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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,

v.

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

Defendants.

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

DEFENDANTS' RESPONSE IN OPPOSITION TO PLAINTIFFS' MOTION TO LIMIT CONSIDERATION OF THE EXPERT REPORT OF HENRY MILLER, PH.D.

Honorable Vince Chhabria

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Plaintiffs have filed a motion to limit this Court's consideration of Dr. Henry Miller's expert report. Plaintiffs' motion is meritless and should be denied.

The context for Plaintiffs' challenge to Dr. Miller's opinions is their pending motion for class certification. That motion seeks certification of three national, multiyear classes of present and former UnitedHealth members who allegedly were denied access to lactation services and harmed as a result. As explained in Defendants' opposition to Plaintiffs' certification motion, however, no such classes can be certified consistent with Rule 23. Among other deficiencies, Plaintiffs urge the Court to focus solely on what they characterize as unlawful conduct on the part of Defendants yet do not identify a common injury among class members, such that the class action device facilitates common answers through common proof.

Dr. Miller's report illustrates, in part, why this is so. With respect to the Claims Review Class, for example, Dr. Miller explains why individual assessments of each class member's circumstances would be needed to determine whether Defendants' denial language was inadequate in any given circumstance and therefore harmed a particular class member. Further, with respect to the ACA and Lactation Services Classes, Dr. Miller explains that Defendants are unable to track claims payment or collection information, thus requiring individualized inquiries to determine whether a specific class member paid a cost-share or other amount and therefore suffered a compensable injury.

Plaintiffs' motion attempts to obscure this essential context, mischaracterizing the nature of Dr. Miller's opinions, the methodology he employed to arrive at his opinions, and the relevance of those opinions to the Court's class certification inquiry. Plaintiffs also gloss over Dr. Miller's extensive qualifications in an effort to diminish his opinions and preserve Plaintiffs' expansive certification theories. As discussed more fully below, however, Dr. Miller's testimony is directly relevant to Plaintiffs' obligation to identify a common injury across the class as a whole, and Dr. Miller is amply qualified to offer the relevant and reliable opinions set forth in his report. That Plaintiffs may not like Dr. Miller's opinions and/or the deficiencies they expose in Plaintiffs'

certification motion does not provide a valid basis for disregarding Dr. Miller's report. For these reasons, among others, the Court should deny Plaintiffs' motion in its entirety.

II. LEGAL STANDARD

When an expert is challenged at the class certification stage, the district court is required to assess the expert's opinions under the *Daubert* standard. *Sali v. Corona Reg'l Med. Cty.*, 909 F.3d 996, 1006 (9th Cir. 2018). Expert testimony passes muster under that rubric if it is relevant to the issues before the Court and rests on a reliable foundation. *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 597 (1993). A court may not refuse to consider an expert report at class certification solely because the report "may ultimately be inadmissible." *Sali*, 909 F.3d at 1004-05 & n.2.

III. ARGUMENT

A. Dr. Miller's Remark Code Opinions are Relevant to Class Certification Proceedings.

Dr. Miller's opinions regarding remark codes are relevant to this Court's consideration of class certification. *See* Fed. R. Evid. 702 (requiring that an "expert's scientific, technical, or other specialized knowledge" assist "the trier of fact to understand the evidence or to determine a fact in issue"). One of the classes alleged by Plaintiffs is the Claims Review Class, which purports to consist of "[a]ll participants and beneficiaries … in one or more of the ERISA employee health benefit plans administered by Defendants … who received … an explanation of benefits for Comprehensive Lactation Services … that included one or more of" four enumerated remark codes. (Dkt. 161, Pls.' Cert. Mot. at 13-14.) According to Plaintiffs, the common contention for the Claims Review Class is whether each remark code at issue was objectively understandable and, therefore, complied with ERISA. (*Id.* at 16.) Yet Plaintiffs acknowledge that the pertinent inquiry under ERISA's full and fair review provisions is whether Defendants engaged in a "meaningful dialogue" with each class member, giving "the members of the Class a reasonable opportunity for a full and fair review of the denials." (*Id.*); *see also Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997).

Dr. Miller's report highlights why this meaningful dialogue determination cannot be made on a class-wide basis. In particular, Dr. Miller explains that remark codes are designed to initiate a

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dialogue between the member, the provider, and Defendants, and to provide enough information, often through the use of industry-standard language, for the member to understand the benefits determination and capitalize on other available resources. (Dkt. 169, Miller Decl., Ex. A, Miller Expert Report at 3-5, 9-11.) Dr. Miller's report and the evidence on which he relies show that this process works as designed: members understand the basis for claim denials and regularly communicate with Defendants thereafter, with some obtaining adjustments to their claims. (*Id.* at 11.) Thus, no assumption can be made that any given remark code was inadequate as to each and every class member. (*Id.* at 9-10); *see also Coleman v. Am. Int'l Grp., Inc. Group Benefit Plan*, 87 F. Supp. 3d 1250, 1260-62 (N.D. Cal. 2015) (deficiencies in denial letter were mitigated by subsequent communications); *Palmer v. Unum Life Ins. Co. of Am.*, No. C04-2735 MJJ, 2005 WL 1562800, at *4-5 (N.D. Cal. June 24, 2005) (examining entire appeals process in analyzing meaningful dialogue). Instead, the circumstances of each class member would need to be examined.

These opinions bear directly on Plaintiffs' burden to establish "that the entire class suffered a common injury" and are therefore relevant to this Court's consideration of class certification. *Thomasson v. GC Servs. Ltd. P'Ship*, 539 Fed. App'x 809, 810 (9th Cir. 2013); *see also Ellis v. Costco Wholesale Corp.*, 657 F.3d 970, 981 (9th Cir. 2011) (similarly discussing plaintiffs' burden to establish common injury under Rule 23). Nevertheless, Plaintiffs argue that Dr. Miller's remark code opinions are irrelevant and "will not assist the Court in understanding or determining any facts at issue." (Dkt. 189, Pls.' Miller Mot. at 3.) According to Plaintiffs, the law of the case doctrine bars Dr. Miller's opinions because "the Court already decided the Remark Code issues that Dr. Miller purports to address" in its order on the parties' cross-motions for summary judgment. (*Id.*)

Plaintiffs are wrong. As a threshold matter, the Court's summary judgment order pertained only to ***the named Plaintiffs' claims***, not the claims of the putative class members. (*See generally* Dkt. 146, June 27, 2018 Order.) Plaintiffs cite no authority for the proposition that a liability determination made prior to class certification proceedings that was expressly limited to the named Plaintiffs' claims applies not only to the named Plaintiffs, but also to the putative class members. *See, e.g.*, *Harrison v. E.I. DuPont De Nemours & Co.*, No. 13-cv-01180-BLF, 2016 WL 3231535, at

*6 (N.D. Cal. June 13, 2016) (claims of the named plaintiffs control prior to class certification). Plaintiffs' position is untenable.

Regardless, Plaintiffs' argument misses the mark in that it erroneously focuses on the merits of Plaintiffs' claims, rather than the extent to which those claims can be resolved via the class action device. (*See* Dkt. 189, Pls.' Miller Mot. at 1 (incorrectly suggesting that Dr. Miller's opinions focus solely on whether Defendants breached their duties under ERISA)); *Amgen Inc. v. Conn. Ret. Plans & Tr. Funds*, 568 U.S. 455, 466 (2013) ("Merits questions may be considered to the extent—but only to the extent—that they are relevant to determining whether the Rule 23 prerequisites for class certification are satisfied."). Although Defendants disagree with Plaintiffs that a violation of ERISA's full and fair review requirements occurred in this case and reserve the right to rely on Dr. Miller's opinions for that purpose, the relevance of Dr. Miller's opinion ***at this juncture*** is to assist the Court in determining whether meaningful dialogue determinations can be made on a class-wide basis, even assuming the remark codes at issue were confusing in the abstract—*i.e.*, whether Plaintiffs can establish common injury through common proof.[1] Properly framed in this light, Dr. Miller's opinions are relevant to the certification issues currently before this Court. *See Daubert*, 509 U.S. at 591-92 (expert testimony is relevant when there is a "valid scientific connection to ***the pertinent inquiry***")(emphasis added). Plaintiffs' law-of-the-case arguments are unpersuasive.

Plaintiffs also argue that Dr. Miller's opinions are irrelevant because they focus "purely on Defendants' perspective" and do not analyze whether "plan members could understand the Remark Codes as a general matter." (Dkt. 189, Pls.' Miller Mot. at 4.) Plaintiffs are incorrect. Preliminarily, Plaintiffs' argument impermissibly attempts to place the burden of establishing the propriety of class certification on Defendants by suggesting that Defendants must prove that class members understood the remark codes at issue. It is ***Plaintiffs***, not Defendants, who must identify a viable mechanism for determining whether a full and fair review occurred across the class as a whole. *See Wal-Mart*

[1] For this reason, the cases cited by Plaintiffs are inapposite. Indeed, those cases involved experts who purported to opine on previously resolved legal matters, thus raising concerns about expert testimony invading the province of the court. *See Radiologix, Inc. v. Radiology & Nuclear Med., LLC*, No. 15-cv-4927, 2018 WL 1070876, at *6 (D. Kan. Feb. 26, 2018) (excluding testimony regarding legality of agreement under Kansas law); *Godard v. Alabama Pilot, Inc.*, No. 06-cv-0267, 2007 WL 1266361, at *2 (S.D. Ala. Apr. 26, 2007) (similarly excluding testimony on previously decided legal issue). Such concerns are not at issue here.

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1 *Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011) (a plaintiff must "affirmatively demonstrate [her]
2 compliance with the Rule"). Regardless, Dr. Miller grounds his opinions in Defendants' data
3 regarding member communications, which indicate that "a significant number of members do reach
4 out to [Defendants] after receiving EOBs, and that some obtain adjustments in their claims." (Dkt.
5 169, Miller Decl., Ex. A, Miller Expert Report at 11.) Dr. Miller also relies on his industry
6 knowledge and expertise, as well as the experiences of the named Plaintiffs and the documentation
7 they received. (*Id.* at 8-11 & n.18.) Thus, the assertion that Dr. Miller failed to account for members'
8 perspective is simply not true. The Court should reject Plaintiffs' relevance arguments.

9 **B. Dr. Miller is Qualified to Offer Opinions Regarding Remark Codes.**

10 Dr. Miller is qualified to offer the remark code opinions set forth in his report. *See* Fed. R.
11 Evid. 702 (requiring an expert to have sufficient "knowledge, skill, experience, training, or
12 education"). Indeed, Dr. Miller has been involved in health insurance and managed care issues for
13 more than forty-five years. (Dkt. 169, Miller Decl., Ex. A, Miller Expert Report at 1.) His work has
14 included, among other things, the design of health benefit programs, the development of provider
15 networks, the direction of several public policy and regulatory analysis projects for the U.S.
16 Department of Health and Human Services, and the evaluation and review of issues pertaining to the
17 Affordable Care Act's various requirements. (*Id.*) Dr. Miller's experience also includes reviews of
18 ERISA requirements regarding the clarity of communications between payors and insureds. (*Id.*; *see*
19 *also* Souza Decl., Ex. 1, Miller Dep. at 44:18-48:13 (elaborating on his experience with such issues,
20 including in the context of "the clarity of EOB communications between payers and insureds").) Dr.
21 Miller is appropriately credentialed to opine on the matters detailed in his report.

22 Plaintiffs concede that "Dr. Miller is, no doubt, qualified to testify about certain aspects of
23 the health insurance industry." (Dkt. 189, Pls.' Miller Mot. at 6.) But Plaintiffs argue that Dr. Miller
24 "is not qualified … to testify about the clarity of language used in [Defendants'] Remark Codes, the
25 design and intent of the … Remark Codes, or whether the denials using the Remark Codes need to
26 be assessed on an individual basis." (*Id.*) In doing so, Plaintiffs seek to impose an unduly narrow and
27 unworkable standard for expert qualifications that is inconsistent with applicable law. *See Doe v.*
28 *Cutter Biological, Inc.*, 971 F.2d 375, 385 (9th Cir. 1992) (experts did not testify "beyond their area

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of expertise" even though they were not licensed hematologists, because "courts impose no requirement that an expert be a specialist in a given field"). Setting that aside, Plaintiffs' argument also ignores Dr. Miller's extensive qualifications and years of experience. For instance, although Plaintiffs cite a portion of Dr. Miller's deposition testimony to suggest that Dr. Miller disclaimed expertise in remark code issues, Plaintiffs fail to acknowledge that, in response to ***the same line of questioning***, Dr. Miller testified that he has studied and presented on the development and use of remark codes for many years. (Souza Decl., Ex. 1, Miller Dep., at 31:20-32:3.) Dr. Miller further testified that remark codes fall under the umbrella of claims processing, with which Dr. Miller has substantial experience. (*Id.* at 35:21-36:4 and 21:9-24:22 (discussing expertise and consulting work in remark code issues specifically and claims processing more broadly).)

Courts in this circuit routinely find experts with similar industry knowledge and experience qualified to offer expert opinions like those at issue here. *See, e.g.*, *Hangarter v. Provident Life & Acc. Ins. Co.*, 373 F.3d 998, 1015-16 (9th Cir. 2004) (expert with twenty-five years of experience working in insurance was sufficiently qualified to testify about claims adjustment standards); *Thomas v. Newton Int'l Enters.*, 42 F.3d 1266, 1269-70 (9th Cir. 1994) (twenty-nine years of industry experience established the requisite foundation for expert testimony regarding aspects of industry); *Kanellakopoulos v. Unimerica Life Ins. Co.*, No. 15-CV-04674-BLF, 2018 WL 984826, at *2 (N.D. Cal. Feb. 20, 2018) (finding expert "qualified to testify regarding industry standards and practices, as she has more than 40 years of experience in the insurance field"). Plaintiffs' arguments regarding Dr. Miller's qualifications do not provide a viable basis for disregarding his report.

C. Dr. Miller's Remark Code Opinions are Reliable.

Dr. Miller's remark code opinions are also grounded in a reliable methodology. *See* Fed. R. Evid. 702 (requiring an expert's opinions to be "based on sufficient facts or data" and "the product of reliable principles and methods"). In arriving at his opinions, Dr. Miller relies on his extensive experience in the managed care industry, as well as his review of industry-standard remark code language issued by CMS and X12 and employed by other payors, documentation and deposition testimony pertaining to the named Plaintiffs' experiences, and declarations of Defendants' employees. (Dkt. 169, Miller Decl., Ex. A, Miller Expert Report at 3-11 & nn. 14-15, 17-19.) Dr.

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Miller's methodology passes muster under *Daubert*. *See Hsingching Hsu v. Puma Biotechnology, Inc.*, No. SACV1500865AG (JCGx), 2018 WL 4956520, at *2 (C.D. Cal. Oct. 5, 2018) (denying motion to exclude testimony of expert who "carefully dr[ew] on his experience," among other things, to provide the opinions set forth in his report); *Radware, Ltd. v. F5 Networks, Inc.*, No. 13-CV-02024-RMW, 2016 WL 590121, at *21 (N.D. Cal. Feb. 13, 2016) (same because the expert "base[d] his opinions on his experience … and … explain[ed] how he reached his conclusions").

Plaintiffs selectively quote from Dr. Miller's deposition testimony to suggest that the sole basis for his opinions is information ascertained from Google searches. (Dkt. 189, Pls.' Miller Mot. at 8-9.) Not true. Dr. Miller testified at length regarding his review of industry-standard language, including remark codes utilized by other payors in the managed care industry. (Souza Decl., Ex. 1, Miller Dep., Excerpts at 50:21-51:11.) Dr. Miller also testified about his experience with communications between and among members, payors, and providers, as well as his analysis of the named Plaintiffs' circumstances and the declarations of Defendants' employees. (*See* Souza Decl., Ex. 1, Miller Dep. at 98:19-100:12, 157:7-18 (testifying that, based on his experience and his review of documentation pertaining to the named Plaintiffs, members often contact their providers after receiving a claim denial); *id.* at 101:23-102:16 (explaining that providers have a financial interest in ensuring that members obtain coverage for their claims and, thus, resolve claims processing issues); *id.* at 106:24-107:20 (testifying that, based on his experience and his review of the Declaration of Debbie Savercool (Dkt. 165), members often contact payors like Defendants to obtain more information about claim denials).) That Dr. Miller may have conducted ***some*** of his research on the Internet certainly does not, in this day in age, render his opinions unreliable. *See, e.g.*, *Positive Ions, Inc. v. Ion Media Networks, Inc.*, No. 06-cv-4296, 2007 WL 9701734, at *9 (C.D. Cal. Nov. 7, 2007) (denying motion to exclude expert testimony, in part because "internet search engines like Google and Yahoo [were] reliable tools" for investigating the subject matter at issue). The Court should reject Plaintiffs' arguments regarding Dr. Miller's methodology.

D. Dr. Miller's Opinion Regarding Out-of-Pocket Costs is Reliable.

Equally reliable is Dr. Miller's opinion that determining whether a member paid out-of-pocket for a health care service would entail an individualized analysis of each member's

circumstances. As Dr. Miller explains, payors like Defendants can determine whether a cost-share or other amount was assessed to a particular health care claim, but they are unable to track whether a member actually paid a cost-share or other amount.[2] (Dkt. 169, Miller Decl., Ex. A, Miller Expert Report at 11.) Thus, determining whether a member made such a payment would require an individualized examination of information within the possession of the member or the provider, not Defendants. (*Id.* at 11-12.) In addition to his robust experience in the managed care industry, Dr. Miller relies on the December 3, 2018 Declaration of Abby Seay to support his opinion, which establishes that Defendants do not track collection or claims payment information pertaining to in- or out-of-network providers. (Dkt. 161-2, Pls.' Ex. 40, Seay Decl. at ¶¶ 6-8.)

Plaintiffs argue that Dr. Miller's opinion on this issue "is pure *ipse dixit*." (Dkt. 189, Pls.' Miller Mot. at 9.) But, as indicated above, Dr. Miller sufficiently grounds his testimony both in his expertise in managed care industry standards and the Declaration of Abby of Seay, the latter of which specifically pertains to Defendants' practices. (*See* Dkt. 161-2, Pls.' Ex. 40, Seay Decl. at ¶¶ 6-8); *see also Hsingching Hsu*, 2018 WL 4956520, at *2 (declining to exclude opinion grounded in expert's extensive experience); *Radware, Ltd.*, 2016 WL 590121, at *21 (similar).

Plaintiffs also contend that Dr. Miller's opinion "assumes rampant insurance fraud by providers," in part because Defendants' Administrative Guide identifies providers' failure to collect copays or deductibles as a potentially fraudulent, wasteful, or abusive billing practice. (Dkt. 189, Pls.' Miller Mot. at 10; Dkt. 161, Pls.' Cert. Mot. at 20.) As explained in Defendants' opposition to Plaintiffs' motion for class certification, however, the Administrative Guide upon which Plaintiffs rely applies only to ***network*** providers. (*See* Dkt. 161, Pls.' Cert Mot. at 20.) Plaintiffs do not provide any mechanism for determining whether out-of-network providers collected unpaid amounts from members on a class-wide basis, and there is no such process. (Dkt. 163, Defs.' Class Cert. Opp. at 17 n.11.) Regardless, it is well known that failure to collect cost-sharing amounts is a regrettable but common practice. *See, e.g.*, *Kennedy v. Connecticut Gen. Life Ins. Co.*, 924 F.2d 698, 699 (7th

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[2] Defendants are not obliged to keep records or data in a manner that facilitates certification of class actions—Plaintiffs, not Defendants, have the burden of proof. *See Dukes*, 564 U.S. at 356 (expert testimony based on Wal-Mart's available data was "insufficient to establish that respondents' theory can be proved on a classwide basis").

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Cir. 1991) (discussing same). Plaintiffs' arguments regarding fraudulent billing do not render Dr. Miller's opinions unreliable.

IV. CONCLUSION

Dr. Miller offers reliable opinions that are directly relevant to this Court's class certification inquiry. He appropriately grounds his opinions not only in his experience in the managed care industry, but also in his detailed review of the evidence in the record. Plaintiffs' attacks on the relevance of his opinions, as well as the methodology he employed to reach those opinions and his extensive qualifications, do not provide a valid basis for disregarding Dr. Miller's report. For these reasons, and all of those set forth above, Plaintiffs' motion should be denied in its entirety.

DATED: April 17, 2019

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