

STATE OF NORTH CAROLINA
DURHAM COUNTY

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
05 CVS 5606

MACY M. HAMM, Individually and on)
behalf of All Others Similarly Situated,)
)
Plaintiff,)
)
v.)
)
BLUE CROSS AND BLUE SHIELD)
OF NORTH CAROLINA)
FOUNDATION and BLUE CROSS)
AND BLUE SHIELD OF NORTH)
CAROLINA,)
)
Defendants.)

**PLAINTIFF’S MEMORANDUM IN
SUPPORT OF MOTION FOR CLASS
CERTIFICATION**

Plaintiff, Macy M. Hamm, individually and on behalf of all others similarly situated, by and through the undersigned counsel, hereby submits the following Memorandum in Support of Motion for Class Certification.

I. INTRODUCTION

Blue Cross and Blue Shield of North Carolina’s Blue Advantage PPO contract made a promise to Macy Hamm -- if she and her family used “in-network” providers with whom BCBSNC had negotiated a reduced rate called the “allowed amount”, she would never be responsible for paying more than the allowed amount. So long as BCBSNC was paying for the services, Ms. Hamm’s expenses for medical services provided to her disabled son by BCBSNC’s in-network providers were based on the allowed amount. Once Ms. Hamm’s son reached his annual maximum in paid benefits for a service under the BCBSNC policy and Ms. Hamm was responsible for paying the in-network providers, BCBSNC allowed them to charge Ms. Hamm their full provider charge instead of the allowed amount. Whether the in-network provider’s

charge was reduced to the allowed amount depended upon whether BCBSNC or Ms. Hamm was paying the bill. Ms. Hamm has sued BCBSNC on behalf of herself and other insureds who have had the same experience to enforce their rights under their policies of insurance to only be charged the allowed amount by the in-network providers.

II. FACTS

Ms. Hamm's son, Alexandre, has cerebral palsy and is covered as a dependent under Ms. Hamm's preferred provider organization (PPO) health benefit plan, Blue Advantage, offered by Defendant Blue Cross Blue Shield of North Carolina ["BCBSNC"]¹. As a PPO, Defendant BCBSNC has a network of medical providers under contract who have agreed to accept a contracted rate from BCBSNC called the *allowed amount* for medical services covered under the PPO plan and provided to the PPO *members* such as Ms. Hamm and her son in order to contain its costs.² Ms. Hamm and other BCBSNC PPO *members* are offered financial incentives by BCBSNC to use the *in-network providers*, including differentials in deductibles, coinsurance and copayments, as well as through an unequivocal promise that if the *member* uses an *in-network provider* then they are not responsible for any charge over the *allowed amount*.

Defendant's PPO contracts contain *benefit period* maximums and *lifetime maximums* for certain services, which are the dollar amounts that a *member* can receive in paid benefits for those services either during the *benefit period* or their lifetime. Once a *member* reaches their *benefit period* maximum or *lifetime maximum*, the *member* rather than BCBSNC has to pay the provider. Per the terms of the PPO contract, the amount owed by the *member* after reaching a maximum is determined by whether the *member* received the services from an *in-network*

¹ Based upon the Defendants' responses to discovery and the submission to Plaintiff of an affidavit prepared by the President of Blue Cross and Blue Shield of North Carolina Foundation, the parties have tentatively agreed to dismiss the Defendant Blue and Blue Shield of North Carolina Foundation upon approval by the Court.

² Use of italics corresponds with the use of Italics by BCBSNC in the Benefits Booklet for each of its PPO plans, including Blue Advantage, Blue Advantage Plan A, Blue Advantage Plan B, and Blue Options.

provider or *out-of-network provider*. Under the plain language of the contract, if the *member* received *covered services* from an *in-network provider*, they are only responsible for the *allowed amount*. Conversely, if the *member* received services from an *out-of-network provider*, the *member* is responsible for that portion of the charge over the *allowed amount* in addition to the *allowed amount*, or, simply put, the full provider charge. Nothing in the Defendant's PPO contracts states that the *member* can be required to pay an *in-network provider* more than the *allowed amount* for *covered services* once the *member* exceeds a *benefit period* maximum or *lifetime maximum*.

Ms. Hamm's son reached and exceeded his *benefit period* maximum for certain therapies that were *covered services* provided by *in-network providers*. Despite the plain language of her contract with BCBSNC that stated that she would never be charged more than the *allowed amount* for *covered services* provided by an *in-network provider*, she was charged the full provider charge for Alexandre's therapies after he reached his *benefit period* maximum. To recover for her losses, and those of others similarly situated, she has brought this class action alleging breach of contract, breach of good faith and fair dealing and commission of an unfair trade practice.

The primary issue raised by this case is one of contract interpretation: When a *member* reaches their *benefit period* maximum, under the insurance contract as written by BCBSNC, are they responsible for paying the *in-network provider* the *allowed amount* – the amount that BCBSNC would pay had it been responsible for payment - or a higher amount that the provider charges. Plaintiff will establish that, as a matter of law, under the terms of her contract of insurance she and other *members* are not responsible for any charge above the *allowed amount* for *covered services* received from an *in-network provider*.

A. The Defendant – Blue Cross and Blue Shield of North Carolina

Blue Cross and Blue Shield of North Carolina is a non-profit medical services corporation organized under Chapter 58 of the North Carolina General Statutes. (See Defendants' Answer, attached hereto as Exhibit "B"). Presently, BCBSNC is North Carolina's largest health insurer, having approximately 3.3 million members or roughly one-third of North Carolina's population. (See BCBSNC 2005 Annual Report, attached hereto as Exhibit "C"). The BCBSNC network of medical providers covers the entire state of North Carolina with providers in each of the 100 counties. (*Id.*). Blue Cross and Blue Shield of North Carolina processes more than 117,000 claims per day on behalf of its *members*. (*Id.*).

From 2002 through the present, Blue Cross and Blue Shield of North Carolina has offered four PPO plans: Blue Advantage, Blue Advantage Plan A, Blue Advantage Plan B, and Blue Options. (Defendants' Responses to Plaintiff's First Set of Interrogatories, No. 2, Attached hereto as Exhibit "D"). Defendant's PPO plans are governed by N.C.G.S. § 58-50-56, which provides the statutory authority for BCBSNC to enter into the preferred provider contracts and other cost-containment arrangements with health care providers and, consequently, offer a preferred provider benefit plan whereby enrollees are offered incentives to use the contracted or "preferred" providers.

As of 2004, BSBSNC had 678,606 *members* in its PPO plans, capturing 75.7% of the PPO enrollees within North Carolina. (See, Managed Care in North Carolina, Annual Report and Analysis of 2004 Activity, N.C. Dept. of Insurance, May 2005, attached hereto as Exhibit "E"). As of November 2004, BCBSNC had over 265,000 members of Blue Advantage, the individual PPO plan in which Ms. Hamm was enrolled. (See Letter to Macy Hamm from BCBSNC dated November 5, 2004 attached hereto as Exhibit "O"). Furthermore, in responses

to discovery, BCBSNC identified 201 BCBSNC group PPO plans that claimed exemption from ERISA, including several plans for city and county governments throughout North Carolina. (See Defendant's Responses to Plaintiff's Third Set of Interrogatories attached hereto as Exhibit "L"; see also BCBS005250-5253, attached hereto as Exhibit "M").

1. The PPO Plans and Their Terms

Blue Cross and Blue Shield of North Carolina defines a PPO plan as "[a] health plan that contracts with various physicians and hospitals. Enrollees are offered a financial incentive to use providers on a preferred list, but may use non-network providers as well." (Defendants' Responses to Plaintiff's First Set of Interrogatories, No. 2, Attached hereto as Exhibit "D"). An enrollee, or *member*, of a BCBSNC PPO plan receives a Benefit Booklet that, along with the Summary of Benefits, application and any optional benefit endorsement, becomes the legal contract between the member and BCBSNC. (Blue Advantage Benefit Booklet 2005, Attached hereto as Exhibit "F"). The use of italics within the Benefit Booklet for a particular word indicates that the word is a defined term and will appear in the "Definitions" section of the booklet. (*Id.* at page 1).

The BCBSNC benefit booklets are standardized and their contractual language is identical and uniform in all material respects from plan to plan and from year to year during the class period.³ The benefit booklets are divided into several sections, including sections entitled

³ Blue Cross and Blue Shield of North Carolina has identified the following benefit booklets for the relevant class period: Blue Advantage (A and B) July 2001 Booklet, BCBS3323-92 (Attached hereto as Exhibit "G-1"); Blue Advantage (A and B) June 2002, BCBS 3261-322 (Attached hereto as Exhibit "G-2"); Blue Advantage (A and B) June 2004, BCBS 2926-3007, BCBS 3009-90, and BCBS 3093-3148 (Attached hereto as Exhibits "G-3", "G-4" and "G-5" respectively); Blue Advantage (A and B) August 2004, BCBS 3149-204 (Attached hereto as Exhibit "G-6"); Blue Advantage (A and B) July 2005, BCBS 3205-60 (Attached hereto as Exhibit "G-7"); f. Blue Options November 2001, BCBS 3383-477 (Attached hereto as "G-8"); Blue Options May 2002, BCBS 3478-565 (Attached hereto as "G-9"); Blue Options May 2003, BCBS 3656-729 (Attached hereto as "G-10"); Blue Options January 2005, BCBS 3566-655 and BCBS 3730-97 (Attached hereto as Exhibits "G-11" and "G-12" respectively); Blue Options September 2005, BCBS 3798-866 (Attached hereto as Exhibit "G-13")(See Response to Plaintiffs' Requests for

“Understanding Your Share of the Cost,” “What is Not Covered” and “*Provider Reimbursement*.” (See Exhibits G1-G10). At the end of the booklets there is a “Definitions” section that sets forth the definitions of the various italicized terms used in the contract. (*Id.*).

“Allowed amount” is defined as follows:

Allowed Amount – the charge that *BCBSNC* determines is reasonable for *covered services* provided to a *member*. This may be established in accordance with an agreement between the *provider* and *BCBSNC*. In the case of *providers* that have not entered into an agreement with *BCBSNC*, the allowed amount will be the lesser of the *provider’s* actual charge or a reasonable charge established by *BCBSNC* using a methodology which is applied to comparable *providers* for similar services under a similar health benefit plan. *BCBSNC’s* methodology is based upon several factors including *BCBSNC’s* medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the *provider* may be combined into one procedure for reimbursement purposes.

(See Exhibit G-2, BCBS3315; see also Response to Requests for Admissions and Interrogatories Served Upon Defendant Blue Cross and Blue Shield of North Carolina attached as Exhibit “H”, response to request for admission no. 1).

The section entitled “Understanding Your Share of the Cost” explains to the *member* the costs for which the *member* will be responsible. Within this section for its Blue Advantage plans, BCBSNC states, “If you receive *covered services* from an *in-network provider*, then you **are not responsible** for any charge over the *allowed amount*.” (Exhibit H, response to request for admission no. 5). For its Blue Options plans, BCBSNC states, “If you receive *covered services* from an *in-network provider*, you **are not responsible** for any charge over the *allowed amount*.” (*Id.*). Nowhere in the in any benefits booklet is there any statement qualifying those promises. Nowhere does any benefit booklet say that once you reach a *benefit period maximum*,

Admission and Interrogatories Served Upon Defendant Blue Cross Blue Shield of North Carolina, attached hereto as Exhibit “H”).

you will have to pay more than the *allowed amount* for *covered services* received from an *in-network provider*.

With respect to provider reimbursements, BCBSNC states as follows:

In-network providers – benefits are based on the lesser of the *allowed amount* or the *provider's* charge. *In-network providers* agree to limit charges for *covered services* to the *allowed amount*. However, *members* are responsible for any *deductibles, copayments, coinsurance* and charges not covered by Blue Advantage, such as amounts above benefit maximums. *Members* are responsible for the full cost of noncovered services.

(See Exhibit G-2, BCBS3306; see also Exhibit G-8, BCBS 3454-3455; see also Exhibit H, pp. 14-16). Finally, the *benefit period* maximum is generally defined as “the dollar amount that each covered *member* can receive in paid benefits from *BCBSNC* for certain services.” (See Exhibit G-2, BCBS3274).

The benefit booklets for the Blue Advantage and Blue Options plans for the proposed class period from 2002 through the present uniformly state that if a *member* receives *covered services* from an *in-network provider* they will never be responsible for charges above and beyond the *allowed amount*; thus, the plans pose the same issue of liability – whether a member can be charged amounts over the *allowed amount* by *in-network providers* for *covered services* after reaching an annual or lifetime maximum.

B. The Plaintiff

Plaintiff Macy M. Hamm is a citizen and resident of Wake County, North Carolina. Ms. Hamm is married to Olivier Arraou, who is a citizen of France and a resident of Wake County, North Carolina. Ms. Hamm holds both undergraduate and law degrees. Plaintiff and her husband are self-employed, owning and operating a company that raises funds for a private equity fund of funds and another company that operates drug treatment clinics. Plaintiff has

been a member of Blue Advantage since 2002. Plaintiff's policy is not part of an employee benefit plan.

On June 12, 2003, Plaintiff gave birth to a son, Alexandre, at Rex Hospital in Raleigh, North Carolina. Consequently, Alexandre, as Ms. Hamm's dependent, became a member of Blue Advantage as well. Alexandre was diagnosed with cerebral palsy and has had to undergo extensive treatment and therapies. Because of Alexandre's cerebral palsy, he exceeded his *benefit period* maximum for certain therapies.

Upon exceeding the *benefit period* maximum for Alexandre's therapies during any given *benefit period*, Ms. Hamm received an Explanation of Benefits from BCBSNC wherein it stated that she was responsible for paying the full provider charge for the therapies instead of the *allowed amount* that BCBSNC had negotiated. (See, for example, Explanation of Benefits for Macy M. Hamm and Alexandre, Attached hereto as Exhibits "I", "J" and "K").

a. The Proposed Class

Plaintiff seeks certification of the following class:

- a. Individuals who were ever a member of one of Defendant's PPO plans between November 2002 and the present; and
- b. Whose PPO plan was not an ERISA plan; and
- c. Who in any benefit period reached their *benefit period* maximum or who reached their *lifetime maximum* as those phrases are defined under the terms of their PPO contract; and
- d. Who were charged by *in-network* providers more than the allowed amount for covered services or supplies after they reached their *benefit period* maximum or *lifetime maximum*.

Plaintiff anticipates that the class will number in the thousands of individuals. In response to discovery requests, BCBSNC has listed 201 group PPO plans that self-identify as being ERISA-exempt, many of which are groups for county and municipal governments in North Carolina. (See Exhibits “L” and “M” attached hereto). Furthermore, there were over 265,000 members of Blue Advantage, the individual PPO plan, the majority of whom are most likely ERISA-exempt. (See Exhibit “O”). Plaintiff has requested the identification of class members through interrogatories and anticipates supplementing her Motion once she receives adequate responses from BCBSNC.

Specifically, with respect to ERISA-exempt Blue Options PPO plans, the exemptions to ERISA are clearly delineated under 29 U.S.C.S. § 1003(b) and include governmental plans along with church plans. Given that BCBSNC captures 75% of the PPO market in North Carolina, and that there are 201 groups who identify as being ERISA-exempt, including several county and municipal governments along with church plans, Plaintiff anticipates that a substantial portion of the Blue Options *members* will be enrolled in ERISA-exempt plans. Even the most conservative scenario of only one person per ERISA-exempt group plan falling within the class definition would mitigate in favor of class treatment, especially when combined with the members of the individual PPO plan who meet the class definition. If only 1% of the Blue Advantage members fell within the class definition, that number would be in excess of 2,600 individuals.

b. Plaintiff’s Claims

Plaintiff has asserted the following claims in her Complaint: breach of contract; breach of good faith; unfair and deceptive trade practices; and a claim for declaratory judgment. (See Plaintiff’s Complaint, Attached hereto as Exhibit “A”). The questions of law and of fact that are common to the proposed class include but are not limited to the following:

a. Whether Defendant's insurance contracts with the class members promise that class members will not be responsible for payment of any charge over the *allowed amount* negotiated between Defendant and its *in-network providers* when *members* receive medical services from *in-network providers* and have reached the *benefit period* maximum or *lifetime maximum* under their contracts of insurance;

b. Whether Defendant breached promises in its insurance contracts with the proposed class members when Defendant's *in-network providers* charged class members more than the *allowed amount* for medical services;

c. Whether Defendant breached the duty of good faith it owed to the proposed class members if it negotiated contracts with *in-network providers* that allowed the *providers* to charge class members the full provider charge rather than the *allowed amount* once the class members reached their *benefit period* maximum or *lifetime maximum*;

d. Whether Defendant's statements in its Benefits Booklet and in promotional materials for PPO plans that plan members would not be charged more than the *allowed amount* for services provided by an *in-network provider* constituted an unfair and deceptive trade practice if Defendant allowed its *in-network providers* to charge class members more than the *allowed amount* for covered

services after the member reached the *benefit period* or *lifetime* maximum.

III. ARGUMENT

A. Introduction

The Court's interpretation of a standardized contract of insurance is the central issue in this case. Class certification is essential to this case because of the need for efficient and uniform interpretation among the class of insureds. Our Supreme Court has stated that "[c]lass actions should be permitted where they are likely to serve useful purposes such as preventing a multiplicity of suits or inconsistent results." *Crow v. Citicorp Acceptance Co.*, 319 N.C. 274, 284, 354 S.E.2d 459, 464 (1987). This Court will decide the key liability question in this case by answering one question: Do the BCBSNC contracts promise *members* they will not be charged more than the *allowed amount* for *covered services* from *in-network providers* even after reaching their *benefit period* maximums or *lifetime maximums*? In answering that question for the class of plaintiffs, this Court can prevent the outcomes feared by the North Carolina Supreme Court - multiple suits and inconsistent results. Though plaintiff presents claims of unfair trade practice and bad faith, those claims are contingent upon the Court's initial determination of the uniform contract issue.

A "class" exists where "each of the members has an interest in either the same issue of law or of fact, and that issue predominates over issues affecting only individual members." *Id.* at 277, 354 S.E.2d at 462. Where a class exists, the party seeking to utilize the class action procedure under Rule 23 has the burden of providing that the prerequisites to class certification have been satisfied:

- the named party must establish that she will fairly and adequately represent the interests of all members of the class;

- there is no conflict of interest between the named representative and the other members of the class who are not named as parties;
- the named party has a genuine personal interest in the action;
- the named party must adequately represent those outside the jurisdiction;
- the class members are so numerous that it is impractical to bring them all before the court; and
- adequate notice must be given to members of the class.

Id. at 282-83, 354 S.E.2d at 465-66. Once these prerequisites are established, it is within the trial court's discretion to determine whether a class action is the superior method to adjudicate the controversy. *Id.* at 284, 354 S.E.2d at 466. In doing so, Rule 23, which authorizes class actions, should be liberally construed and "should not be loaded down with arbitrary and technical restrictions." *English v. Holden Beach Realty Corp.*, 41 N.C.App. 1, 9, 254 S.E.2d 223, 230, *disc. rev. denied*, 297 N.C. 609, 257 S.E.2d 217 (1979).

B. Plaintiff Has Properly Alleged the Existence of a Class

An initial question for the Court in considering class certification will be whether Plaintiff has properly alleged the existence of a class. *See, generally, Crow v. Citicorp Acceptance Co.*, 319 N.C. at 280, 354 S.E.2d at 464. In answering this question, a key subsidiary question is whether it is alleged that each members of Plaintiff's proposed class has a common interest in the same issues of law arising from the same issues of law and fact. Here, Plaintiff alleges that each *member* has a common interest in these issues: (1) whether Defendant BCBSNC breached the contract of insurance with the *members* of its PPO plans by allowing the *members* to be charged an amount in excess of the *allowed amount by in-network providers* once the members reached their *benefit period* maximums or *lifetime maximums*; (2) whether this breach, in turn, constituted an unfair trade practice in light of BCBSNC's promotional and marketing materials; and (3) whether BCBSNC breached its duty of good faith and fair dealing owed to its *members* by allowing the *in-network providers* to charge amounts in excess of the

allowed amount to BCBSNC members once they reached benefit period maximums or lifetime maximums. These common issues of law and of fact define the basis of BCBSNC's liability to the class and, as such, they predominate over any issues that affect only individual members, such as the calculation of damages. For this reason, Plaintiff has properly alleged the existence of a class under North Carolina law.

1. Plaintiff's Claims Require the Interpretation of A Standardized Contract of Insurance and are Particularly Appropriate for Treatment as a Class Action

Courts have consistently held that breaches of standardized written contracts are appropriate for treatment as a class action since the uniformity of the standard contracts readily creates common issues of fact and of law that determine liability for the class. *See, Kleiner v. The First National Bank of Atlanta*, 97 F.R.D. 683 (N.D.Ga. 1983), *aff'd in part and rev'd in part*, 751 F.2d 1193 (11th Cir. 1985); *see also Haroco, Inc. v. American National Bank and Trust Company of Chicago*, 121 F.R.D. 664 (N.D.Ill. 1988); *Collins v. Int'l Dairy Queen, Inc.*, 168 F.R.D. 668 (N.D.Ga. 1996); *Baughman v. State Farm Mutual Auto Ins. Co.*, 727 N.E.2d 1265 (Ohio 2000); *Janicik v. Prudential Insurance Co. of America*, 451 A.2d. 451 (Pa. Super. 1982). "When viewed in light of Rule 23, claims arising from interpretations of a form contract appear to present the classic case for treatments as a class action, and breach of contract cases are routinely certified as such." *Kleiner v. The First National Bank of Atlanta*, 97 F.R.D. at 690 (*citations omitted*). Standardized form contracts are most often contracts of adhesion, binding multitudes of individuals to uniform language. Moreover, as a matter of public policy, especially when dealing with insurance contracts, standardized contracts should be interpreted by the courts uniformly. *See, generally, Crow v. Citicorp*, 319 N.C. at 284, 354 S.E.2d at 466; *see also, RESTATEMENT (SECOND) OF CONTRACTS § 211*. Treatment as a class action allows the court to

effect a uniform construction of a standardized form contract and avoid a multiplicity of suits and, consequently, the possibility of inconsistent interpretations.

With respect to the class, BCBSNC's uniform construction of its PPO contracts that *members* are not contractually entitled to the lower negotiated *allowed amounts* once they reach their benefit maximums and are responsible for payment creates a common nucleus of operative facts that determines liability for the class. This common nucleus of facts satisfies the commonality and predominance requirements for the definition of a "class." *See, generally, Patrykus v. Gomilla*, 121 F.R.D. 357, 361 (N.D. Ill. 1988). This Court's decision on whether BCBSNC's construction or Plaintiff's construction of the PPO contract is correct will be the determinative liability decision for the proposed class.

2. The Common Issue of Whether BCBSNC's *In-Network Providers* May Charge *Members* of BCBSNC's PPO Plans Amounts in Excess of the *Allowed Amount* Predominates Over the Individual Issues.

The common issue of whether BCBSNC's PPO contracts allow *in-network providers* to charge BCBSNC PPO *members* amounts in excess of the *allowed amount* for medical services is the predominate issue in this case. All other issues, including those related to damages, are collateral and are insufficient to preclude class certification. *See, generally, Pitts v. American Insurance Company et al.*, 144 N.C. App. 1, 550 S.E.2d 179 (2001), *aff'd without precedential value*, 356 N.C. 292, 569 S.E.2d 647 (2002), *citing, Faulkenbury v. Teachers' and State Employees' Ret. Sys.*, 345 N.C. 683, 483 S.E.2d 422 (1997). "Common issues of fact and law predominate if they 'have a direct impact on every class member's effort to establish liability and on every class member's entitlement to injunctive and monetary relief.'" *Klay v. Humana, Inc.*, 382 F.3d 1241, 1255 (11th Cir. 2004), *quoting, Ingram v. Coca-Cola Co.*, 200 F.R.D. 685, 699 (N.D. Ga. 2001). "Whether an issue predominates can only be determined after considering

what value the resolution of the class-wide issue will have in each class member's underlying cause of action.” *Id.*, quoting, *Rustein v. Avis Rent-A-Car Sys.*, 211 F.3d 1228, 1234 (11th Cir. 2000). The interpretation of the PPO agreement is the essential determinant of BCBSNC's liability to each class member and, thus, each class member's underlying cause of action.

**a. Individual Damages Assessments Are Collateral to the
Predominant Issue of Liability: Whether Members
May be Charged Amounts in Excess of the Allowed
Amount by In-Network Providers.**

Defendants opposing class certification often argue that each Plaintiff has a unique damage issue and that such differences preclude class treatment. North Carolina and other states have rejected that argument. In *Faulkenbury*, the defendant argued that differences in the amounts of class members' damages created "individual issues" that rendered class certification inappropriate. The North Carolina Supreme Court rejected that assertion holding that once the predominance of the common issues was established, individualized damages were collateral issues. *Faulkenbury*, 345 N.C. at 698, 483 S.E.2d at 431-32; *see also*, *Pitts v. American Security Insurance Company*, 144 N.C. App. 1, 20-21, 550 S.E.2d 179, 188-189, *citing Faulkenbury*; *also citing*, 1 *Class Actions* § 3.16, at 3-87. The North Carolina Supreme Court's holding in *Faulkenbury* is consistent with the holdings of courts across the country. *See, In re Visa Check/MasterMoney Antitrust Litigation*, 280 F.3d 124 (2d Cir. 2001), *cert. denied*, 2002 U.S. LEXIS 4394 (June 10, 2002); *Blackie v. Barrack*, 524 F.2d 891, 905 (9th Cir. 1975), *cert. denied*, 429 U.S. 816 (1976); *Bolanos v. Norwegian Cruise Lines, Ltd.*, 212 F.R.D. 144 (D.N.Y. 2002); *In re Methionine Antitrust Litig.*, 204 F.R.D. 161 (D. Cal. 2001). Thus, regardless of whether different PPO policies may have had different *benefit period* maximums, or that different *in-network providers* may have had different *allowed amounts*, or different members may have used different *in-network providers* to obtain difference services at different costs, these issues do not

preclude class certification. So long as the common issue determines liability for the class then the common issue predominates, and individualized issues such as amounts of damages become collateral. *Faulkenbury*, 345 N.C at 698, 483 S.E.2d at 431-32.

b. BCBSNC's Affirmative Defense of Failure to Mitigate does not raise individual issues on liability.

In this case the Defendant has advanced the defense of failure to mitigate. Presumably the Defendant will argue that such a defense relates to individual plaintiffs and creates individual issues that preclude class certification. This argument fails because it is nothing more than the prior damages argument dressed differently. Claims of failure to mitigate, even if successful, only affect the amount of damages a party may recover. They are not a bar to liability. *See, Stimpson v. Hoisery Mills, Inc. v. Pam Trading Corporation*, 98 N.C. App. 543, 392 S.E.2d 128 (1990). Moreover, affirmative defenses may not be used to defeat class certification because consideration of such defenses in the class certification phase of a case impermissibly looks toward determination of the merits of those defenses and, consequently, the issue of liability rather than the issue of class certification. *See, generally, Pitts v. American Security Ins. Co.*, 144 N.C. App. 1, 550 S.E.2d 179 (2001), *aff'd*, 356 N.C. 392, 569 S.E.2d 647 (*per curiam*)(*without precedential value*); *see also, Bentley v. Honeywell Int'l, Inc.*, 223 F.R.D. 471 (D. Ohio 2004); *Cook v. Rockwell Int'l Corp.*, 151 F.R.D. 378 (D. Colo. 1993); *Rishcoff v. Community Fluctuations Sys., Inc.*, 111 F.R.D. 381 (E.D. Pa. 1986). Interestingly, while BCBSNC asserts this defense in its Answer, it has offered no supporting facts in its responses to discovery. (See Exhibit D, response to interrogatory number 12).

c. The Defense of Failure to Exhaust Administrative and Contractual Remedies Does Not Raise Individual Issues

Defendants often assert in opposition to class certification that administrative remedies have not been exhausted arguing that if the remedies were pursued the matter might be resolved without the intervention of the Court. That argument fails in this case because the PPO contracts offer no administrative remedies that embrace the issues presented by the class. The contracts do provide a grievance procedure for BCBSNC's policy or decision regarding the availability, delivery or quality of health care services. (Blue Advantage Benefit Booklet 2005, Exhibit "F"). However, the claim here is not one on which Ms. Hamm could have filed a grievance because her claim on behalf of the class does not involve the quality or delivery of health care and does not seek payment for health care services by BCBSNC. Instead, her claim is premised upon the amount that the *members* have to pay *in-network providers*. The grievance procedure is designed, for example, for situations where BCBSNC denies a claim or refuses to authorize a service.

Defendant also asserts the "Limitations of Action" section of the contract as the basis of an affirmative defense challenging Plaintiff's right to sue. This assertion fails because only those actions enforcing a *member's* right to have a claim **paid on her behalf by BCBSNC** are embraced by the "Limitations of Action" section in the contract. (*Id.*) Plaintiffs had no right to be reimbursed by BCBSNC for *covered services* after they had reached their *benefit period* maximum or *lifetime maximum*. Plaintiff seeks only to enforce her right – and the rights of the class members - under the contract to be charged the *allowed amount by in-network providers* - the same *allowed amount* on which she paid her deductible and co-insurance under her contract before reaching her maximums. Since the class's claim is not for payment of benefits, it falls outside of the "Limitation of Actions" clause on which BCBSNC relies in the hopes of defeating class certification and the claims of the class. Plaintiff's claim is not about whether she was able

to obtain services (availability), the delivery of those services or the quality of the services she received; it is about the amount she was charged for the services after exceeding benefit maximums.

C. Plaintiff Satisfies the Prerequisites for Maintaining a Class Action

Plaintiff satisfies the criteria for pursuing a class action under North Carolina law, namely those of adequacy of representation and numerosity.

1. Ms. Hamm will fairly and adequately represent the interests of all members of the class.

Ms. Hamm's claim – that she was charged an amount in excess of the *allowed amount* for medical services her dependent, Alexandre, received once he reached his *benefit period* maximum – is typical of that of the class. Ms. Hamm has hired competent counsel experienced in complex litigation, class actions and health care litigation; has made herself available to confer with her counsel in this matter; has reviewed the Complaint and understands the claims which she is bringing on behalf of the class; and is willing and able to take a leading role in the prosecution of this litigation to protect the interests of the absentees, including those outside of the Court's jurisdiction. *See, Tomlin v. Wiggins*, 2002 NCBC 1, 22-23 (2002), *quoting, Berger v. Compaq Computer Corporation*, 257 F.3d 475, 479 (5th Cir. 2001).

As for class counsel, Ms. Hamm and the proposed class are represented by five attorneys among three law firms: Donald Beskind of Twiggs, Beskind, Strickland & Rabenau, P.A. of Raleigh, North Carolina; Jerome Marcus and Jonathan Auerbach of Marcus Auerbach and Zylstra, LLC, of Philadelphia, PA; David Senoff and J. Martin Futrell of Billet & Connor, P.C. of Philadelphia, PA. Mr. Beskind and Mr. Futrell are admitted to practice in the Courts of the State of North Carolina. Professional biographies for the attorneys who have entered their appearance on behalf of Ms. Hamm and the proposed class have been attached for the Court's

review. Mr. Marcus and Mr. Auerbach have extensive experience as lead counsel on ERISA, antitrust, and consumer class actions, including class actions involving claims against health insurers. Mr. Senoff has extensive experience in bad faith litigation as well as experience in class actions involving insurers. Mr. Futrell is experienced in complex litigation and trial practice, and while based in Philadelphia, is licensed in North Carolina as well as Pennsylvania, New Jersey and New York. Mr. Beskind is consistently rated one of North Carolina's leading trial lawyers. He is also a faculty member at Duke's law school. The combined talents of the lawyers representing Ms. Hamm and the proposed class, along with their collective financial resources, will ensure that the class members will be protected and their interests vigorously prosecuted.

2. Ms. Hamm Has No Conflicts of Interest with the Class and Her Interest in the Class is a Genuine, Personal Interest in the Action.

Ms. Hamm's interests are aligned with those of the proposed class – to enforce the plain language of her PPO agreement so that she is not responsible for payment of any amount above the *allowed amount* for services rendered by *in-network providers*. Ms. Hamm's interest in this matter is personal, as her child – a dependent on her policy – has cerebral palsy and most likely will require extensive physical therapy for some time. The difference between the *allowed amount* and the provider's charge can be as much as double, which, given the high costs of medical care, can quickly accumulate to several thousands of dollars per year. This issue is of obvious importance to Ms. Hamm and the proposed class members.

3. Class members are so numerous that it is impractical to bring them all before the court and adequate notice can be provided to all members of the class.

There are approximately 678,000 members of a BCBSNC preferred provider organization plan. There are 201 group PPO plans that are self-identified as being ERISA-exempt, including group plans for several of North Carolina's largest municipalities and counties. As of November 2004, there were over 265,000 members in the individual PPO plan Blue Advantage, the majority of whom, like Ms. Hamm, will most likely be exempt from ERISA. While the exact number of class members – those under ERISA-exempt PPO plans who have paid amounts in excess of the *allowed amount* for services from *in-network providers* over the preceding three years – is unknown at this time, there is sufficient evidence forming a reasonable basis for establishing that the number meets the minimum threshold. Even if the class consists of only 1% of the BCBSNC PPO members, that number approaches 6,700 individuals. Alternatively, an even more conservative approach that yields only one individual per group plan that meets the class definition would result in at least 201 class members, not including the class members who had individual PPO plans.

The numerosity requirement is satisfied so long as there is a reasonable basis for believing that the number of class members exceeds the minimum requirement. *See, generally, Pitts v. American Security Insurance Company*, 144 N.C. App. 1, 550 S.E.2d 179 (2001), *aff'd without precedential value*, 356 N.C. 292, 569 S.E.2d 647; *see also, Peters v. AT&T Corp.*, 179 F.R.D. 564 (N.D. Ill. 1998); *Andre v. Chater*, 910 F. Supp. 1352 (S.D. Ind. 1995); *Kornick v. Talley*, 86 F.R.D. 715 (N.D. Ga. 1980). Furthermore, BCBSNC has access to the data regarding the number of class members, and courts have consistently held that where the defendant is in possession of the data, the plaintiff's lack of knowledge as to the particular class size should not bar certification. *See, generally, Jackson v. Foley*, 156 F.R.D. 538 (E.D.N.Y. 1994). Finally, since the *member* names and addresses most certainly will be within the possession of BCBSNC,

notice to the class members should not be an issue. *See, generally, Frost v. Mazda Motor of Am. Inc.*, 353 N.C. 188, 540 S.E.2d 324 (2000).

C. A Class Action is the Superior Method of Adjudication of the Claims in this Litigation.

“Class actions should be permitted where they are likely to serve useful purposes such as preventing a multiplicity of suits or inconsistent results.” *Crow v. Citicorp*, 319 N.C. 274, 284, 354 S.E.2d 459, 466. The driving issue in this litigation is the need to have the standardized written insurance contracts interpreted and applied uniformly. Liability, be it in favor of the Plaintiff and the proposed class or in favor of BCBSNC, needs to be uniform. Otherwise, there is the risk of inconsistent results and, thus, inconsistent interpretations of the same contract among different courts addressing the issue. Such disparity in the contracts’ construction hardly serves the public good and, if anything, undermines the public confidence in the legal system. *See, generally, Cauble v. Trexler*, 277 N.C.307, 311, 42 S.E.2d 77, 80 (1911)(contracts are against public policy when they injure the public confidence in the purity of the administration of the law). Moreover, while the damages per class member will likely be in the thousands of dollars and, thus, significant, the damages, in and of themselves, will be insufficient to make individual suits practical, as the costs of litigation for an individual suit will easily surpass the recovery obtainable for that individual. *See generally Deposit Guaranty Nat’l Bank v. Roper*, 445 U.S. 326, 339, 63 L.Ed.2d 427, 440, *reh’g denied*, 446, U.S. 947, 64 L.Ed.2d 804 (1980)(class actions are particularly appropriate for situations where it is not economically feasible to obtain relief through individual suits for damages and, thus, individuals may be denied any effective redress unless they utilize a class action).

Resolution of this contract issue by class action is the most efficient, and the only economically viable, solution for the class members. Moreover, the calculation of damages,

while individualized, will be relatively simple, since damages have already been calculated through the Explanation of Benefits. Through an examination of the Explanation of Benefits for each class member, the full provider charge and the *allowed amount* can readily be discerned, such that the difference between the two can be easily calculated. Furthermore, BCBSNC certainly has within its records the *allowed amount* for the services referenced in the class members' Explanation of Benefits. Finally, per their discovery responses, BCBSNC utilized certain computer programs to process claims for their PPO *members*. These same computer programs should be able to be used to calculate the damages for each class member. (See Responses to Interrogatories, no. 3, attached hereto as Exhibit "D"). In effect, by identifying the class members and calculating their damages, Defendant BCBSNC will be required to do no more than what it does every day when it processes the hundreds of thousands of claims for its *members*. (See BCBSNC 2005 Annual Report attached hereto as Exhibit "C"). The difference will be that in this instance, BCBSNC will have to honor the terms of the PPO agreements and pass on to *members* who have exceeded their maximums the *allowed amount* rather than the full provider charge by *in-network providers*.

IV. CONCLUSION

For the reasons stated herein, Plaintiff respectfully requests this Court to enter an Order certifying the above-captioned action as a class action under N.C. Rule of Civ. P. 23.

This the 7th day of February, 2007.

Respectfully submitted,

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STATE OF NORTH CAROLINA

IN THE GENERAL COURT OF JUSTICE

SUPERIOR COURT DIVISION

DURHAM COUNTY

05 CVS 5606

MACY M. HAMM, Individually and on)
behalf of All Others Similarly Situated,)

Plaintiffs,)

v.)

BLUE CROSS BLUE SHIELD OF NORTH)
CAROLINA FOUNDATION and BLUE)
CROSS BLUE SHIELD OF NORTH)
CAROLINA,)

Defendants.)

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing Plaintiff's Memorandum in Support of Motion for Class Certification was electronically filed with the North Carolina Business Court except for the Exhibits which were not electronically filed due to the size of the documents. The Exhibits were served by U.S. Mail on all parties as follows:

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This the 7th day of February, 2007.

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