IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

LAURA BRISCOE, KRISTIN MAGIERSKI, and EMILY ADAMS, on behalf of themselves and all others similarly situated, Plaintiffs, v. HEALTH CARE SERVICE CORPORATION and BLUE CROSS AND BLUE SHIELD OF ILLINOIS, Defendants.	)))))))))))))	Case No. 1:16-cv-10294 Judge John Robert Blakey **REDACTED**

HEALTH CARE SERVICE CORPORATION'S RESPONSE IN OPPOSITION TO PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

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I. INTRODUCTION

Plaintiffs' motion for class certification asks this Court to certify two multi-state, multi-year classes of present and former Health Care Service Corporation ("HCSC") members who allegedly were denied access to lactation services and harmed as a result. But under the very laws Plaintiffs invoke, each putative class member's claim turns on whether an in-network lactation service was available to the class member, and why HCSC denied any claim for reimbursement or imposed a cost-share. As such, these claims cannot be adjudicated on a classwide basis, so no classes can be certified consistent with Rule 23.

The putative premise for Plaintiffs' motion is the Affordable Care Act's ("ACA") requirements pertaining to preventive lactation support and counseling services. Under ACA, health plans must cover such services without cost-shares (*i.e.*, deductibles, copayments, coinsurance) when a plan member obtains such services from in-network providers. But plans may impose cost-shares on, or deny coverage for, out-of-network services, so long as the member had available to her a network provider of the services. A health plan must cover out-of-network services without cost-shares only if the member had no in-network provider available.

By their very terms, these requirements mandate an individualized inquiry into the particular facts that show why any given class member's claim for coverage was denied, or had a cost-share imposed. Indeed, two federal courts have analyzed these requirements at summary judgment, conducted the required individualized inquiry, and reached ***different*** outcomes based on the particular facts of each named plaintiff's claim. *Condry v. UnitedHealth Group Inc.*, No. 17-cv-00183, 2018 WL 3203046 (N.D. Cal. June 27, 2018) ("*Condry SJ Order*"); *York v. Wellmark, Inc.*, No. 4:16-cv-00627, 2019 WL 1493715 (S.D. Iowa Feb. 28, 2019). Relying on its individualized summary judgment analysis, one of these courts recently denied certification of classes substantially similar to those asserted here. *Condry v. UnitedHealth Group Inc.*, No. 17-

cv-00183, 2019 WL 2552776, at *1 (N.D. Cal. May 23, 2019) ("*Condry Class Order*"). These rulings show how individual issues permeate any analysis involving ACA's lactation services requirements, precluding certification of a putative class.

Nevertheless, the Plaintiffs attempt to homogenize their claims and urge the Court to focus solely on purported uniform policies and practices, with no assessment of the ***impact*** of such policies and practices on any particular class member in terms of liability, remedies, and available defenses. Plaintiffs avoid referencing the monetary recovery they seek and refrain from moving for certification under Rule 23(b)(3), which requires that common issues "predominate."

These tactics, however, cannot mask the individualized nature of the issues to be determined. A plaintiff cannot meet her Rule 23 burden merely by identifying common questions that a defendant's conduct raises. Rather, a plaintiff must assert a common injury among class members, such that the class action device facilitates common answers through common proof. Plaintiffs have not satisfied that burden here.

Such is the case with Plaintiffs' contention that HCSC has an inadequate number of in-network providers of lactation services, or fails to provide members with sufficient information about those providers. In fact, the evidence shows that, over time and across markets, the vast majority of women who submitted claims for lactation services pursuant to HCSC's coding guidance received the services in-network. This evidence demonstrates that network providers were not "needle[s] in a haystack," and that there were no "administrative barriers that render[ed] full coverage … illusory." (Dkt. 50, Order on Mot. to Dismiss, at 10, 12.)

Critically, the wide availability of network providers undermines Plaintiffs' assertion that the Court can presume that all women who obtained out-of-network services were forced to do so. Rather, applicable law and known facts require an individualized inquiry into why each

putative class member sought services out-of-network, including consideration of:

- Whether a network provider was available within a "reasonable" distance;
- Whether the member investigated the availability of a network provider;
- Whether the member chose an out-of-network provider for personal reasons;
- Whether the provider collected any amounts due from the member;
- Whether the member applied for a waiver or submitted an appeal.

Similarly riddled with individualized issues is Plaintiffs' assertion that HCSC adopted an unduly narrow set of billing codes for the ACA-mandated service. ACA does not prescribe the billing codes that a health plan must adopt for lactation services, so HCSC was free to provide coding guidance that allows providers to bill for lactation issues. HCSC did so using procedure-level codes for lactation classes and preventive counseling—logical codes for the ACA preventive service. As relevant here, nothing in HCSC's billing codes permits a ***classwide*** adjudication, as the evidence shows that thousands of claims were submitted to HCSC for the ACA-mandated service using HCSC's billing codes. This means that an individualized examination of each claim billed with ***other*** codes would be required to assess why that claim was not billed with HCSC's coding guidance and whether the claim could have been submitted using HCSC's suggested codes.

Tellingly, none of Plaintiffs' suggested additional procedure codes indicate a lactation service on their face, even after combining them with diagnosis codes offered by Plaintiffs. If Plaintiffs' list of codes is used to identify claims, the only way to ensure those claims are for lactation services would be to review the medical records (which HCSC typically does not have) associated with each and every such claim—an individualized inquiry. And, the Court would need to determine whether the cost-share or claim denial resulted from the codes used or some other, unrelated, reason. These questions are not susceptible to class-wide resolution.

Plaintiffs' putative classes suffer from a number of other deficiencies. For instance,

Plaintiffs attempt to include pediatric claims (indicated by pediatric medical codes on their list of codes), even though the ACA benefit is plainly limited to women. Further, Plaintiffs seek to include members who received lactation services from in-network providers. By definition, such members were not injured by a lack of network providers, thus requiring different proof and subjecting them to unique defenses. Plaintiffs also sweep in members who purportedly received lactation services but never submitted claims. Setting aside issues regarding how the Court could reliably identify such members, these claims present numerous unique issues and defenses, including ***why*** they did not submit a claim. In any event, adding likely unidentifiable members to the class with no scrutiny of their individual circumstances would expand substantive rights and alter the scope of the benefits at issue, in violation of the Rules Enabling Act.

As other courts considering similar claims already have recognized, the application of the law at issue turns on the particular circumstances of each class member's claims. Because the Court cannot adjudicate those claims in one stroke, the Court should deny Plaintiffs' motion.

II. BACKGROUND[1]

A. Lactation and Related Care Present a Range of Individualized Issues.

Lactation is the process of milk production and secretion by women in connection with childbirth. (Pls.' Ex. 24, Expert Report of Dr. Henry Lee ("Lee Report"), at 3-4.) Socioeconomic, workplace, cultural, and other factors play a role in individual breastfeeding decisions, including whether a woman chooses to breastfeed and the level and type of care sought. (*Id.* at 4.)

Some women do not need or want lactation assistance, such as mothers with prior breastfeeding experience. (*Id.*) Others benefit from lactation care, but the services that facilitate successful breastfeeding vary for each individual based on a myriad of issues. (*Id.*) Some women need help for complex issues, while others require only basic advice. (Ex. A, Deposition of Dr.

[1] Exhibits are listed in HCSC's Appendix filed contemporaneously herewith.

Lauren Hanley ("Hanley Dep."), at 83:1-3, 85:24-86:2.) A woman's choice of provider may be affected by language barriers or personal preference. (Pls.' Ex. 24, Lee Report, at 4.)

B. ACA Gives Health Plans Discretion to Implement the Benefit.

ACA requires health plans to cover certain preventive services for women without cost sharing as specified in guidelines supported by the Health Resources and Services Administration ("HRSA"). 42 U.S.C. § 300gg-13(a)(4). ACA defines "cost-sharing" to include "deductibles, coinsurance, [and] copayments." 42 U.S.C. § 18022(c)(3)(A)(i). HRSA's Guidelines identify "Breastfeeding Services And Supplies" as a women's preventive service under ACA requiring coverage for "comprehensive lactation support services," that include "counseling" and "education" during the "antenatal, perinatal, and the postpartum period."[2]

ACA and HRSA do not elaborate on what constitutes "[c]omprehensive lactation support services," beyond "counseling" and "education." Lactation services can be rendered by any "provider type acting within the scope of [her] license or certification (for example, a registered nurse)."[3] Health plans have discretion to adopt billing codes that pay at no cost-share for services and to use "reasonable medical management techniques to determine the frequency, method, treatment, or setting for coverage." 29 C.F.R. § 2590.715-2713(a)(4); Ex. B, June 6, 2019 Expert Report of Palma D'Apuzzo in Rebuttal to Report of Nicole Peluso ("Peluso Rebuttal"), ¶¶ 25-27.)

ACA's supporting regulations allow health plans to deny coverage for, or impose cost-shares on, lactation services rendered by out-of-network providers, so long as those health plans

[2] A copy of the HRSA Guidelines is available at https://www.hrsa.gov/womens-guidelines-2016/index.html. Breastfeeding supplies, such as breast pumps, are also part of the ACA-mandated benefit, but are not part of this litigation. (*See generally* Second Am. Compl. (Dkt. 56).)

[3] FAQs About ACA Implementation (Part XXIX) at Q.3, https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs. *See also* Pls.' Ex. 13, WPSI Report, at 39 (listing examples of lactation providers).

have providers in their networks who offer the services. 29 C.F.R. § 2590.715-2713(a)(3)(i)-(ii). Only when a health plan does not have in its network providers who offer lactation services must the health plan cover out-of-network services without cost-shares. *Id.* § 2590.715-2713(a)(3)(ii).

C. HCSC Has Established a Network of Providers and Billing Guidance.

HCSC provides coverage without cost-shares for lactation services when rendered by an in-network provider.[4] (Pls.' Ex. 19, Preventive Care Services Medical Policy ("Medical Policy"), at HCSC_0177107-8; Pls.' Ex. 20, Clinical Payment and Coding Policy ("CPCP"), at HCSC_0177651, 656-7.) HCSC has thousands of in-network providers of lactation services, including OB/GYNs, pediatricians, and lactation consultants.[5] (Ex. C, Declaration of A. Bourgeois ("Bourgeois Decl."), ¶ 7; Pls.' Ex. 24, Lee Report, at 11.) The number and location of network providers vis-à-vis HCSC's members varies by region and depends, in part, on federal and state-specific network adequacy laws, which identify the number of providers with whom health plans must contract to maintain sufficient networks.[6] Similarly, federal and state-law rules differ with respect to member notification requirements, such as provider directories, and the

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[4] Plaintiffs' implication that HCSC should have implemented ACA by choosing not to impose cost-shares on any claims regardless of network status (Dkt. 91 at 2) is a non-sequitur, given that ACA expressly allows plans to apply cost-shares to out-of-network claims if a network provider is available to the member. 29 C.F.R. § 2590.715-2713(a)(3)(i)-(ii).

[5] *See also* Ex. D-5, Declaration of Lisy Peters, ¶¶ 4-6 (Healthy Babies Healthy Families); Ex. D-4, Declaration of Jo Ann Dominick Meigs, ¶¶ 4-7 (Presence Resurrection Medical Center); Ex. D-2, Declaration of Vicky Harter ("Harter Decl."), ¶¶ 4-7 (INTEGRIS Baptist Medical Center); Ex. D-3, Declaration of Cynthia Hartwig, ¶¶ 4-6 (Advocate Lutheran General Hospital); Ex. D-1, Declaration of Lori Guinane ("Guinane Decl."), ¶¶ 4-7 (Swedish Covenant Health); Ex. H, Deposition of Natalee Deschamps ("Deschamps Dep."), at 29:17-61:25 (Community Medical Center); Ex. G, Deposition of Cindy Delay, at 41:8-86:15 (St. John Medical Center); Ex. I, Deposition of Don Houchins ("Houchins Dep."), at 27:8-73:22 (Northwest Community Hospital); Ex. E, Deposition of Carol Chamblin ("Chamblin Dep."), at 26:8-52:9 (Dr. Chamblin); Ex. K, Deposition of Caroline McConville ("McConville Dep."), at 28:10-75:25 (Benefis Health System); Ex. J, Deposition of Kassandra Meadows ("Meadows Dep."), at 40:14-75:12 (Methodist Healthcare System of San Antonio, Ltd., LLP); Ex. F, Deposition of Kathy Chaney ("Chaney Dep."), at 42:9-54:12, 58:14-111:23 (Baylor University Medical Center); Ex. L, Cress Decl., ¶¶ 22-38 (noting the providers identified above are in-network). HCSC has not filed the referenced deposition exhibits but will promptly do so at the Court's request.

[6] *See, e.g.*, 50 Ill. Admin. Code § 2051.310; Mont. Admin. Code § 37.108.219; 45 C.F.R. § 156.230. Many of these requirements distinguish between urban and rural areas and/or areas with certain populations. *See, e.g.*, Tex. Admin. Code § 3.3704(f); N. M. Admin. Code § 13.10.22.8(A).

particular requirements may vary by plan type.[7]

Women are exposed to and receive lactation services from various provider types throughout pregnancy, during the hospitalization associated with delivery, and during postpartum visits. (Pls.' Ex. 24, Lee Report, at 4-11; Ex. C, Bourgeois Decl., ¶ 7; *see also supra* at n.4.) HCSC directs members to network providers, including through HCSC's provider directory, which is available online and, contrary to Plaintiffs' suggestion (Dkt. 91 ("Pls.' Mem.") at 14), has not failed a CMS audit. (Pls.' Ex. 14 at 3; Pls.' Ex. 15 at 3; Ex. L, Declaration of K. Cress ("Cress Decl."), ¶ 41).) Further, HCSC customer service representatives encourage members to work with their primary care providers to obtain the services they need. (Pls.' Ex. 16 at 1, part (b).) Even so, studies indicate that most people seeking a provider do not turn to their insurance company, but are more likely to seek referrals from their primary care physician or through recommendations of friends and family. (Ex. M, Expert Report of Brian Hoyt ("Hoyt Report"), at 11-15.) This is likely true for women seeking lactation providers. (*Id*: Pls.' Ex. 24, Lee Report, at 4-11.) Regardless, if in-network providers are unavailable, HCSC plan members may be eligible to receive the in-network level of benefits for out-of-network services through HCSC's "waiver" or appeals processes. (Ex. L, Cress Decl., ¶¶ 3-8.) Members may also contact HCSC to obtain a claim adjustment. (Ex. N, Deposition of Karla Cress, at 247:6-248:19; Ex. O, 8/16/2017 Note, at HCSC_0051451-53, 10/15/14 Note, at HCSC_0072429-30.)

Medical codes are the language used between providers and insurance/managed care companies to communicate the services rendered for reimbursement purposes. (Ex. B, Peluso

[7] *See, e.g.*, 50 Ill. Admin. Code § 2051.310(a)(5) (requiring payors to maintain a website and toll-free number and to "prominently display[]" the web address); N. M. Admin. Code § 13.10.22.8(D) (setting forth requirements for "provider lists"); 45 C.F.R. § 156.230(b) (requiring Qualified Health Plans to provide information about providers' acceptance of new patients, medical groups, institutional affiliations, etc.); 29 C.F.R. § 2520.102-3 (listing requirements applicable to ERISA plans).

Rebuttal, ¶¶ 15-21.) It is industry standard for an insurer, like HCSC, to provide coding guidance for services, such as lactation services, where neither industry standard, nor the law, mandates the use of particular codes, and there is thus no reasonable way to determine whether a lactation encounter has occurred. (*Id.* ¶¶ 25-29; Ex. A, Hanley Dep., at 197:2-7.) Without such guidance, payors would not be readily able to identify claims that need to be processed according to particular rules, such as network lactation claims under ACA. HCSC identifies the procedure codes providers should select to obtain reimbursement for lactation services. (*See* Pls.' Ex. 19, Medical Policy; Pls.' Ex. 20, CPCP; *see also* Ex. B, Peluso Rebuttal, ¶ 28.) In light of the preventive benefit at issue, HCSC's procedure-level codes correspond to lactation classes and preventive counseling. (Ex. A, Hanley Dep., at 180:4-11, 187:5-16.)

With respect to diagnosis codes, it is industry standard that a provider will bill using the most-specific coding possible, which here means selecting diagnosis codes that contain the word "lactation" in their descriptions. (Ex. B, Peluso Rebuttal, ¶ 34; *see also* Pls.' Ex. 23, Expert Report of Palma D'Apuzzo in Rebuttal to Expert Report of Dr. Lauren Hanley ("Hanley Rebuttal"), ¶ 23 & n.1.) However, HCSC processes its suggested procedure-level codes for network claims without cost-shares regardless of the diagnosis code used. (Ex. B, Peluso Rebuttal, ¶ 34.) Because all but one of the procedure codes (S9443) could apply to a number of preventive services, and numerous diagnosis codes say nothing on their face about lactation, determining whether claims billed actually involved lactation services would require an individualized examination of medical records. (*Id.* ¶¶ 32-33, 41; Pls.' Ex. 23, Hanley Rebuttal, ¶ 23 & n.2; *see also* Ex. A, Hanley Dep., at 222:4-14, 215:10-216:8.)

If a provider deviates from HCSC's coding guidance, it becomes even more difficult to determine whether the claim related to lactation, because it is assumed, based on industry

standards, that a provider who does not comply with HCSC's coding guidance for lactation services intends to seek reimbursement for some other, non-lactation service. (Ex. B, Peluso Rebuttal, ¶ 41; *see also* Pls. Ex. 18, Expert Report of Nicole Peluso, at 10-12.) Diagnosis codes do not help; while some diagnosis codes use the word "lactation" in their descriptions, many others do not. (Pls.' Ex. 23, Hanley Rebuttal, ¶ 23 & n.2.) "[T]he only way to determine whether visits documented with these … not overtly lactation-related … codes involved breastfeeding issues would be to perform a patient-by-patient review of medical records." (*Id.*) [REDACTED] (Ex. L, Cress Decl., ¶ 11)

D. HCSC's Members Have Regularly Accessed and Obtained Coverage Without Cost-Shares for Lactation Services Across Markets and Over Time.

HCSC's claims data confirms that thousands of members regularly found and received lactation services in-network for a variety of diagnoses and obtained coverage for those services without cost-shares, both across markets and over time. (Ex. C, Bourgeois Decl., ¶ 7.) [REDACTED] Other members likely also received lactation services through global billing, free services, or bundled postpartum wellness visits, which do not appear in HCSC's claims data in a manner that can be identified as lactation

services.[8] Accordingly, even if one assumes that the named Plaintiffs experienced difficulties finding a network provider, what is plain is that the vast majority of HCSC members identified network providers and did not incur cost-shares, consistent with the ACA requirements.

E. The Named Plaintiffs Sought Lactation Services From Out-Of-Network Providers, But Their Individual Experiences Varied Substantially.

Plaintiffs here [REDACTED] Their experiences with lactation services varied substantially.

Briscoe attended a prenatal breastfeeding class offered by a network provider (Carol Chamblin) and obtained lactation assistance from an in-network midwife (Hillary Kieser). (Ex. P, Deposition of Laura Briscoe ("Briscoe Dep."), at 51:17-53:25, 107:14-108:2; Ex. L, Cress Decl., ¶¶ 33-34 ([REDACTED]).) Aware that in-network services were available, Briscoe nevertheless received services in her home from an out-of-network lactation consultant referred to her by a friend. (Ex. P, Briscoe Dep., at 55:9-15; Pls.' Ex. 7 at 8.) Prior to receiving these services, Briscoe did not contact her providers to ask for a recommendation as to other providers of the service.[9] (Ex. P, Briscoe Dep., at 54:23-55:15.) Instead, Briscoe claims that she contacted HCSC by phone (there is no record of such a call) and consulted HCSC's online provider directory. (Pls. Ex. 7 at 7-8; Ex. P, Briscoe Dep., at 58:2-15.) HCSC covered Briscoe's out-of-network claim but allocated a portion to coinsurance. (Ex. P, Briscoe Dep., at 101:2-11.) Briscoe claims she filed a written appeal, but there is no record of it.

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[8] *See, e.g.*, Ex. F, Chaney Dep., at 114:17-23 (Baylor does not separately bill for inpatient lactation services); Ex. K, McConville Dep., at 33:16-34:1 (consultations are free at Benefis for first two weeks after birth); Ex. H, Deschamps Dep., at 55:4-56:8 (Community Medical Center has had a free breastfeeding class at least since 2012); Ex. J, Meadows Dep., at 58:3-10 (Methodist has not charged for one-on-one appointments since at least 2012); Ex. D-1, Guinane Decl., ¶ 7 ([REDACTED]); Ex. D-2, Harter Decl., ¶ 7 [REDACTED]).

[9] Briscoe claims that Chamblin, who taught Briscoe's breastfeeding class, did not offer one-on-one consultations. (Ex. P, Briscoe Dep., at 54:1-13.) Not so; Chamblin testified that she did. (Ex. E, Chamblin Dep., at 52:19-53:3.)

(*Id.* at 139:9-22; Ex. L, Cress Decl., ¶ 21 ([REDACTED]).)

Magierski received lactation services at her in-network hospital, and hospital staff informed her that she could receive additional lactation services after discharge. (Ex. Q, Deposition of Kristin Magierski ("Magierski Dep."), at 50:20-54:15; Ex. L, Cress Decl., ¶ 35 ([REDACTED]).) Magierski also received lactation assistance from her in-network primary care provider. (Ex. Q, Magierski Dep., at 56:3-57:4.) Nevertheless, Magierski received services from an out-of-network lactation consultant she located on "Google and Yelp."[10] (*Id.* at 59:3-16.) Magierski claims she contacted HCSC twice by phone (there is no record of such calls) and consulted HCSC's online provider directory prior to seeking out-of-network services. (*Id.* at 71:24-73:6, 77:4-12; Pls.' Ex. 8 at 7-8.) HCSC partially covered Magierski's claim, but Magierski was responsible for the billed charges because she had not satisfied her annual deductible. (Ex. Q, Magierski Dep., at 101:3-21.) Magierski claims she filed a written appeal, but there is no record of such an appeal. (*Id.* at 100:8-22, 190:17-19, 192:21-193:19; Ex. L, Cress Decl., ¶ 21 [REDACTED]).)

Adams received lactation services from an in-network hospital. (Ex. R, Deposition of Emily Adams ("Adams Dep."), at 78:8-79:23, 81:2-24, 83:1-84:9, 86:4-88:19; Ex. L, Cress Decl., ¶ 37 ([REDACTED]).) Rather than seek additional services in-network, Adams received services in her home from an out-of-network lactation consultant. (Ex. R, Adams Dep., at 92:15-93:20.) Prior to seeking out-of-network services, Adams claims that she contacted HCSC by phone and consulted HCSC's online provider directory. (*Id.* at 55:17-57:13; Pls.' Ex. 9 at 7-8.) HCSC partially covered Adams's out-of-network claim and allocated a portion of the billed charges to coinsurance. (Ex. R, Adams Dep., at 148:24-149:2.) Adams

[10] Magierski claims that the hospital could not resolve her issues because it did not have a breast shield. (Ex. Q, Magierski Dep., at 153:14-154:2.) Not so; the hospital testified that breast shields, among other supplies, were available and provided to patients. (Ex. I, Houchins Dep., at 42:16-24.)

appealed, and HCSC upheld its decision. (Pls.' Ex. 9 at 15.)

F. Plaintiffs Sue for Damages Based on Out-Of-Network Services.

In their Second Amended Complaint, Plaintiffs allege that HCSC violated ACA when it failed to provide "in-network … providers within a reasonable distance of … plan participants." (Dkt. 56 ("Second Am. Compl.") ¶ 146.) The Second Amended Complaint seeks certification of classes under Rule 23(b)(2) and (3), with no mention of (b)(1) or (c)(4). (*Id.* ¶ 127.)

G. Plaintiffs Seek Certification of New Classes Under (b)(1), (2), and (c)(4).

Plaintiffs seek certification of two classes (together, the "Classes"), which vary from the class definitions in the Second Amended Complaint. (*Compare id. with* Pls.' Mem. at 15.) Plaintiffs attempt to expand the Classes outside the named Plaintiffs' experiences to include members who supposedly received lactation services in-network, as well as those who never submitted a claim. (*See* Pls.' Mem. at 17.)

Plaintiffs urge the Court to focus solely on HCSC's practices. (*Id.* at 1-2.) In particular, Plaintiffs contend that HCSC had an inadequate number of network lactation providers and/or that HCSC failed to provide sufficient information about those providers. (*Id.* at 2, 11-14.) Plaintiffs also assert that HCSC reimburses a limited set of billing codes. (*Id.* at 1-2, 6-10.)

Plaintiffs seek certification of the Classes under Rule 23(b)(1) and (2), yet acknowledge that they still seek damages by asserting that they are entitled to have HCSC "reprocess" their claims "under an ACA-compliant policy." (*Id.* at 20.) In the alternative, Plaintiffs seek certification of an "issue class" under Rule 23(c)(4). (*Id.* at 25.)

H. Two Other Courts Conduct Individualized Analyses at Summary Judgment.

Two federal courts have examined claims involving ACA-mandated lactation services at summary judgment. In *Condry*, the United States District Court for the Northern District of California assessed the circumstances of the six named plaintiffs, analyzing: (i) whether each

named plaintiff attempted to locate in-network providers; (ii) whether "nearby" providers were available; and (iii) whether each named plaintiff contacted customer service, and if so, whether customer service informed each plaintiff about network providers. *Condry SJ Order*, 2018 WL 3203046, at *2-3. The court granted summary judgment in favor of two plaintiffs and granted summary judgment in favor of the defendants with respect to two plaintiffs. *Id.* at *1-4. As to the two other plaintiffs, the court denied summary judgment due to factual disputes. *Id.*

In *York*, the United States District Court for the Southern District of Iowa also conducted an individualized examination of the plaintiffs' claims, finding the defendants were entitled to summary judgment because the plaintiffs had access to and received in-network services. *York*, 2019 WL 1493715, at *4-6.

I. The *Condry* Court Denies Class Certification.

After its summary judgment ruling, the *Condry* court denied class certification. *Condry Class Order*, 2019 WL 2552776, at *1. The classes consisted of "all people denied lactation coverage … whether in-network or out-of-network." *Id.* This was problematic, because the complaint's allegations focused on out-of-network services, and "[n]o evidence was presented … to suggest that the claim of a person … for out-of-network services is similar to the claim of a person who was denied coverage in-network." *Id.* Further, the court observed that "it's not the failure to offer in-network services that violates [ACA]; it's the failure to reimburse for out-of-network services when … services are not available in-network." *Id.*

Even limiting the classes to out-of-network claimants, "the plaintiffs ha[d] not presented adequate evidence that … any significant issues could be resolved … on a classwide basis." *Id.* at *2. There was no "evidence that UHC uniformly applied an unlawful policy to out-of-network claims." *Id.* The court concluded that the named plaintiffs lacked standing to seek prospective relief "because they [were] no longer … plan participants." *Id.* The court also expressed concerns

about the plaintiffs' request that the defendants "be ordered to 'reprocess claims under a corrected standard,"' since they did "not describe what a corrected standard looks like." *Id.* The *Condry* plaintiffs filed a renewed motion, but failed to correct the problems the court identified.

III. ARGUMENT

A. Plaintiffs Face a Significant Burden Under Rule 23.

Rule 23 requires a court to deny class certification unless the plaintiff can satisfy all the requirements of Rule 23(a) and at least one requirement of Rule 23(b). Class treatment is "an exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only." *Comcast Corp. v. Behrend*, 569 U.S. 27, 33 (2013). Rule 23 "imposes stringent requirements for certification that in practice exclude most claims." *Am. Express Co. v. Italian Colors Rest.*, 570 U.S. 228, 234 (2013). Consequently, Rule 23 requires a plaintiff to "affirmatively demonstrate [her] compliance with the Rule." *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011).

These standards are not relaxed when a plaintiff seeks certification under Rule 23(b)(1) or (2). Courts must scrutinize classes in this context to ensure that the plaintiff ***proves*** "that there are ***in fact*** sufficiently numerous parties, common questions of law or fact, etc." *Id.* at 350 (bolded emphasis added). Thinly veiled efforts to use (b)(1) or (2) to obtain monetary relief while avoiding the protections of Rule 23(b)(3) should be discouraged. *Id.* at 360, 363; *see also Kartman v. State Farm Mut. Auto. Ins. Co.*, 634 F.3d 883, 889, 894-95 (7th Cir. 2011); *Butler v. Ill. Bell Tel. Co.*, No. 06 C 5400, 2008 WL 474367, at *6 (N.D. Ill. Feb. 14, 2008).

B. Plaintiffs Cannot Satisfy the Prerequisites of Rule 23(a).

1. Plaintiffs' Classes Lack Commonality.

Rule 23(a)(2) requires a plaintiff to do more than raise common questions, such as whether a defendant's alleged conduct is unlawful. *Dukes*, 564 U.S. at 349; *McCaster v. Darden*

Rests., Inc., 845 F.3d 794, 800 (7th Cir. 2017). "What matters to class certification … is … ***the capacity of a classwide proceeding to generate common answers apt to drive the resolution of the litigation***." *Dukes*, 564 U.S. at 350 (bolded emphasis added); *see also Phillips v. Sheriff of Cook County*, 828 F.3d 541, 550 (7th Cir. 2016); *Bolden v. Walsh Constr. Co.*, 688 F.3d 893, 896-99 (7th Cir. 2012). Plaintiffs do not satisfy commonality, because HCSC's liability to each class member cannot be determined with common proof. *Dukes*, 564 U.S. at 350. As demonstrated by the *Condry* and *York* courts' summary judgment orders and the *Condry* court's order denying class certification, determining HCSC's compliance with ACA class-wide would require a granular, fact-bound analysis.

a. Plaintiffs' Claim Regarding Network Providers Does Not Establish Common Policies or Injuries.

Plaintiffs contend that HCSC violated ACA because HCSC purportedly has an inadequate number of in-network lactation providers, or fails to provide members with sufficient information about those providers, thereby forcing class members to seek services out-of-network and incur costs. (Pls.' Mem. at 11-14.) This claim does not satisfy commonality. There is no "meaningful evidence" that HCSC "uniformly applied an unlawful policy to out-of-network claims." *Condry Class Order*, 2019 WL 2552776, at *2.

[REDACTED].[11] *See supra* at 9. Additional members likely received the service post-delivery and at wellness visits that were not billed individually or

[11] [REDACTED] (Ex. C, Bourgeois Decl., ¶ 6.) Plaintiffs cite the same claims data to establish numerosity, thus acknowledging the breadth and reliability of this information. (Pls.' Mem. at 17.)

obtained free in-network services through hospital clinics. *See, e.g.*, *supra* at n.7. And HCSC covered without cost-shares the majority of all claims (both in-network and out-of-network) billed as described above, including through HCSC's waiver process. *See supra* at 7, 9; Ex. L, Cress Decl., ¶¶ 3-8.

Thus, ***most*** members were aware of and able to obtain in-network lactation services without cost-shares.[12] The Court therefore cannot assume that every denial of, or cost-share imposed on, out-of-network claims resulted from conduct that violated ACA. Rather, the Court must examine each instance in which a claim was denied or a cost-share was imposed to determine, among other things, whether the member had an in network provider available, and if not, if there were any other reasons why the claim was denied or a cost-share imposed.

First, the Court would need to determine whether each class member had network providers available, and whether HCSC provided that member with sufficient information about those providers. *York*, 2019 WL 1493715, at *4-6; *Condry SJ Order*, 2018 WL 3203046, at *2-3. The named Plaintiffs' circumstances demonstrate the individualized nature of this exercise. All three Plaintiffs received in-network services, albeit from different providers and under unique factual circumstances. *See supra* at 10-12. While the named Plaintiffs claim that customer service representatives informed them that no network providers were available, this assertion necessarily requires the Court to examine each customer service call to determine the validity of Plaintiffs' claims. There is no evidence that each and every class member had contact with customer service, but this analysis would need to be conducted for each absent class member who did.

[12] Plaintiffs' efforts to undermine this indisputable fact are unpersuasive. Plaintiffs concede that HCSC surveyed providers asking them if they render lactation services, even though ACA does not require a survey. (*Id.* at 13-14.) Nevertheless, Plaintiffs contend that the survey resulted in "duplicate entries for providers" and other issues. (*Id.* at 14.) Yet Plaintiffs did not conduct any discovery regarding these providers or whether members are able to locate providers using the tool. Discovery is now closed.

[REDACTED]

[REDACTED]. (Pls.' Exs. 27-33.)

The fact-bound and individualized exercise of determining the availability of network providers is rendered more complex by Plaintiffs' legal theories, which contend that HCSC deprived members of access to "in-network lactation service providers within a ***reasonable distance*** of" their homes. (*See, e.g.*, Second Am. Compl. ¶ 140 (emphasis added).) Even assuming ACA incorporates this "reasonable distance" requirement, the Court cannot evaluate the extent to which HCSC complied with it across the class on a uniform basis. Determining the "reasonable distance" applicable to each class member, and whether a network provider was nearby under that standard, would require an assessment of state and federal network adequacy laws, including laws applicable to different regions within states. *See supra* at 6 & n.5.

Various federal and state-law rules similarly regulate the manner in which health plans notify members of the providers within their networks. *See supra* at 7 & n.6. Thus, identifying the standard for determining whether HCSC made members sufficiently aware of in-network providers would vary depending on the class member, plan type, and geographic region.

Second, the Court would need to decipher the various standards of care applicable to the situations presented by class members to determine whether the network providers who were available lived up to Plaintiffs' subjective standards.[13] How much and what type of training must a provider have? How much time should providers devote to various questions and conditions? What practices, methods, or treatments should be applied? A class action is not a proper forum for resolving these complex and multifaceted questions. *Phillips*, 828 F.3d at 554-55.

Third, the Court would need to analyze what efforts the member made to look for the

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[13] (*See id.* at 12 (vaguely contending that providers must have "specific CLS training" and suggesting that lactation services include "observed feedings" among potentially other services).)

service, including any communications with HCSC and the extent to which the member previously or subsequently obtained services from network providers. *York*, 2019 WL 1493715, at *4-6; *Condry SJ Order*, 2018 WL 3203046, at *2-3. And the Court would need to assess ***why*** the member sought services out-of-network, including whether she did so for personal or subjective reasons, such as on the recommendation of a friend or family member. *Id.* Furthermore, the Court would need to determine whether any given class member actually paid a cost-share or other amount and thereby suffered a compensable injury.[14] *See Oshana v. Coca-Cola Co.*, 472 F.3d 506, 514 (7th Cir. 2006) ("[c]ountless" class members "could not show any damage"). This analysis would be member-specific, given that HCSC is unable to [REDACTED] [REDACTED]. (Ex. L, Cress Decl., ¶¶ 12-15.) Moreover, the Court would need to analyze available defenses, including whether HCSC denied a claim for reasons unrelated to the lactation benefit, such as untimely submission or the member's lapse of coverage under the plan. (Ex. C, Bourgeois Decl., ¶ 8.) The Court would also need to assess whether the member attempted to obtain a waiver or claim adjustment or appealed their claim. *See supra* at 7.

Plaintiffs cannot circumvent the need for individual inquiries with anecdotal opinions that some physicians do not have the proper training to provide lactation services, by citing out-of-context quotations from HCSC's emails, or by focusing on a self-serving and limited subset of HCSC's claims data.[15] (*See* Pls.' Mem. at 9-12; Pls. Ex. 21, Dkt. 93-9, Expert Report of Dr. Lauren Hanley, at 4-10; *see also Daubert* motion as to Dr. Hanley.) Plaintiffs acknowledge that resolving the Classes' claims would require HCSC to seek and receive individualized

[14] Plaintiffs' Classes are further overbroad in that they purport to include all members who "incurred costs." (*Id.* at 15.) Not all "costs" are prohibited under ACA. Out-of-network providers can charge patients for the difference between their billed charges and an insurer's allowed amount ("balance billing"). Balance billing is not cost-sharing under ACA. 42 U.S.C. §§ 18022(c)(3)(B).

[15] Plaintiffs contend that certain in-network providers do not or rarely appear in HCSC's claims data, (Pls.' Mem. at 10), but this is easily explained by the fact that many of the providers they cite render at least some services ***for free*** and do not separately bill for others. (*See, e.g.*, *supra* n.7.)

information from class members, yet they suggest "that factual variations in class members' situations" are no concern. (Pls.' Mem. at 17-18 & n.27.) This is not proof of commonality. The Court cannot derive any common answers from this complex matrix of questions.

b. Plaintiffs' Claim Based on Purportedly Narrow Coding Similarly Requires Individualized Inquiries.

Plaintiffs' claim that HCSC adopted an unduly narrow set of billing codes for lactation services similarly does not provide a viable basis for certifying a putative class. As a threshold matter, and as discussed further in section C.3 below, ACA does not require HCSC to adopt any specific billing codes. As a result, the supposed harm Plaintiffs assert on behalf of the Classes is simply a concoction Plaintiffs developed in an attempt to avoid denial of class certification.

Setting that aside, Plaintiffs' claim cannot be adjudicated on a class-wide basis because the evidence shows that many providers were able to bill for a full range of lactation services using HCSC's billing codes, including diagnoses identified by Plaintiffs' coding expert. (Ex. C, A. Bourgeois Decl., ¶ 7; Pls.' Ex. 21, Hanley Report, at 14-19.) Thus, an individualized examination of each claim billed with ***other*** codes would be required to assess why a provider did not bill for a specific claim in accordance with HCSC's coding guidance and whether the provider could have billed for the services using one of HCSC's suggested codes.

The individual inquiries do not stop there. Since ACA and HRSA do not identify the medical codes health plans must adopt, the Court would be required to identify a complete set of billing codes for the service, and then determine whether each and every code submitted on behalf of a class member falls within its parameters. This type of expansive and individualized undertaking is not the purpose of the class action device. *See Dukes*, 564 U.S. at 352.

Additional individualized assessments would be required. Many of the codes Plaintiffs seek to include do not indicate on their face that an encounter for lactation services occurred—

including pediatric codes, which indicate that services have been rendered to ***children*** and thus bear no relationship to the ***women's*** preventive benefit at issue. *See supra* at 5. The Court would thus need to examine each class member's treatment, including the underlying medical records (which HCSC does not typically have), to determine whether the class member received lactation services or some other type of service, or whether the "primary purpose" of an office visit was lactation care. *See* 29 C.F.R. § 2590.715-2713(a)(2) (coverage for office visits required ***only if*** the "primary purpose" of the visit is preventive care). And HCSC would be entitled to present the defense that, in accordance with its discretion to identify codes that it would recognize as a particular covered service, it appropriately excluded the billing code(s) at issue from cost-share-free coverage. *See supra* at 7-9. Moreover, the Court would need to determine whether the cost-share or claim denial resulted from the codes used to seek reimbursement, or some other issue unrelated to the benefit. Ex. C, Bourgeois Decl., ¶ 8. These individual issues are incompatible with Rule 23.[16]

c. Plaintiffs' Efforts to Expand the Classes Compound the Individualized Inquiries.

Plaintiffs' efforts to expand the Classes beyond the core allegations and proof specific to the named Plaintiffs only increase the number of individualized inquiries necessary to resolve the case on a class-wide basis. As alleged in their Second Amended Complaint and their motion for class certification, the named Plaintiffs' claims focus on HCSC's coverage for ***out-of-network*** lactation services, but the Classes purport to encompass members who submitted ***in-network*** claims. (Pls.' Mem. at 15.) Plaintiffs' inclusion of in-network claims at this juncture prejudices HCSC, as Plaintiffs' tactics deprive HCSC of the opportunity to explore Plaintiffs' theories on

[16] Plaintiffs did not conduct discovery on many codes identified by their expert, Peluso. (*See* Pls.' Ex. 18, Dkt. 93-6, at Ex. B (CPT codes 99502, 99221-23, 99231-33, 99356-57, 99382, 99384, 99392, 99394, 96150-55, 96161, 96127, 98961-62, 99050-51, 99056, 99058, 99060, 99078, S9444-46 and S9452).)

this issue during discovery. Regardless, by definition, members who submitted in-network claims ***could not have been injured by a lack of in-network providers***. The claims of these class members would require different proof and would be subject to unique defenses—*e.g.*, that a claim was denied for reasons unrelated to the benefit. (Ex. C, Bourgeois Decl., ¶ 8.; *see Condry Class Order*, 2019 WL 2552776, at *1; *Doiron v. Conseco Health*, 279 Fed. App'x 313, 316 (5th Cir. 2008) (class members "had claims denied for reasons other than" those at issue).)

A similarly individualized analysis applies to Plaintiffs' claim that the Classes include members who did not submit claims ***at all***. (Pls.' Mem. at 17.) As an initial matter, Plaintiffs have focused throughout this litigation on cost-shares and claim denials, and the Court should not permit their last-minute attempt to add this amorphous cohort.[17] *See, e.g.*, *Davis v. AT&T Corp.*, No. 15-cv-2342, 2017 WL 1155350, at *2 (S.D. Cal. Mar. 28, 2017) (rejecting "entirely different class" than that alleged in the Complaint). Indeed, like Plaintiffs' inclusion of in-network claims, Plaintiffs' eleventh-hour expansion of the Classes seeks to deprive HCSC of its right to explore the issue during discovery. In any event, Plaintiffs conducted no discovery regarding these unidentified class members and, consequently, offer no proof that HCSC's supposed practices impacted them at all, let alone in a uniform manner. *See Dukes*, 564 U.S. at 350. Even if these members could be located, the Court has to conduct individualized inquiries to determine ***why*** each member did not submit a claim and whether unique defenses apply. Indeed, the claims data demonstrates that women ***do*** submit claims for out-of-network services, precluding an assumption that members did not submit claims due to HCSC's purported conduct.

These individualized issues demonstrate that Plaintiffs' claims cannot be resolved on a

[17] Plaintiffs cite *Beaton v. SpeedyPC Software*, No. 13-cv-08389, 2017 WL 4740628, at *3 (N.D. Ill. Oct. 19, 2017), and argue that the Court may consider a revised class definition. (Pls.' Mem. at 15 n.25.) The cases on which the *Beaton* court relied, however, merely stand for the proposition that ***the court*** has discretion to modify class definitions. *See, e.g.*, *Green v. Service Master on Location Servs. Corp.*, No. 07 C 4705, 2009 WL 1810769, at *3-4 (N.D. Ill. June 22, 2009).

class-wide basis. Plaintiffs' cited cases do not warrant a different outcome. Those cases involved challenges to policies that applied to ***every*** claim and uniformly impacted ***all*** class members. *See, e.g.*, *A.F. v Providence Health Plan*, 300 F.R.D. 474, 477 (D. Or. 2013) (challenge to exclusion of all claims for ABA therapy); *Holmes v. Godinez*, 311 F.R.D. 177, 218 (N.D. Ill. 2015) (challenge to system-wide policies that impacted all class members); *Flanagan v. Allstate Ins. Co.*, 242 F.R.D. 421, 428 (N.D. Ill. 2007) (challenge to alleged breach of identical contract for all class members). By contrast, Plaintiffs assert misconduct involving multiple plans, alleged policies and practices, across five states and a broad time period. (Pls.' Mem. at 6-14.)

Even if HCSC's alleged practices could be deemed "common," determining the ***impact*** of these practices in terms of liability, remedies, and available defenses is fraught with individualized issues. *See, e.g.*, *Dennis F. v. Aetna Life Ins.*, No. 12-cv-02819, 2013 WL 5377144, at *4 (N.D. Cal. Sept. 25, 2013) (liability to class did not turn on the challenged policy); *Graddy v. BlueCross BlueShield of Tenn., Inc.*, No. 4:09-cv-84, 2010 WL 670081, at *9 (E.D. Tenn. Feb. 19, 2010) (policies did "not eliminate the need for an individualized assessment"); *DWFII Corp. v. State Farm Mut. Auto. Ins. Co.*, 469 F. App'x 762, 764-65 (11th Cir. 2012) (similar). Plaintiffs have not established commonality.

2. Plaintiffs Are Not Typical or Adequate Class Representatives.

The test for typicality is whether the named plaintiff's claim "arises from the same event or practice or course of conduct that gives rise to the claims of other class members." *Oshana*, 472 F.3d at 514. The typicality and adequacy-of-representation requirements "tend[] to merge." *Amchem Products, Inc. v. Windsor*, 521 U.S. 591, 626 n.20 (1997). Plaintiffs fall short of satisfying typicality and adequacy for reasons similar to those relating to commonality. The varying circumstances of the named Plaintiffs' claims render Plaintiffs' typicality and adequacy arguments nonstarters. Beyond that problem, Plaintiffs' claims are focused on coverage for out-

of-network services, yet the Classes purport to encompass members with in-network claims, as well as members who did not submit claims at all. *See Condry Class Order*, 2019 WL 2552776, at *2. Briscoe and Adams are [redacted] making them subject to the defense of lack of standing. *See infra* at 10. Briscoe and Magierski [redacted] and are subject to this [redacted] defense. *See supra* at 10-11; *see also* Dkts. 34-1 at 99-109, Dkt. 34-3 at 95-103 (appeals procedures); *Lindemann v. Mobil Oil Corp.*, 79 F.3d 647, 649–50 (7th Cir. 1996) (exhaustion required for ***all*** ERISA claims). All three Plaintiffs' receipt of in-network care renders them atypical (and inadequate) representatives of those who did not.

C. Plaintiffs Cannot Satisfy the Prerequisites of Rule 23(b)(1) or (2).

1. Briscoe Lacks Standing to Represent the ERISA Plan Class.

The Court should deny certification of the ERISA Plan Class because Briscoe—that class' sole representative—lacks standing. A plaintiff must have standing to obtain the relief she seeks on behalf of a class. *Banks v. N.C.A.A.*, 977 F.2d 1081, 1085-86 (7th Cir. 1992); *Portis v. City of Chicago*, 347 F. Supp. 2d 573, 575-76 (N.D. Ill. 2004). To make that showing, a plaintiff seeking an injunction must establish "a significant likelihood and immediacy of sustaining some direct injury." *Sierakowski v. Ryan*, 223 F.3d 440, 443 (7th Cir. 2000); *see also Simic v. City of Chicago*, 851 F.3d 734, 738 (7th Cir. 2017). A named plaintiff cannot piggyback on the standing of class members prior to class certification. *Simic*, 851 F.3d at 740.

[redacted], (Ex. L, Cress Decl., ¶ 17), and therefore cannot establish a likelihood of sustaining any injury in the future for purposes of declaratory and injunctive remedies. *See Condry Class Order*, 2019 WL 2552776, at *2.

2. Plaintiffs' Classes do not Meet the Requirements of Rule 23(b)(1)(A).

Plaintiffs fail to satisfy the requirements of Rule 23(b)(1)(A) because "Rule 23(b)(1)(A) … requires more … than a risk that separate judgments would oblige the opposing party to pay

damages to some class members but not to others." *Zinser v. Accufix Research Inst., Inc.*, 253 F.3d 1180, 1193 (9th Cir. 2001). At best, Plaintiffs suggest that HCSC may be liable to some class members but not others. (Pls.' Mem. at 22; *see also McDaniel v. Qwest Commc'ns Corp.*, No. 05 C 1008, 2006 WL 1476110, at *11 (N.D. Ill. May 23, 2006).) Further, Plaintiffs' belated invocation of Rule 23(b)(1) does not change the fact that they still seek significant monetary recovery in the form of reprocessed claims (*see, e.g.*, Pls.' Mem. at 20) and that Rule 23(b)(1)(A) is not an avenue to class certification in such circumstances. *Butler*, 2008 WL 474367, at *6. Plaintiffs cannot avoid individualized issues by re-labeling their class.

3. Plaintiffs' Classes Do Not Meet the Requirements of Rule 23(b)(2).

Rule 23(b)(2) requires a showing that the relief be both (1) final and (2) appropriate. *Kartman*, 634 F.3d at 892. ***First***, declaratory or injunctive relief is not "final" when it "would merely initiate a process through which highly individualized determinations of liability and remedy are made." *Jamie S. v. Milwaukee Pub. Schs.*, 668 F.3d 481, 499 (7th Cir. 2012); *see also Dukes*, 564 U.S. at 360-61; *Kartman*, 634 F.3d at 893. A systemic reform of HCSC's practices would not establish liability or remedies class-wide, and Plaintiffs are seeking individualized damages. *Kartman*, 634 F.3d at 893 ("uniform" standard would require individual inquiries).

Second, Plaintiffs' proposed injunction is not "appropriate." Plaintiffs seek an order requiring HCSC to "reprocess" claims under a single, "ACA-complaint policy." (Pls.' Mem. at 24.) But neither ACA nor HRSA impose such a standard. *See supra* at 5. As the Seventh Circuit noted in *Kartman*, "there is no independent cognizable wrong to support a claim for injunctive relief" requiring HCSC to reprocess claims under such standard.[18] *Kartman*, 634 F.3d at 886.

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[18] Plaintiffs do not identify which of their expert's codes the Court should order HCSC to include, nor does their expert. (Ex. S, Peluso Dep., at 188:18-189:15). The Centers for Disease Control and others in the industry do suggest most of the codes identified by Plaintiffs. (*See id.* at 223:5-9; Ex. B, Peluso Rebuttal, ¶¶ 36-39.) Plaintiffs' counsel recently settled a case where the payor agreed to use codes similar

Plaintiffs' focus on significant monetary recovery also precludes them from establishing irreparable harm. *Id.* at 892; *Cates v. Whirlpool Corp.*, No. 15-cv-5980, 2017 WL 1862640, at *24 (N.D. Ill. May 9, 2017). And Plaintiffs' request that the Court order HCSC to reprocess lactation claims under an "ACA-compliant policy" runs afoul of Rule 65(d), which requires that every injunction "state its terms specifically" and "describe in reasonable detail" the "act or acts restrained or required." *Kartman*, 634 F.3d at 893 (injunction imposing "reasonable, uniform, and objective standard" was "far too general"). The Court should deny (b)(2) certification.

D. Plaintiffs Cannot Satisfy Rule 23(c)(4).

Lastly, Plaintiffs fail to develop their argument for certification of an "issue class" under Rule 23(c)(4), and the Court should decline to certify such a class for this reason alone. *See Quevedo v. Top-Line Furniture Warehouse Corp.*, No. 16-cv-5991, 2018 WL 1508530, at *10 (N.D. Ill. Mar. 27, 2018) (Blakey, J.) (undeveloped arguments are waived). Regardless, Plaintiffs' request that the Court certify a class to determine "whether HCSC's coverage for [lactation services] violated the ACA," (Pls.' Mem. at 25), means that all of the individualized issues discussed above would come to the fore. *See Kartman*, 634 F.3d at 886 (denying (c)(4) certification due to individualized issues); *Clark v. Experian Info. Solutions, Inc.*, 256 Fed. App'x 818, 822 (7th Cir. 2007) (same); *Van v. Ford Motor Co.*, No. 14-cv-8708, 2019 WL 3976370, at *30 (N.D. Ill. Aug. 22, 2019) (same); *Jones v. BRG Sports, Inc.*, No. 18 C 7250, 2019 WL 3554374, at *9 (N.D. Ill. Aug. 1, 2019) (same). Plaintiffs have not satisfied (c)(4).

IV. CONCLUSION

For the foregoing reasons, the Court should deny Plaintiffs' motion for class certification.

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to HCSC's current list of codes for lactation counseling. (Ex. T (Ex. C to Settlement Agreement in *Ferrer v. CareFirst, Inc.*, Case No. 1:16-cv-02162, Dkt. 30-1, Dec. 10, 2018).)

Dated: September 27, 2019

Respectfully submitted,

By: */s/ Rebecca R. Hanson*

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CERTIFICATE OF SERVICE

I, Rebecca R. Hanson, an attorney, hereby certify that on September 27, 2019, I caused a true and correct copy of the foregoing document to be filed electronically. Notice of this filing will be sent by operation of the Court's electronic filing system to all counsel of record.

/s/ Rebecca R. Hanson