Martin J. Bishop (admitted *pro hac vice*)
Email: mbishop@reedsmith.com
Rebecca R. Hanson (admitted *pro hac vice*)
Email: rhanson@reedsmith.com
REED SMITH LLP
10 South Wacker Drive, 40th Floor
Chicago, IL 60606
Telephone: +1 312 207 1000
Facsimile: +1 312 207 6400

Karen A. Braje (SBN 193900)
Email: kbraje@reedsmith.com
REED SMITH LLP
101 Second Street, Suite 1800
San Francisco, CA 94105-3659
Telephone: +1 415 543 8700
Facsimile: +1 415 391 8269

Attorneys for Defendants UnitedHealth Group Inc., UnitedHealthcare, Inc., UnitedHealthcare Insurance Company, United HealthCare Services, Inc., and UMR, Inc.

(Additional Counsel on Signature Page)

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

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

Plaintiffs,

vs.

UNITEDHEALTH GROUP INC., UNITEDHEALTHCARE, INC., UNITEDHEALTHCARE INSURANCE COMPANY, UNITED HEALTHCARE SERVICES, INC., and UMR, INC.,

Defendants.

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

DEFENDANTS UNITEDHEALTH GROUP INC., UNITEDHEALTHCARE, INC., UNITEDHEALTHCARE INSURANCE COMPANY, UNITED HEALTHCARE SERVICES, INC., AND UMR, INC.'S NOTICE OF MOTION AND MOTION FOR SUMMARY JUDGMENT; MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT THEREOF

Date: February 8, 2018
Time: 10:00 a.m.
Place: Courtroom 4

Compl. Filed: Jan. 13, 2017

Honorable Vincent Chhabria

PLEASE TAKE NOTICE that on February 8, 2018 at 10:00 a.m. in Courtroom 4 of the above-captioned court, located at 450 Golden Gate Avenue, San Francisco, CA 94102, Defendants UnitedHealth Group Inc., UnitedHealthcare, Inc., UnitedHealthcare Insurance Company, UnitedHealthCare Services, Inc., and UMR, Inc. will, and hereby do, move the Court for an order granting the instant Motion for Summary Judgment and granting final judgment in their favor. This Motion relies upon this Notice of Motion, the attached Memorandum of Points and Authorities, and the arguments of counsel at the hearing on this motion.

DATED: November 20, 2017

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By: */s/ Rebecca R. Hanson*
Karen A. Braje (SBN 193900)
Martin J. Bishop (admitted *pro hac vice*)
Rebecca R. Hanson (admitted *pro hac vice*)
Dianna C. Wyrick (admitted *pro hac vice*)
Thomas C. Hardy (admitted *pro hac vice*)
Abraham J. Souza (admitted *pro hac vice*)
Attorneys for Defendants UnitedHealth Group Inc., UnitedHealthcare, Inc., UnitedHealthcare Insurance Company, United HealthCare Services, Inc., and UMR, Inc.

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TABLE OF CONTENTS

REED SMITH LLP
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REED SMITH LLP
A limited liability partnership formed in the State of Delaware

TABLE OF AUTHORITIES

Page(s)

Cases

REED SMITH LLP
A limited liability partnership formed in the State of Delaware

REED SMITH LLP
A limited liability partnership formed in the State of Delaware

Statutes

Rules

Regulations

REED SMITH LLP
A limited liability partnership formed in the State of Delaware

Other Authorities

REED SMITH LLP
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I. INTRODUCTION

Concerned that "women … forgo … preventive screenings because they … cannot afford [them]," Congress enacted 42 U.S.C. § 300gg-13 as part of the Patient Protection and Affordable Care Act of 2010 ("ACA"). *See* 155 Cong. Rec. S11985-02, at S11987 (Nov. 30, 2009) (statement of Sen. Mikulski). That provision requires health plans and insurers to provide coverage for specified preventive services for women without imposing cost-shares (*i.e.*, deductibles, coinsurance, and copayments) on members and insureds. To facilitate the goal of removing economic barriers to the ACA-mandated preventive services, the agencies charged with implementing the statute crafted straightforward rules in ACA's supporting regulations and, otherwise, gave plans and insurers discretion in determining the scope of the preventive benefits. The regulations explicitly allow plans and insurers to deny coverage for or impose cost-shares on preventive services received from providers outside of their provider networks, so long as they have in-network providers who offer the services. 29 C.F.R. § 2590.715-2713(a)(3)(i)–(ii).

Each of the Plaintiffs contends that Defendants violated ACA when they denied coverage for, or imposed cost-shares on, Plaintiffs' out-of-network claims for one of the ACA-mandated preventive services for women – breastfeeding support and counseling. But the facts demonstrate that Defendants were in full compliance with ACA's requirements. In accordance with the text of ACA and its supporting regulations, Defendants cover breastfeeding support and counseling services without cost-shares when provided by an in-network provider as a preventive service. Defendants' networks include thousands of providers, like obstetrician-gynecologists ("OB/GYNs"), pediatricians, and lactation specialists, who are trained to provide this preventive counseling to their patients. Defendants also provide a mechanism in plan documents by which members, like Plaintiffs, can receive preventive services from the out-of-network providers of their choice and have those services processed at the in-network level of benefits so long as they coordinate with Defendants and their network physicians in advance. Plaintiffs' claims, however, present entirely different factual circumstances, which undercut their legal arguments. The six named Plaintiffs received services from out-of-network providers after [redacted] that

they sought to address and did so without properly seeking in-network treatment of that care. Accordingly, Defendants complied with ACA when they denied coverage for, or imposed cost-shares on, Plaintiffs' out-of-network services. This indisputable material conclusion requires summary judgment in Defendants' favor.

Plaintiffs ask this Court to rewrite ACA by creating requirements that simply do not exist in in the text of ACA or its supporting regulations, such as the provision of a separate list of breastfeeding support and counseling providers, restrictions on the type of provider who can (or cannot) provide the service, and strictures regarding the level of service those providers must offer under the benefit. This approach violates ACA's plain language and the maxim that statutory interpretation "begin[s], as always, with the language of the statute." *Chubb Custom Ins. Co. v. Space Sys./Loral, Inc.*, 710 F.3d 946, 958 (9th Cir. 2013) (internal quotation marks and citations omitted). Plaintiffs' arguments also invite this Court to impermissibly consider matters outside the Court's purview here, such as setting the standard of care for lactation counseling and other healthcare services when none has been provided by ACA or its implementing regulations. *Lamie v. U.S. Trustee*, 540 U.S. 526, 542 (2004) ("It is beyond our province … to provide for what we might think … is the preferred result." (second alteration in original) (internal quotation marks and citations omitted)). Not only is this request unsupportable, it is unwarranted in an industry that is as heavily regulated as healthcare and where Congress, through ACA, made no effort itself to regulate such things. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002) (explaining that courts should be "reluctant to tamper" with "comprehensive and reticulated statute[s]" (internal quotation marks and citations omitted)).

ACA is plainly and simply focused on ensuring financial access to preventive care, nothing more. Because Defendants complied with ACA when processing Plaintiffs' claims, and Plaintiffs' allegations lack the requisite legal and factual support needed to take this case to trial, the Court should grant Defendants summary judgment.

II. BACKGROUND

A. ACA Requires Coverage For Certain Services Without Cost-Sharing.

ACA provides that a "group health plan and a health insurance issuer shall … provide

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coverage … and … not impose any cost-sharing requirements for … preventive care … [for women] as provided … in comprehensive guidelines supported by the Health Resources and Services Administration" ("HRSA"). 42 U.S.C. § 300gg-13(a)(4). HRSA's preventive services guidelines require "[b]reastfeeding support, supplies, and counseling," 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." Health Resources and Services Administration, Women's Preventive Services Guidelines, https://www.hrsa.gov/womensguidelines/ (last visited Nov. 15, 2017) ("HRSA Guidelines"). ACA defines "coverage" as "benefits consisting of medical care," and "cost sharing" as "deductibles, coinsurance, copayments, or similar charges." 42 U.S.C. §§ 300gg-91(b)(1), 18022(c)(3)(A)(i); *see Hartford Healthcare Corp. v. Anthem Health Plans, Inc.*, No. 3:17-cv-1686 (JCH), 2017 WL 4955505, at *7 (D. Conn. Nov. 1, 2017) ("[T]he plain meaning of the term 'coverage' [under ACA] refers to the type or amount of benefits or services covered under a plan.").

ACA and HRSA do not elaborate as to what constitutes "[c]omprehensive lactation support and counseling" or specify the level of instruction that qualifies a provider as a "trained provider" of such care. *See generally* 42 U.S.C. § 300gg-13(a)(4) (lacking any such guidance); HRSA Guidelines (same). Plans and insurers thus have discretion to "rely on … established reasonable medical management techniques to determine the frequency, method, treatment, or setting for coverage," including adopting procedure and diagnosis codes associated with the ACA-mandated preventive service that pay at no cost-share. 29 C.F.R. § 2590.715-2713(a)(4); Centers for Disease Control & Prevention, Prevention, Billing Codes, https://www.cdc.gov/prevention/billingcodes.html (hereinafter "CDC, Billing Codes") (noting there is discretion for plans and insurers to choose codes and listing billing codes associated with the ACA-mandated preventive service).

ACA's implementing regulations also allow plans and insurers to deny coverage for, or impose cost-shares on, the ACA-mandated preventive services if members or insureds receive them out-of-network, so long as those plans and insurers have in-network providers who offer the services. 29 C.F.R. § 2590.715-2713(a)(3)(i)–(ii) (a plan or insurer may deny coverage or impose cost-shares when it has "in its network a provider who can provide an item or service"). When a plan

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or insurer "does not have in its network a provider who can" offer the ACA-mandated preventive services, the regulations prohibit cost-shares on out-of-network services. 29 C.F.R. § 2590.715-2713(a)(3)(ii).

B. Plaintiffs' Health Benefit Plans Provide Coverage In Accordance With ACA And Contain Provisions Relating To Claims Processing And Appeals.

Plaintiffs Rachel Condry ("Condry"), Jance Hoy ("Hoy"), Christine Endicott ("Endicott"), Laura Bishop ("Bishop"), Felicity Barber ("Barber"), and Rachel Carroll ("Carroll") (collectively, "Plaintiffs") are current or former members or beneficiaries of employer-sponsored health benefit plans (collectively, the "Plans") administered by one of the Defendants – UnitedHealth Group Inc., UnitedHealthcare, Inc., UnitedHealthcare Insurance Company, UnitedHealthCare Services, Inc., or UMR, Inc. (collectively, "Defendants"). (Exs. A–F, Seay Decls., Exs. 1).) The separate Plans provide coverage in accordance with ACA's requirements for breastfeeding support and counseling services by covering the ACA-mandated preventive services without cost-shares when they are received from an in-network provider. (*See, e.g.*, Ex. F, Seay/Condry Decl., Ex. 1 at UHC_000262 ("[I]n-network benefits for preventive care services … will be paid at 100%, and not subject to any deductible, coinsurance, or copayment"); *see also* Ex. A, Seay/Hoy Decl., Ex. 1 at UHC_000921 (similar); Ex. B, Seay/Bishop Decl., Ex. 1 at UHC_002135 (similar); Ex. C, Seay/Carroll Decl., Ex. 1 at UHC_000578 (similar); Ex. D, Seay/Endicott Decl., Ex. 1 at UHC_000709 (similar); Ex. E, Seay/Barber Decl., Ex. 1 at UHC_001964 (similar).)

To facilitate the receipt of in-network care from OB/GYNs, pediatricians, and other providers, the Plans direct members and beneficiaries to Defendants' provider directory, which is available online. (*See, e.g.*, Ex. C, Seay/Carroll Decl., Ex. 1 at UHC_000570; Ex. G, Souza Decl., Ex. 8 (Dr. Miller Report), at 5.) Further, if in-network providers are unavailable within thirty miles of members' or insureds' urban zip codes, members and insureds may be eligible to receive the in-network level of benefits for out-of-network services, including the ACA-mandated preventive services. (*See, e.g.*, Ex. A, Seay/Hoy Decl., Ex. 1 at UHC_000908.) In such cases, the Plans require members to coordinate with their network physicians to obtain the in-network level of coverage. For example, Bishop's plan states:

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> If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

(Ex. B, Seay/Bishop Decl., Ex. 1 at UHC_002150.) The other Plaintiffs' Plans contain similar language. (Ex. A, Seay/Hoy Decl., Ex. 1 at UHC_000908; Ex. C, Seay/Carroll Decl., Ex. 1 at UHC_002305; Ex. D, Seay/Endicott Decl., Ex. 1 at UHC_000694; Ex. E, Seay/Barber Decl., Ex. 1 at UHC_001856; Ex. F, Seay/Condry Decl., Ex. 1 at UHC_000145.)

In accordance with the grant of discretion to "rely on … established reasonable medical management techniques to determine the frequency, method, treatment, or setting for coverage" in ACA's implementing regulations, 29 C.F.R. § 2590.715-2713(a)(4), Defendants have adopted and made publicly available policies regarding coverage for preventive services, which, among other things, specify the procedure and diagnosis codes members, insureds, and/or providers should select when billing preventive care in order for the claim to be reimbursed without cost-shares for the ACA-mandated preventive services. (Ex. H, Huckaby Decl., ¶ 5.) In accordance with publically available guidance, Defendants' policies distinguish between ***preventive*** services, which prevent illness or disease and may include certain therapeutic care, and ***diagnostic*** services, which treat existing conditions, and restrict coverage without cost-shares to the former. (*Id.*, Ex. 1 (Preventive Care Services Coverage Determination Guideline (hereinafter, "Coverage Guidelines") dated February 15, 2015) at UHC_149631-632)); *see also* Centers for Disease Control & Prevention, Preventive Care, https://www.cdc.gov/prevention/ (last visited November 20, 2017) (hereinafter "CDC, Preventive Care") ("Preventive care includes health services like screenings, check-ups, and patient counseling that are used to prevent illnesses, disease, and other health problems."); *compare* Ex. H, Huckaby Decl., Ex. 1 (Coverage Guidelines) at UHC_149674-675 (codes listed for "Breastfeeding Support, Supplies, and Counseling"), *with* CDC, Billing Codes, https://www.cdc.gov/prevention/billingcodes.html (last visited November 19, 2017) (providing non-comprehensive list of codes identified by the CDC as associated with "Breastfeeding Support,

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Supplies, and Counseling" and acknowledging the discretion plans and insurers have in developing their own set of codes). The policies serve as guidelines for providers to bill preventive services, but providers are the ones who select codes for any given service they provide, not Defendants. (*See generally* Ex. H, Huckaby Decl., Ex. 1 (Coverage Guidelines).) If network providers bill in accordance with the Coverage Guidelines and other applicable policies and procedures, Defendants' practice is to reimburse the members' claims without imposing cost-shares. (*Id.* at UHC_149630.) Non-network or out-of-network providers' claims are reimbursed at the out-of-network level of benefits, if available, unless the member coordinated with Defendants in advance to seek in-network treatment of the services. (*Id*.)

The Plans also contain claims procedures, which explain the process for submitting claims and filing appeals if claims are denied. (Ex. A, Seay/Hoy Decl., Ex. 1 at UHC_000973; Ex. B, Seay/Bishop Decl., Ex. 1 at UHC_002091-2096; Ex. C, Seay/Carroll Decl., Ex. 1 at UHC_000610-617; Ex. D, Seay/Endicott Decl., Ex. 1 at UHC_000756-766; Ex. E, Seay/Barber Decl., Ex. 1 at UHC_001907-1912; Ex. F, Seay/Condry Decl., Ex. 1 at UHC_000196-202.) For instance, to receive reimbursement for out-of-network services, members and beneficiaries must submit accurate claims to Defendants within a specified period. (Ex. A, Seay/Hoy Decl., Ex. 1 at UHC_000971-981; Ex. B, Seay/Bishop Decl., Ex. 1 at UHC_002091; Ex. C, Seay/Carroll Decl., Ex. 1 at UHC_002346-48; Ex. D, Seay/Endicott Decl., Ex. 1 at UHC_000758; Ex. E, Seay/Barber Decl., Ex. 1 at UHC_001905; Ex. F, Seay/Condry Decl., Ex. 1 at UHC_000196.) If claims are denied, members must file written appeals, and Defendants must respond, within specified time frames. (Ex. A, Seay/Hoy Decl., Ex. 1 at UHC_000977; Ex. B, Seay/Bishop Decl., Ex. 1 at UHC_002094; Ex. C, Seay/Carroll Decl., Ex. 1 at UHC_000616; Ex. D, Seay/Endicott Decl., Ex. 1 at UHC_000764; Ex. E, Seay/Barber Decl., Ex. 1 at UHC_001909; Ex. F, Seay/Condry Decl., Ex. 1 at UHC_000199-200.)

C. Plaintiffs Received Breastfeeding Services From Out-Of-Network Providers Even Though In-Network Providers Were Available.

Plaintiffs Barber, Condry, Endicott, and Carroll had at least one in-network "Lactation Specialist" within thirty miles of their zip codes at the time they sought lactation services from out-of-network providers. (Ex. I, Nielsen Decl., ¶ 21 (noting that Defendants' online provider portal

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contained two network "lactation specialists" (searchable as such on the directory) within thirty miles of Barber's and Condry's zip codes (94110 and 94619, respectively) in 2015 and 2016); *see also* Ex. G, Souza Decl., Ex. 5 (Carroll Dep.), at 89:10-91:8 ([redacted]); Ex. D, Seay/Endicott Decl., Ex. 9 at UHC_002422 (noting that Defendants' online provider portal contained one network "lactation specialist" (searchable as such) within thirty miles of Endicott's zip code in 2015).) Further, all of the Plaintiffs had access to Defendants' networks, which include tens of thousands of pediatricians, OB/GYNs, and other providers who have received training in the ACA-mandated preventive service. (Ex. J, Fusco Decl., ¶ 4(a); Ex. G, Souza Decl., Ex. 10 (Dr. Lee Report) at 12 (explaining that "pediatricians, OB/GYNs, and labor and delivery nurses and nurse practitioners all have the necessary training and experience to provide preventive lactation counseling and support as required by … ACA"); Ex. G, Souza Decl., Ex. 9 (Dr. Cooper Report) at 10 ("General in-network providers such as obstetricians, pediatricians, nurse midwives, and nurse practitioners are trained providers of lactation counseling and support services and can provide those services to new and expectant mothers"); Ex. G, Souza Decl., Ex. 8 (Dr. Miller Report) at 6-7 (noting that Defendants provide their "members with substantial numbers of choices of in-network providers" of the ACA-mandated preventive service).) Each Plaintiff had hundreds or even thousands of network OB/GYNS and pediatricians available to them within thirty miles of their zip codes. (*See* Ex. J, Fusco Decl., ¶¶ 4-21 (noting the number of such providers within thirty miles of each of the Plaintiffs' zip codes around the time they sought the services at issue here).) Many of these providers publically held themselves out as providers of the ACA-mandated preventive services at the time Plaintiffs sought the services.[1] (Ex. K, Christopher Butler Aff. & Exs. thereto (noting several providers near Plaintiffs at Exhibits 1-8, 10-21, 23, and 24 identified in Nielsen Decl. who advertised on their websites that they provide breastfeeding counseling and support around the time Plaintiffs sought those services).

[1] As various courts have held, this Court may consider properly authenticated archived webpages from the Wayback Machine. *See Abu-Lughod v. Calis*, No. CV 13-2792 DMG (RZX), 2015 WL 12746198, at **2-3 (C.D. Cal. May 20, 2015).

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Despite the existence of in-network providers, Plaintiffs sought services from out-of-network providers and either did not seek, or did not properly request, in-network treatment of these out of-network claims in accordance with the terms of the Plans.

1. Condry

In connection with her home birth on February 13, 2015, Condry received services from out-of-network midwives, which were bundled and treated by UnitedHealthcare Insurance Company as in-network under a network gap exception that Condry received in advance of the care. (Ex. G, Souza Decl., Ex. 2 (Condry Dep.) at 32:10-33:3 (gap exception honored even though it had expired), 215:16-216:2 (claims were bundled); Dkt. 78 ("SAC") ¶ 89.) Condry obtained breastfeeding support and counseling from the midwives, [redacted]. (Ex. G, Souza Decl., Ex. 2 (Condry Dep.) at 103:23-105:3, 107:9-20; *see also* Ex. G, Souza Decl., Ex. 14 (Medical Records Stipulation), Group Ex., at PL_RC000263-65.)[2] Condry also received breastfeeding support and counseling from her in-network nurse practitioner. (Ex. G, Souza Decl., Ex. 2 (Condry Dep.) at 123:2-22 (Condry could not readily distinguish between the care she received from the midwife and the pediatrician), 132:4-133:13 (nurse practitioner discussed Condry's intention to breastfeed prior to her daughter's birth); *see also* Ex. G, Souza Decl., Ex. 14 (Medical Records Stipulation), Group Ex. at PL_RC000344, 346, 349 [redacted] *id.* at PL_RC000293 ([redacted]); *id.* at PL_RC0000308 ([redacted]); *id.* at PL_RC0000295 [redacted].)

[2] The parties have stipulated to the authenticity of Plaintiffs' medical records and to the fact that such records were "prepared and maintained by Plaintiffs' health care providers in the ordinary course of business and as part of their regular practice." (*See* Ex. G, Souza Decl., Ex. 14 (Medical Records Stipulation), ¶ 2); *see also* Fed. R. Evid. 803(6) (excepting business records from the rule against hearsay). Not all of the medical records sought by Defendants have been produced by Plaintiffs, who insisted on controlling the collection of such documents. (Ex. G, Souza Decl., ¶ 14.) Further, in producing the medical records, Plaintiffs produced what were, in some cases, heavily redacted copies of the records. (*Id.*)

Condry sought services from an out-of-network lactation consultant on March 4, March 19, and April 14, 2015 [redacted]. (Ex. G, Souza Decl., Ex. 2 (Condry Dep.) at 29:14-17; *id.* at 115:23-25; *id.* at 189:2-190:24; Ex. G, Souza Decl., Ex. 15 (Interrog. Resps.) at 6 (Resp. #2) [redacted]; Ex. G, Souza Decl., Ex. 14 (Medical Records Stipulation), Group Ex., at PL_RC000290 [redacted].) Even though such providers were available, as noted on Defendants' online provider portal (*see supra* at 6-7), Condry made no attempt to locate other in-network providers prior to receiving the services or otherwise determine the lactation consultant's network status. (Ex. G, Souza Decl., Ex. 15 (Interrog. Resps.) at 6 (Resp. #2); Ex. G, Souza Decl., Ex. 2 (Condry Dep.) at 46:12-14 (noting that she did not call UnitedHealthcare Insurance Company to inquire about a network provider); *id.* at 83:19-84:16 (noting that Condry did not ask her in-network provider for a referral); *id.* at 84:17-85:19 (noting that Condry did not request an exception to have the out-of-network provider treated as in-network, despite knowing the process from her home birth experience); *id.* at 93:15-25 (Condry knew there was a mechanism by which UnitedHealthcare Insurance Company would "treat [her] provider as in-network" if there were no network providers available); *id.* at 165:22-166:2 (acknowledging Condry did not ask UnitedHealthcare Insurance Company for information about lactation benefits).)

Condry sought reimbursement for the March 4 out-of-network service, but UnitedHealthcare Insurance Company denied her claim, explaining in an Explanation of Benefits ("EOB") that "[t]his is not a reimburseable service" and that "[t]here 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." (SAC ¶ 90; Ex. F, Seay/Condry Decl., Ex. 2 (claim), Ex. 3 (EOB).) Condry understood that the out-of-network lactation consultant had provided the codes on the bill for the services, but Condry did not ask her for [redacted]. (Ex. G, Souza Decl., Ex. 2 (Condry Dep.) at 82:19-83:8.) Although the EOB provided the address and timeframe for submitting appeals, Condry did not

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appeal her denied claim. (Ex. F, Seay/Condry Decl., Ex. 3 (EOB); SAC ¶ 92.) Condry did not file claims for the services she received on March 19 and April 14. (SAC ¶ 92.)

2. Endicott

After giving birth to her daughter on July 22, 2015, Endicott [redacted]. (*Id.* ¶ 116; Ex. G, Souza Decl., Ex. 4 (Endicott Dep.) at 54:6-16, 55:21-25 [redacted].) Endicott also [redacted]. (Ex. G, Souza Decl., Ex. 4 (Endicott Dep.) at 64:5-67:12; Ex. G, Souza Decl., Ex. 14 (Medical Records Stipulation), Group Ex. at PL_CE000161 [redacted]), PL_CE000166-68 ([redacted]), PL_CE000172 ([redacted]).)

Aware that UnitedHealthCare Services, Inc. had in-network providers of the ACA-mandated preventive service, Endicott contacted the network hospital at which she gave birth but was told by the hospital-based lactation consultant that her conditions did not require care. (SAC ¶ 117.) [redacted] Endicott located an out-of-network lactation consultant by searching on the Internet and received services on September 23 and October 1, 2015 [redacted] (Ex. D, Seay/Endicott Decl., Ex. 2 at UHC_002372-2373; Ex. G, Souza Decl., Ex. 14 (Medical Records Stipulation), Group Ex. at PL_CE000161-62, 163-64, 166, 168-70, 172 ([redacted]"); SAC ¶ 118.) Endicott [redacted] (Ex. G, Souza Decl., Ex. 4 (Endicott Dep.) at 146:16-23, 148:4-149:1 ([redacted]); Ex. D, Seay/Endicott Decl., Ex. 9 at UHC_002422 (Lactation Specialist was listed on Defendants' website at the time Endicott sought care.).) Endicott [redacted]

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[redacted] ve. (Ex. G, Souza Decl., Ex. 4 (Endicott Dep.) at 77:9-13 ([redacted], 78:10-12 ([redacted]).)

Endicott submitted a claim for reimbursement, and UnitedHealthCare Services, Inc. sent Endicott copies of letters it had mailed to her lactation consultant asking the consultant to submit corrected claims with valid diagnosis codes. (Ex. D, Seay/Endicott Decl., Exs. 2-6 (claim and letters).) When the provider failed to provide the requested information, UnitedHealthCare Services, Inc. sent Endicott an EOB denying her claim, explaining that [redacted]" (Ex. D, Seay Endicott Decl., Ex. 7.)

Even though Endicott's claim remained incomplete, UnitedHealthCare Services, Inc. made an exception and processed her claim, allowing an amount payable under her plan. (SAC ¶ 121; Ex. D, Seay/Endicott Decl., Ex. 11 (February 12, 2016 EOB noting the claim for the September 23, 2015 services was partially denied because "[y]our plan covers the eligible expense amount reimbursable under your plan for covered out-of-network health services" and "benefits are not available for that portion of the charge that exceeds the eligible amount determined for this service" and that for the October 1, 2015 services, Endicott's deductible "ha[d] not been met" and therefore applied the charge to Endicott's deductible).) Endicott [redacted]. (Ex. G, Souza Decl., Ex. 4 (Endicott Dep.) at 45:15-20; 46:1-47:3; Ex. D, Seay/Endicott Decl., ¶ 18.) Both the EOB and Endicott's benefit booklet explain how her deductible works for out-of-network claims. (Ex. D, Seay/Endicott Decl., Exs. 1, 11-16; Ex. G, Souza Decl., Ex. 4 (Endicott Dep.) at 151:6-153:3, 154:18-21 ([redacted]).)

3. Carroll

Carroll [redacted] (Ex. G, Souza Decl., Ex. 5 (Carroll Dep.) at 24:10-25: 2, 45:3-10.) Following discharge, [redacted]. (*Id.* at 27:18-28:4.) Carroll also [redacted]

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[redacted]. (*Id.* at 60:23-61:7, 64:21-65:10, 66:11-23 ([redacted]), 69:5-21 ([redacted]), 109:11-110:2 ([redacted]), 114:14-115:9; *see also* Souza Decl., Ex. 14 (Medical Records Stipulation), Group Ex. at PL_RAC000135, 138-144 ([redacted]), PL_RAC000150 ([redacted]).)

On September 16 and 19, 2015, Carroll received services from an out-of-network lactation provider [redacted]. (Ex. G, Souza Decl., Ex. 5 (Carroll Dep.) at 28:4-7; Ex. C, Seay/Carroll Decl., Ex. 2 at UHC_002208, Ex. 3 at UHC_002210.) Prior to receiving the services, [redacted]. (Ex. G, Souza Decl., Ex. 16 (Interrog. Reps.) at 6 (Resp. #2(c)).) Carroll [redacted]r. (Ex. G, Souza Decl., Ex. 5 (Carroll Dep.) at 92:21-93:6, 102:15-103:16 ([redacted]), 172:2-14 [redacted]).) In addition, Carroll [redacted] (*Id.* at 89:10-91:8 ([redacted]; *see also* Ex. I, Nielsen Decl., ¶ 20 (clinic was in-network at the time Carroll sought services for breastfeeding support and counseling).)

[redacted], Carroll sought services from an out-of-network lactation consultant on November 2 and 14, 2015 to [redacted] Ex. G, Souza Decl., Ex. 14 (Medical Records Stipulation), Group

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Ex., at PL_RAC000150.) That lactation consultant [redacted] (*Id.*)

Carroll submitted claims for the services she received on September 16 and 19. (SAC ¶ 142; Ex. C, Seay/Carroll Decl., Exs. 2-5.) The first EOB from UMR, Inc. indicated that the September 16 claim processed under Carroll's out-of-network benefits and that the charges "exceed[ed] the usual, reasonable and customary fees." (SAC ¶ 142; Ex. C, Seay/Carroll Decl., Ex. 4.) Likewise, the second EOB denied Carroll's September 19 claim as "excluded by [her] health plan." (SAC ¶ 142; Ex. C, Seay/Carroll Decl., Ex. 5.) Carroll also submitted claims for the services [redacted] received on November 2 and 14, 2015, which were denied. (SAC ¶ 145; Ex. G, Souza Decl., Ex. 5 (Carroll Dep.), at 185:18-189:15, Ex. 81 at PL_RAC00004-5 (claims), Ex. 82, at PL_RAC000132 (EOB).) The EOB explained that the service was "excluded by [her] health plan." (SAC ¶ 145.)

Carroll [redacted]. (Ex. G, Souza Decl., Ex. 5 (Carroll Dep.) at 159:16-161:12.) She asserts that she was unable to locate a claim form online, but such forms were available on UMR, Inc.'s website in 2015 and 2016. (Ex. C, Seay/Carroll Decl., ¶ 14.) Carroll did not further contact UMR, Inc. or take any other steps to appeal. (Ex. G, Souza Decl., Ex. 5 (Carroll Dep.) at 159:16-161:12.)

4. Bishop

After the birth of her son on July 2, 2015, Bishop (who now goes by Hipple) received in-network breastfeeding support and counseling services from a lactation consultant during her hospital stay. (Ex. G, Souza Decl., Ex. 1 (Bishop Dep.) at 49:22-50:4, 158:22-160:13 (hospital gave Bishop educational materials regarding breastfeeding), 161:23-162:14 (same).) Following discharge, Bishop [redacted]. (Ex. G, Souza Decl., Ex. 17 (Interrog. Resps.) at 6-7 (Resp. #2); Ex. G, Souza Decl., Ex. 14 (Medical Records Stipulation), Group Ex. at PL_LB00089 ([redacted]), PL_LB000114-132 ([redacted]); Ex. G, Souza Decl., Ex. 1 (Bishop Dep.) at 51:7-54:4

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[redacted]

Bishop decided to seek the services of an out-of-network lactation consultant on August 5, 2015 [redacted] (Dkt. 78 (SAC) ¶ 130; Ex. G, Souza Decl., Ex. 14 (Medical Records Stipulation), Group Ex. at PL_LB000082 ([redacted]).) Prior to that appointment, [redacted] (Ex. G, Souza Decl., Ex. 17 (Interrog. Resps.) at 6-7 (Resp. 2).) Bishop also [redacted]. (*Id.*)

On August 5, 2015, the same day she saw the lactation consultant, Bishop asked her OB/GYN practice to fax UnitedHealthcare Insurance Company to request that the out-of-network lactation consultant's services be treated as in-network. (Ex. G, Souza Decl., Ex. 5 (Bishop Dep.) at 45:24-46:24 (explaining that her OB/GYN faxed UnitedHealthcare Insurance Company requesting in-network treatment for out-of-network benefits on the same day as her out-of-network appointment).) The practice sent the fax to UnitedHealthcare Insurance Company just over one hour before the appointment was scheduled to take place. (*Id.* at 46: 3-12, 136:13-137:11; *see also* Ex. L, Leigh Decl., ¶¶ 4-5 (noting that the fax was not received by UnitedHealthcare Insurance Company until 4:46 p.m.); Ex. G, Souza Decl., Ex. 1 (Bishop Dep.) at 143:22-144:3, Ex. 7 at PL_LB00017-18 ([redacted] Ex. B, Seay/Bishop Decl., Ex. 1 at UHC_002150 (requiring members to coordinate with UnitedHealthcare Insurance Company regarding the lack of in-network services).)

After Bishop submitted a claim for reimbursement, UnitedHealthcare Insurance Company sent Bishop an EOB, denying the claim because "[t]his is not a reimbursable service" and "[t]here 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." (SAC ¶ 131; Ex. B, Seay/Bishop Decl., Exs. 2, 4.) Although Bishop understood that the out-of-network provider selected the codes, Bishop did not ask her if there were "more appropriate" codes to use. (Ex. G, Souza Decl., Ex. 1 (Bishop Dep.) at

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118:20-119: 13 (Bishop claims she submitted an appeal, but neither she nor UnitedHealthcare Insurance Company has any record of such an appeal. (*Id.* at 96: 6–97: 22; Ex. B, Seay/Bishop Decl., ¶ 16.)

5. Barber

Barber was seen by lactation consultants at the in-network hospital where she gave birth on although she claims they never observed her breastfeeding. (SAC ¶ 138; Ex. G, Souza Decl. Ex. 3 (Barber Dep.) at 12:17-17:17.) Without trying to locate in-network care (which was available, as noted on Defendants' online provider portal at the time (*see supra* at 6-7)), Barber then saw an out-of-network provider with whom she already had a relationship who was referred to her by her doula. (Ex. G, Souza Decl., Ex. 3 (Barber Dep.) at 87:24-89:2; *see also id.* at 80:15-82:8.)

After Barber filed a claim for reimbursement, UnitedHealthcare Insurance Company sent Barber an EOB that denied her claim, explaining that "[y]our plan does not cover this non-medical service or personal item." (Ex. E, Seay/Barber Decl., Exs. 2-3, 6.) Barber disagreed with the denial reason but understood what it was communicating to her. (Ex. G, Souza Decl., Ex. 3 (Barber Dep.) at 219:7-24 (noting the claim denied coverage, finding the service was a parenting class).) Barber did not appeal under her plan's claims procedures, instead filing an "appeal" outside of the plan's 180-day time period. (Ex. E, Seay/Barber Decl., Ex. 6 (noting Barber had 180 days from April 29, 2016 to appeal); Ex. G, Souza Decl., Ex. 3 (Barber Dep.) at 197:19-198:5 ("appeal" filed in 2017).)

6. Hoy

Hoy received in-network lactation services in the hospital after giving birth on September 4, 2015. (SAC ¶ 97.) Shortly after, Hoy's in-network pediatrician expressed concern about her son's weight and suggested Hoy receive care from an out-of-network lactation provider. (*Id.*) Hoy attempted to locate an in-network provider to remedy that condition by searching for the term "lactation consultant" on UnitedHealthcare's website but did not find what she was looking for. (*Id.* at ¶ 98; Ex. A, Seay/Hoy Decl., Ex. 10 at UHC_000845 (noting her search was for "lactation consultant").) Hoy, . (Ex. G, Souza Decl., Ex. 6 (Hoy Dep.) at 37:15-19, 39:16-19 (l).)

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On September 10, September 28, and October 5, 2015, Hoy sought services from an out-of-network provider to address [redacted]y. (SAC ¶¶ 97, 100; Ex. G, Souza Decl., Ex. 14 (Medical Records Stipulation), Group Ex. at PL_JH00070-75 ([redacted]), PL_JH000259 ([redacted]).) Rather than file a claim for reimbursement in accordance with the terms of her benefit plan, Hoy called customer service and asserted that UnitedHealthCare Services, Inc.'s purported failure to cover her out-of-network services constituted an ACA violation. (SAC ¶ 101; Ex. G, Souza Decl., Ex. 6 (Hoy Dep.) at 27:13-22 ([redacted]; Ex. A, Seay/Hoy Decl., Ex. 1 at UHC_000971-973 (containing instructions for filing claims, including that members must file claims for out-of-network services); Ex. G, Souza Decl., Ex. 6 (Hoy Dep.) at 61:20-62:8 ([redacted]).) The customer service representative informed Hoy that (a) no claims had been submitted, and thus no denials had issued; (b) the ACA-mandated preventive service is covered without cost-shares when received from an in-network provider; and (c) typically, members consult with their OB/GYNs or pediatricians regarding the ACA-mandated preventive service. (Ex. G, Souza Decl., Ex. 7 (regarding October 22, 2015 call).)

Hoy subsequently submitted a letter, which she characterized as an "appeal," [redacted]. (SAC ¶ 102; Ex. G, Souza Decl., Ex. 6 (Hoy Dep.) at 64:10-65:8 ([redacted]).) In her letter, Hoy asserted that ACA required full coverage of her claims because there were no network providers of breastfeeding support and counseling s. (Ex. A, Seay/Hoy Decl., Ex. 2.) UnitedHealthCare Services, Inc. acknowledged her letter but informed her that her letter did not qualify as an appeal. (Ex. A, Seay/Hoy Decl., Exs. 3-4.) UnitedHealthCare Services, Inc. then sent letters to Hoy's lactation consultant, requesting diagnosis codes that were necessary to process it as a claim for benefits, to which Hoy's provider responded. (Ex. A, Seay/Hoy Decl., Exs. 5-6.) Notwithstanding Hoy's failure to comply with the plan's claims procedures, UnitedHealthCare Services, Inc. processed Hoy's claims and sent her EOBs denying them, [redacted]

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[redacted] (Ex. A, Seay/Hoy Decl., Exs. 8-9.) [redacted] (Ex. G, Souza Decl., Ex. 6 (Hoy Dep.) at 195:7-196:13.) Notably, UnitedHealthCare Services, Inc. did not deny Hoy's claims because she received services from an out-of-network provider or that she was not entitled to coverage under ACA. (Ex. A, Seay/Hoy Decl., Exs. 8-9.)

Hoy submitted an appeal just days after the EOBs were issued. (SAC ¶ 104; Ex. A, Seay/Hoy Decl., Ex. 10.) Hoy did not address the coding issue raised in the EOBs, instead continuing to assert a violation of ACA. (*Id.*) UnitedHealthCare Services, Inc. acknowledged Hoy's letter and informed her that her letter did not "qualify as an appeal." (SAC ¶ 107; Ex. A, Seay/Hoy Decl., Exs. 12-13.)

III. LEGAL STANDARD

Summary judgment is required when the evidence shows that "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); *Samuels v. Holland Am. Line – USA Inc.*, 656 F.3d 948, 952 (9th Cir. 2011). "[T]he mere existence of *some* alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no *genuine* issue of *material* fact."' *United States ex rel. Kelly v. Serco, Inc.*, 846 F.3d 325, 329 (9th Cir. 2017) (alteration and emphases in original) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986)).

IV. ARGUMENT

A. Defendants Complied With ACA In Processing Plaintiffs' Claims.

Counts II through VI are premised on an alleged violation of ACA. (*See* SAC ¶ 212 (Count II); *id.* ¶ 216 (Count III); *id.* ¶ 236 (Count IV); *id.* ¶ 244 (Count V); *id.* ¶ 247 (Count VI).) Under ACA, plans and insurers that have network providers of the ACA-mandated preventive services must provide "coverage" (*i.e.*, payment or reimbursement) for breastfeeding support and counseling services received in-network without cost-shares (*i.e.*, deductibles, coinsurance, and copayments). *See* 42 U.S.C. § 300gg-13(a)(4); *see also* 42 U.S.C. § 300gg-91(b)(1) (defining "health insurance coverage" for purposes of ACA as "benefits consisting of medical care"); *Hartford Healthcare*, 2017

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WL 4955505, at *7 (discussing "coverage" under ACA); 42 U.S.C. § 18022(c)(3)(A)(i) (defining "cost sharing" for purposes of ACA); 29 C.F.R. § 2590.715-2713(a)(3)(ii) (coverage for out-of-network services may be denied or provided with cost-shares if in-network providers are available). Because there is no genuine dispute that Defendants complied with these requirements, Defendants are entitled to summary judgment on Counts II through VI.

1. ACA Does Not Cover Out-of-Network Diagnostic Services.

Defendants complied with ACA in processing Plaintiffs' out-of-network claims because Plaintiffs received diagnostic, rather than preventive, breastfeeding services, thereby excluding the services from eligibility for cost-share-free coverage under Defendants' policies and procedures altogether. In accordance with ACA's grant of discretion to "rely on … established reasonable medical management techniques to determine the frequency, method, treatment, or setting for coverage," Defendants' policies regarding coverage of preventive care distinguish between ***preventive*** services, which prevent illness or disease, and ***diagnostic*** services, which treat existing conditions; only the former qualify for coverage without cost-shares. 29 C.F.R. § 2590.715-2713(a)(4); (Ex. H, Huckaby Decl., Ex. 1 (Coverage Guidelines) at UHC_149631-632.)

Each Plaintiff sought services for clinically apparent medical problems, [redacted] (*See supra* at 6-17 (noting that each Plaintiff had been [redacted] Since those services were designed to treat ongoing symptoms, not prevent illness or disease, ACA did not require Defendants to provide coverage without cost-shares. (*See* Ex. H, Huckaby Decl., Ex. 1 (Coverage Guidelines), at UHC_149632 (care is diagnostic if the member "had a symptom(s) that required further diagnosis"); Ex. G, Souza Decl., Ex. 9 (Dr. Cooper Report) at 9 ([redacted]s); *see also* CDC, Preventive Care (distinguishing between preventive and diagnostic care); I.R.S., Health Savings Accounts – Preventive Care, 2004-1 C.B. 725 (Mar. 30, 2004) (same). Further, in [redacted]. (*See supra* at 13.) The ACA-mandated preventive benefit accrues only to women, not children, and thus, those claims were not

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subject to ACA's requirements for that reasons, as well. *See* 42 U.S.C. § 300gg-13 (requiring coverage for preventive services "for women"); HRSA Guidelines (same). Plaintiffs' out-of-network claims do not fall under ACA, and Counts II through IV fail for this reason alone.

2. Defendants' Coverage Complies With ACA.

Even if the services Plaintiffs received constituted preventive care, Defendants complied with ACA in processing Plaintiffs' out-of-network claims. Indeed, Defendants provide coverage for the ACA-mandated preventive services without imposing cost-shares when members or insureds receive them from in-network providers. (*See supra* at 4 (Plaintiffs' benefit booklets comply with the coverage requirement).) Defendants had numerous in-network providers who offered the ACA-mandated preventive services during the time period in question, including Lactation Specialists, as well as hundreds and, for some Plaintiffs, thousands of OB/GYNs and pediatricians within thirty miles of Plaintiffs' zip codes, many of whom publically advertised that they offered the ACA-mandated services. (*See supra* at 6-7.) Not surprisingly, therefore, several Plaintiffs discussed breastfeeding issues and received the ACA-mandated service from their in-network OB/GYNs, pediatricians, and other providers, yet sought services out-of-network.[3] (*See supra* at 6-17.) Moreover, notwithstanding the availability of a process by which Plaintiffs could have received in-network treatment of the out-of-network services that is plainly stated in their benefit booklets, none of the Plaintiffs properly sought in-network treatment for their out-of-network claims. (*See id.*) Accordingly, Defendants did not violate ACA when they denied coverage for, or imposed cost-shares on, Plaintiffs' out-of-network claims. *See* 29 C.F.R. § 2590.715-2713(a)(3)(ii).

3. ACA's Plain Language Focuses On Financial Barriers To Breastfeeding Services.

Defendants' approach to coverage for the ACA-mandated preventive services is grounded in ACA's plain language, which focuses on financial barriers to breastfeeding support and counseling services. By contrast, Plaintiffs' efforts to impose liability upon Defendants by reading requirements

[3] Providers often bill the breastfeeding counseling and support they provide as part of another service, such as well-child visits, and thus, are not recognizable by the procedure codes the providers put on a bill. (Ex. H, Huckaby Decl., ¶ 4; *see also* Ex. G, Souza Decl., Ex. 14 (Medical Records Stipulation), Group Ex. at PL_RAC0000135, 138, 142 ([redacted].) Defendants supply guidelines for billing, such as the Coverage Guidelines, but ultimately the provider fills out the claim form and provides the codes describing the service.

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into ACA's plain language are untethered to ACA's statutory or regulatory text and, therefore, wrong. For instance, Plaintiffs contend that Defendants violated ACA by erecting "administrative barriers" that inhibited Plaintiffs' access to the ACA-mandated preventive services, such failing to create a separate list of lactation providers. (SAC ¶¶ 84-85.)

ACA's statutory and regulatory text, however, does not address these types of administrative issues related to how plans and insurers carry out the applicable standard of care, let alone appointment lengths, notice requirements, or other means of carrying out the ACA-mandated preventive service. *See* 155 Cong. Rec. S11985-02, at S11987 (discussing Congress's desire to remove financial barriers to care). Such determinations are already part of the heavily regulated healthcare sphere, where issues such as network adequacy and the quality of patient care are governed by a comprehensive scheme of state and federal laws, regulations, sub-regulatory materials, and contractual provisions. *See, e.g.*, 10 C.C.R. § 2240.1 (listing requirements for "adequacy and accessibility of provider services"); Victor E. Schwartz & Phil Goldberg, *Carrots and Sticks: Placing Rewards As Well As Punishment in Regulatory and Tort Law*, 51 Harv. J. on Legis. 315, 350 (2014) (noting that "there are 130,000 pages of government health care rules"); (*see also* Ex. G, Souza Decl., Ex. 8 (Dr. Miller Report) at 4-5.)

By seeking to inject requirements into ACA's text that go well beyond the financial access Congress expressly provided for, Plaintiffs run afoul of the cardinal principles that "a court should not read words into a statute that are not there," and courts should not assume "that whatever might appear to further the statute's primary objective must be the law [because] [l]egislation is, after all, the art of compromise." *See Henson v. Santander Consumer USA, Inc.*, 137 S. Ct. 1718, 1725 (2017); *United States v. Watkins*, 278 F.3d 961, 965 (9th Cir. 2002). Courts should strictly apply these rules where, as here, they are construing a statutory and regulatory scheme as complex as ACA in the heavily regulated healthcare industry. *See Lamie*, 540 U.S. at 542 (explaining that courts are loathe to depart from the plain language of a "carefully crafted and detailed enforcement scheme"). To do otherwise would require courts "to untenably assume the role of a 'superlegislature' second-guessing the policy choices of other branches of government." *Schroeder v. United States*, 793 F.3d 1080, 1083 (9th Cir. 2015); *see also York v. Wellmark, Inc. d/b/a Wellmark Blue Cross and Blue*

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Shield of Iowa et. al., No. 4:16-00627-RGE-DFB, Slip. Op. at 19 n.5 (S.D. Iowa Sept. 6, 2017) (attached hereto as Ex. 11 to Souza Decl.) ("[ACA] does not provide grounds to read into the statute procedural requirements Plaintiffs believe necessary to ensure easy access to those benefits, even if the effect would ultimately further the law's apparent objective."). In other words, Plaintiffs invite this Court to descend a slippery slope, in which non-existent requirements could be added to ACA without limitation solely based on ACA's perceived spirit or intent.

Specifically, Plaintiffs argue that Defendants are required to maintain a list of network providers of the ACA-mandated preventive service, but Defendants provide an online provider directory that satisfies any and all disclosure requirements set forth in applicable law. *See, e.g.*, 29 C.F.R. § 2590.715-2715(a)(2)(i)(K) (requiring certain plans and insurers provide "an Internet address (or similar contact information) for obtaining a list of network providers,"); 29 C.F.R. § 2520.102-3(j)(3) (requiring that plans and insurers provide information about "the composition of the provider network"). To the extent the terse and informal FAQ document that was only issued in October 2015 and upon which Plaintiffs rely purports to require a ***separate*** list of providers of the ACA-mandated service, that agency pronouncement is due no deference by the Court because the agencies that adopted the informal FAQ acknowledged that ACA requires no such list, and the authorities upon which the FAQ relies do not support the conclusion that a separate list is required. (*See* FAQs About Affordable Care Act Implementation (Part XXIX) and Mental Health Parity Implementation at Q.1 (Oct. 23, 2015) ("the preventive services requirements … do not include specific disclosure requirements")); *see also Horn v. Provident Life & Acc. Ins. Co.*, 351 F. Supp. 2d 954, 962-64 & n.4 (N.D. Cal. 2004) ("Where an agency makes an argument that has no reasoned basis in the governing law … its opinion is due no respect whatsoever.")); *York*, Slip. Op. at 22 (FAQ does not require separate list of lactation providers).

In short, Defendants' approach to coverage for the ACA-mandated preventive service complies with the requirements set forth in ACA's text. The Court, therefore, should grant summary judgment in Defendants' favor on Counts II through VI.

B. Plaintiffs Received A Full And Fair Review And Have An Adequate Remedy.

In Count I, Plaintiffs Condry, Hoy, Bishop, Endicott, and Barber allege that Defendants

breached their "full and fair review" obligation under section 503 of ERISA, as well as their duty to "administer plan benefits in strict accordance with the terms of the underlying plan documents," when they "fail[ed] to provide timely and substantive responses to requests for out-of-network benefits and/or appeals to denials of [such] requests." (SAC ¶¶ 206-07.) Plaintiffs purport to bring Count I pursuant to section 502(a)(3) of ERISA, which provides that a participant, beneficiary, or fiduciary may bring a civil action "to obtain other appropriate equitable relief" to redress violations of ERISA or the terms of the plan. *See* 29 U.S.C. § 1132(a)(3). But Plaintiffs are not entitled to "other appropriate equitable relief" under section 502(a)(3), because (1) Defendants provided them with a "full and fair review," and (2) with respect to their remaining allegations, ERISA section 502(a)(1)(B) provides an adequate remedy.

1. Defendants Provided Plaintiffs With A Full And Fair Review.

Section 503 of ERISA provides that ERISA plans must "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review." 29 U.S.C. § 1133. A participant's right to a full and fair review is not triggered until a participant submits a claim for benefits. *See* 29 C.F.R. § 2560.503-1(h)(2); *Tolle v. Carroll Touch, Inc.*, 23 F.3d 174, 181 (7th Cir. 1994); *Thygeson v. U.S. Bancorp*, No. CV-03-467-ST, 2004 WL 2066746, at *14 (D. Or. Sept. 15, 2004); *Hamilton v. Mecca*, 930 F. Supp. 1540, 1552 (S.D. Ga. 1996). Once that occurs, section 503's implementing regulations require denials of benefits to contain certain elements, including "[t]he specific reasons for the adverse determination" and "[a] description of the plan's review procedures," and also permit the plan to require the participant to file up to two levels of appeals of an adverse benefit determination in order to exhaust administrative remedies. 29 C.F.R. § 2560.503-1(g)(1). The applicable regulations further require administrators to provide a benefit determination within thirty days of receipt of a claim and an appeal determination within thirty days of receipt of an appeal if the plan provides two levels of review, and otherwise within sixty days of receipt of an appeal. 29 C.F.R. § 2560.503-1(f)(2)(iii)(B), (i)(2)(iii)(A). If an administrator informs a member that it needs additional information to process the claim within the initial thirty-day period, the time to respond is extended by forty-five days. 29 C.F.R. § 2560.503-1(f)(2)(iii)(B).

In determining compliance with section 503, the critical inquiry is whether the plan engaged

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in a "meaningful dialogue" with the member regarding the reasons for the denial. *Silver v. Executive Car Leasing Long-Term Disability Plan*, 466 F.3d 727, 731 n.1 (9th Cir. 2006). While a plan has the right to deny benefits that are not covered by the plan, "it must couch its ruling in terms that are responsive and intelligible to the ordinary reader." *Booton v. Lockwood Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1995). Failure to provide the specific plan provision on which the plan bases the denial will not, by itself, stand as a failure to provide full and fair review, as long as the claimant is provided "a clear reason for the denial and the specific steps necessary to perfect her claim." *Morningred v. Delta Family-Care & Survivorship Plan*, 790 F. Supp. 2d 177, 194-95 (D. Del. 2011). A denial letter substantially complies with these requirements if it provides the claimant with "a statement of reasons that, under the circumstances of the case, permitted a sufficiently clear understanding of the administrator's position to permit effective review." *Brogan v. Holland*, 105 F.3d 158, 165 (4th Cir. 1997); *see also Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1032 (9th Cir. 2006) ("substantial compliance" is what section 503 requires); *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 382 (7th Cir. 1992) (same). There is no genuine factual dispute that Defendants substantially, if not fully, complied with section 503's requirements with respect to each Plaintiff.

First, Defendants are not required to provide full and fair review of claims that are never submitted. Condry did not file claims for the services she received on March 19 and April 14, 2015, and therefore was not entitled to a full and fair review of those services under section 503. *See Thygeson*, 2004 WL 2066746, at *14; *Hamilton*, 930 F. Supp. at 1552; *see also* SAC ¶ 92.

Second, where Plaintiffs submitted claims, Defendants provided notices of adverse benefit determinations that "permitted a sufficiently clear understanding of the administrator's position to permit effective review." *Brogan*, 105 F.3d at 165. Specifically:

- Condry's, Hoy's, and Bishop's notices stated that "[t]here may be a more appropriate CPT or HCPCS code that describes this service" and, in the case of Bishop, that "[t]his service code is not separately reimbursable in this setting." (Ex. A, Seay/Hoy Decl., Exs. 8, 9, 13; Ex. B, Seay/Bishop Decl., Ex. 4; Ex. F, Seay/Condry Decl., Ex. 3.) Despite understanding that their providers had provided the codes on the bills, none of these Plaintiffs asked their providers for [redacted] codes. (Ex. G, Souza Decl., Ex. 1 (Bishop Dep.) at 118:20-119:13; Ex. G, Souza Decl., Ex. 2 (Condry Dep.) at 82:19-83:8.) In Hoy's case, [redacted]

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[redacted] (Ex. G, Souza Decl., Ex. 6 (Hoy Dep.) at 196:14-197:13.)

- Barber understood her notice's statement that "[y]our plan does not cover this non-medical service or personal item," yet failed to timely appeal. (Ex. G, Souza Decl., Ex. 3 (Barber Dep.) at 219:7-24; Ex. F, Seay/Barber Decl., Ex. 6.)

- Endicott received notification in response to her claim that, while the claim was allowed, portions of the allowed amount had been applied to her deductible. (Ex. D, Seay/Endicott Decl., Ex. 11.) [redacted] (Ex. G, Souza Decl., Ex. 4 (Endicott Dep.) at 154:6-21.)

Third, there is no genuine factual dispute that Defendants responded to the Plaintiffs' claims and appeals (only Plaintiffs Endicott, Bishop, and Hoy submitted them) well within the timeframes required by the applicable regulations or that, with respect to Hoy, any error was harmless:

- UnitedHealthCare Service, Inc. sent Endicott a letter alerting her that it needed additional information, extending the response timeframe by forty-five days to allow the provider time to submit the requested information, and then responded within that timeframe. (Ex. D, Seay/Endicott Decl., Exs. 3-7.) Endicott [redacted] (Ex. D, Seay/Endicott Decl., ¶ 18; Ex. G, Souza Decl., Ex. 4 (Endicott Dep.) at 45:15-47:1.)

- There is no evidence that Bishop filed an appeal. (Ex. B, Seay/Bishop Decl., ¶ 16; Ex. G, Souza Decl., Ex. 1 (Bishop Dep.) at 14:1-14.)

- United HealthCare Services, Inc. did not respond to Hoy's December 29, 2015 appeal based on EOBs generated just days prior (on December 22 and 23, 2015), but any remand would have been a "useless formality" – and, thus, harmless error – given that Hoy did not direct her appeal at the actual basis for the denial of her claims (*i.e.*, her provider used inappropriate diagnosis codes). *See Ellenburg v. Brockway, Inc.*, 763 F.2d 1091, 1096 (9th Cir. 1985) (remand of benefits claim not required despite procedural defects, where it would be "useless formality"); *Hancock v. Montgomery Ward Long Term Disability Trust*, 787 F.2d 1302, 1308 (9th Cir. 1986), *disapproved on other grounds by Firestone Tire & Rubber v. Bruch* 489 U.S. 101 (1989) (remand for benefits determination was "useless formality" where it would not change outcome).

In short, Defendants complied with their full and fair review obligations for each of the Plaintiffs, and summary judgment should be granted on this portion of Count I.

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2. Plaintiffs Cannot Circumvent The Procedural Requirements Of ERISA Section 502(a)(1)(B) By Asserting Their Claim Under Section 502(a)(3).

The remainder of Count I fails as a matter of law because section 502(a)(1)(B) of ERISA provides an adequate remedy and, therefore, Plaintiffs cannot avail themselves of section 502(a)(3). As the Supreme Court has explained, section 502(a)(3) is a "catchall" provision that acts as a "safety net" for claims for which relief is not available under other provisions in section 502. *See Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996); *Forsyth v. Humana, Inc.*, 114 F.3d 1467, 1475 (9th Cir. 1997), *overruled on other grounds by* 693 F.3d 896 (9th Cir. 2012). In Count I, Plaintiffs contend that Defendants breached their fiduciary duties "to administer plan benefits in strict accordance with the terms of the underlying plan documents." (SAC ¶ 204.) But such a claim must be asserted under ERISA section 502(a)(1)(B), which provides the mechanism for recovering benefits allegedly due under the Plans. *See* 29 U.S.C. § 1132(a)(1)(B) ("to recover benefits due … under the terms of [the] plan"); *Forsyth*, 114 F.3d at 1475 (affirming summary judgment against plaintiffs on section 502(a)(3) claim where section 502(a)(1)(B) provided adequate remedy). Indeed, it is well established that a plaintiff may not "circumvent the exhaustion requirement [for claims under section 502(a)(1)(B)] by artfully pleading benefit claims as breach of fiduciary duty claims." *Harrow v. Prudential Ins. Co. of Am.*, 279 F.3d 244, 253 (3d Cir. 2002). Since Plaintiffs' allegation regarding Defendants' purported failure to comply with the terms of Plaintiffs' plan documents is a thinly veiled attempt to assert a claim for benefits without the accompanying procedural burdens, such as exhaustion of administrative remedies, summary judgment is required.

C. Summary Judgment Must Be Granted With Respect To Count III.

1. Defendants Are Not Fiduciaries "Of The Same Plan."

Count III alleges co-fiduciary liability under section 405 of ERISA, which states that "a fiduciary with respect to a plan shall be liable for a breach of fiduciary responsibility of another fiduciary with respect to the same plan" if the fiduciary (1) "participates knowingly in, or knowingly undertakes to conceal" another fiduciary's breach of duty; (2) "enable[s] such other fiduciary to commit a breach"; or (3) "has knowledge of a breach by such other fiduciary, unless [it] makes reasonable efforts . . . to remedy the breach." 29 U.S.C. § 1105(a)(1)–(3); SAC ¶¶ 213-20.

A key component of a claim for co-fiduciary liability is that the defendants be fiduciaries of "the same plan." *See* 29 U.S.C. § 1105(a) ("a fiduciary with respect to a plan shall be liable for a breach … of another fiduciary … ***with respect to the same plan***" (emphasis added)); *LoPresti v. Ctigroup, Inc.*, No. 02-cv-6492(SJ), 2005 WL 195521, at *5 (E.D.N.Y. Jan. 18, 2005) (plaintiff must identify two or more fiduciaries "of the same plan" to show co-fiduciary liability). As Plaintiffs admit, however, each Plaintiff is a member of a ***different*** health plan involving ***different*** employer groups and administered by ***one*** of the Defendants, and, thus, Defendants are not fiduciaries of the same plan. (*See* SAC ¶¶ 20–25; Exs. A-F, Seay Decls.); *see also LoPresti*, 2005 WL 195521, at *5 (co-fiduciary claim failed where defendants were fiduciaries "of the same plan"). Further, Plaintiffs cannot establish that each Defendant participated in, enabled, or had knowledge of the other Defendants' purported breaches of duty. (*See* Exs. A-F, Seay Decls. (noting only one UnitedHealthcare entity is associated with each of Plaintiffs' plans)); *see also Keach v. U.S. Trust Co.*, 240 F. Supp. 2d 840, 844 (C.D. Ill. 2002) (granting summary judgment on co-fiduciary claim where there was no evidence that defendants had knowledge of another fiduciary's breach).

2. Non-Fiduciary Participation Liability Is Inapplicable Here.

Plaintiffs also allege in Count III that "to the extent Defendants are not deemed fiduciaries or co-fiduciaries under ERISA," they are liable as "non-fiduciar[ies] that knowingly participated in a breach of trust." (SAC ¶ 220.) A non-fiduciary, however, may not be held liable solely "for participating in another's breach of fiduciary duty." *Landwehr v. DuPree*, 72 F.3d 726, 734 (9th Cir. 1995); *see also Mertens v. Hewitt Assocs.*, 508 U.S. 248, 254 (1993) ("no [ERISA] provision explicitly requires [nonfiduciaries] to avoid participation … in a fiduciary's breach of duty"); *Renfro v. Unisys Corp.*, 671 F.3d 314, 325 (3d Cir. 2011) (same). Instead, non-fiduciary liability under ERISA is limited to "nonfiduciaries who: (1) are 'parties' in interest' with respect to the plan … and (2) engage in transactions prohibited by [section 406 of ERISA]." *Landwehr*, 72 F.3d at 733; *Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 244-45 (2000). Because those circumstances are inapplicable here, Plaintiffs' non-fiduciary-participation theory in Count III is foreclosed. *See Landwehr*, 72 F.3d at 733; *Renfro*, 671 F.3d at 325.

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D. Carroll Cannot Pursue Her Claims In Counts IV, V, And VI Because She Failed To Exhaust The Claims Procedures Set Forth In Her Group Health Plan.

Carroll failed to exhaust the internal claims procedures required by her non-ERISA group health plan. A plaintiff must avail herself of contractual review procedures before filing suit in court. *See Pepp-Zotter v. Liberty Life Surr. Co. of Boston*, No. C 06-04200 WHA, 2006 WL 2560701, at *3 (N.D. Cal. Sept. 5, 2006) (explaining that the exhaustion requirement applies "to lawsuits against private organizations that have internal-claims procedures"); *see also Westlake Cmty. Hosp. v. Super. Ct. of L.A. Cnty.*, 551 P. 2d 410, 416 (Cal. 1976) (same), *superseded by statute on other grounds*; *New Design Contr. Co. v. Harmon Contractors, Inc.*, 215 P.3d 1172, 1178 (Colo. App. 2008) (similar). To do otherwise would "constitute[] both an intrusion into the internal affairs of [private associations] and an unwise burden on judicial administration of the courts." *Jonathan Neil & Assocs., Inc. v. Jones*, 94 P.3d 1055, 1063 (Cal. 2004) (second alteration in original).

Carroll's benefit plan requires a member to pursue a first-level appeal before filing suit in court**.** (*See* Ex. C, Seay/Carroll Decl., Ex. 1 at UHC_000614 (noting that a first level appeal is mandatory; members "must exhaust the … internal procedures before any outside action is taken.").) Carroll [redacted] (Ex. G, Souza Decl., Ex. 5 (Carroll Dep.) at 159:16-161:12, 192:20-24.) Consequently, Carroll's claims are barred. *See Brown v. Lucky Stores, Inc.*, 246 F.3d 1182, 1189 (9th Cir. 2001) (plaintiff could not pursue claims because she failed to exhaust contractual grievance procedures); *Pepp-Zotter*, 2006 WL 2560701, at *3 (same).

E. Plaintiffs' Sex Discrimination Claim Is Legally And Factually Deficient.

In Count IV, Plaintiffs attempt to assert a claim for sex discrimination under section 1557 of ACA, which provides that:

> [A]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 … title IX of the Education Amendments of 1972 … the Age Discrimination Act of 1975 … or section 504 of the Rehabilitation Act of 1973 … be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity ….

See 42 U.S.C. § 18116(a). Section 1557 also provides that "[t]he enforcement mechanisms provided for and available under . . . title IX" and other referenced statutes "shall apply." *Id.* § 18116(b). Thus, Count III is governed by Title IX's framework. *See Se. Pa. Transp. Auth. v. Gilead Scis., Inc.*,

102 F. Supp. 3d 688, 698-99 (E.D. Pa. 2015). Plaintiffs cannot establish a claim under Title IX.

1. Defendants' Coverage Decisions Were Not Based On Plaintiffs' Sex.

"Title IX prohibits intentional discrimination." *Lopez v. Regents of Univ. of Cal.*, 5 F. Supp. 3d 1106, 1120 (N.D. Cal. 2015). To survive summary judgment on a disparate treatment claim under Title IX, therefore, a plaintiff must submit evidence "that the defendant discriminated against … her *because of* sex." *Doe v. Regents of Univ. of Cal.*, No. 2:15-cv-02478-SVW-JEM, 2016 WL 5515711, at *4 (C.D. Cal. July 25, 2016) (emphasis in original). In this case, Plaintiffs have no evidence that their sex motivated Defendants' coverage decisions. *See Lopez v. Pac. Mar. Ass'n*, 657 F.3d 762, 765 (9th Cir. 2011) ("nothing … leads us to conclude that Defendant adopted the rule with a discriminatory purpose"); *Doe*, 2016 WL 5515711, at *4 (same at motion to dismiss stage).

Plaintiffs cannot circumvent the need to identify evidence of discriminatory purpose by vaguely asserting that Defendants' coverage decisions were "facially sex-based." (*See* SAC ¶ 160); *see also Pac. Mar. Ass'n*, 657 F.3d at 764 (a plaintiff may establish a disparate treatment claim by pointing to a facially discriminatory policy). Indeed, the reasons for Plaintiffs' adverse benefit determinations, such as failure to provide the proper diagnosis codes, apply regardless of gender. *See Pac. Mar. Ass'n*, 657 F.3d at 764 (policy was not facially discriminatory against individual suffering from drug addiction because it "eliminate[d] all candidates who test[ed] positive for drug use"); *Idaho Aids Found. Inc. v. Idaho Hous. & Fin. Ass'n*, No. CV04-155-S-BLW, 2008 WL 2746025, at *3 (D. Idaho July 11, 2008) (similar).

2. Disparate Impact Claims Are Not Cognizable Under Title IX.

Disparate impact claims, like the one Plaintiffs' assert, are not cognizable under Title IX. *See Doe*, 2016 WL 5515711, at *4 ("A claim under Title IX cannot be premised on the disparate impact a policy has with respect to a protected group." (citing *Alexander v. Sandoval*, 532 U.S. 275, 280 (2001)); *Regents*, 5 F. Supp. 3d at 1120 (recognizing same); (SAC ¶¶ 162, 165, 226, 232, 235.)

In response to public comments received in connection with the promulgation of final regulations implementing section 1557, the Department of Health and Human Services' Office for Civil Rights ("OCR") stated that it "interprets section 1557 as authorizing a private right of action for claims of disparate impact discrimination on the basis of any of the criteria enumerated in the

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legislation." *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376-01, 31439 (May 18, 2016). OCR's statement conflicts with section 1557's unequivocal statement that "[t]he enforcement mechanisms provided for and available under . . . title IX" and the other referenced statutes "shall apply" for purposes of sex discrimination claims brought pursuant to section 1557. *See* 42 U.S.C. § 18116(b). Accordingly, it is due no deference. *See Horn*, 351 F. Supp. at 962–64 & n.4. "[T]he plain language of [section] 1557 unambiguously allows discrimination claims under the enforcement mechanisms of the four identified statutes only." *See York*, Slip Op. at 35. Because Title IX does not allow for disparate impact claims, Plaintiffs cannot pursue a sex discrimination claim under section 1557 on that basis. *Id.* at 9.

3. Plaintiffs Have No Evidence Of A Statistically Significant Disparate Impact On Pregnant Women.

Plaintiffs have produced no evidence demonstrating that Defendants' coverage decisions had a disproportionately adverse impact on pregnant women. *See Texas Dep't of Hous. & Cmty. Affs. v. Inclusive Communities Project, Inc.*, 135 S. Ct. 2507, 2523 (2015) ("A plaintiff who fails to … produce statistical evidence demonstrating a causal connection cannot make out a *prima facie* case of disparate impact."); *Pac. Mar. Ass'n*, 657 F.3d at 766, 768 (granting summary judgment when plaintiff only offered a "bald assertion" that the policy in question disparately affected a group and explaining that, "[a]t the summary judgment stage, a party no longer can rely on allegations alone"); *Doubt v. NCR Corp.*, No. C 09-5917 SBA, 2014 WL 3897590, at *8 (N.D. Cal. Aug. 7, 2014) (same). This is not surprising as Plaintiffs' position is illogical. As several Plaintiffs have acknowledged, Defendants' coverage decisions impacted their husbands and male children, particularly those Plaintiffs whose husbands are the members of the health benefit plans in question. (*See, e.g.*, Ex. G, Souza Decl., Ex. 1 (Bishop Dep.) at 141:20-143:21; Ex. G, Souza Decl., Ex. 5 (Carroll Dep.) at 221:22-222:16; Ex. G, Souza Decl., Ex. 3 (Barber Dep.) at 195:25-196:6.) Plaintiffs' own experts [redacted] (Ex. G, Souza Decl., Ex. 12 (Dr. Morton Report) at 6, Ex. 13 (Meek Report) ¶ 23-4.)

Plaintiffs must show "a significant disparate impact on a protected class caused by a specific,

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identified … practice ….” *See Stout v. Potter*, 276 F.3d 1118, 1121 (9th Cir. 2002). Plaintiffs’ failure to define the precise contours of Defendants’ supposed policy and to establish any facts supporting a disparate impact theory is fatal to Plaintiffs’ disparate impact claim. *See Inclusive Communities Project*, 135 S. Ct. at 2523 (“[A] disparate-impact claim … must fail if the plaintiff cannot point to a defendant’s policy or policies causing [the alleged] disparity.”); *Doubt*, 2014 WL 3897590, at *7 (granting summary judgment on disparate impact claim on same basis).

F. Carroll’s Unjust Enrichment Claim Is Premised On Contractual Obligations.

Finally, Carroll’s Count VI claim fails because a cause of action for unjust enrichment is “unavailable in cases where … the parties are bound to an express contract.” *See Peterson v. AWJ Global Sustainable Fund, LP*, No. 15-cv-00650-CRB, 2015 WL 5921225, at *5 (N.D. Cal. Oct. 11, 2015). Carroll contends that Defendants were unjustly enriched when they “failed to fulfill [their] responsibilities” under ACA (*see* SAC, ¶ 247) – obligations she admits are incorporated as terms of her health benefit plan. (*See id.* ¶ 242; Ex. C, Seay/Carroll Decl., Ex. 1 at UHC_000578 (providing that “[t]he Plan pays benefits for … preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration”).) Now that discovery has confirmed that Carroll’s unjust enrichment claim has no basis other than the alleged breach of the terms of her health benefit plan, Carroll may only advance her allegations pursuant to a state-law breach of contract claim. *See Ellis v. J.P. Morgan Chase & Co.*, No. 12-cv—03897-YGR, 2016 WL 5815733, at *5 (N.D. Cal. Oct. 5, 2016), *appeal filed*, (unjust enrichment claim barred because of the “existence of an express contract between the parties”); *Peterson*, 2015 WL 5921225, at *5 (same on motion to dismiss). Summary judgment is called for here.

V. CONCLUSION

For the foregoing reasons, Defendants respectfully request that the Court grant summary judgment in their favor and such other relief as the Court deems just and proper.

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By: */s/ Rebecca R. Hanson*

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Karen A. Braje (SBN 193900)
Martin J. Bishop (admitted *pro hac vice*)
Rebecca R. Hanson (admitted *pro hac vice*)
Dianna C. Wyrick (admitted *pro hac vice*)
Abraham J. Souza (admitted *pro hac vice*)
Attorneys for Defendants UnitedHealth Group Inc., UnitedHealthcare, Inc., UnitedHealthcare Insurance Company, and United HealthCare Services, Inc.

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