CHIMICLES SCHWARTZ KRINER & DONALDSON-SMITH LLP
Nicholas E. Chimicles (admitted *pro hac vice)*
Kimberly Donaldson Smith (admitted *pro hac vice)*
Stephanie E. Saunders (admitted *pro hac vice)*
361 W. Lancaster Avenue
Haverford, PA 19041
Phone: (610) 642-8500
Fax: 610-649-3633

TYCKO & ZAVAREEI LLP
KRISTEN LAW SAGAFI, California Bar No. 222249
ksagafi@tzlegal.com
483 Ninth Street, Suite 200
Oakland, CA 94607
Telephone: (510) 254-6808
Facsimile: (202) 973-0950

Counsel for Plaintiffs

Additional counsel for Plaintiffs on signature page

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

RACHEL CONDRY, JANCE HOY, CHRISTINE ENDICOTT, LAURA BISHOP, FELICITY BARBER, and RACHEL CARROLL on behalf of themselves and all others similarly situated,

Plaintiffs,

TERESA HARRIS, on behalf of herself and all others similarly situated,

Intervenor Plaintiff,

v.

UnitedHealth Group Inc.; UnitedHealthcare, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Services, Inc.; and UMR, Inc.,

Defendants.

Case No.: 3:17-cv-00183-VC

PLAINTIFFS' AND INTERVENOR PLAINTIFF'S NOTICE OF MOTION AND MOTION FOR CLASS CERTIFICATION; MEMORANDUM OF POINTS AND AUTHORITIES

Date: November 21, 2019
Time: 10:00 am
Place: Courtroom 4

Honorable Vince G. Chhabria

PLEASE TAKE NOTICE that on November 21, 2019, at 10:00 am in Courtroom 4 of the above-captioned court, located at 450 Golden Gate Avenue, San Francisco, CA 94102, Plaintiffs Rachel Condry, Jance Hoy, Christine Endicott, Laura Bishop, Felicity Barber, and Rachel Carroll, and putative class member and proposed Intervenor Plaintiff Teresa Harris ("Plaintiffs") will move the Court for an order, pursuant to Rules 23(a), (b)(1) and (b)(2), and in the alternative 23(c)(4), of the Federal Rules of Civil Procedure ("Rule 23"), certifying the following Classes with respect to their claims against UnitedHealth Group Incorporated, through its subsidiaries, including Defendants UnitedHealthcare, Inc., UnitedHealthccare Services, Inc. ("UHS"), and UnitedHealthcare Insurance Company, and UHS's subsidiary UMR, Inc. (collectively "UHC" or "Defendants"):

A. The "Claims Review Class" defined as:

> All participants and beneficiaries, in one or more of the ERISA employee health benefit plans administered by Defendants in the United States, which provide benefits for healthcare services and for which claims administration duties are delegated to one or more of the Defendants, who received from August 1, 2012 to present, an explanation of benefits for Comprehensive Lactation Services rendered by an out-of-network provider, that included one or more of the following denial reasons (the "Remark Codes"):
>
> (1) Remark code KM ("This is not a reimbursable service. There may be a more appropriate CPT or HCPCS code that describes this service and/or the use of the modifier or modifier combination is inappropriate.")
>
> (2) Remark code I5 ("This service code is not separately reimbursable in this setting.")
>
> (3) Remark code 13 ("Your plan does not cover this non-medical service or personal item.")
>
> (4) Remark code B5 ("Payment for services is denied. We asked the member for more information and didn't receive it on time.")

B. The ERISA Plan Class defined as:

> All persons who were insured by or participants in ERISA, non-grandfathered, and non-federal employee health benefit plans insured or administered by Defendants in the United States, who from August 1, 2012 to present received Comprehensive Lactation Services from an out-of-network provider for which Defendants did not provide coverage and/or imposed cost-sharing.

C. The Non-ERISA Plan Class defined as:

> All persons who were insured by or participants in non-ERISA, non-grandfathered, non-federal employee health plans insured or administered by Defendants in the

United States, who from August 1, 2012 to present received Comprehensive Lactation Services from an out-of-network provider for which Defendants did not provide coverage and/or imposed cost-sharing.

For the ERISA Plan and Non-ERISA Plan Classes a non-grandfathered plan means: (i) any health insurance policy created or purchased after March 23, 2010, and (ii) any health insurance policy created or purchased on or before March 23, 2010, that subsequently lost its grandfathered status.

For each of the Classes, Comprehensive Lactation Services means comprehensive lactation support, counseling and education services provided during the antenatal, perinatal, and the postpartum period.

Excluded from the Classes are Defendants, their subsidiaries or affiliate companies, their legal representatives, assigns, successors and employees.

Plaintiffs also request that the Court appoint:

1. For the Claims Review Class, Plaintiffs Barber, Bishop, Condry, Endicott, and Hoy as Class Representatives;

2. For the ERISA Plan Class, Plaintiffs Bishop, Hoy, Endicott and Harris as Class Representatives; and,

3. For the Non-ERISA Plan Class, Plaintiff Carroll as Class Representative.

Plaintiffs also request that the Court appoint their counsel, Chimicles Schwartz Kriner & Donaldson-Smith LLP and Shepherd, Finkelman, Miller and Shah, LLP as Co-Lead Class Counsel, and Axler Goldich LLC as Class Counsel.

This Motion is based on this Notice of Motion, the attached Memorandum of Points and Authorities, the supporting Declaration of Kimberly Donaldson-Smith and Exhibits thereto ("KDS Decl., Ex. __"), and the arguments of counsel at the hearing on Plaintiffs' Motion.

Dated: September 9, 2019

CHIMICLES SCHWARTZ KRINER & DONALDSON-SMITH LLP

By: */s/ Kimberly Donaldson-Smith*
Nicholas E. Chimicles (admitted *pro hac vice*)
Kimberly Donaldson-Smith (admitted *pro hac vice*)
Stephanie E. Saunders (admitted *pro hac vice*)
361 W. Lancaster Avenue
Haverford, PA 19041

Phone: (610) 642-8500
Fax: 610-649-3633
NEC@Chimicles.com
KMD@Chimicles.com
SES@Chimicles.com

James E. Miller (admitted *pro hac vice*)
Laurie Rubinow (to seek admission *pro hac vice*)
SHEPHERD, FINKELMAN, MILLER AND SHAH, LLP
65 Main Street
Chester, CT 06412
Phone: (860) 526-1100
Fax: (866) 300-7367
jmiller@sfmslaw.com
lrubinow@sfmslaw.com

Proposed Co-Lead Class Counsel and Counsel for Plaintiffs

Marc A. Goldich (admitted *pro hac vice*)
Noah Axler (admitted *pro hac vice*)
AXLER GOLDICH LLC
1520 Locust Street
Suite 301
Philadelphia, PA 19102
Phone: (267) 534-7400
Fax: (267) 534-7407
mgoldich@axgolaw.com
naxler@axgolaw.com

Proposed Class Counsel and Counsel for Plaintiffs

KRISTEN LAW SAGAFI, California Bar No. 222249
TYCKO & ZAVAREEI LLP
483 Ninth Street, Suite 200
Oakland, CA 94607
Phone: (510) 254-6808
Fax: (202) 973-0950
ksagafi@tzlegal.com

Jonathan W. Cuneo (to seek admission pro hac vice)
Pamela B. Gilbert (to seek admission pro hac vice)
Monica E. Miller (to seek admission pro hac vice)
Katherine Van Dyck (to seek admission pro hac vice)
CUNEO GILBERT & LADUCA, LLP
4725 Wisconsin Ave. NW, Suite 200
Washington, DC 20016
Phone: (202) 789-3960
Fax: (202) 789-1813

Counsel for Plaintiffs

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I. INTRODUCTION

Plaintiffs' renewed Motion for Class Certification[1] presents a tailored set of classes and addresses the Court's concerns set forth in its May 23, 2019 Order Denying Class Certification ("CC Order", Dkt. 213, pg. 1). *First*, the classes are redefined to include only UHC insureds who received comprehensive breastfeeding and lactation support services ("CLS") rendered by out-of-network providers (*see* CC Order at p. 2-3, 5). Plaintiffs' primary claim is that UHC did not provide coverage for CLS rendered by out-of-network ("OON") providers as required by the Affordable Care Act's ("ACA") preventive care coverage mandate (Count II and III, the ERISA and Non-ERISA Plan Classes). Also, Plaintiffs assert UHC gave insureds incomprehensible denial explanations with its use of the 4 Remark Codes (Count I, Claims Review Class).

Second, for these narrower classes, Plaintiffs demonstrate that liability can be resolved on a classwide basis. (*See* CC Order at 3-4). UHC's policy was that OON CLS claims were not eligible for coverage without cost-sharing. *See* Section III.A. Because of that blanket policy, UHC did not adjudicate an OON CLS claim from the standpoint of the ACA-coverage mandate, *i.e.* UHC did not adjudicate an OON CLS claim based on whether in-network CLS services were available or unavailable to the claimant (*see* CC Order at 3). Conversely, UHC did not request (or provide the opportunity for) the insured to demonstrate that in-network CLS was or was not available to them. Instead, UHC made no ACA-grounded determination of whether an OON CLS claim was eligible for coverage without cost-sharing. Rather, it operated from the singular principle that OON CLS claims are not eligible for the ACA's no-cost-share coverage mandate. The resolution of whether UHC's blanket policy comported with the ACA is not tethered to UHC's fabricated "availability" construct; rather, it is a significant issue resolvable on a classwide basis.

Similarly, each member of the Claims Review Class received one of the 4 Remark Codes when UHC denied their OON CLS claims. The determination of whether each of the 4 Remark Codes provides adequate notice about the denial of benefits or sufficient information to make an informed decision (and the Court already determined that they did (SJ Order, Dkt. 146, at 5-6), resolves "in one stroke", and on a classwide basis, the significant issue that UHC's Remark Codes violated ERISA.

[1] Exhibits are attached to the Declaration of Kimberly Donaldson-Smith ("KDS Decl., Ex. __").

Even if UHC provided some coverage for OON CLS claims, it does not defeat certification (*see* CC Order at 4). Indeed, the Court acknowledged (CC Order at 3) that "the Court could award classwide relief by requiring the company to reprocess all claims previously denied pursuant to that noncompliant policy, ***even if some claims were granted pursuant to that non-compliant policy (and even if some claims would still be denied pursuant to a compliant policy)***. (*Id.,* emphasis added). That a "squeaky wheel" claim was covered, or that an insured's policy covered a portion of any OON claim, does not alter overarching application of the Policy. Most fundamentally, if differing adjudications of the class members' claims appear as haphazard, that appearance does not result from the spotty or accidental treatment by UHC of an OON CLS claim under the ACA mandate. Rather, it is because of UHC's Policy that OON CLS claims are not eligible for the ACA coverage.

Third, contemporaneous with this Motion, putative class member and proposed Intervenor Plaintiff Teresa Harris is seeking to intervene in this Action. As her filings state, Ms. Harris is currently insured by UHC, and UHC applied cost-sharing to her two OON CLS claims. Ms. Harris has standing to seek prospective relief (*cf.* CC Order at 4-5). Further, the Plaintiffs have standing to seek an order remedying UHC's past violations. (*See* CC Order at 5).

Fourth, Plaintiffs explain the relief sought for the Classes, describe what the "corrected standard" looks like, and explain why the remedies should be considered for class certification under Fed. R. Civ. P 23(b)(1)-(2). (*See* CC Order at 5, 6).

II. THE ACA MANDATE AND SCOPE OF CLS

UHC is a diversified health care company in the business of insuring and administering health plans. UHC's Answer, Dkt. 82, at ¶¶ 27-30. As Defendants admit, they or their subsidiaries administer and underwrite health care plans that are subject to the ACA's preventive services requirements, including those pertaining to breastfeeding support and counseling services. UHC's Answer, Dkt. 82, at ¶79.

A. The ACA Provision

The coverage policy at issue here derives from a single source – the ACA – and it applies uniformly to all of UHC's non-grandfathered, non-federal health benefit plans. The ACA added Section 2713 to the Public Health Service Act (29 CFR 2590.715-2713) stating "[Non-grandfathered

health plans] must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements...:

> (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force [USPSTF];
> * * *
> (4) with respect to women, such additional preventive care and screenings…provided for in comprehensive guidelines supported by the Health Resources and Services Administration [HRSA]. . . ."

See 42 U.S.C. § 300gg-13(a)(1), (a)(4); 29 C.F.R. § 2590.715-2713 (a)(i) and (iv); UHC Answer, Dkt. 82, at ¶¶56, 68-69. The term "cost-sharing" "in general" includes "deductibles, co-insurance, copayments, or similar charges…." 42 U.S.C § 18022(c)(3)(A).

The mandate was expressly identified as necessary to increase "access and utilization" of these services, to address "underutilization of preventive services" and to "eliminate cost-sharing requirements, thereby removing a barrier that could otherwise lead an individual to not obtain such services." KDS Decl., Ex. 1, at 75 FR 41726 at 41730-31, and Table 1. Also, to ensure that access and utilization is established, the ACA includes a commonsensical directive to insurers: do not circumvent the ACA's mandate by not having in-network providers for the enumerated preventive services, and yet refuse to cover OON preventive service claims. *See* 29 C.F.R. § 2590.715-2713(a)(3)(i)-(ii). UHC, nevertheless, established a policy that OON CLS claims were not eligible for the ACA- mandated benefit. The February 20, 2013 ACA Implementation FAQ #3 underscores that UHC could not implement and apply a blanket Policy about OON CLS claims. KDS Decl. Ex. 2.

B. Comprehensive Lactation Support and Counseling Services

1. *HRSA Guidelines*

On August 1, 2011 and December 20, 2016, pursuant to 42 U.S.C. § 300gg-13(a)(4), HRSA adopted and released its guidelines, referenced above, (the "HRSA Guidelines") for "[b]reastfeeding support, supplies, and counseling" which HRSA described as:

- "[c]omprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment", and
- "[c]omprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and the postpartum period to ensure the successful initiation and maintenance of breastfeeding"

See KDS Decl., Ex. 3 (the 2011 Guidelines); Ex. 4 (the 2016 Guidelines). UHC admits that the

HRSA Guidelines are as stated above. (UHC Answer, Dkt. 82, at ¶¶5, 62).

2. *The IOM and WPSI Reports*

The HRSA Guidelines describe and mandate coverage of a comprehensive service with respect to breastfeeding support and counseling. The 2011 HRSA Guidelines were based on studies and recommendations of the independent Institute of Medicine ("IOM") as set forth in its report, Clinical Preventive Services for Women: Closing the Gaps. ("IOM Report", KDS Decl., Ex. 5 (excerpts)). The IOM Report defined Preventive Health Services as "measures—including medications, procedures, devices, tests, education and counseling—shown to improve well-being, and/or decrease the likelihood or delay the onset of a targeted disease or condition." (*Id.,* page 3). In addition, the IOM Report made the following pertinent points regarding CLS: "Contrary to popular conception, breastfeeding appears to be a learned skill and the mother must be supported to be successful. Nevertheless, a large gap exists in the area of providers discussing breastfeeding with patients prenatally and assisting with breastfeeding issues postnatally." *Id.* at 110-111.

The 2016 HRSA Guidelines were based on the Women's Preventive Services Initiative 2016 Final Report ("WPSI Report" excerpts, KDS Decl., Ex. 6), which states that "The IOM recommendation includes an ***explicit description of a [ ] comprehensive set of services***…" (Emphasis added). *Id.* at 41; KDS Decl., Ex. 5, IOM Report at 116.[2] Fundamentally, the IOM and WPSI Reports recognize an essential element to providing CLS preventive care coverage that UHC's policy ignores: (1) "mothers may have no means of identifying or obtaining the skilled support needed to address their concerns about lactation and breastfeeding" following discharge from the hospital and (2) "gaps existed between providers' intentions surrounding breastfeeding counseling and their training, experience and practice in supporting patients with breastfeeding." KDS Decl. Ex. 5, IOM

[2] That point is underscored by the following. The 2008 USPSTF recommendation on breastfeeding (KDS Decl., Ex. 27), states that breastfeeding support includes "interventions…after birth to promote and support breastfeeding" and "Professional support" which "can include providing information about the benefits of breastfeeding, psychological support [ ] and direct support during breastfeeding observations (helping with the positioning of the infant and observing latching)…Sessions generally last from 15 to 45 minutes... Most successful interventions include multiple sessions and are delivered at more than 1 point in time." The HRSA Guidelines were not just repetitive of these USPSTF recommendations, but required comprehensive pre- and post-natal CLS. *See* KDS Decl. Ex. 28, 2/20/2013 FAQs, Part XII at Q18, "…The HRSA Guidelines specifically incorporate comprehensive prenatal and postnatal lactation support, counseling, and equipment ...")

Report at 111; *and* Ex. 6, WPSI Report at 50.

III. UHC'S CONDUCT

A. UHC's Policy for Out-Of-Network CLS Claims

UHC's Policy is that "preventive services…will be eligible for coverage without cost-shares ***provided that such services are provided by a network provider***…" KDS Decl., Ex. 7, UHC Rog. 3 (emphasis added). UHC states that its CLS coverage policy is reflected in the Preventive Care Services Coverage Determination Guideline (the "CDG"). *Id.*, UHC Rog. 1; KDS Decl. Ex. 8 (the CDG). UHC's CDG states its Policy clearly, unequivocally: "Out-of-Network preventive care services ***are not part of the [ACA] requirements***." KDS Decl., Ex. 8 at pg. 2. In full, it provides:

> **Cost Sharing for Non-Grandfathered Health Plans**
> ….
> 2. **Out-of-Network** preventive care services are not part of the [ACA] requirements. Many plans do not cover out-of-network preventive care services. If a plan covers out-of-network preventive care services, the benefit for out-of-network is allowed to have member cost sharing. Please refer to the member specific plan document for out-of-network information.

Id. This Policy expressly states that, even if a health plan covered OON services, the claim's status as "out-of-network" still trumps, and cost-sharing "is allowed", meaning, cost-sharing is imposed. *Id.*

UHC's 2014 "Preventive Care Services" "Snapshot" states "Under the health reform law, non-grandfathered health plans are required to cover women's preventive care services such as breast-feeding counseling. . . as long as they are received in the health plan's network." KDS Decl., Ex. 9 (UHC_001408-09). Under the "Lactation Support and Counseling" heading (pg. 2), it states "The health reform law does not require services outside of our network to be covered without cost-share." *Id.* Likewise, UHC members were informed that only in-network benefits for CLS are covered without cost-sharing. *See* KDS Decl., Ex. 10, UHC_007982, June 19, 2014 email.

In the CC Order, the Court stated that "[i]t appears…that UHC's approach to compliance with the Affordable Care Act's lactation coverage mandate was disinterested and haphazard…" CC Order at 4. To the contrary, UHC's approach to OON CLS coverage was neither disinterested nor haphazard: it was a fundamentally wrong, express Policy to uniformly exclude OON CLS claims from eligibility for the ACA-mandated benefit.

B. UHC Recognized the Harm to Insureds that Resulted From its Policy

Under UHC's Policy, class members were stuck on UHC's proverbial merry-go-round: "What if the member is requesting a Gap exception stating there is no one in network to provide these services? ***We would not have a way to search for someone who can provide them."*** KDS Decl., Ex. 11, UHC_056770, 056772, 056774 (emphasis added).

UHC employed a Catch 22: tell its members they could only receive the ACA benefit for CLS by using in-network providers, when UHC organizationally did not know which of its in-network providers would and did render CLS. The escape room into which insureds were placed was not lost on UHC's employees. Ms. Naccarato, Director Member Services, stated that:

> We have tested multiple scenarios in the portal and we tried checking physicians/hospitals individual websites for searches. Sometimes we come up with it and sometimes we do not-the time it takes would be a considerable AHT buster. ..I think our only option is to call the members OBGYN to see if they have [a lactation specialist] on staff or one that they recommend. The big drawback is that the person they are using may not be INN.

KDS Decl., Ex. 12, UHC_114402-06 (5/30/14 Email). Further, as Ms. Proctor pointed out,

> ***The concern is access to care and how this is being addressed at UHC***. I did a national search on our directory and had very few hits across the country…Our communications say we have various in-network clinics[,] where are these clinics in the event the OB/GYNs and pediatricians are not providing the service? We provide very detailed info about breast pumps and how to access yet limited info on lactation support.

KDS Decl., Ex. 13, UHC_109546 (11/2014) (emphasis added). Further, evidencing UHC's knowledge of the import of such an egregiously wrong Policy, on January 4, 2016 UnitedHealth Group's Chief Medical Officer, East Region from 2002 through 2016, Catherine Palmier, M.D. wrote, "***Unless we have some lactation consultants contracted*** we will have member dissatisfaction...***ob's and peds are not automatically skilled in lactation support***." KDS Ex. 14 at UHC_028002, emphasis added).[3] Nevertheless, UHC's Standard Operating Procedures ("SOPs") perpetuated the confounding and substantively useless response. KDS Decl., Ex. 7, UHC Rogs. 7, 9.

The paradox of UHC's conduct is reflected in the Court's Summary Judgment Order at 3, ¶ 3:

[3] Dr. Palmier's points were the centerpiece of a UHC group discussion in mid-January 2016, as per Sharon Wakefield's 1/14/2016 notes: "**Issue:** Guidance requires insurers to provide a list of lactation counselors. Unless we have some lactation consultants contracted (*and searchable in the provider directory lists*) we will have member dissatisfaction. 'OB's and peds are not automatically skilled in lactation support. (Cathy Palmier 1/4/16)'" (KDS Ex. 15, UHC_052645, emphasis in original).

"Even assuming that some pediatricians, OBGYNs and their practices provide [CLS], this fact - absent evidence that pediatricians and OBGYNs …were in fact providing those services to their patients and that the Defendants made the plaintiff aware of that - does not create a genuine issue of fact as to whether a particular plaintiff had meaningful access to [CLS]."

C. In-Network CLS Services Were Presumptively Unavailable To Class Members

The CC Order stated that claims consist of people "denied reimbursement for out-of-network lactation services despite in-network services being unavailable to them." CC Order at 3.

It is important to emphasize that under UHC's Policy OON CLS claims are not eligible for the ACA-mandated coverage. UHC did not adjudicate an OON CLS claim based on whether in-network services were available or unavailable. UHC did not inform the insured her claim was denied because UHC identified an available in-network provider. UHC also did not respond by asking the insured to demonstrate that she did not have in-network CLS available to her. Instead, UHC avoided undertaking any determination of whether an OON CLS claim was eligible for ACA coverage.

This motion is based on UHC's uniform wrong-headed Policy. "Availability" of an in-network provider is a red herring given that UHC's adjudication of the OON CLS claims did not consider nor ultimately give (and was incapable of giving) "availability" as a reason for a claim's outcome. Having eschewed any consideration or reference to availability of an in-network provider as part of its claims adjudication, UHC cannot now seek to defeat class certification on that basis.

Indeed, if "availability" were such a reason for the claim to have been properly denied ACA-mandated coverage, a determination that UHC was in the best position to make—*e.g.,* UHC has admitted that its providers may be in-network for certain services and OON for others[4]—it was obligated to convey such a reason with appropriate detail to the claimants. *See, e.g., Trujillo, et al. v. UnitedHealth Group, Inc., et al.,* CV 17-2547, 2019 U.S. Dist. LEXIS 21927 *2 (C.D. Cal. Feb. 4 2019) (Insurers must establish reasonable claims procedures and provide adequate notice of adverse

[4] UHC's "Network" definition acknowledges that network providers are not "in-network" for any and all services: "A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services….In this case, the provider will be a Network provider for the Covered Health Services…***and a non-Network provider for other Covered Health*** services..." *E.g.,* KDS Decl., Ex. 17(Excerpt, UHC_001011); Ex. 18 (Excerpt, UHC_002112) (emphasis added).

benefit determinations); 29 USC 1133(1). UHC did not convey any such reasons.[5]

Likewise, it is apparent from discovery, as discussed *supra* at Section III.B, that UHC internally recognized that its avowed assumption that all OB/GYNs and Pediatricians could deliver CLS was baseless, something that has been further established through expert evidence. *See* KDS Decl., Ex. 16, Dr. Hanley 1/25/2019 Rebuttal Report at ¶ 5 (Noting the "the material gaps in physicians' education, training and experience regarding breastfeeding support and counseling [;] and [ ] an absence of coordinated care among providers during the post-partum period. [UHC's expert] implies that the hand-off of care from a hospital team or mid-wife to a pediatrician provides adequate and complete patient access to breastfeeding and lactation counseling; I disagree.").[6]

As this Court held: "The service must be available in a meaningful way for the plan to comply with the [ACA]." (8/15/17 MTD Order, Dkt. 68 at 3); and, the ACA requires meaningful access, "[i]llusory or de minimus access is not sufficient…." (SJ Order at 2, ¶ 1). *See also,* Dkt. 81-2, 7/27/17 Tr. at 5:1-3, 7/27/17 hearing: "But it seems like at a minimum, what [the ACA] requires is…meaningful access to lactation services." Coupling this Court's "meaningful access" holdings together with UHC's Policy (under which an OON CLS claim was not given consideration under any "availability" construct), it is Plaintiffs' position that "availability" is irrelevant to certification of the Classes of OON CLS claimants. If an insured stumbled upon an in-network provider, that person is not in any class sought to be certified. Also, in the SJ Order, this Court dismissed two claimants' claims because UHC had providers identified specifically as "lactation specialists" proximate to them (SJ Order at 4), but later discovery revealed that nationally there are only a handful of those providers identified in UHC's provider directories.[7] Again, for the reasons discussed and the existence of the

[5] UHC could not determine "availability" to deny an OON CLS on such ground, as evidenced by UHC's internal communications (Section III.B, *supra*) and that UHC did not affirmatively determine or survey its network providers to determine if they were able to and would deliver CLS. *See,* KDS Decl., Ex. 19 (Wakefield Tr. at 117, 199). UHC circumvented the inquiry with its blanket Policy.

[6] *See* KDS Decl., Ex. 20, Morton 12/4/2018 Report at 12 ("Although some pediatricians or OB/GYNs may provide CLS, it is by no means the norm, the availability of [] [CLS] from OB/GYNs or pediatricians is inconsistent and sporadic at best. It is impractical and unrealistic to expect mothers to be able to determine which OB/GYNs, pediatricians or other primary care providers [] [in their health plan's network are providing] CLS" as a covered benefit, and such policy ignores many practical aspects of a physicians practice, including, among other things, that care is limited to established patients, and availability of appointments for new patients typically require lengthy wait times.)

[7] UHC admits that only the network providers identified by the specialty code '380' have been

UHC's blanket Policy on OON CLS claims, UHC cannot oppose and defeat class certification based on "availability". Even, *assuming arguendo,* availability was relevant, it goes not to the denial of class certification, but logically and consistent with the SJ Order, it is part of the ordered reprocessing of OON CLS claims by UHC (*i.e.*, If UHC were to deny or impose cost-sharing on an OON CLS claim because a provider, proximate to the claimant, was identified as a lactation specialist in its directory at the time the CLS service was received, UHC would communicate (clearly) that reason to the insured, which determination is appealable, if she disagrees).

D. UHC's Deficient Remark Codes

UHC utilized "Remark codes" in its Explanation of Benefits ("EOBs") sent to all members by UHC to explain to the member why the claim was denied. *See* KDS Decl., Ex. 21, Declaration of Nina Thompson at ¶¶ 2, 6. Four of the Remark Codes (as set forth in the definition of the Claims Review Class) are at issue in this Action. According to UHC, the 4 Remark Codes were purportedly to be "written to be short, understandable narratives and descriptions", because UHC's system is not "designed to extract the specific exclusion language from the member's specific plan to include in the remark code section of the EOB." *Id.* at ¶¶ 7-8. As the Court has previously held, the 4 Remark Codes are not understandable and violate ERISA. The Court granted judgment to Plaintiffs Barber, Bishop, Condry, Endicott and Hoy under Count One, finding that the 4 Remark Codes contained in the EOBs denying their CLS claims were "written in a way that made [the denials] virtually impossible to understand." SJ Order at 5-6.

IV. THE CLAIMS DATA

In discovery, without agreeing they constituted CLS, UHC produced data for claims: that reflected the use of procedure ("CPT" or "HCPCS") and diagnosis ("ICD") codes that were identified

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electronically searchable as "Lactation Specialists" in UHC's provider directory since March 2014. KDS Decl., Ex. 7, UHC Rog. 7. As summarized and depicted in the Report of Plaintiffs' Expert Daniel McGlone (KDS Decl., Ex. 22) and the maps thereto (*id.* at Ex. 22-A), as of the date of the production, nationwide UHC had only 122 unique in-network lactation specialists (and 22 unique terminated). *Id.* at 6. In addition, for 20 states, UHC's data reflected that it had no in-network providers identified during the Class Period as lactation specialists. *Id.* at 11.Further, even viewing the data by the metropolitan statistical areas ("MSAs") where such identified lactation specialists were located, there were four or less providers identified per 1,000 live births, with most MSAs having less than one provider per 1,000 live births. *Id.* at 13.

by Plaintiffs; and, that were submitted by the OON providers identified in UHC's claims data as lactation specialists.[8] (Collectively, the "Claims Data"). *See* KDS Decl. ¶¶2-3. From the Claims Data, for purposes of the below analysis only, Plaintiffs identified approximately 33,000 lines for out-of-network claims only that included certain of the procedure and diagnoses codes related to CLS ("OON CLS Claim Lines"). *See* KDS Decl. ¶¶4-9.

A. UHC's Adjudication of Out-of-Network CLS Claims

Of the 33,000 OON CLS Claim Lines, 88% were denied or had cost-sharing imposed, resulting in over $1.1 million of cost-share imposed and over $3.4 million of billed charges denied. Therefore, UHC's treatment of the OON CLS claims confirms the harm resulting from UHC's policy: Thousands of OON CLS claims were flatly denied or not covered without the burden of cost-sharing.

B. UHC's Adjudication of Out-of-Network CLS Claims With the 4 Remark Codes

Of the 33,000 ONN CLS Claim Lines, approximately 7,600 were adjudicated utilizing one of the 4 Remark Codes, were denied with over $1.3 million of billed charges denied.

C. UHC's CDG

UHC states that its CDG "identifies certain procedure codes (and a diagnosis code for certain of those procedure codes) as those eligible for coverage without cost-shares when billed as described in the CDG and in accordance with Defendants' policies and procedures." KDS Decl., Ex. 7, UHC Rog. 1. There are two sections of the CDG: one specific to the HRSA CLS benefit and the general Wellness section which the HRSA section cross references. *See* KDS Decl. ¶¶ 7-9. UHC's position is that it sufficiently adjudicates *in-network* CLS claims as part of the ACA mandate without cost-sharing, if the in-network claims used the CPT and diagnosis codes set out in its CDG. KDS Decl. Ex. 7, UHC Rogs. 1-3, 5.

Reviewing the CDG codes in the context of the 33,000 OON CLS Claim Lines supports two points: (1) UHC's CDG does not capture the full scope of CLS services being rendered; and (2) UHC cannot argue that it adjudicated OON CLS claims without cost-sharing under the CDG.

Regarding the first point: UHC acknowledged that the CDG incorporates the preventive

[8] These are the claims that were produced pursuant to the Court's June 26, 2019 Order (Dkt. 218).

versus diagnostic care construct for CLS,[9] which the Court already declared non-ACA compliant (SJ Order, ¶ 2). Over 16,800 of the OON CLS Claim Lines utilized CPT/HCPCS Codes and ICD Codes that were not included as part of UHC's CDG for CLS coverage. Of those, 92% had cost sharing imposed or were denied, resulting in over $640,000 of cost share imposed, and over $1.5 million of billed charges denied. In the CC Order at 4, the Court referenced the import of the "erroneous 'preventive / diagnostic care construct.'" In response, what the foregoing shows is (i) the magnitude of the OON CLS claims submitted by CLS providers who utilized CPT and ICD codes that do not appear in UHC's CDG; and (ii) the CDG, whether viewed as a "preventive/diagnostic care construct" or otherwise, does not capture the CLS services being rendered.

Regarding the second point: Of the ONN CLS Claim Lines submitted with procedure and diagnosis codes reflected in the CDG, 83% had cost sharing imposed or were denied, resulting in over $460,000 of cost share imposed (42% of the over $1.1 million of cost share imposed on ONN CLS Claim Lines) and over $1.84 million of billed charges denied (54% of the $3.4 million billed charges denied for ONN CLS Claim Lines). UHC cannot argue that it adjudicates OON CLS claims without cost-sharing under the CDG.

V. RELIEF SOUGHT BY THE MEMBERS OF THE CLASSES

In the CC Order, the Court stated that it was not clear: (1) what Plaintiffs meant by UHC being ordered to "reprocess claims under a corrected standard," and "what a corrected standard looks like" for the ERISA and Non-ERISA Plan Classes; and, (2) as to the basis for and the relief sought on behalf of the Claims Review Class. *See* CC Order at 5-6.

A. The ERISA and Non-ERISA Plan Classes

Plaintiffs and the members of the ERISA and Non-ERISA Plan Classes seek declaratory and injunctive relief that includes:

> (1) An order declaring UHC's Policy that out-of-network preventive care services for CLS are not part of the ACA requirements and that out-of-network CLS claims are not

[9] Services billed without the codes in its CDG would be denied or processed with cost-sharing. *See* KDS Decl., Ex. 7, UHC Rog. 2 ("[UHC's] Sixteenth Affirmative Defense refers to breastfeeding services designed to treat existing symptoms, which fall outside the scope of the preventive services encompassed by ACA. If such services are billed using codes in a manner not set out in the CDG, they will be processed as non-preventive care."; "[A]s reflected in the CDG, diagnostic care occurs where the member 'had a symptom(s) that required further diagnosis.'")

eligible for ACA-mandated preventive care coverage without cost-sharing, to be in violation of the ACA, ERISA and its duties as an insurer / administrator of health plans to provide ACA- compliant plans.

(2) An injunction requiring UHC to revise the language of its CDG (and to any billing, coding or coverage guidance that pertains to out-of-network CLS used internally or communicated to insureds or providers), to require that out-of-network CLS will be eligible for coverage without cost-sharing as an ACA-mandated preventive benefit.

(3) An injunction requiring UHC to adopt and utilize proper claims procedures for the consideration of out-of-network CLS claims.

(4) An injunction requiring UHC to evaluate and process Plaintiffs' and class members' claims under the revised claim procedures for out-of-network CLS claims; and

(5) An injunction requiring UHC to provide notice to all class members of the processing and evaluation of out-of-network CLS claims under a proper claims procedure.

What are the proper claim procedures, or the "corrected standard"? The corrected standard is not simply UHC's application, retrospectively and prospectively, of the CDG's CPT and ICD codes to the OON CLS claims. *First*, there is no one "code" for CLS. It is Plaintiffs' position that, grounded in the HRSA Guidelines and the supporting reports, CLS means comprehensive lactation support, counseling and education services provided during the antenatal, perinatal, and the postpartum period. To that end, Plaintiffs' Expert, Dr. Hanley (KDS Decl., Ex. 24, at 4-8) identifies diagnoses codes that may be reasonably used by providers to indicate that their encounter with a patient was for CLS.

Second, as described and shown above in Section IV.C, there are thousands of OON CLS claims that, even if they were for CLS rendered by an in-network provider, would not have been processed by UHC as a preventive benefit eligible for coverage without cost-sharing. The current CDG (even for in-network CLS claims) does not capture the manner in which providers must bill for their services consistent with their duties to report the nature of the CLS visit (through CPT codes) and the conditions treated (though ICD codes). Whether one terms UHC's CDG as reflective of a diagnostic / preventive construct, or a failure to cover the full scope of ACA and HRSA mandated CLS, the corrected standard must include the additional CPT and ICD codes identified by Plaintiffs and their experts. *See* KDS Decl. Ex. 24, Table 1 in Dr. Hanley's Amended Report[10] and Exhibit 32

[10] A majority of which are diagnosis codes that Defendants' expert, Ms. D'Apuzzo identifies in her Report (KDS Decl. Ex. 23) as diagnosis codes that describe lactation related issues (fn. 2); and, diagnosis codes that relate to breast issues but, in her opinion, "not lactation issues overtly" (fn. 3).

to the KDS Decl. which is a compilation of the CPT Codes, by number and description. That other UHC adjudication guidelines may apply, such as a requirement that the insured's policy has not lapsed, is expected. But, it would be contrary to the coverage mandate to use adjudication guidelines with the aim of limiting the OON CLS coverage.[11] In sum, the corrected standard incorporates the procedure and diagnosis codes necessary to identify OON CLS claims as eligible for cost-share-free coverage under the ACA preventive services mandate.

B. The Claims Review Class

"Having found that the Plan violated [29 U.S.C. § 1133], the procedural requirements for notice of denial of benefits, the Court has some discretion in determining the appropriate remedy." *Schaub v. Consolidated Freightways, Inc. Extended Sick Pay Plan*, 895 F.Supp. 1136, 1145 (S.D. Ind. 1995). In the case at bar, Plaintiffs "may invoke section 1132(a)(3) to compel the plan administrators to establish claim procedures which comply with the ERISA regulations promulgated by the Secretary of Labor." *Arsenault v. Bell*, 724 F.Supp. 1064, 1068 (D. Mass. 1989).

Defendants offered incomprehensible reasons with their use of the 4 Remark Codes for denying Plaintiffs' claims (SJ Order, Dkt. 146, at 5-7), and in light of the broad discretion of the Court, Plaintiffs seek to have the Court require Defendants to provide full explanations of their benefits and any reasons why previous claims for OON CLS were denied. *See Schneider v. Sentry Grp. Long Term Disability Plan*, 422 F.3d 621, 629 (7th Cir. 2005) (holding that, in a case where the court granted summary judgment for plaintiffs' §1133 claims, "[i]n fashioning relief for a plaintiff who has sued to enforce her rights under ERISA, we have focused 'on what is required in each case

[11] For example, UHC asserts that the Nonphysician Health Care Professionals Billing Evaluation and Management Codes Policy ("NP Policy", KDS Decl. Ex. 25) applies. *See* KDS Decl. Ex. 7, UHC Rogs. 10-11. The NP Policy in conjunction with the CDG, as UHC's expert admits, prohibits non-physician providers of CLS (the typical provider type) from billing the CLS procedure codes, except one, S9443 for "Lactation Classes." KDS Decl. Ex. 23 (D'Apuzzo Report at ¶ 26). As Dr. Hanley opined, that approach prevents providers from accurately billing for the CLS services provided; S9443 does not accurately reflect the breastfeeding support and counseling services that are provided by non-physician lactation specialists. *See* KDS Decl., Ex. 26, Dr. Hanley 1/18/2019 Rebuttal Report at ¶ 5. Fundamentally, the NP Policy does not *need* to apply; it expressly states that it "*does not address all issues related to reimbursement for health care services...Other factors affecting reimbursement may ...modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates...*" KDS Decl. Ex. 25 at UHC_002635 (emphasis added).

to fully remedy the defective procedures given the *status quo* prior to the denial or termination' of benefits") (citing *Hackett v. Xerox Corp. Long-Term Disability Income Plan*, 315 F.3d 771, 776 (7th Cir. 2003))). Accordingly, Plaintiffs and the members of the Claims Review Class seek declaratory and injunctive relief that includes, *inter alia*:

(1) An order declaring that the 4 Remark Codes violate ERISA;

(2) An order requiring UHC to comply with the procedural requirements of 29 U.S.C. § 1133 and 29 C.F.R. § 2560.503-1, *et seq.* promulgated thereunder by the Department of Labor with regard to their explanation of denials for out-of-network CLS;

(3) An order declaring that UHC's denials of out-of-network CLS claims that used the 4 Remark Codes have been made in violation of ERISA; and,

(4) An injunction requiring UHC to re-issue to each class member an amended explanation of benefits that: (i) provides a clear explanation as to their benefits and why the claim was denied, and (ii) re-starts the time from which the class member can appeal the denial.

VI. CERTIFICATION OF THE CLASSES UNDER RULE 23 IS PROPER

Plaintiffs seek certification of the three classes set forth in their Motion: The ERISA Plan Class, the Non-ERISA Plan Class, and the Claims Review Class. Plaintiffs address herein the elements of Fed. R. Civ. P. 23 and the Court's attendant statements in the CC Order.

A. The Proposed Classes Meet the Requirements of Rule 23(a)

1. *The Proposed Classes are Sufficiently Numerous*

Rule 23(a)(1) requires that a class be so numerous that joinder of all members is impracticable. *See Moeller v. Taco Bell Corp.* 220 F.R.D. 604, 608 (N.D. Cal 2004). Plaintiffs are not required to identify each and every potential member of the class or specify the exact number of potential class members. *See Martial v. Coronet Ins. Co.*, 880 2d 954, 957 (7th Cir. 1989). Instead, plaintiffs need only provide a supported estimate. *Id.*[12] Based on UHC's claims data produced, discussed *supra* at Section IV, there are thousands of OON claims at issue in each of the Classes. Also, for the ERISA and Non-ERISA Plan Classes, there are additional UHC insureds who did not submit their OON CLS

[12] Additionally, courts may consider factors such as "the geographical diversity of class members, the ability of individual claimants to institute separate suits, and whether injunctive or declaratory relief is sought." *Ogbuehi v. Comcast of Cal,/Colo./Fla./Or., Inc.,* 303 F.R.D. 337, 345 (E.D. Cal. 2014) (citing *Jordan v. Cnty. of Los Angeles,* 669 F.2d 1311, 1319 (9th Cir. 1982), *vacated on other grounds,* 459 U.S. 810 (1982)). Those factors exist here and further satisfy the numerosity prong.

claim to UHC, but based on their records will demonstrate the receipt and costs incurred for CLS.[13] The members of the Classes are sufficiently numerous.

2. *Plaintiffs Establish Commonality*

The commonality prerequisite looks to whether the "claims 'depend upon a common contention' such that 'determination of its truth or falsity will resolve an issue that is central to the validity of each claim in one stroke.'" *Mazza v. Am. Honda Motor Co*., 666 F.3d 581, 588 (9th Cir. 2012) (quoting *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011)). "What matters to class certification is not the raising of common 'questions' - even in droves — but rather the capacity of a classwide proceeding to generate common answers apt to drive the resolution of the litigation." *Dukes*, 564 U.S. at 350. "[E]very question of law or fact [need not] be common to the class; Rule 23(a)(2) requires 'a single significant question of law or fact.'" *Abdullah v. U.S. Security Associates, Inc.*, 731 F.3d 952, 957 (9th Cir. 2013)(quoting *Mazza*, 666 F.3d at 589).

a. <u>ERISA Plan and Non-ERISA Plan Classes</u>

In the CC Order, the Court stated that "the plaintiffs have not presented adequate evidence that liability could be determined (or that any significant issues could be resolved) on a classwide basis." CC Order at 3, citing *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011).

With respect to the ERISA and Non-ERISA Plan Classes, Plaintiffs have presented documentary and statistical evidence that UHC has a uniform policy with respect to OON CLS claims: UHC deems them not eligible for coverage without cost-sharing under the ACA preventive services mandate. UHC's policy precluded every OON CLS claim from having the opportunity of being covered without cost-sharing and adjudicated in accordance with the ACA. The determination as to whether UHC's adoption of such a policy with respect to OON CLS claims violated the ACA will and must apply equally to each of the ERISA and Non-ERISA class members and their OON

[13] Such class members will be identified through the receipt of the notice of the pendency of the Class Action published nationwide, as well as a direct notice provided to UHC insureds who had submitted a claim for a breast pump to UHC since August 1, 2012, which is an expression of an intention to initiate breastfeeding and tied to the breastfeeding support, supplies and counseling preventive benefit. *See, e.g., Kumar v. Salov N. Am. Corp.*, 2016 U.S. Dist. LEXIS 92374, *6 (N.D. Cal. July 15, 2016) (finding class members ascertainable despite defendant's arguments that class members would have to self-identify and show "what they paid, where they purchased it, and how many times, plus whether they saw and were deceived" by a product's label).

CLS claims. The significant issue that can be resolved on a classwide basis is whether such policy violates the ACA, and, in turn whether that renders UHC in violation of its ERISA duties and its duties as an insurer / administrator of health plans that are to be ACA compliant.

For the reasons discussed *supra,* Section III.C., there are no differing standards or an "availability" construct applicable to the members of the Classes that preclude a finding of commonality. The resolution of whether UHC's blanket Policy comported with the ACA is the significant issue resolvable on a classwide basis, and it is not tethered to "availability". UHC did not: adjudicate each OON CLS claim by determining any in-network provider availability; inform the insured that its claim was denied because UHC identified an available in-network provider; or invite its insureds to demonstrate the negative, that is, that each insured did not have in-network CLS available to them. UHC's policy did not hinge on or even account for each insured's circumstances or conduct. Moreover, at best, UHC's Policy was based on a necessarily blanket presumption that all providers provide CLS, which is baseless and belied by its own documents.

Also as discussed *supra,* Section III.C., the Summary Judgment proceedings are consistent with Plaintiffs' position. The Court did not address UHC's blanket Policy in that ruling. What may be obscured when summary judgment proceedings on individual claims are pursued in this type of class action is the liability stemming from UHC's uniform policy that: comprise the common contentions to be determined; which when resolved are primary to the validity of putative class members' claims; and, are primary to a Rule 23 analysis. *See, e.g., Abdullah*, 731 F.3d at 957 (every question of law or fact need not be common to the class; all that Rule 23(a)(2) requires is a single significant question of law or fact). This may be reflected in the CC Order (at pg. 3), when the Court points to such "differing results" but then states that they "do not automatically defeat class certification – after all if UHC applied the same ACA-noncompliant policy in processing claims across the board, the Court could award classwide relief by requiring the company to reprocess all claims previously denied pursuant to that noncompliant policy, even if some claims were granted pursuant to that non-compliant policy (and even if some claims would still be denied pursuant to a compliant policy)." CC Order at 3, citing to *Des Roches*, and *Wit*.

Following *Dukes* and *Mazza*, district courts in this Circuit have found common issues in cases

involving coverage policies and ERISA claims handling practices. In *Des Roches v. California Physicians' Service*, 320 F.R.D. 486, 497-504 (N.D. Cal. 2017) the court certified a class of health plan participants over challenges to commonality, holding that "even if the Guidelines were not dispositive in every case, this does not change the fact that, assuming Plaintiffs' allegations are true, Defendants applied an incorrect standard in evaluating every class member's claims." *Id.* at 500. Here, as in *Des Roches*, the "harm alleged []—the promulgation and application of defective guidelines to the putative class members—is common to all of the [] class members." *Id.* (internal quotation omitted). Likewise, in *Trujillo, et al. v. UnitedHealth Group, Inc., et al.,* CV 17-2547, 2019 U.S. Dist. LEXIS 21927 (C.D. Cal. Feb. 4, 2019), the court granted class certification where insureds alleged that "United has failed to ensure that benefit claim determinations are made in accordance with governing plan documents, failed to establish reasonable claims procedures, and failed to provide adequate notice of adverse benefit determinations in violation of [ERISA]". *Id.* at *2. In doing so, the court rejected defendants' arguments (akin to what UHC has argued here) that (1) coverage involved, for prosthetic devices, "a series of billing codes" and that a prosthetic limb will typically have ten to twenty different L-codes; and, (2) "providers sometimes ignore that guidance and use the miscellaneous codes..." *Id.* at *4-5.[14]

Whether UHC's Policy that OON CLS claims were not eligible for the ACA's preventive care mandate of coverage without cost-sharing and whether UHC's CDG was fundamentally deficient, are two common issues that are resolvable on a classwide basis. Again, the same ACA-noncompliant policy – that OON CLS claims were not eligible for coverage under the ACA's preventive services mandate – applied to each OON CLS claim incurred by UHC's insureds; therefore the necessary

[14] *See also, Escalante v California Physicians Service d/b/a Blue Shield of California,* 309 F.R.D. 612, 618 (C.D. Cal. 2015) (common issue found as to health plan's practice in denying claims for artificial lumbar disc surgery); *see, e.g, In re Conseco Life Ins. Co. LifeTrend Ins. Sales & Mktg. Litig*., 270 F.R.D. 521, 529-30 (N.D. Cal. 2010) (holding commonality satisfied because "interpretation of the standard written policy language will present a question common to the class"). The Ninth Circuit has upheld commonality findings regarding less distinct practices than those presented here for the Classes. *See Abdullah v. U.S. Security Assoc., Inc*., 731 F.3d 952, 962-963 (9th Cir. 2013) (legality of employer's meal break practice was common issue that was "apt to drive the resolution of the litigation"); *see also Parsons,* 754 F.3d at 679-680 (commonality existed as to adequacy of state's system of privatized health care for inmates that created a risk of substantial harm for all class members); *Jimenez v. Allstate Ins. Co*., 765 F.3d 1161, 1165-1166 (9th Cir. 2014) (employer's practice of requiring unpaid off-the-clock overtime presented common issue).

classwide relief is the processing of all OON CLS claims, pursuant to an ACA-compliant policy. *See* Section V.A, *supra.*

b. The Claims Review Class

As UHC's witness identified, the 4 Remark Codes were included in UHC's Explanation of Benefits form ("EOBs") that are sent to UHC members in response to and as part of the denial of their claim for coverage. *See* KDS Decl., Ex. 21, Declaration of Nina Thompson at ¶¶ 2, 6. The Court granted summary judgment in favor of the five Plaintiffs who brought a secondary claim against UHC for its failure with the use of the Remark Codes to "provide adequate notice . . . setting forth the specific reasons" for the denial of benefits. 29 U.S.C. § 1133(1). As the Court has recognized, Defendants' violation of 29 U.S.C. § 1133 was particularly egregious in that the denials "were written in a way that made them virtually impossible to understand." SJ Order at 5-6.

As a result of Defendants' failure to provide adequate notice about the denial of benefits, Plaintiffs are entitled to a remedy under ERISA. *See Soon v. PNM Resources, Inc. Employees' Retirement Plan*, No. CIV-O4-0676 BB/DJS, 2005 WL 8164217, at *7-*8 (D.N.M. May 27, 2005) (holding that "[p]roviding insufficient information to permit a participant to make an informed decision can be a breach of fiduciary duty"); *see also Arsenault,* 724 F.Supp. at 1067(holding that "[a] plan's failure to provide an adequate claim procedure [in accordance with 29 U.S.C. § 1132 and 29 C.F.R. § 2560.503-1, *et seq.* promulgated thereunder] may give rise to a private cause of action against plan administrators under 29 U.S.C. § 1132(a)(3)"). Accordingly, having made the determination that each of the 4 Remark Codes provides inadequate notice about the denial of benefits or sufficient information to make an informed decision, the Court can resolve "in one stroke" that UHC's conveying to each member of the Claims Review Class an EOB with any such Remark Code violated ERISA and subject it to the same relief, *see* Section V.B. *Mazza*, 666 F.3d at 588.

3. *Plaintiffs' Claims are Typical*

Typicality exists when "the claims or defenses of the representative parties are typical of the claims or defenses of the class." Fed. R. Civ. P. 23(a)(3) . The requirement is permissive, such that "representative claims are 'typical' if they are reasonably coextensive with those of absent class members; they need not be substantially identical." *Parsons v. Ryan,* 754 F.3d 657, 685 (9th Cir.

2014 (quoting *Hanlon,* 150 F.3d at 1020).

For the ERISA Plan Class Plaintiffs Bishop, Hoy, Endicott and Harris are the proposed Class Representatives. For the Non-ERISA Plan Class, Plaintiff Carroll is the proposed Class Representative. UHC's Policy about OON CLS applied equally to each of these Plaintiffs, who like each of their fellow class members, had OON CLS claims that were not covered without cost-sharing. The Plaintiffs seek to enforce the rights of their fellow insureds to be covered by ACA-compliant policies and procedures. For the Claims Review Class, Plaintiffs Barber, Bishop, Condry, Endicott, and Hoy are the proposed Class Representatives. Each of these Plaintiffs received an EOB from UHC with one or more of the Remark Codes, had their CLS claims denied based on one or more of the Remark Codes, and secured, on summary judgment, a finding by the Court that each of the 4 Remark Codes was "virtually impossible to understand".

As summarized in *Just Film, Inc. v. Buono*, 847 F.3d 1108, 1116 (9th Cir. 2017): "Typicality focuses on the class representative's claim—*but not the specific facts from which the claim arose*—and ensures that the interest of the class representative aligns with the interests of the class." (Emphasis added). On that basis, and for the reasons already discussed, UHC's arguments (whether raised in terms of addressing commonality, typicality or otherwise), that a deep dive into Plaintiffs' medical records is required, or individual review of providers' accounts payable and receivables is needed, or assessing OON CLS claims is based on "individualized circumstances", are just not applicable to the inquiry of whether UHC's Policy on OON CLS claims violated the ACA.[15]

As noted, the Court's CC Order pointed to "differing results" that it suggested may or may not have occurred as a result of UHC's application of the non-ACA compliant policy; however, no such differing results arose from the UHC Policy.[16] At bottom, like the court in *Hill v. UnitedhealthCare*

[15] Those are disguised ascertainability and administrative feasibility arguments, which Plaintiff need not demonstrate. *See Briseno v. ConAgra Foods, Inc.*, 844 F.3d 1121, 1126 (9th Cir. 2017) ("[T]he language of Rule 23 does not impose a freestanding administrative feasibility prerequisite to class certification. Mindful of the Supreme Court's guidance, we decline to impose an additional hurdle into the class certification process delineated in the enacted Rule.").

[16] But, even experiences akin to differing results, such as a defective product that does not manifest its defect for certain class members, does not defeat class certification. "[P]roof of the manifestation of a defect is not a prerequisite to class certification." *Wolin v. Jaguar Land Rover N. Am., LLC*, 617 F.3d 1168, 1173 (9th Cir. 2010) (citation omitted)). Similarly, the argument that the defect may *never* manifest is immaterial to class certification. *Baker v. Microsoft Corp.*, 797 F.3d 607, 614 (9th Cir.

Ins. Co., 2017 U.S. Dist. LEXIS 218139, at *25-27 (C.D. Cal. Mar. 21, 2017) found, individual inquiry into each patient's circumstances was unnecessary where "the main issue of the case…challenges Defendant's policy on its face, not Defendant's individualized coverage decisions."

4. *Plaintiffs and Counsel Are Adequate Representatives*

"To establish adequacy of representation [under Rule 23(a)(4)], the Court must resolve whether 'the named plaintiffs and their counsel have any conflicts of interest with other class members' and whether 'the named plaintiffs and their counsel will prosecute the action vigorously on behalf of the class.'" *Arthur v. United Indus. Corp.*, Case No. 2:17-cv-06983-CAS (SKx), 2018 U.S. Dist. LEXIS 83607, at *27 (C.D. Cal. May 17, 2018) (quoting *Hanlon v. Chrysler Corp.*, 150 F.3d 1011, 1020 (9th Cir. 1998)).[17] Both elements of adequacy are satisfied here. The proposed Class Representatives for each of the Classes (identified as set forth above) do not have conflicts of interests with, and have no interests that are antagonistic to the interests of, the proposed Classes. *See* Section III.C.3. Plaintiffs, who are now joined by proposed Intervenor Plaintiff Harris, have vigorously advocated the claims against UHC. Other than Harris, Plaintiffs have each responded to: forty-two requests for production and produced several hundred pages of documents each; over twenty interrogatories; and spent many hours over several days preparing for and being deposed.

The second prong of adequacy is also easily satisfied. Proposed Co-Lead Class Counsel, Chimicles Schwartz Kriner & Donaldson-Smith LLP and Shepherd, Finkelman, Miller & Shah, LLP, and Proposed Class Counsel Axler Goldich LLC are experienced and qualified in class action litigation, including ERISA class actions, and have secured certification of numerous class actions and brought them to successful conclusions. *See* KDS Decl., Exs. 29-31 (Firm Resumes). Plaintiffs and Class Counsel will continue to adequately and zealously represent the members of the Classes.

2015) (citation omitted); *Jimenez v. Allstate Ins. Co.*, 765 F.3d 1161, 1168 (9th Cir. 2014) (citation omitted) ("So long as the plaintiffs were harmed by the same conduct, disparities in how or by how much they were harmed [does] not defeat class certification.").

[17] Defendants may point to small factual differences between Plaintiffs and class members, but they do not defeat adequacy. *See Walters v. Reno*, 145 F.3d 1032, 1046 (9th Cir. 1998) (factual differences in the merits of the plaintiffs' underlying claims "have no bearing on the class representatives' abilities to pursue the class claims vigorously and represent [their] interests…").

B. The Proposed Classes Meet the Requirements of Rule 23(b)

Here, Plaintiffs seek certification under subsections (b)(1)(A) and (b)(2). UHC has engaged in an undisputed, unitary course of conduct. With respect to the ERISA and Non-ERISA Plan Classes, UHC enacted a blanket Policy that OON CLS claims were not eligible for the ACA-mandated coverage. With respect to the Claims Review Class, it utilized 4 Remark Codes that were facially unintelligible. Because UHC's illegal conduct was the same with respect to the members of each respective Class, and class members seek injunctive and declaratory relief, the Court should certify the Classes under Rule 23(b)(1)(A) and (b)(2).

1. The Class Should Be Certified Under Rule 23(b)(1)(A).

Rule 23(b)(1)(A) authorizes certification where prosecuting separate actions would create a risk of incompatible standards of conduct for the defendant. *See Zinser v. Accufix Research Inst., Inc.*, 253 F.3d 1180, 1193 (9th Cir. 2001); *see also McCluskey v. Trustees of Red Dot Corp. Emp. Stock Ownership Plan & Trust*, 268 F.R.D. 670, 678 (W.D. Wash. 2010). The phrase "incompatible standards of conduct" refers to the situation where "different results in separate actions would impair the opposing party's ability to pursue a uniform continuing course of conduct." *Zinser*, 253 F.3d at 1193. Indeed, certification under Rule 23(b)(1)(A) is particularly appropriate in ERISA and injunctive relief class actions because health plans generally, and ERISA fiduciaries, must apply the same proper standards to all members. *Des Roches,* 320 F.R.D. at 506 ("The Court can envision few better scenarios for certification under (b)(1)(A)....This is because Rule 23(b)(1)(A) takes in cases where the party is obliged by law to treat the members of the class alike ….")(citations omitted).

ERISA requires that, where appropriate, plan provisions must be "applied consistently with respect to similarly situated claimants." 29 C.F.R. § 2560.503-1(b)(5). Accordingly, if this Court were to find that UHC's OON CLS policy and the 4 Remark Codes required UHC to act in a certain fashion, and another court found that same OON CLS policy and those same 4 Remark Codes required UHC to act in a different fashion, UHC would face an incompatible standard of conduct. To avoid such a result, certification pursuant to Rule 23(b)(1)(A) is mandated. *See Trujillo,* 2019 U.S. Dist. LEXIS 21927 at *21-22. Further, the same rationale applies to the claims of the ERISA and the Non-ERISA Plan Class members as, fundamentally, the policy for the ACA-mandated preventive

care coverage of OON CLS claims comes from the ACA, which applies equally and must be then applied consistently to ERISA and Non-ERISA plans.

The policies and procedures at issue here are not impacting a single or few of UHC's plans. This Action evokes: (1) the ACA coverage requirement; (2) UHC's policy that applies to all OON CLS claims, that such claims are not ACA-coverage eligible; and (3) UHC's 4 Remark Codes applied to its members' explanation of benefits. *See also, Vill. of Bedford Park v. Expedia, Inc. (WA)*, 2015 U.S. Dist. LEXIS 1012 (N.D. Ill. Jan. 6, 2015) ("Rule 23(b)(1)(A) takes in cases where the party is obliged by law to treat the members of the class alike…"). Accordingly, the Classes should be certified under Rule 23(b)(1)(A).

2. *The Class Also Should Be Certified Under Rule 23(b)(2)*

Certification of the Classes are also proper under Rule 23(b)(2) because UHC has "acted or refused to act on grounds that apply generally to the [Classes]", so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." The key to certification under Rule 23(b)(2) is establishing, as Plaintiffs have done here, the uniform, class-wide conduct on the part of UHC. *See Parsons*, 754 F.3d at 688. This requirement is "unquestionably satisfied when members of a putative class seek uniform injunctive or declaratory relief from policies or practices that are generally applicable to the class a whole." *Id.*[18]

Rule "23(b)(2) is the appropriate rule to enlist when the plaintiffs' primary goal is not monetary relief, but rather to require the defendant to do or not do something that would benefit the whole class." *See e.g., Chicago Teachers Union, Local No. 1 v. Bd. of Educ. of Chicago*, 797 F.3d 426, 441 (7th Cir. 2015). As discussed in the following section, certification under Rule 23(b)(2) is also particularly appropriate here because Plaintiffs are requesting that UHC (1) adopt a new standard under which OON CLS claims would be processed, and then (2) process past OON CLS claims for health benefits under that new standard. *See Des Roches*, 320 F.R.D. at 508; *Wit*, 317 F.R.D. at 134-138; *see also Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability*

[18] "That inquiry does not require an examination of the viability or bases of the class members' claims for relief, does not require that the issues common to the class satisfy a Rule 23(b)(3)-like predominance test, and does not require a finding that all members of the class have suffered identical injuries." *Parsons*, 754 F.3d at 688.

Income Plan, 85 F.3d 455, 460-461 (9th Cir. 1996). Here, Plaintiffs and the members of the Classes are seeking declaratory and injunctive relief to remedy the same conduct, described above, with respect to CLS. This Action "necessarily involve[s] acts that are generally applicable to the class." *Moeller*, 220 F.R.D. at 612; *see also Arnold v. United Theatre Circuit, Inc.*, 158 F.R.D. 439, 452 (N.D. Cal. 1994) (where class members challenged defendant's failure to change certain architectural features found at its theatres, and the challenged design features affected all class members in the same way, the court determined that such a scenario "is a paradigm of the type of action for which the (b)(2) form was created"). Each of the three Classes is appropriately certified under Rule 23(b)(2).

3. *The Relief Sought Here is Proper Under (b)(1) or (2)*

In the CC Order, the Court stated Plaintiffs must explain "why their requested remedy should be considered for class certification under Federal Rule of Civil Procedure 23(b)(1)-(2), rather than under Rule 23(b)(3)". CC Order at 5. Courts, including courts in this circuit, have used Federal Rule of Civil Procedure 23(b)(2) to certify classes seeking injunctive and declaratory relief that includes, among other things, an injunction requiring health plans to (1) adopt a new standard for processing claims, and then (2) "reprocess" past denied claims for health benefits under that new standard. In *Wit v. United Behavioral Health*, 317 F.R.D. 106 (N.D. Cal. 2016), the plaintiffs also sought a reprocessing injunction, which the court certified under Rule 23(b)(2), holding that "the Plaintiffs' injury can be remedied for all class members by requiring [the plan] to modify its Guidelines and reprocess claims that were denied under the allegedly defective guidelines." In *Trujillo,* 2019 U.S. Dist. LEXIS 21927 at *9-10, the court certified a Rule 23 (b)(2) class because, "Plaintiffs and the class members seek declaratory and injunctive relief that includes…:

> (1) '[a]n order declaring that United's denials of claims…without adequate notices of adverse benefit determination as required by ERISA;' (2) '[a]n injunction requiring United to revise the language of [the] CDG…;' (3) '[a]n injunction requiring United to adopt and utilize proper claims procedures …;' (4) '[a]n injunction requiring United to reevaluate and reprocess Plaintiffs' and class members' claims under revised procedures compliant with the provisions of ERISA;' and (5) '[a]n injunction requiring United to provide notice to all class members of the reevaluation and reprocessing in the form and manner required by ERISA.'"

In *Des Roches,* 320 F.R.D. at 497-98, 508 (emphasis added), Judge Koh court certified a class under Rules 23(b)(1)(A) and 23(b)(2) relying on Ninth Circuit authority (*Saffle*, 85 F.3d at

461), and holding that where a plan administrator with discretion to construe plan terms misconstrues a term, the court should "remand the claim to the administrator for it to make that decision under the plan, *properly construed*." *Id.* at 456 (emphasis added). Thus, the court continued, "*far from being improper retrospective relief, the reprocessing injunction that Plaintiffs seek is precisely the sort of final relief that the Court should order under binding Ninth Circuit precedent*." *Id.* at 508 (emphasis added).[19]

VII. PLAINTIFFS HAVE STANDING TO SEEK THE RELIEF SOUGHT

In Section V, *supra,* Plaintiffs outlined the proposed relief.[20] Plaintiffs have standing to seek an order remedying UHC's past violations, including an order requiring UHC to process out-of-network CLS claims under a corrected standard. (CC Order at 5). As discussed in Section VI.B.3, *supra*, courts certify classes awarding the precise relief sought here. *See, Trujillo,* 2019 U.S. Dist. LEXIS 21927 at *9-10; *Wit*, 2017 U.S. Dist. LEXIS 129076, at *41-44; *Des Roches,* 320 F.R.D. at 508; *Saffle,* 85 F.3d at 456 (An ERISA Plan participant or beneficiary may bring a claim for arbitrary and capricious denial of benefits based on an injury other than the actual denial if the process by which a coverage determination was made was defective); *Ballas v. Anthem Blue Cross Life & Health Ins. Co.*, 2013 U.S. Dist. LEXIS 199523, (C.D. Cal. Apr. 29, 2013)(certification appropriate based on a requested injunction requiring the defendant to reprocess class members' claims under a different policy). Plaintiffs have standing to pursue the retrospective injunctions because (1) they

[19] In the unlikely event that the Court were to conclude that the requirements of Rule 23(b) have not been satisfied, the Court should nevertheless certify the ERISA and Non-ERISA Plan Classes under subsection (c)(4)("[w]hen appropriate, an action may be brought or maintained as a class action with respect to particular issues.") "The Ninth Circuit has endorsed the use of issue classes where individualized questions predominate and make certification under Rule 23(b)(3) inappropriate." *In re Conagra Foods, Inc.*, 302 F.R.D. 537, 580-81 (C.D. Cal. 2014) (citing *Valentino v. Carter—Wallace, Inc*., 97 F.3d 1227, 1234 (9th Cir. 1996) ("Even if the common questions do not predominate over the individual questions…, Rule 23 authorizes the district court in appropriate cases to isolate the common issues under Rule 23(c)(4)(A) and proceed with class treatment of these particular issues")). With respect to the ERISA and Non-ERISA Classes, this case presents the following common issues: Whether UHC's Policy that OON CLS claims were not eligible for the ACA's preventive care mandate of coverage without cost-sharing and whether UHC's CDG was fundamentally deficient.

[20] "[P]laintiffs are not 'required to come forward with an injunction that satisfies Rule 65(d) with exacting precision at the class certification stage.'" *Wit*, 317 F.R.D. at 138 (*quoting Parsons v. Ryan*, 289 F.R.D. 513, 524 (D. Ariz. 2013), aff'd, 754 F.3d 657 (9th Cir. 2014)).

have alleged an injury in fact, in the form of a deprivation of the health insurance benefits to which they allege they were entitled, namely the consideration of their OON CLS claims as eligible for the ACA-mandated preventive care coverage; (2) there is a causal connection between their injury and the conduct complained of, namely, UHC's Policy that OON preventive care services are not part of the ACA requirements and OON CLS claims were ineligible for coverage without cost-sharing, and (3) it is likely, as opposed to merely speculative, that this injury will be redressed by the order Plaintiffs seek. *Lujan v. Defenders of Wildlife,* 504 U.S. 555, 560-61 (1992) (internal quotation marks omitted). In order to have a personal stake in retrospective relief, a plaintiff need not have likelihood of future harm because the relief sought seeks to remedy past wrong to the Plaintiffs and class members. Finally, in certifying a class under Rule 23(b)(1) and 23(b)(2), the court in *Wit*, 317 F.R.D. at 132, rejected defendant's argument that because some of the named plaintiffs are no longer members of its insurance plans, they do not have standing to seek injunctive or declaratory relief.

In addition, in the CC Order, the Court stated that "It does not appear that the named plaintiffs have standing to seek prospective relief because they are no longer UHC plan participants." CC Order at 4. Intervenor Plaintiff Teresa Harris is currently insured by UHC, and, additionally, had cost-sharing imposed on her two OON CLS claims. To establish standing for prospective injunctive relief, a plaintiff must demonstrate that he or she has suffered or is threatened with a concrete and particularized legal harm coupled with a sufficient likelihood that he or she will again be wronged in a similar way." *Des Roches*, 320 F.R.D. at 511 (citations and quotations omitted). In *Des Roches,* because defendants no longer used the challenged guidelines, the plaintiffs did not have standing to pursue prospective injunctive relief. *Id.* ("Plaintiffs provide essentially no argument that Defendants are likely to return to the Guidelines"). In contrast, UHC's Policy and the CDG remain in effect, and UHC's insureds continue to be subjected to UHC policies that violate the ACA mandate. Accordingly, Plaintiffs have standing to pursue the relief sought.

VIII. CONCLUSION

Plaintiffs respectfully request that the Court certify the Classes as defined above under Federal Rules of Civil Procedure (b)(1) and (b)(2), or, in the alternative Rule 23(c)(4).

Dated: September 9, 2019

CHIMICLES SCHWARTZ KRINER & DONALDSON-SMITH LLP

By: */s/ Kimberly Donaldson-Smith*
Nicholas E. Chimicles (admitted *pro hac vice*)
Kimberly Donaldson-Smith (admitted *pro hac vice*)
Stephanie E. Saunders (admitted *pro hac vice*)
361 W. Lancaster Avenue
Haverford, PA 19041
Phone: (610) 642-8500
Fax: 610-649-3633
NEC@Chimicles.com
KMD@Chimicles.com
SES@Chimicles.com

James E. Miller (admitted *pro hac vice*)
Laurie Rubinow (to seek admission *pro hac vice*)
SHEPHERD, FINKELMAN, MILLER AND SHAH, LLP
65 Main Street
Chester, CT 06412
Phone: (860) 526-1100
Fax: (866) 300-7367
jmiller@sfmslaw.com
lrubinow@sfmslaw.com

Proposed Co-Lead Class Counsel and Counsel for Plaintiffs

Marc A. Goldich (admitted *pro hac vice*)
Noah Axler (admitted *pro hac vice*)
AXLER GOLDICH LLC
1520 Locust Street
Suite 301
Philadelphia, PA 19102
Phone: (267) 534-7400
Fax: (267) 534-7407
mgoldich@axgolaw.com
naxler@axgolaw.com

Proposed Class Counsel and Counsel for Plaintiffs

KRISTEN LAW SAGAFI, California Bar No. 222249
TYCKO & ZAVAREEI LLP
483 Ninth Street, Suite 200
Oakland, CA 94607
Phone: (510) 254-6808
Fax: (202) 973-0950
ksagafi@tzlegal.com

Jonathan W. Cuneo (to seek admission *pro hac vice*)
Pamela B. Gilbert (to seek admission *pro hac vice*)
Monica E. Miller (to seek admission *pro hac vice*)
Katherine Van Dyck (to seek admission *pro hac vice*)
CUNEO GILBERT & LADUCA, LLP
4725 Wisconsin Ave. NW, Suite 200
Washington, DC 20016
Phone: (202) 789-3960
Fax: (202) 789-1813

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on September 9, 2019, I served the foregoing **PLAINTIFFS' AND INTERVENOR PLAINTIFFS' NOTICE OF MOTION AND MOTION FOR CLASS CERTIFICATION; MEMORANDUM OF POINTS AND AUTHORITIES** on the following counsel of record via email:

Martin J. Bishop
Rebecca R. Hanson
Thomas C. Hardy
Abraham J. Souza
Reed Smith LLP
10 S. Wacker Drive, 40th Floor
Chicago, IL 60606
mbishop@reedsmith.com
rhanson@reedsmith.com
thardy@reedsmith.com
asouza@reedsmith.com

Karen A. Braje
Reed Smith LLP
101 Second Street, Suite 1800
San Francisco, CA 94105
kbraje@reedsmith.com

Dianna C. Wyrick
Reed Smith LLP
Reed Smith Centre
225 Fifth Avenue
Pittsburgh, PA 15222
dwyrick@reedsmith.com

Janet H. Kwuon
Reed Smith LLP
355 S. Grand Ave., Suite 2900
Los Angeles, CA 90071
jkwuon@reedsmith.com

Attorneys for Defendants

/s/ Kimberly M. Donalson-Smith
Kimberly M. Donaldson-Smith