (3) resulting from the insurer's bad faith or unreasonable action in breach of an implied covenant of good faith and fair dealing arising on the contract; (4) causing damage to the insured.” *Crossley v. State Farm Mut. Auto. Ins. Co.*, 307 S.C. 354, 359–60, 415 S.E.2d 393, 396–97 (1992). “An insured may recover damages for a bad faith denial of coverage if he or she proves **there was no reasonable basis to support the insurer's decision to deny benefits under a mutually binding insurance contract.**” *Dowling v. Home Buyers Warranty Corp.*, 303 S.C. 295, 297, 400 S.E.2d 143, 144 (1991) (emphasis added) (citing *Varnadore v. Nationwide Mut. Ins. Co.*, 289 S.C. 155, 345 S.E.2d 711 (1986); *Nichols v. State Farm Mut. Auto. Ins. Co.*, 279 S.C. 336, 306 S.E.2d 616

(1983)); See also, *Cock-N-Bull Steak House, Inc. v. Generali Ins. Co.*, 321 S.C. 1, 6, 466 S.E.2d 727, 730 (1996).

In the present case, Plaintiff alleges that there was a mutually binding contract under which the insurer refused to pay benefits and those benefits proximately effected Decedent's quality of care. This is shown throughout Plaintiff's Complaint.

For the reasons stated above, this matter is properly within the jurisdiction of this Court.

II. Defendants are Parties to and Insurers of the MUSC Health Plan.

Defendants contend that they cannot be liable for breach of contract because they are not parties to a contract with Plaintiff. Def. MTD at 11-12. Defendants further allege they cannot be liable for bad faith failure to pay insurance benefits as a matter of law because they are not the insurer of the MUSC Health Plan. See, generally, Def. MTD.

"Under Rule 12(b)(6), SCRCPP, a defendant may make a motion to dismiss based on a failure to state facts sufficient to constitute a cause of action." *Baird v. Charleston Cty.*, 333 S.C. 519, 527, 511 S.E.2d 69, 73 (S.C. 1999). "A ruling on a motion to dismiss pursuant to Rule 12(b)(6) must be based solely on the factual allegations set forth in the complaint, and the court must consider **all well-pled allegations as true.**" *Fabian v. Lindsay*, 410 S.C. 475, 481, 765 S.E.2d 132, 136 (S.C. 2014) (citing *Disabato v. S.C. Ass'n of Sch. Adm'rs*, 404 S.C. 433, 441, 746 S.E.2d 329, 333 (S.C. 2013)). (emphasis added). "If the facts alleged and inferences reasonably deducible therefrom, **viewed in the light most favorable to the plaintiff, would entitle the plaintiff to relief on any theory, dismissal under Rule 12(b)(6) is improper.**" *Id.* (citing *Carnival Corp. v. Historic Ansonborough Neighborhood Ass'n*, 407 S.C. 67, 74-75, 753 S.E.2d 846, 850 (S.C. 2014).) (emphasis added).

Plaintiff alleges that Defendants took on numerous duties and responsibilities enumerated within the four corners of the MUSC Health Plan and commensurate duties of good faith and fair dealing arose with regard to these duties and responsibilities. Under the terms of the MUSC Health Plan, BCBSSC was the Third-Party Claims Processor (Complaint ¶ 15; Plan ¶ 2.90) and CBA was the Behavioral Health Manager and a Utilization Review Agency. (Complaint ¶ 15; Plan ¶¶ 2.12, 2.92).

As the standard, when this Court takes the facts pled as true, the decision making with regards to payment of health insurance benefits under the plan was vested solely with Defendants. *E.g., Deyerberg v. Holder*, 2010 WL 2131834 (D. D.C.). (The principle that a court may disregard patently implausible factual claims is distinct from the principle that a complaint will be inadequate if, accepting well-pleaded factual allegations as true, it fails to give rise to a plausible inference of liability.)

Generally, the duty of good faith and fair dealing under a contract of insurance does not extend to persons who are not parties to the contract. *Carolina Bank and Trust Co., v. St. Paul Fire and Marine Co.*, 279 S.C. 576, 310 S.C. 2d 163 (1983). This case law has been used in various contexts to hold that independent adjusters are not subject to bad faith claims because they are not parties to the contract from which such duties arise. See, e.g., *Charleston Dry Cleaners & Laundry, Inc. v. Zurich Am. Ins. Co.*, 355 S.C. 614, 586 S.E.2d 586 (2003).

South Carolina courts, however, have recognized that *Carolina Bank and Trust Co.* and its progeny are not blanket absolution to all non-insurer bad faith claims. For example, courts have declined to apply the ruling of *Carolina Bank and Trust Co.* to in-house adjusters. See, e.g., *Price v. Allstate Ins. Co.*, 2015 WL 4389335 (D.S.C. 7/15/15).

Here (1) Plaintiff sufficiently alleges claims of bad faith against Defendants (Complaint ¶ 79 – 84); (2) Plaintiff alleges that Branch Beattie was covered under the Plan (Complaint ¶ 17); (3) Plaintiff alleges the insurance contract outlines specific duties for BSBSSC and CBA such as administering and managing the MUSC Health Plan, managing behavioral health services, including pre-certifying Mental Health and Substance Abuse Disorder Benefits for inpatient and outpatient services (see, generally Complaint); (4) Plaintiff alleges that Defendants breached duties of good faith and fair dealing and acted unreasonably and in bad faith and in reckless disregard for the rights, safety, and well-being of Branch (Complaint ¶ 79 – 84); Plaintiff alleges Defendants made adverse benefits decisions such as denying Branch’s outpatient treatment that was medically prescribed (Id.).

Therefore, Defendants’ Motion to Dismiss is denied as Plaintiff has pled sufficient facts to constitute causes of action for bad faith refusal to pay insurance benefits, wrongful death and breach of contract.

III. Class Action Requirements Have Been Met.

Defendants contend that Plaintiff’s class action allegations should be dismissed or stricken because they do not meet the requirements of SCRCP 23(a).

If looking at the face of the Complaint, the facts alleged and inferences reasonably deducible therefrom would entitle the Plaintiff to any relief on any theory of the case, a defendant’s motion to be dismissed should be denied. *Plyler v. Burns*, 373 S.C. 637, 645, 647 S.E.2d 188, 192 (2007). On the face of the Complaint, Plaintiff alleged sufficient facts to support each requirement of SCRCP 23(a).

Defendants' Motion to Strike must be denied based on the current available facts. The parties have not engaged in discovery, including class certification discovery. Absent at least some discovery to clarify this discrepancy, this Court cannot find in Defendants' favor.

Accordingly, it is hereby

ORDERED, ADJUDGED and DECREED that Plaintiff's claims are properly before this Court.

IT IS FURTHER ORDERED, ADJUDGED and DECREED that Defendants' Motion to Dismiss is **DENIED**.

IT IS FURTHER ORDERED, ADJUDGED and DECREED that Defendants' Motion to Strike is **DENIED**.

AND IT IS SO ORDERED!

The Honorable Roger Couch
Circuit Court Judge

February _____, 2020.
Richland County, South Carolina



Richland Common Pleas

Case Caption: Lisa Beattie , plaintiff, et al vs Blue Cross Blue Shield Of South Carolina , defendant, et al
Case Number: 2019CP4000341
Type: Order/Dismissal

IT IS SO ORDERED

s/ Roger L. Couch