UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TENNESSEE AT KNOXVILLE

MARLENA L. MILLS,
by and through her next friends and parents,
DAVID G. MILLS and
JULIA MILLS,
and the parents for themselves individually

Plaintiffs

VS. **NO. 3:15-cv-00552**
Judge Reeves
Magistrate Judge Guyton

BLUECROSS BLUESHIELD
OF TENNESSEE, INC.

Defendant

PLAINTIFFS' MEMORANDUM IN SUPPPORT OF THEIR RESPONSE TO DEFENDANT'S MOTION TO RECONSIDER AND PLAINTIFFS' MOTION TO RECONSIDER

I. INTRODUCTION

Defendant, BlueCross BlueShield of Tennessee, Inc. (BCBST), has filed a motion to reconsider the court's Memorandum and Order of January 9, 2017 of Section IV Part A. Plaintiffs, the Mills, file this response to their motion and simultaneously ask the Court to reconsider its decision in Section IV Part E.

Defendant has filed a motion that asks the Court to revisit a ruling that was clearly correct and makes no different argument than it made last time. Plaintiffs on the other hand, will show that the Court dismissed a claim of the Plaintiffs based on the grounds that there was no statutory

right to assert the claim but never considered whether there was a common law right to assert the claim when in fact there was.

And regrettably, Plaintiffs must begin this response by pointing out something in Defendant's Introduction concerning the Court's Order that is patently false. Defendant asserts on Page 2 of its Memorandum that the Court dismissed all of Plaintiffs claims other than Plaintiffs' breach of contract claim when the court clearly held that Plaintiffs have a bad faith claim in addition to the breach of contract claim. Plaintiffs are puzzled as to how and or why the Defendant made such a mischaracterization of the Court's order.

II. STANDARD OF REVIEW

Plaintiffs agree that the court has the inherent right to reconsider its interlocutory order of January 9, 2017. However, Plaintiffs fail to see how Defendant's motion met any of the grounds it cites are necessary to alter or reverse the court's decision. The Defendant has not shown that the court has made a clear error of law, the Defendant provided no new evidence, it has not shown there has not been an intervening change in the law and it has not shown there is any need to change the order to prevent manifest injustice. See Defendant's Memorandum page 2 citing these requirements set out in *Henderson v. Walled Lake Conol. Schs.*, 469 F.3d 479, 496 (6th Cir. 2006).

On the other hand, Plaintiffs will show that the Court's striking of its claim regarding the Affordable Care Act (ACA) and the Mental Health Parity Act was erroneous and that there is a clear need to change the order to prevent manifest injustice. While it is true that these acts do not provide a statutory private cause of action, Plaintiffs still have the right to the insurance coverages guaranteed them under these laws under the common law action of breach of implied or quasi contract.

Failure to get the full benefits and coverages of these acts would be manifestly unjust to the Plaintiffs and could cause them considerable harm. Without the protection of these laws, Plaintiffs will be subject to much higher deductibles, and much less reimbursement under fee schedules for out–of-network charges, and they should never have been subjected to these extra charges had the Defendant provided mental health parity in-network as required.

III. ARGUMENT

A. The Court Properly Held That the Grievance Procedure is Not Mandatory

The Court noted in its opinion that contracts of insurance are strictly construed in favor of the insured and if the disputed provision is capable of more than one meaning, the meaning favorable to the insured controls." Court's Opinion p. 7, citing *Garrison v. Bickford*, 377 S.W. 659, 664 (Tenn. 2012). The Defendant, in its motion to reconsider, cites Tennessee law which holds that the meaning of a contract is to be determined from all of its language, read together to determine intent from the common meaning. Defendant's Memorandum P. 7, citing *Dick Broad Co., Inc. v. Oak Ridge FM, Inc*., 395 S.W.3d 653, 659 (Tenn .2013).

Defendant attempts to argue that the language of the Policy which holds that "Any grievance related to coverage under this policy will be resolved in accordance with the Grievance Procedure Section of the policy," (Policy p.1) means only one thing: that the grievance procedure is mandatory. The problem for the Defendant is that there are numerous other provisions in the policy that suggest that the grievance procedure is not mandatory. It's omissions in this regard can only suggest it meant to mislead the court about the totality of the policy.

First of all, in the "General Provisions" section of the policy, Part E, the provision entitled "Legal Action," states as follows: "You cannot bring a legal action under this policy until sixty

days after proof of loss has been furnished." (Policy p. 11). There is nothing here that says that the Insured is also required to go through the Grievance Process as a condition precedent to filing a suit. If such was the intention of the policy, here was the place and opportunity to say so. But there is no mandate here. The Defendant had cited this very section for the Court in its Motion to Dismiss; yet, it still dumbfoundedly asserts that the policy must be read as having only one meaning: the grievance process is mandatory. But there are at least three other provisions of the policy that imply the grievance process is not mandatory.

A second time the policy implies that the grievance process is not mandatory is under the "When Coverage Ends" Section of the policy. There we find this provision under Part F, entitled, Right to Request a hearing: "You ***may*** request that We conduct a Grievance Hearing to appeal the termination of Your membership for cause as explained in the "Grievance Procedure" section of this policy." (Policy p. 9). So clearly, if the Insured wants to contest a loss of coverage due to termination, there is no mandatory requirement that the grievance process be followed in that situation. If the grievance process is not mandatory when the Insured faces the loss of all coverage, why should it be required to do so when there is a dispute over a particular matter of coverage?

Thirdly, as the court noted, in its Order, the section on the grievance process uses the term "a" rather than "the sole" or "the only" means of resolving disputes between the carrier and the insured. Court's opinion pp. 6 and 7. The court's conclusion on this point, that "a" meant multiple methods of resolving disputes were available to the Plaintiffs was absolutely right.

Finally, if we look at the "Grievance Procedure" section of the policy it is quite clear that the time a grievance process would take would often be far longer than the 60 day waiting period for litigation as noted above. Under Part 2 B entitled "Grievance," the insured cannot even file a

grievance unless an adverse benefit determination has been made first or the insured has some other reason to have a grievance. But if the insured has no other grievance it must wait until an adverse determination has been made: "You must begin the Dispute Process within one-hundred and eighty (180) days from the date We issue notice of Adverse Benefit Determination or from the date of the event that is otherwise causing You to be dissatisfied with Us." (Policy p. 23). So in most situations then the Insured is likely to have to wait for an Adverse Benefit Determination before it can file a grievance and that could be well beyond the sixty days the Insured has to wait to file suit.

Clearly the Defendant's claim that the policy requires the insured to go through the grievance process prior to suit is just not supported by the totality of the language of the policy itself. The language of the policy regarding a 60 day waiting period is in clear conflict with the Defendant's position and the other provisions cited herein suggest otherwise as well; or at least these other provisions cast enough doubt about a mandatory grievance procedure, that at best this is an ambiguous requirement of the policy and should still be resolved in favor of the Plaintiffs. The court was clearly right in its initial determination that the grievance process was not mandatory.

The other two points raised by the Defendant are probably moot since they only address the court's rationale for its ultimate decision that a grievance process is not required prior to suit, but the Defendant is clearly wrong about the court's two main rationales as well. But Plaintiffs will discuss them to further demonstrate the court's rationales for its decision was quite sound.

B. Prior Authorization, the Ambiguity of the Term, and Impossibility of Getting it

The term "Prior Authorization" is fraught with ambiguity throughout the entirety of the policy: for example, is it always required, when it is required, what does it really mean, and what are the penalties if it is not obtained prior to the service provided. These ambiguities really made it impossible for the Plaintiffs to attempt to get it in any timely way that would have mattered.

The question Plaintiffs first faced was whether prior authorization was required in a medical emergency. The Plaintiffs have always maintained the hospitalization at Pasadena Villa was a medical emergency, which under the policy is determined by the "prudent layperson, with average knowledge of health and medicine" standard. (See Policy definition of emergency p. 33).

Most reasonable people would think that a person with a long history of mental illness in a state of mental crisis would constitute a medical emergency. The policy appears to suggest, for obvious reasons, that in medical emergencies, prior authorization is not required prior to service but nowhere does the policy expressly say that. Plaintiffs could never get an answer one way or the other as to whether this was the case and since this ambiguity exists, the grievance process is not the place to get a definitive answer. What happens next time there is an apparent medical emergency?

Next, the policy also puts the onus on the insured to get prior authorization for out-of-network providers in one section of the policy as a general matter, (see Policy p. 13) but for behavioral matters all it says is that prior authorization is required, (see p.45). The policy says nothing about how a mentally incompetent insured is supposed to get prior authorization when out-of-network; this question was also never answered by the Defendant making it impossible to get at an answer a time when it mattered. Defendants are still raising the claim that Marlena did not have a written authorization on file to allow her father to act in her behalf. The evidence at trial will be that she had sent one shortly after she moved to Knoxville and Defendant claimed it

never got it when her father called to attempt to get prior authorization on her behalf. The delay caused by having to get a second authorization made it impossible to get authorization when it really mattered.

The Defendant maintains in its motion that the Plaintiff could get "retroactive prior authorization." And this is the Defendant's ridiculous rejoinder to the Court's conclusion getting prior authorization was impossible. This term, "retroactive prior authorization" is totally fabricated by the Defendant for this litigation, and is patently nonsensical, as "prior" and "retroactive" are mutually exclusive terms. There is nothing in the policy definitions that suggests authorization can be given in a retroactive manner which is why the Defendant concocted this nonsensical term.

The definition of prior authorization states that prior authorization is necessary "to determine *if* such services *will be* considered Covered Services." (Policy p. 42). Looking at the policy as a whole, the language in this definition suggests that prior authorization must be interpreted as a preliminary advisory opinion as to whether certain services will be covered. The policy clearly gives the Defendant the right to change its opinion and deny coverage later, so it really cannot be seen as anything but advisory. So getting retroactive authorization is a meaningless act if services have already been performed.

More ridiculously, the Defendant maintains that it was possible to get prior authorization retroactively as late as the summer of 2016. Counsel for the Defendant sent a document in the summer of 2016 (seven or eight months after admission at Pasadena Villa) and touts this as proof getting prior authorization is not impossible. Since it refers to nothing in the policy, it has no legal significance whatsoever. What good would an advisory opinion as to coverage be seven or eight months after services are rendered? Absolutely none in this case once Plaintiffs paid the hospital

charges. But this nonsense is the best the Defendant can come up with to show getting prior authorization was not impossible.

Plaintiffs needed to know whether Marlena was covered before she was admitted, or very soon thereafter, in hopes that the Defendant would pay its share of the charges when they were due so Plaintiffs would not have to worry and wonder whether coverage existed, about how much they would ultimately owe, and for how long they could afford hospitalization when they had been advised Marlena would need a long term stay. Defendant made all of that impossible to do or learn when it mattered.

Finally the prior authorization requirement is ambiguous as to what kind of penalty or loss the Insured faces for failure to get prior authorization. The policy states: "Failure to obtain the necessary authorization ***may*** result in additional Member Payments and reduced Plan payments." (Policy p. 14). The court noted another section of the policy which states: "Some Covered Services must be authorized by BlueCross in advance in order to be paid at the Maximum Allowable Charge without penalty." (Court's opinion p.5 citing the policy at page 13). The court interpreted this provision to be a mandatory penalty but that is in conflict with the other sited provision which is permissive; the court was obviously unaware of conflicting provisions regarding a penalty for failing to get prior authorization. It is not surprising the court would conclude that the penalty was mandatory as it is quite rational to assume provisions don't disagree with each other. But the court needs to be aware that this conflict in provisions also exists.

In summary, it was absolutely fitting and proper for the court to conclude that the impossibility of getting prior authorization when it mattered was a legitimate rationale for not requiring the Plaintiffs to go through the grievance process prior to suit.

C. The Court Was Correct in Its Conclusion Concerning the Futility of the Claims Process

Defendant maintains that it would not be futile for the Plaintiffs to go through the grievance process. The Defendant has made it clear that in spite of all the ambiguities surrounding the requirement of prior authorization it maintains that the Plaintiff is required to get prior authorization retroactively. There is no provision in the policy that suggests prior authorization can be retroactive. Yet the Defendant is still requiring Plaintiffs do something the policy does not require, and that does not serve the intended purpose of getting prior authorization -- of getting an advisory opinion on coverage before health services are rendered. That demand alone, which has no support in the policy itself makes returning to the grievance process futile.

Moreover, Defendant has continued to demand of Plaintiffs they make up evidence "like superbills" that do not exist. There is no requirement in the policy that Plaintiffs make up "superbills" and Plaintiffs do not intend to make up evidence which they would apparently be required to do in a grievance process. The still ever present demand for "superbills" is just one more small bit of evidence that the grievance process would be a futile endeavor.

Defendant also insists claim forms of various kinds be made just for the sake of filling out forms when Defendant has all the evidence the forms request and due to this litigation has probably already got far more information that would have acquired in a grievance process. The nonsensical requirement of filling out forms just to fill them out will continue and be opposed by the Plaintiffs and would be opposed in a grievance process.

Much more importantly for proof of futility, is the fact that Plaintiffs have filed the affidavit of Dr. Rahman, the admitting physician at Pasadena Villa, as an Exhibit to their Motion for Partial Summary Judgment, yet Defendants still refused to be satisfied with his conclusion on medical

necessity despite that fact this opinion was given under oath (in affidavit form) as to medical necessity.

Defendants failed to file any expert "affidavit" in opposition to Dr. Rahman's affidavit testimony on medical necessity, yet they insist medical necessity is still an issue.

Moreover, despite having the affidavit of Dr. Rahman and no expert of their own yet designated after all this time, the Defendant still wanted all of the medical records of the hospitalization at Pasadena Villa none of which had any bearing whatsoever with respect to Dr. Rahman's opinion as to medical necessity.

Plaintiffs contend that a medical expert is necessary to contest Dr. Rahman's opinion that Marlena's hospitalization was medically necessary and Defendant has never designated an expert to contest Dr. Rahman's opinion though Dr. Rahman's affidavit has been on file with the court for eight or nine months.

Thus it appears that the Defendant would intend to contest medical necessity in a grievance process when medical necessity has been proven in court without evidence to the contrary. It seems that any attempts to prove medical necessity have been futile when it comes to convincing the Defendant even though Plaintiffs have complied with the rules regarding Summary Judgment proof. What good would going through a grievance process do at this point?

Moreover, Defendant has elected to withhold the out-of-network fee schedule from the Plaintiffs, depriving Plaintiffs of the ability to itemize for services that might be covered under the policy. Refusal to give Plaintiffs the fee schedule has deprived the Plaintiffs from asking questions about things that might be covered if they looked through the medical records or consulted with the medical providers. Moreover the refusal to produce the fee schedule produces a major

ambiguity as to the extent of Plaintiffs' coverage. So requiring the Plaintiffs to go through a grievance process without the fee schedule that they won't even produce in a legal proceeding would be yet another act of futility.

So clearly the court was right in its rationale that going through the grievance process would be a case of futility because there are still so many points of contention that likely would not be resolved in a grievance process.

D. The Plaintiffs' Claims Under the Affordable Health Care Act and Mental Health Parity Act Are Legitimate Common Law Claims for Breach of Implied or Quasi Contract

In Section E of the Court's opinion, the court held that Plaintiffs failed to state a cause of action under the Affordable Care Act and under the Mental Health Parity Act. The court concluded that the Plaintiffs have no private cause of action to enforce insurance plan requirements imposed by the Affordable Care Act. The court and the Defendant relied upon a single case for this position, a case that was decided even before the Affordable Care Act was enacted. Plaintiffs would show that reliance on this case is misplaced and erroneous because it presumes that an express statutory private cause of action is the only means a Plaintiff can enforce the provisions of these acts.

The court never addressed whether the coverage mandated by these acts could be the basis of a common law cause of action. It should do so now because justice and fairness require it to reconsider the loss of a legitimate cause of action.

Insureds have a common law cause of action for breach of implied contract or quasi contract in order to ensure that insureds get the coverage statutes mandate.

The Supreme Court of Tennessee has long held there is a common law action for implied or quasi contracts. In *Paschall's Inc. v Dosier*, 407 S.W.2d 150 (1966), the court made this pronouncement about implied, constructive and quasi contracts.

> The law recognizes two distinct types of implied contracts; namely, contracts implied in fact and contracts implied in law, commonly referred to as quasi contracts. The distinction between the two has been explicitly stated by the Court of Appeals in Weatherly v. American Agr. *154 Chemical Co., 16 Tenn.App. 613, 65 S.W.2d 592:
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> "Contracts implied in fact arise under circumstances which, according to the ordinary course of dealing and common understanding of men, show a mutual intention to contract. Such an agreement may result as a legal inference from the facts and circumstances of the case. * * * `Contracts implied in law, or more appropriately, quasi or construction contracts, are a class of obligations which are imposed or created by law without the assent of the party bound, on the ground that they are dictated by reason and justice * * *.'"
>
> Actions brought upon theories of unjust enrichment, quasi contract, contracts implied in law, and quantum meruit are essentially the same. Courts frequently employ the various terminology interchangeably to describe that class of implied obligations where, on the basis of justice and equity, the law will impose a contractual relationship between parties, regardless of their assent thereto.

Thus it is clear that the Plaintiffs have a right to get the coverage mandated by the Affordable Care Act and the Mental Health Parity Act because the coverages are imposed by law and justice and equity require the insureds get the coverage the law mandates the carrier provide.

Moreover the proper way of pleading the right to insurance coverage mandated by statutes is exactly the way the Plaintiffs did in their First Amended Complaint. All that is required is that the insured plead the statutes that mandate coverage and state that the insured is entitled to the coverage guaranteed under the statutes.

The court must also consider the implications of its decision not to allow Plaintiffs to get the coverage mandated by the Affordable Health Care Act. It would not only mean that an insured under the act cannot sue to ensure the carrier provide for the mental health parity the ACA requires,

but an insured could not sue to ensure any of the coverage the ACA mandates a carrier to provide. In other words, if a carrier decided to limit lifetime benefits in violation of the act, the insured could do nothing about it. The same would happen if the carrier refused to cover pre-existing conditions. The carrier could refuse to do anything the statute mandates.

It was the clear intent of Congress that carriers who issue ACA policies provide coverage the law mandates. If an insured is not permitted to sue on the basis of implied or quasi contract, the law will lose all of its effect. The attorneys general of the federal and state courts could never adequately protect the people who buy these policies on a case by case basis, given the volume of them. The insureds need to be able to protect themselves and a suit based on the well- recognized long established common law action of breach of implied contract or quasi contract is the means by which they should be able to do it.

The court therefore should permit the claims Plaintiffs made under the Affordable Health Care Act and the Mental Health Parity Act particularly because the primary rationale for the common law action of breach of implied or quasi contract, is that justice and fairness require the common law action to be available for adequate redress. Denying Plaintiffs this cause of action would deny them justice and fairness. And a ruling which would cause manifest injustice happens to be one of the main considerations the court should take into account when a request is made to reconsider a prior order.

And as previously mentioned, the court's refusal to allow the Plaintiffs to sue for breach of implied or quasi contract could mean harm to the Plaintiffs that could be very financially significant. Plaintiffs could well be assessed steep out-of-network deductibles and forced to accept chincy reimbursement based on out-of-network fee schedules the Defendant refuses to produce.

None of this financial jeopardy would have happened if Defendant had complied with the requirements of the mental health provisions of the ACA. Marlena's treatment should have been supplied in-network at *de minimus* cost to the Plaintiffs.

IV. CONCLUSION

For the foregoing reasons, Plaintiffs would request that the court deny the Motion of the Defendant and grant the Motion of the Plaintiffs.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify under Rule 5 of the Federal Rules of Civil Procedure that a true and exact copy of the foregoing Memorandum in Opposition of Defendant BlueCross BlueShield of Tennessee, Inc.'s Motion to Reconsider Part IV of the Court's January 9, 2017 Order and Plaintiffs' Memorandum in Support of Plaintiffs' Motion to Reconsider Section IV Part E of the Court's January 9, 2017 Order was served on the following counsel of record via operation of the Court's electronic filing system.

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Dated: February 2, 2017

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