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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 REPLY IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT AND RESPONSE TO PLAINTIFFS' CROSS MOTION FOR PARTIAL SUMMARY JUDGMENT

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

Compl. Filed: Jan. 13, 2017

Honorable Vincent Chhabria

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TABLE OF CONTENTS

REED SMITH LLP
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TABLE OF AUTHORITIES

Federal Cases

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

Other Authorities

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

REED SMITH LLP
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I. INTRODUCTION

Plaintiffs' Response to Defendants' Motion for Summary Judgment is a misguided attempt to obscure straightforward facts and legal principles.[1] Stripped of that noise, the undisputed material facts reveal that Plaintiffs sought and received breastfeeding services from out-of-network providers without seeking in-network treatment of the resulting claims, despite having network providers available and, remarkably in some cases, even after receiving services from in-network providers. When Plaintiffs requested reimbursement for these out-of-network claims, Defendants imposed cost-shares or denied coverage in accordance with the terms of Plaintiffs' health plans. Defendants' coverage decisions complied with ACA, which explicitly allows plans and insurers to deny coverage for or impose cost-shares on out-of-network services where, as here, the network offers providers who provide the ACA-mandated preventive services. Because virtually all of Plaintiffs' claims are based on an alleged violation of ACA, this indisputable material conclusion requires summary judgment in Defendants' favor.

Plaintiffs' brief in opposition neither genuinely disputes these points nor demonstrates Plaintiffs' entitlement to summary judgment. Instead, Plaintiffs endeavor to distract the Court from the narrow issues at stake in this case by loading up their brief with cherry-picked, irrelevant evidentiary materials, as well as pejorative and unsupported negative characterizations about Defendants. Plaintiffs gloss over the experiences of each named Plaintiff, choosing instead to generalize about Defendants' coverage for the ACA-mandated preventive services and conceal the weaknesses inherent in their individualized circumstances. Plaintiffs fail to muster any legal authority supporting their expansive reading of ACA – an interpretation that is untethered to, and at odds with, the text of ACA and its supporting regulations. As is further established below, the Court should (i) grant Defendants' Motion for Summary Judgment, and (ii) deny Plaintiffs' request for partial summary judgment.

[1] Capitalized terms carry the meanings ascribed to them in Defendants' opening brief. (Dkt. 100.)

II. ARGUMENT

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

Plaintiffs concede in their Response that Counts II through VI are premised entirely on an alleged violation of ACA. (*See* Dkt. 117 ("Resp.") at 12.) Under ACA, Defendants may deny coverage for, or impose cost-shares on, services received out-of-network, so long as they have in-network providers of the ACA-mandated preventive services. 29 C.F.R. § 2590.715-2713(a)(3)(i). Defendants must provide coverage for out-of-network services without cost-sharing only if they do not have in-network providers of the ACA-mandated preventive services. 29 C.F.R. § 2590.714-2713(a)(3)(ii). These straightforward requirements constitute the totality of ACA's mandates, which are designed to eliminate economic barriers to the ACA-mandated services, not dictate the substantive scope of care.[2] *See* 155 Cong. Rec. S11985-02, at S11987 (Nov. 30, 2009) (statement of Sen. Mikulski) (discussing ACA's focus on financial access to the services). Because there is no genuine dispute that Defendants complied with ACA in processing Plaintiffs' out-of-network claims, Defendants are entitled to summary judgment on Counts II through VI, and Plaintiffs' request for partial summary judgment must be denied.

1. Plaintiffs Had In-Network Providers Available To Them.

Defendants complied with ACA in processing Plaintiffs' out-of-network claims because Plaintiffs had a multitude of network providers available at the time they sought out-of-network care. Barber, Condry, and Endicott had at least one in-network "Lactation Specialist," and Carroll received care from in-network lactation consultants and also easily located an in-network pediatric practice that had IBCLCs on staff. (Dkt. 100 ("Op. Br.") at 6-7.) Likewise, each Plaintiff had hundreds or even thousands of network OB/GYNs and pediatricians within thirty miles of their zip

[2] The Interim Final Rules for ACA's preventive services provision, which Plaintiffs cite and incorrectly term "regulations," (Resp. at 3), support this conclusion. *See* Interim Final Rules for Group Health Plans and Health Insurance Issuers ("Interim Final Rules"), 75 Fed. Reg. 41726-01, at 41731 (July 19, 2010) (explaining that ACA's preventive services provision "eliminate[s] cost-sharing requirements, thereby removing a barrier that could otherwise lead an individual to not obtain such services"). Further, ACA contains no "mandate" to "increase access and utilization" as Plaintiffs erroneously suggest. (Resp. at 3.) Rather, as made clear in the Interim Final Rules, the agencies tasked with implementing ACA surmised that a ***byproduct of the elimination of cost-sharing*** would be an "increase in access and utilization." *See* Interim Final Rules, 75 Fed. Reg. 41726-01, at 41736 (July 19, 2010).

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codes,[3] and there is no dispute – genuine or otherwise – that many of these providers publically held themselves out as providers of the ACA-mandated preventives services. (*Id.* at 7.) Furthermore, several Plaintiffs discussed breastfeeding issues and received the ACA-mandated preventive services from their in-network OB/GYNs, pediatricians, and other providers. (*Id.* at 6-17.) Accordingly, Plaintiffs' unsupported statement that there was a "virtual absence of any in-network trained … providers" is belied by the record, (Resp. at 2), and Defendants did not violate ACA when they denied coverage for, or imposed cost-shares on, Plaintiffs' claims. 29 C.F.R. § 2590.715-2713(a)(3)(ii).

Plaintiffs fail to submit any evidence rebutting Defendants' showing that each Plaintiff had in-network providers of the ACA-mandated preventive services available to them during the relevant time periods.[4] (*See* Resp. at 16 (speculating whether the providers "would … have been identified by

[3] Plaintiffs' unsupported suggestion that OB/GYNs and pediatricians are not contracted to provide the ACA-mandated preventive services is false. (*See* Ex. O, Nielsen Reply Decl. ¶ 4 ("Preventive lactation/breastfeeding services are services that are encompassed as covered services to be provided under contracts associated with UHC's network pediatricians, obstetricians, and lactation specialists. Such providers are able to bill for such services as covered services under their contracts.").)

[4] Plaintiffs' efforts to do so with rhetoric alone are grossly deficient. (Resp. at 14-16 & nn. 12-16.) ***First***, notwithstanding Plaintiffs' selective quoting, the deposition excerpts submitted by Plaintiffs establish that they received the ACA-mandated preventive services from their network physicians. (*See, e.g.*, D. Smith Decl., Exs. 45 (Carroll Dep.) at 43:6-17, 60:11-14 [redacted] and 64:24-67:10 ([redacted]), 50 (Endicott Dep.) at 64:2-65:1 ([redacted]).) ***Second***, the Lactation Specialists within Barber's, Condry's, and Endicott's networks were listed in Defendants' provider directory during the time period in question, and the addresses listed for those providers represented their places of service. (Ex. O, Nielsen Reply Decl., ¶¶ 5, 7-8; *see also* Ex. N, Souza Decl., Exs. 5-6 (establishing that those providers' places of service were within thirty miles of Barber's, Condry's, and Endicott's zip codes.) Plaintiffs' assertion that those providers were more than thirty miles away from Barber's and Condry's residences confuses driving distance with radius (Resp. at 15), but, regardless, even if true, nothing prevented them from seeking a gap exception, which they did not do. Plaintiffs' suggestion that Defendants have not demonstrated that Endicott had a trained provider within thirty miles of her residence is baffling, given that Defendants submitted a printout from Defendants' online portal that was from the time Endicott sought services in connection with their opening brief. (Op. Br. at 7 (citing Ex. D, Seay/Endicott Decl., Ex. 9 at UHC_002422).) ***Third***, Carroll does not explain [redacted]. (*See* D. Smith Decl., Ex. 45 (Carroll Dep.) at 90:16-18 ([redacted]).) ***Fourth***, Plaintiffs' purported "investigation" of the network providers identified by Defendants is inconclusive, completely unsupported by declaration, and, therefore, inadmissible for purposes of summary judgment. *See* Fed. R. Civ. P. 56(e) (a party must "properly support an assertion of fact" at summary judgment); *Zinni v. M&I Marshall & Ilsley Bank*, 565 Fed. App'x 604, 605 (9th Cir. 2014) (recognizing same). ***Fifth***, Plaintiffs misconstrue the evidence regarding Hoy, who was not given inaccurate information as she now claims; rather, [redacted] (Resp. at 17 n.18.) Further, [redacted] (*Id.*; D.

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the UHC Customer Care call center" but offering no evidence to support this assertion).) Instead, Plaintiffs make a series of unsupported arguments that fall short of raising a genuine dispute of material fact. *See McIndoe v. Huntington Ingalls Inc.*, 817 F.3d 1170, 1173 (9th Cir. 2016) ("Arguments based on conjecture or speculation are insufficient [to survive summary judgment].").

For instance, Plaintiffs rely on the opinions of their retained expert witnesses, whom Defendants have concurrently moved to strike, to contend that OB/GYNs and pediatricians lack the requisite training and experience to provide breastfeeding support and counseling services.[5] (*See* Resp. at 12-13.) [redacted]

Thus, Plaintiffs' arguments rest on the erroneous legal premise that ACA mandates – or, at least, requires this Court to set – a certain standard of care for lactation counseling above and beyond what OB/GYNs and pediatricians provide, even though the relevant section of ACA only mandates coverage of preventive services, is silent on the specific services encompassed by that mandate, and, as a result, gives plans and insurers substantial discretion to implement the benefit. (*See* Resp. at 12

Smith Decl., Ex. 56 at UHC_000888.) Had she informed Defendants and Defendants had confirmed that the network providers available to her could not provide the services, a gap exception would have been considered. (Ex. M, Huckaby Reply Decl. ¶ 6.) ***Finally***, Plaintiffs' speculation as to what Defendants' customer service representatives would have told Plaintiffs about the availability of network lactation providers is evidence of nothing given that many of the Plaintiffs never even asked and is especially belied by the fact that there were Lactation Specialists listed in Defendants' directory for Barber, Condry, and Endicott. (*See* Resp. at 16; *see also* Op. Br. at 6-7 (establishing there were network lactation specialists available to Condry, Barber, and Endicott at the time they sought the services at issue in this case).)

[5] Defendants have concurrently moved to strike the opinions of Kristi L. Martin and Dr. Ellen Chetwynd.

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(suggesting that OB/GYNs and pediatricians are not "trained lactation provider[s]" but failing to cite any legal or evidentiary support for Plaintiff's assertion that the particular providers Plaintiffs saw are not qualified to provide the services)); 29 C.F.R. § 2590.715-2713(a)(4) (plans and insurers may "determine the frequency, method, treatment, or setting for coverage"). Since these arguments impermissibly invite this Court to consider matters outside the purview of the judiciary – an exercise particularly unwarranted in an industry as heavily regulated as healthcare – the Court should reject Plaintiffs' assertions.[6] *See Lamie v. U.S. Trustee*, 540 U.S. 526, 542 (2004) ("It is beyond our province … to provide for what we think … is the preferred result."); *Great West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002) (courts should be "reluctant to tamper" with "comprehensive and reticulated statute[s]"). To do otherwise would require the Court "to untenably assume the role of a 'superlegislature' second-guessing the policy choices of other branches of government."[7] *Schroeder v. United States*, 793 F.3d 1080, 1083 (9th Cir. 2015).

Regardless, Plaintiffs' own experts express no opinions about the specific providers identified by Defendants – providers who indisputably held their practices out as providers of the ACA-mandated preventive services. (*See* Op. Br. at 7.) Additionally, the opinions of Plaintiffs' experts as to the qualifications of OB/GYNs and pediatricians cannot be squared with the fact that several Plaintiffs received the ACA-mandated preventive services from their in-network physicians. (*See id.* at 6-17.) Moreover, the experts' opinions do not dispute that OB/GYNs and pediatricians often have lactation consultants on staff who are able to provide the services, even assuming that the OB/GYNs or pediatricians cannot. (*See id.* at 6-7 (Carroll saw in-network lactation consultants and located an in-network pediatric practice with IBCLCs on staff).) Plaintiffs' experts thus fall short of

[6] Notably, the proposition that ACA requires providers to have a heightened level of lactation expertise is inconsistent with the U.S. Preventive Services Task Force materials Plaintiffs cite, which demonstrate that the benefit consists of the basic provision of "information about the benefits of breastfeeding, psychological support … and direct support" during "[s]essions … last[ing] from 15 to 45 minutes." (D. Smith Decl., Ex. 7, at 1690.) Had nationwide payors, such as Defendants, been implementing the ACA-mandated preventive benefit in such a glaringly deficient manner, as Plaintiffs suggest, the U.S. Preventive Services Task Force would have likely clarified the scope of the benefit when it updated its guidance in 2016, but it did not do so. Instead, the Task Force ratified its description of the benefit, making no changes whatsoever. (Resp. at 4 n.4 (noting that the 2016 recommendation reiterated previous guidance).)

[7] Notwithstanding Plaintiffs' argument to the contrary, *King v. Burwell*, 135 S.Ct. 2480 (2015) (cited in Resp. at 5 n.5) supports this assertion. *See id.* at 2496 (courts merely '"say what the law is."' (citations omitted)).

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establishing a genuine dispute of material fact regarding whether Plaintiffs had in-network providers available to them.

Plaintiffs fill their brief with citations to documents produced by Defendants that are taken out of context, have nothing to do with the named Plaintiffs' circumstances, only demonstrate Defendants' good faith efforts to implement the benefit in accordance with ACA and in a manner advantageous to the interests of their members, and fail to raise a genuine dispute of material fact.[8] (Resp. at 5-11.) For example, Plaintiffs cite a single ambiguous statement from one of Defendants' regional medical officers to argue that Defendants were on notice that OB/GYNs and pediatricians are incapable of providing breastfeeding support and counseling to their patients. (*Id.* at 10, 12 (citing D. Smith Decl., Ex. 1, at UHC_028002).) Such an approach plainly ignores the plethora of documents submitted by Plaintiffs supporting the fact that OB/GYNs and pediatricians are trained providers of the ACA-mandated services. (*See, e.g.,* D. Smith Decl., Exs. 2, 23 (noting that physicians and nurses provide the services); *see also* D. Smith Decl., Exs. 16, 22 (similar).)

Plaintiffs also point to several emails and other internal documents in which Defendants consider the propriety of including lactation consultants in their networks and claim that such documents establish that Defendants lack in-network providers of the ACA-mandated preventive services. (*See, e.g.*, D. Smith Decl., Exs. 23, 24.) As established by the Frequently Asked Questions ("FAQ") documents Plaintiffs cite throughout their brief, however, Defendants are not required to contract with such providers, and there is no genuine dispute that providers other than lactation consultants are fully capable of providing, and regularly do provide, the ACA-mandated preventive services. *See* Frequently Asked Questions About Affordable Care Act and Mental Health Parity Implementation Part XXIX, at Q.3 (Oct. 23, 2015) ("FAQ") (ACA-mandated breastfeeding support and counseling services need not be provided by lactation consultants and can be provided "by another provider type acting within the scope of his or her license or certification (for example, a

[8] Plaintiffs imply in footnote 2 of their brief that they did not have a full opportunity to develop the record on summary judgment, which is only directed at named Plaintiffs. (Resp. at 1 n.2.) That is not the case. Plaintiffs made the strategic decision to take zero depositions and not to address any perceived deficiencies in Defendants' discovery. The time for doing so has passed. (Standing Order for Civil Cases Before Judge Chhabria ¶ 17 (discovery disputes must be addressed by joint letter no later than seven days after the discovery cutoff); Dkt. 77 (setting discovery cutoff date of November 15, 2017).)

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registered nurse)"); *see also* Op. Br. at 7 (discussing reports of Drs. Lee, Cooper, and Miller). Thus, Plaintiffs' conclusion that such documents reflect an internal policy to intentionally circumvent ACA's requirements lacks any basis in fact or law and does not create a triable issue of fact.

Equally meritless is Plaintiffs' emphasis on emails and other documents reflecting Defendants' consideration of the feasibility of creating a list of in-network providers who provide the ACA-mandated preventive services, many of which pre-date the October 2015 sub-regulatory guidance that Plaintiffs claim requires such a list. (*See* Resp. at 9 (citing D. Smith Decl., Ex. 25); *see also* D. Smith Decl., Ex. 3.) Indeed, the agencies charged with implementing ACA have unequivocally acknowledged that the statute does not require a separate list. *See* FAQ at Q.1 ("[T]he preventive services requirements … do not include specific disclosure requirements."). Importantly, Plaintiffs have failed to cite any legal authority in response to Defendants' argument that, to the extent the terse and informal FAQ document upon which Plaintiffs rely purports to require a separate list of providers of the ACA-mandated service, the agency pronouncement is due no deference. (*See* Resp. at 16 (asserting, without any citation to supporting authority, that '"coverage' cannot be accomplished if … a patient cannot find the network provider")). Plaintiffs have therefore waived any opposition. *United States v. Cazares*, 788 F.3d 956, 983 (9th Cir. 2015) (failure to cite legal authority results in waiver).

Nonetheless, there is no genuine dispute that Plaintiffs' plan documents comply with the regulatory guidance cited in the FAQ by directing members to Defendants' provider directory, which: is available online; includes information such as physician specialty, whether the physician is accepting new patients, costs for selected services, and patient reviews; and satisfies any and all disclosure requirements under applicable law.[9] (Op. Br. at 21 (citing 29 C.F.R. § 2590.715-2715(a)(2)(i)(K) (requiring certain plans and insurers to 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 plans and insurers to provide information about "the composition of the provider

[9] Plaintiffs' suggestion that Defendants made it impossible to locate network providers of the ACA-mandated preventive services is unsupported, particularly given that Carroll saw in-network lactation consultants and located an in-network pediatric practice with IBCLCs on staff. (Op. Br. at 7.) Plaintiffs' unsupported suggestion is also undercut by the fact that Barber and Condry did nothing to locate network providers of the ACA-mandated services. (*Id.* at 6-17.)

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network")).) There likewise is no genuine dispute that Plaintiffs could have coordinated with Defendants to receive in-network benefits for out-of-network services in accordance with the terms of their plan documents, yet failed to do so.[10] (Op. Br. at 5, 19; *see also* Ex. M, Huckaby Reply Decl., ¶ 6.) Plaintiffs contend that Defendants' gap exception policy is "fantasy," but submit no evidence contradicting Defendants' declarations and other materials. (Resp. at 17; *see also* Ex. M, Huckaby Reply Decl., ¶ 6 (Defendants grant gap exceptions when the proper procedure is followed).) Thus, Plaintiffs' assertion that "it is admitted … that UHC's policy is to merely have in-network pediatricians and OB/GYNs while taking no further steps … to identify[] … in-network trained providers" is patently wrong. (Resp. at 1.)

In short, Plaintiffs had network providers available to them when they sought services out-of-network. Plaintiffs' arguments to the contrary are entitled unsupported and do not raise a genuine dispute of material fact on these issues. The Court should grant Defendants summary judgment on Counts II through VI and deny Plaintiffs' request for partial summary judgment.

2. ACA Does Not Cover Plaintiffs' Out-of-Network Diagnostic Services.

Defendants complied with ACA in processing Plaintiffs' out-of-network claims for an additional reason: under ACA's plain language, only ***preventive*** services, which focus on the prevention or detection of illness or disease, qualify for cost-share-free coverage under Defendants' policies for preventive care.[11] (Op. Br. at 18.) Since each Plaintiff sought services for clinically apparent medical problems, and thus received ***diagnostic*** services, ACA did not require Defendants to provide coverage without cost-shares.[12] (*Id.* at 18-19.)

[10] Plaintiffs' assertion that Bishop complied with this procedure, (Resp. at 17 n.19), is belied by the undisputed fact that her OB/GYN faxed UnitedHealthcare Insurance Company just over one hour before Bishop's out-of-network appointment was to take place. (Op. Br. at 14.)

[11] Plaintiffs point to notes specific to Endicott in a failed attempt to undermine the clear language of the Coverage Guidelines. (*See* Resp. at 19 (citing D. Smith Decl., Ex. 54).) The notes merely reflect that "[c]omprehensive lactation support and counseling is covered under preventive benefits." (D. Smith Decl., Ex. 54, at UHC_149496.) The notes' ***separate statement*** that "[l]actation support related to infections or other medical conditions [is] covered based on the place of service" plainly does not refer to Defendants' coverage for preventive care. (*Id.*) Likewise, Plaintiffs ignore that therapeutic care may be covered under the Guidelines only if provided during "the same encounter" as preventive care, not over "a series of encounters," as Plaintiffs suggest. (Resp. at 20 (quoting Ex. H, Huckaby Decl., Ex. 1 at UHC_149632).)

[12] Plaintiffs do not address, and thus concede, [redacted] and, therefore, are not subject to ACA's preventive services requirements. (Op. Br. at 18-19); *Foster v. City of Fresno*, 392 F. Supp. 2d 1140, 1146-47 (E.D. Cal. 2005) (failure to respond to argument

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Plaintiffs do not dispute that they sought out-of-network services for existing conditions, [redacted].[13] (*Id.* at 18; Resp. at 19.) Rather, Plaintiffs rely on the word "comprehensive" in the HRSA Guidelines to contend that ACA requires coverage without cost-shares for ***all*** breastfeeding-related services, including those to treat existing, diagnostic conditions. (Resp. at 19-22.) ACA and the HRSA Guidelines, however, plainly mandate coverage without cost-sharing for ***preventive*** services, and the term "comprehensive" in the HRSA Guidelines is necessarily modified by the phrase "preventive health services." *See* 42 U.S.C. § 300gg-13; 29 C.F.R. §2590.715-2713; Health Resources & Services Administration, Women's Preventive Services Guidelines, https://www.hrsa.gov/womens-guidelines/index.html (last visited Dec. 22, 2017). Thus, adopting Plaintiffs' interpretation would require the Court to read the word "preventive" out of ACA and the HRSA Guidelines and, in doing so, violate longstanding maxims of statutory construction. *See United States v. Watkins*, 278 F.3d 961, 965 (9th Cir. 2002) (courts should apply a statute's plain language); *Hooks v. Kitsap Tenant Support Servs.*, Inc., 816 F.3d 550, 560 (9th Cir. 2016) (statutes should be interpreted so that "no clause, sentence, or word [is] superfluous, void, or insignificant"). Further, neither ACA nor HRSA delineate the actual services covered under the mandate, thereby giving plans and issuers like Defendants discretion to articulate the particulars of what will be covered as preventive services. 29 C.F.R. § 2590.715-2713(a)(4) (plans and insurers may "determine the frequency, method, treatment,

raised in summary judgment motion results in waiver). Plaintiffs also concede that Carroll's provider did not code her claims in compliance with Defendants' Coverage Determination Guidelines. (Resp. at 20.)

[13] While Plaintiffs contend that some of the codes submitted by Plaintiffs match those identified in Defendants' policies, Defendants' Coverage Determination Guidelines are clear that services deemed diagnostic will be processed as non-preventive, regardless of the codes used. (Ex. H, Huckaby Decl., Ex. 1 (Coverage Determination Guidelines) at UHC_149632 ("When a service is done for diagnostic purposes it will be adjudicated under the applicable non-preventive medical benefit.").) Additionally, Plaintiffs ignore that several of their claims are not entitled to coverage under any applicable benefits because they were billed with inappropriate codes under Defendants' Nonphysician Health Care Professionals Billing Evaluation and Management Codes Policy, which applies to all health care services, as well as to nonphysician providers regardless of their network status, and thus was not created or utilized to marginalize Plaintiffs' particular out-of-network providers, as Plaintiffs suggest . (*See* Ex. M, Huckaby Reply Dec., ¶ 5, Ex. A.; *see also* Resp. at 19-22.) Nothing in ACA prevents Defendants from utilizing reimbursement policies, such as this billing policy, and the Coverage Determination Guidelines themselves inform providers that billing for preventive services is subject to such rules. (*See* FAQ at Q.19 (noting that "[r]eimbursement policy is outside of the scope of the HRSA Guidelines and the Departments' regulations."); Ex. H, Huckaby Decl., Ex. 1 (Coverage Determination Guidelines) at UHC_149629.)

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or setting for coverage"). Plaintiffs impermissibly ask this Court to legislate on Congress's behalf. *Lamie*, 540 U.S. at 542 (courts apply the law, not draft it).

Nothing in ACA or its supporting regulations requires plans and insurers to apply ACA's preventive services provision outside the context of preventive care. *See id.* ("If Congress enacted into law something different from what it intended, then it should amend the statute to conform it to its intent."). Further, if the agencies charged with implementing ACA interpreted the statute to reach diagnostic treatment, those agencies easily could have clarified the state of the law in regulatory or sub-regulatory materials, such as an FAQ, which the agencies have done on numerous occasions with respect to other matters regarding the benefit at issue in this case. *Christopher v. SmithKline Beecham Corp.*, 567 U.S. 142, 157 (2012) (noting in the context of regulatory interpretation that "despite the industry's decades-long practice of classifying pharmaceutical detailers as exempt employees, the DOL never initiated any enforcement actions with respect to detailers or otherwise suggested that it thought the industry was acting unlawfully"); *see also, e.g.*, FAQ at Q.3 (clarifying that ACA-mandated breastfeeding support and counseling need not be provided by lactation consultants, who are often unlicensed under state law). Notably, the agencies considered, but rejected, prohibiting cost-sharing for office visits where preventive services were provided, but the primary purpose of the visit was treatment of a condition. *See* Interim Final Rules, 75 Fed. Reg. 41726-01, at 41738 (July 19, 2010) ("Prohibiting cost sharing for office visits when any recommended preventive service is provided, regardless of the primary purpose of the visit, could lead to an overly broad application of these interim final regulations; for example, a person who sees a specialist for a particular condition could end up with a zero copayment simply because his or her blood pressure was taken as part of the office visit."). The agencies' inaction on this issue speaks volumes, underscoring the fact that the ACA-mandated benefit only applies to preventive care and not the treatment of conditions.

Plaintiffs also rely on their experts to support their reading of the term "comprehensive," but Plaintiffs' experts admitted that they have no basis for any opinions regarding the distinction between preventive and diagnostic care and, therefore, do not support Plaintiffs' expansive reading of ACA. Dr. Martin, for instance, conceded that she had no basis for her opinion on the distinction

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between preventive and diagnostic care. (*See* Ex. N, Souza Reply Decl., Ex. 1 (Dr. Martin Dep.) at 40:11-21; *see also* Defs.' Mot. Strike at 3 (same).) Dr. Morton admitted that she had never read the relevant ACA provisions prior to being engaged as an expert in this case and, thus, could not properly opine as to the meaning of "comprehensive." (Ex. N, Souza Reply Decl., Ex. 2 (Dr. Morton Dep.) at 71:12-74:9.) Dr. Chetwynd admitted that her opinions as to the meaning of "comprehensive" constituted her own "clinical interpretation," and that her definition of "comprehensive" lactation services is broader than what is recommended by the U.S. Preventive Services Task Force. (Ex. N, Souza Reply Decl., Ex. 3 (Chetwynd Dep.) at 52:12-21, 145:14-23, 148:9-15.) Dr. Chetwynd further admitted that OB/GYNs and pediatricians "may serve as an initial resource for breastfeeding assistance," which comports with ACA's requirement for coverage of "preventive health services." (D. Smith Decl., Ex. 51 (Dr. Chetwynd Report), at 7.) Moreover, Dr. Meek conceded that she could not opine that interventions addressing conditions constitute "preventive health services" for purposes of ACA. (Ex. N, Souza Reply Decl., Ex. 4 (Meek Dep.) at 51:16-21.) Thus, Plaintiffs' experts have no bearing on this Court's determination of the scope of the ACA-mandated benefits.

Lastly, Plaintiffs ignore the preventive/diagnostic distinction recognized by industry authorities, including the Centers for Disease Control & Prevention (the "CDC").[14] CDC, Preventive Checklist, https://www.cdc.gov/prevention/index.html (last visited Dec. 22, 2017) (distinguishing between preventive and diagnostic care); *see also* I.R.S., Health Savings Accounts - Preventive Care, 2004-1 C.B. 725 (Mar. 30, 2004) (same). The CDC has identified only a limited number of procedure and diagnosis codes associated with ACA-mandated breastfeeding support and counseling services, none of which reflect treatment of a condition. *See* CDC, Billing Codes, https://www.cdc.gov/prevention/billingcodes.html (last visited Dec. 22, 2017) (identifying codes for "[b]reastfeeding support . . . and counseling" as 99201-99203, 99211-99214, 99241-99245, 99341-99345, 99347-99350, 99401-99404, 99411-99412, and S9443 but only when coupled with a particular diagnosis code (ICD-9: V241 or ICD-10: Z39.1) that indicates "[e]ncounter for care and

[14] Like the CDC's definition, the Institute of Medicine definition cited by Plaintiffs limits preventive care to services that will '"decrease the likelihood or delay the onset"' of diseases or conditions, not treat them. (Resp. at 20-21 n.26 (quoting D. Smith Decl., Ex. 8, at 3).)

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examination of lactating mother," not the host of codes that indicate treatment of conditions, such as [redacted]). Likewise, Defendants' policies restrict coverage without cost-shares to codes associated with preventive services in accordance with the discretion plans have under ACA. (Ex. H, Huckaby Decl., Ex. 1); 29 C.F.R. § 2590.715-2713(a)(4). Because Plaintiffs received diagnostic, rather than preventive, services, the services they received were not subject to ACA. Summary judgment must be granted on Counts II through VI, and Plaintiffs' request for partial summary judgment must be denied.

B. Count I Fails Because Plaintiffs Received A Full And Fair Review And Have An Adequate Remedy.

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

Plaintiffs do not raise a genuine dispute of material fact as to Count I, because they do not identify how Defendants failed to substantially comply with their obligations to provide a full and fair review under ERISA.

First, Plaintiffs do not offer any basis for holding Defendants liable with respect to the March 19 and April 14, 2015, claims that Condry never submitted. (*See* Resp. at 23.) Plaintiffs cannot hold Defendants liable under section 503 for failure to provide "full and fair review" of claims it never received. *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). Particularly given that Condry never appealed the denial of the single claim that she did submit, Plaintiffs' assertion that her submission of the two later claims would have been futile, (Resp. at 23 n.29), is unsupported speculation. (Ex. F, Seay/Condry Decl., Ex. 3 (EOB); SAC ¶ 92.)

Second, Plaintiffs mischaracterize Defendants' denials as saying nothing more than "we are not persuaded," (Resp. at 23), when in fact Defendants provided Plaintiffs with specific reasons and adequately described information necessary to perfect their claims. For instance, Defendants' explanations to Condry, Hoy, and Bishop that "[t]here may be a more appropriate CPT or HCPCS code that describes this service" or that "[t]he service code is not separately reimbursable in this setting" were not too "cryptic" to be understood by "laypersons like Condry, Hoy, and Bishop." (*Id.*)

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Each of those Plaintiffs ***did*** in fact understand that their lactation consultants had provided the codes submitted to Defendants. (Ex. G, Souza Decl., Ex. 1 (Bishop Dep.), at 118:20-119: 13; Ex. 2 (Condry Dep.) at 82:19-83:8; Ex. 6 (Hoy Dep.) at 195:7-196:13.) Moreover, Plaintiffs ignore that Defendants were in no position to dictate to Plaintiffs or their lactation consultants what specific codes to use – only Plaintiffs and their providers knew what services were provided to Plaintiffs and, therefore, whether other codes might be more appropriate. Under the circumstances, Defendants' explanation that different codes may be "more appropriate" was, at minimum, "reasonably clear" and sufficient to inform Plaintiffs of the type of additional information that might be needed to perfect their claims. *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). Even if Defendants did not explicitly ask Plaintiffs to supply more information, the implication is unmistakable. *See id.* ("meaningful dialogue" is a "common sense standard").

Defendants' explanations to Endicott and Barber also were adequate. Barber admits that she understood Defendants' explanation that her plan does not cover "non-medical service[s] or personal item[s]" to say that Defendants were not covering the service because it was a parenting class. (Ex. G, Souza Decl., Ex. 3 (Barber Dep.) at 219:7-24.) Likewise, Defendants informed Endicott that her claims were processed as out-of-network and that the allowed amounts were applied to her deductible, which Endicott understood in general terms. (Ex. G, Souza Decl., Ex. 4 (Endicott Dep.) at 154:6-21.) These explanations were sufficient to inform Endicott and Barber of the basis for Defendants' determinations.

Third, Plaintiffs' contention that they were unable to respond to Defendants' explanations, either through appeal or by submitting additional information, is belied by the undisputed facts.[15] Barber ***did*** appeal, though it was untimely. (Ex. E, Seay/Barber Decl., Ex. 6; Ex. G, Souza Decl., Ex. 3 (Barber Dep.) at 197:19-198:5.) In her appeal, Hoy did not address the coding issue that formed the basis for the denial of her claims – Plaintiffs' only contention is to incorrectly assert that Defendants did not inform Hoy that she might obtain "more appropriate" codes from her provider. (Resp. at 25.) In fact, as noted above, for Hoy and the other Plaintiffs, Defendants provided

[15] Plaintiffs incorrectly assert that Defendants represented that Endicott and Bishop submitted appeals. (Resp. at 25.) In fact, there is no record Endicott or Bishop ever appealed. (Op. Br. at 11, 15.)

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explanations that "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). In sum, it is indisputable that Defendants provided a "full and fair review" under ERISA. As a result, Defendants are entitled to summary judgment, and Plaintiffs' request for partial summary judgment must be denied.

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

When Plaintiffs allege in Count I that Defendants breached their fiduciary duties "to administer plan benefits in strict accordance with the terms of the underlying plan documents," (SAC ¶ 204), they are necessarily challenging Defendants' benefit determinations and, as such, have an adequate remedy under section 502(a)(1)(B) of ERISA. *Forsyth v. Humana, Inc.*, 114 F.3d 1467, 1475 (9th Cir. 1997), *overruled on other grounds by* 693 F.3d 896 (9th Cir. 2012). While the Supreme Court, in *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011), authorizes Plaintiffs to ***plead*** alternative causes of action under both sections 502(a)(1)(B) and 502(a)(3), they may not obtain equitable relief under section 502(a)(3) when relief available under section 502(a)(1)(B) is adequate to redress Plaintiffs' injury. *Moyle v. Liberty Mut. Retirement Benefit Plan*, 823 F.3d 948, 961-62 (9th Cir. 2016). Moreover, Plaintiffs are not seeking ***alternative*** relief – they seek unspecified relief only under section 502(a)(3). Defendants' motion is directed at that portion of Count I that seeks monetary relief under section 502(a)(3) premised on Defendants' alleged failure to pay benefits owed under the Plaintiffs' plans. (Op. Br. at 25.) Relief available under section 502(a)(1)(B) is adequate to remedy any failure by Defendants to pay plan benefits owed to Plaintiffs. *See Ford v. MCI Commc'ns Corp. Health & Welfare Plan*, 399 F.3d 1076, 1083 (9th Cir. 2005), *overruled on other grounds by* 642 F.3d 1202 (9th Cir. 2011) ("claims asserting a breach of fiduciary duty are not cognizable when the asserted breach is predicated on the mishandling of an individual claim"); *O'Rourke v. N. Calif. Elec. Workers Pension Plan*, No. 3:16-cv-02007-WHO, 2017 WL 5000335, at *13 (N.D. Cal. Nov. 2, 2017) ("[E]quitable relief under § 1132(a)(3) is not available if § 1132(a)(1)(B) provides an adequate remedy," quoting *Moyle*).

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While issues with a plan's overall methodology for determining benefits may justify separate relief under section 502(a)(3), Plaintiffs have not asserted any such issues in Count I. *See, e.g., Hill v. Blue Cross & Blue Shield of Mich.*, 409 F.3d 710, 718 (6th Cir. 2005) (section 502(a)(3) claim challenging plan-wide methodology for adjudicating emergency services benefits allowed, despite availability of relief as to individual benefits claims under section 502(a)(1)(B)). Notably, Count I does not allege that Defendants' benefits methodology relating to lactation consulting claims violates the Plaintiffs' plans – in fact, the word "lactation" does not appear in Count I. (SAC at ¶¶ 201-207.) Count I also does not seek relief for alleged violations of ACA, which is also not mentioned. (*Id.*) Instead, Plaintiffs allege that Defendants have failed to "administer plan benefits in strict accordance ***with the terms of the underlying plan documents***," (*id.* ¶ 204 (emphasis added)), which implicates only the plans' benefit terms and does not allege any plan-wide issues with Defendants' benefits methodology. Therefore, to the extent that Plaintiffs challenge Defendants' adjudication of their benefits claims pursuant to the terms of their plans (as distinct from the preventive services provision of ACA), Plaintiffs have an adequate remedy under section 502(a)(1)(B) and cannot avoid the procedural requirements and standard of review for claims under that provision by seeking relief under section 502(a)(3). *Harrow v. Prudential Ins. Co. of Am.*, 279 F.3d 244, 253 (3d Cir. 2002).

C. Plaintiffs' Response Does Not Save Their Co-Fiduciary Claim In Count III.

There is no genuine dispute that each Plaintiff is a member of a ***different*** health plan involving ***different*** employer groups and administered by ***one*** of the Defendants, and, therefore, Plaintiffs cannot establish that Defendants are fiduciaries of "the same plan" for purposes of their co-fiduciary claim under ERISA. (Op. Br. at 26 (citing 29 U.S.C. § 1105(a)).) Plaintiffs offer no opposition to this point and, therefore, concede its validity. *See Foster v. City of Fresno*, 392 F. Supp. 2d at 1146-47 (failure to respond to argument raised in summary judgment motion results in waiver). Plaintiffs' lack of opposition is not surprising, since Plaintiffs did not even attempt through discovery to identify co-fiduciaries of Plaintiffs' plans.

Plaintiffs refer to this Court's previous statement that, as a general matter, there may be a '"range of situations in which the co-fiduciary or non-fiduciary of a plan may be liable for a breach of fiduciary duty."' (Resp. at 27 (citing Dkt. 68 at 4).) Claims for co-fiduciary liability under ERISA,

however, require Plaintiffs to identify a co-fiduciary, which Plaintiffs have not done, and Plaintiffs do not articulate any other legal theory that would allow their claims to proceed.[16] *See Wright v. Employers Reinsurance Corp.*, No. C 04-03710 JW, 2005 WL 756618, at *8 (N.D. Cal. March 31, 2005) (rejecting similarly unsupported claims because summary judgment is the "put up or shut up" moment of a lawsuit). Likewise, Plaintiffs' speculative assertion that Defendants' "policy with respect to [ACA-mandated breastfeeding support and counseling services] was discussed … [and] addressed 'at the top"' is insufficient to establish that each Defendant participated in, enabled, or had knowledge of the other Defendants' purported breaches of duty. *See Keach v. U.S. Trust Co.*, 240 F. Supp. 2d 840, 844 (C.D. Ill. 2002) (granting summary judgment on co-fiduciary claim when there was no evidence that the defendants had knowledge of other fiduciaries' alleged breaches); *cf. Perez v. City Nat'l Corp.*, 176 F. Supp. 3d 945, 949 (C.D. Cal. 2016) (cited in Resp. at 27) (co-fiduciary liability established when the Secretary of Labor submitted substantial deposition testimony demonstrating that each fiduciary enabled the others' breaches).

Similarly futile is Plaintiffs' effort to hold Defendants liable under a non-fiduciary participation theory. (SAC ¶ 220.) The Ninth Circuit has held that non-fiduciaries may only be held liable under ERISA if they " (1) are 'parties in interest' with respect to the plan … and (2) engage in transactions prohibited by [section 406 of ERISA]." *Landwehr v. DuPree*, 72 F.3d 726, 733 (9th Cir. 1995). Neither of those prongs apply here. Plaintiffs suggest that the Ninth Circuit's limitations on non-fiduciary liability were superseded by the Supreme Court in *Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238 (2000). (Resp. at 27 n.37.) But *Harris* merely held that a participant, beneficiary, or fiduciary of an ERISA plan may file suit "against a nonfiduciary 'party in interest' to a transaction barred by § 406(a)," *see Harris*, 530 U.S. at 241 – a holding entirely consistent with Ninth Circuit precedent. *See Landwehr*, 72 F.3d at 733 (the Ninth Circuit "allows actions for equitable relief against nonfiduciaries who … are 'parties in interest' … and … engage in [prohibited transactions]"). Plaintiffs fail to identify any binding Ninth Circuit case law that allows

[16] Plaintiffs' reference to the law of the case doctrine is inapposite, (*see* Resp. at 27 n.38), as motions to dismiss and motions for summary judgment involve different legal standards and, therefore, "[t]he denial of motions to dismiss do[es] not constitute the law of the case for purposes of summary judgment." *Peck v. Hinchey*, No. cv-12-0137-PHX-JAT, 2017 WL 2929464, at *5 n.5 (D. Ariz. July 10, 2017).

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their claim to proceed.[17] The Court should reject Plaintiffs' attempts to rewrite Ninth Circuit law. *See Carpenter v. Pfeil*, 617 Fed. App'x 658, 661 (9th Cir. 2015) (recognizing that circuit precedent may be overruled only by the Ninth Circuit sitting en banc or by a panel of the Ninth Circuit if Supreme Court decisions have called a Ninth Circuit decision into doubt); *Davidson v. Hewlett-Packard Co.*, No. 5:16-cv-01928-EJD, 2017 WL 106398, at *2 (N.D. Cal. Jan. 11, 2017) (rejecting claim because the plaintiff "ha[d] not alleged that the [non-fiduciaries] engaged in [prohibited] transactions," making *Harris* inapplicable).

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

Carroll concedes that her group health plan required her to file a first-level appeal prior to filing suit but erroneously contends that she is excused from her exhaustion obligations in this instance because doing so would have been futile. (Resp. at 28-29.) Futility "is a narrow exception to the general rule" and applies only when a party conclusively establishes that resorting to internal procedures is "a fait accompli." *Sea & Sage Audubon Soc'y, Inc. v. Planning Comm'n of Anaheim*, 668 P.2d 664, 667-68 (1983) (en banc); *see also Alloure, Inc. v. FA, Cooperative, Inc.*, No. 08-0614 DOC (RNBx), 2009 WL 10673189, at *5 (C.D. Cal. Dec. 16, 2009) (same). Here, Carroll's supposed reasons for failing to file an appeal fall well short of that standard.

First, Carroll asserts that she could not locate an appeal form, but there is no genuine dispute that such forms were readily available online during the relevant time period, (*see* Ex. C, Seay/Carroll Decl., ¶ 14), or that instructions regarding the method and manner of appeal, as well as information regarding the location of appeal forms, were located on the EOBs Carroll received. (*See* Ex. C, Seay/Carroll Decl., Exs. 4, 5.) Carroll also acknowledged that she did not review her benefit booklet to determine how to properly submit an appeal or contact her employer's human resources department for assistance. (*See* Ex. G, Souza Decl., Ex. 5 (Carroll Dep.) at 192:1-7.) ***Second***, Carroll boldly declares that the denial reasons on the EOBs from UMR, Inc. were "false" but offers no evidentiary or other support for such an assertion, let alone explain why the denial reasons precluded

[17] Plaintiffs' reliance on *Solis v. Couturier*, 2:08-cv-02732-RRB-GGH, 2009 WL 1748724 (E.D. Cal. June 19, 2009), is misplaced, because it involved a claim under section 502(a)(5), not section 502(a)(3). *Id.* at *4.

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her from filing an appeal to correct any alleged errors. (Resp. at 28.) ***Finally***, Carroll contends, again without any support, that exhaustion was excused because Defendants' "policy … was not going to be changed by [her] appeal." (*Id.* at 29.) There is no genuine dispute, however, that Carroll's plan documents provide a mechanism by which Carroll could have received in-network benefits for out-of-network services, provided that such care is not available from a network provider. (Op. Br. at 5; *see also* Ex. M, Huckaby Reply Decl., ¶ 6 (explaining that Defendants' practice is to refer members to out-of-network providers if services are not available in-network).) Thus, completing a first-level appeal would have given Carroll the opportunity to demonstrate her position that no in-network providers exist and, therefore, her entitlement to a gap exception. (*See id.*) Carroll's failure to pursue a first-level appeal bars her claims, and this Court should grant summary judgment in Defendants' favor and deny Plaintiffs' request for summary judgment, as a result.[18] *Alloure*, 2009 WL 10673189, at *5 (granting summary judgment and rejecting futility defense); *Sea & Sage Audubon Soc'y, Inc.*, 668 P.2d at 668 (same).

E. Plaintiffs' Sex Discrimination Claim In Count IV Cannot Stand.

Plaintiffs do not respond to Defendants' arguments with respect to Count IV (i) that Plaintiffs have no evidence to support a disparate treatment claim, and (ii) that disparate impact claims are not cognizable under section 1557 of ACA. (*See* Resp. at 29-30; *see also* Op. Br. at 27-30 (setting forth Defendants' arguments)); *Briscoe v. Health Care Serv. Corp.*, No. 16-cv-10294, 2017 WL 5989727, at *10 (N.D. Ill. Dec. 4, 2017) (finding, like the *York* case cited in Defendants' opening brief, that disparate impact claims are not available under section 1557 of ACA). Plaintiffs, therefore, have waived any opposition. *See Foster*, 392 F. Supp. 2d at 1146-47.

Plaintiffs' Response also fails to muster the evidentiary showing necessary to survive summary judgment on a disparate impact claim, even if such claims were available under section

[18] Plaintiffs rely on *Roche v. Aetna, Inc.*, 681 Fed. App'x 117 (3d Cir. 2017), but that case only bolsters Defendants' position. *See id.* at 125 (granting summary judgment for health plan for failure to exhaust administrative remedies and rejecting futility defense because the plaintiff provided "no evidence … [or] testimony … regarding the futility of an appeal"). Plaintiffs' citation to *Tex. Gen. Hosp., LP v. United HealthCare Servs., Inc.*, Civil Action No. 3:15-cv-02096-M, 2016 WL 3541828 (N.D. Tex. June 28, 2016), is inapposite, as that case arose in the motion to dismiss context and, thus, was allowed to proceed based on Plaintiffs' ***allegation*** that the defendants "repeated[ly] fail[ed] to offer any meaningful administrative process." *Id.* at *6. Here, the factual record reveals that Carroll's futility defense lacks any evidentiary basis.

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1557 (which they are not).[19] Indeed, "[a] plaintiff who fails…to produce statistical evidence demonstrating [an adverse impact on a protected class] cannot make out a *prima facie* case of disparate impact." *Texas Dep't of Hous. & Cmty. Affairs. v. Inclusive Communities Project, Inc.*, 135 S. Ct. 2507, 2523 (2015). Plaintiffs' unsupported statement that "all breastfeeding women have been uniquely, specifically and knowingly excluded by [Defendants] from participation in an ACA-mandated preventive health benefit" plainly fails to meet this standard. *See Lopez v. Pac. Mar. Ass'n*, 657 F.3d 762, 766 (9th Cir. 2011) (granting summary judgment when the plaintiff only offered a "bald assertion" that the policy disparately affected a group and explaining that, "[a]t the summary judgment stage, a party no longer can rely on allegations alone") *Id.* at 768; *Doubt v. NCR Corp.*, No. C 09-5917 SBA, 2014 WL 3897590, at *8 (N.D. Cal. Aug. 7, 2014) (same). Plaintiffs likewise fail to identify a specific policy that caused an allegedly disparate impact, choosing instead to generically reference Defendants' unspecified "conduct," which is insufficient. (Resp. at 30); *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."); *Stout v. Potter*, 276 F.3d 1118, 1121 (9th Cir. 2002) (similar); *Doubt*, 2014 WL 3897590, at *7 (similar).

Tellingly, Plaintiffs declined to move for summary judgment on Count IV, choosing to solely oppose Defendants' Motion. The Court should grant summary judgment in Defendants' favor.

F. Carroll's Unjust Enrichment Claim In Count VI Is Duplicative Of Her Breach Of Contract Claim.

Lastly, summary judgment must be granted on Carroll's claim in Count VI because a cause of action for unjust enrichment is unavailable where "the parties are bound to an express contract," *Peterson v. AWJ Global Sustainable Fund, LP*, No. 15-cv-00650-CRB, 2015 WL 5921225, at *5 (N.D. Cal. Oct. 11, 2015), and here, Carroll has not identified any basis for her claims other than her plan documents. (*See* Ex. G, Souza Decl., Ex. 16 (Carroll Interrogatory Responses), Nos. 10, 16 (asserting that Defendants violated the terms of her plan documents).) This is so notwithstanding Plaintiffs' assertion that unjust enrichment claims may be pled in the alternative, which is based on

[19] Plaintiffs assert that Defendants "[r]epeat the previously rejected legal arguments made in [their] motion to dismiss," apparently forgetting that the Court dismissed Plaintiffs' sex discrimination claim without prejudice in its August 15, 2017 Order. (Dkt. 68 at 5.)

case law in the motion to dismiss context that does not apply here. *See Ellis v. J.P. Morgan Chase & Co.*, No. 12-cv-03897-YGR, 2016 WL 5815733, at *5 (N.D. Cal. Oct. 5, 2016) (granting summary judgment after declining to grant motion to dismiss because discovery demonstrated that the plaintiffs had no basis for their claim other than an express contract).

Plaintiffs also contend that Defendants acted in bad faith, thereby allowing them to advance an unjust enrichment claim notwithstanding the existence of an express contract. (Resp. at 28 n.39.) But the narrow exception invoked by Plaintiffs only applies "in instances when the contract was allegedly obtained through fraud and is therefore unenforceable." *Top Agent Network, Inc. v. Zillow, Inc.*, No. 14-cv-04769-RS, 2015 WL 7709655, at *8 (N.D. Cal. Apr. 13, 2015); *see also Sherwin-Williams Co. v. JB Collision Servs.*, No. 13cv1946 LAB (WVG), 2015 WL 3999030, at *5 (S.D. Cal. June 30, 2015) (cited in Resp. at 28 n.39) (similar). Here, Carroll has not alleged, let alone submitted any evidence supporting the proposition, that her benefit plan was procured by fraud. (*See generally* Resp.; SAC.) Accordingly, Plaintiffs' Response does not salvage Carroll's unjust enrichment claim in Count VI, and summary judgment should be granted in Defendants' favor. For the same reasons, Plaintiffs' deficient arguments – which are confined to a footnote in Plaintiffs' Response (*see* Resp. at 28 n.39) – fall short of Plaintiffs' summary judgment burden, and Plaintiffs' request for partial summary judgment must be denied.

III. CONCLUSION

As is detailed above, Defendants have established "that there is no genuine dispute as to any material fact" and that they are "entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). Plaintiffs, by contrast, have not articulated the bases on which they believe summary judgment must be granted in their favor and instead devote the entirety of their brief to opposing Defendants' Motion. In doing so, Plaintiffs fall short of their summary judgment burden under the Federal Rules of Civil Procedure. Accordingly, Defendants respectfully request that the Court (i) grant summary judgment in their favor, (ii) deny Plaintiffs' request for partial summary judgment, and (iii) grant such other relief as the Court deems just and proper.

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DATED: January 5, 2018

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