Martin J. Bishop (admitted *pro hac vice*)
Email: mbishop@reedsmith.com
Rebecca R. Hanson (admitted *pro hac vice*)
Email: rhanson@reedsmith.com
REED SMITH LLP
10 South Wacker Drive
Chicago, IL 60606-7507
Telephone: +1 312 207 1000
Facsimile: +1 312 207 6400

Raymond A. Cardozo (SBN 173263)
Email: rcardozo@reedsmith.com
REED SMITH LLP
101 Second Street
Suite 1800
San Francisco, CA 94105-3659
Telephone: +1 415 543 8700
Facsimile: +1 415 391 8269

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

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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' RENEWED MOTION FOR CLASS CERTIFICATION

Hearing Date: November 21, 2019

Time: 10:00 AM

Place: Courtroom 4

Honorable Vince Chhabria

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I. INTRODUCTION

Plaintiffs' renewed motion for class certification attempts to re-litigate the same, deficient class arguments this Court previously rejected. Like their original motion, this motion asks the Court to certify nationwide, multi-year classes of present and former UnitedHealthcare members who were allegedly denied access to cost-share-free lactation services under the Affordable Care Act ("ACA"). But as the Court previously ruled, each putative class member's claim turns on whether an in-network lactation service was available to the class member, and why the Defendants denied any claim for reimbursement or imposed a cost-share. As a result, these individualized claims cannot be adjudicated on a class-wide basis, so no classes can be certified consistent with Rule 23.

Yet again, Plaintiffs' motion is based on ACA's requirements concerning lactation support and counseling services. But by the very terms of those requirements, determining liability entails 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, in its summary judgment ruling, this Court analyzed the ACA's requirements, conducted the required individualized inquiry, and reached ***different*** outcomes based on the particular facts of each named Plaintiff. The ruling shows how individual issues permeate any analysis involving the ACA's requirements. This Court came to that exact conclusion in denying Plaintiffs' original motion for class certification.

Nevertheless, Plaintiffs once more attempt to homogenize their disparate clams and urge the Court to focus on what they contend are Defendants' uniform policies and practices, with no assessment of the ***impact*** of those alleged policies and practices on any particular class member in terms of liability, remedies, and available defenses. In doing so, Plaintiffs ignore that this Court already found on summary judgment that some Plaintiffs were injured, while others were not. Plaintiffs also continue to downplay the significant 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 some threshold common questions 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

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not satisfied that burden here.

Such is the case with Plaintiffs' theory that Defendants violated the ACA by applying a uniform policy of imposing cost-shares on, or denying coverage for, out-of-network lactation claims. In fact, the evidence shows that members were able to obtain in-network coverage for out-of-network services through Defendants' "gap exception" and appeals processes. This evidence demonstrates that Defendants did not apply a "blanket policy" of excluding out-of-network claims from eligibility for coverage without cost-shares, as Plaintiffs suggest. (Dkt. 222 ("Renewed Mot.") at 1.) Moreover, under the law, the propriety of charging cost-shares for out-of-network claims turns on whether the member had an in-network option available to ***that member***. As the Court held, this is an unavoidably individualized inquiry.

Critically, the evidence also shows that, over time and across markets, the vast majority of women who submitted claims for lactation services in accordance with Defendants' coding guidance received the services in-network and obtained coverage without cost-shares for those services. The wide availability of network providers—and the availability of in-network coverage for out-of-network care when appropriate—undermines Plaintiffs' assertion that the Court may simply 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 gap exception or submitted an appeal.

Plaintiffs' effort to expand the size of the lactation classes only compounds the individualized nature of the issues at stake. In particular, Plaintiffs assert that Defendants adopted an unduly narrow set of billing codes for the ACA-mandated service and seek to sweep in members whose claims were billed using codes other than those set forth in Defendants' coding guidance. The ACA, however, does not prescribe the billing codes a health plan must adopt for lactation services, so Defendants were free to provide coding guidance that allows providers to bill for a full range of

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lactation issues. Most relevant here, nothing in Defendants' billing codes permits a ***class-wide*** adjudication, as the evidence shows that thousands of claims were submitted to Defendants using Defendants' coding guidance. 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 Defendants' coding guidance and whether the claim could have been submitted using Defendants' 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, therefore, the only way to ensure those claims are for lactation services would be to review the medical records (which Defendants typically do not have) associated with each such claim—an individualized inquiry. And, the Court would need to determine whether the cost-share or denial resulted from the codes used or some other reason.

Plaintiffs' efforts to expand the lactation classes cause other problems. For instance, Plaintiffs attempt to include pediatric claims (indicated by pediatric medical codes on their list of codes), which apply to services rendered for children, even though the ACA benefit is limited to women. Additionally, although Plaintiffs now limit their classes to out-of-network claimants, Plaintiffs continue to seek relief for members who purportedly received lactation services but never submitted claims. Setting aside significant issues regarding how the Court could reliably identify such members, their claims present numerous unique issues and defenses, including ***why*** no claim was submitted. In any event, adding these varying cohorts with no scrutiny of their individual circumstances would expand substantive rights and fundamentally alter the scope of the benefits at issue in violation of the Rules Enabling Act.

Plaintiffs' singular focus on the Defendants' conduct, as opposed to proof of whether that conduct gave rise to a common injury, similarly undermines the Claims Review Class. Even assuming the denial reasons at issue were confusing in the abstract, individual assessments of each member's circumstances—including whether additional contact with Defendants occurred or an appeal was filed—would be required to determine whether the alleged procedural violation prevented a "meaningful dialogue," and whether Defendants "substantially complied" with ERISA.

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While Plaintiffs contend that such individualized inquiries are unnecessary in light of the Court's summary judgment ruling, the truth is that the summary judgment record contained the full course of the named Plaintiffs' interactions with Defendants. Before extending the summary judgment ruling to the members of the putative classes, the Court would need to assess each class member's interactions with the Defendants on a comparably complete record, rather than making class-wide assumptions that may or may not be supported by those individual records.

Plaintiffs' class theories suffer from additional deficiencies. As this Court previously recognized, the named Plaintiffs with active claims under the ACA lack Article III standing to obtain the prospective relief they seek on behalf of the classes. While Plaintiffs attempt to cure that deficiency with their pending motion to intervene, the Court should deny that tardy and prejudicial motion, and, regardless, the proposed intervenor would merely cure standing as to the ERISA Plan Class, not the Non-ERISA Plan Class. Moreover, Plaintiffs' vaguely articulated request for an order requiring Defendants to "reprocess" lactation claims under a "corrected standard" raises numerous issues. These include lack of an independent cognizable wrong (the ACA does not require any of the things Plaintiffs want to impose), as well as failure to comply with Rule 65(d), which requires a request for injunctive relief to, among other things, "state its terms specifically." Notably, Plaintiffs ask the Court to order Defendants to adopt numerous additional medical codes, but the procedure codes they propose are identified only by ***counsel*** and without the support of expert testimony, and the diagnosis codes can already be utilized consistent with Defendants' coding guidance.

As this Court has already 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

[1] "Pls.' Ex." as used herein refers to the Declaration of Kimberly Donaldson-Smith filed at Dkt. 222-1 and the associated exhibits filed at Dkts. 222-2 through 222-34.

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childbirth. (Oct. 24, 2019 Souza Decl., Ex. A (Feb. 13, 2019 Hanley Dep.), at 78:8-9.) 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. (Souza Decl., Ex. B (Feb. 11, 2019 Morton Dep.), at 233:19-235:14, 279:10-19.)

Some women do not need or want lactation assistance, such as mothers with prior breastfeeding experience. (*Id.* at 227:15-18, 230:4-12.) Others benefit from lactation care, but the services that facilitate successful breastfeeding "vary tremendously" for each individual based on a "myriad of issues." (*Id.* at 232:1-15.) Some women need only high-level educational information and support, while others may benefit from other types of services. (*Id.* at 231:16-21.) Factors such as language barriers or personal preference may affect a woman's choice of provider. (*Id.* at 232:1-15.)

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

ACA requires health plans to cover without cost-sharing certain preventive services for women as specified in guidelines supported by the Health Resources and Services Administration ("HRSA"). 42 U.S.C. § 300gg-13(a)(4). The 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 an ACA-mandated women's preventive service, requiring coverage for "comprehensive lactation support services" that include "counseling" and "education" during the "antenatal, perinatal, and … postpartum period." HRSA Guidelines, https://www.hrsa.gov/womens-guidelines-2016/index.html.

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 his or her license or certification (for example, a registered nurse)."[2] Health plans have discretion to adopt billing codes that pay at no cost-share for lactation services and to use "reasonable medical management techniques to determine the frequency,

[2] FAQs About Affordable Care Act 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. 6 (WPSI Report), at 39 ("Lactation care providers include, but are not limited to, lactation consultants, breastfeeding counselors, certified midwives, certified nurse-midwives, certified professional midwives, nurses, advanced practice providers … and physicians.").

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method, treatment, or setting" for coverage. 29 C.F.R. § 2590.715-2713(a)(4); *see also* Pls.' Ex. 23 (D'Apuzzo Am. Expert Report), ¶ 14.

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 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 a provider who offers lactation services must the health plan cover out-of-network services without cost shares. 29 C.F.R. § 2590.715-2713(a)(3)(ii).

C. Defendants Have Established A Network of Providers and Billing Guidance.

Defendants provide coverage without cost-shares for lactation services when rendered by a network provider. (Pls.' Ex. 8 (Oct. 1, 2018 Coverage Determination Guideline ("CDG")), at UHC_196573.) Defendants have thousands of in-network providers of lactation services, with OB/GYNs, pediatricians, and lactation specialists making up the majority of these providers.[3] (Oct. 21, 2019 dos Santos Decl., ¶ 9.) The number and location of network providers vis-à-vis Defendants' members varies by geographic 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.[4] Federal and state-law rules also differ with respect to member notification requirements, such as provider directories.[5]

Women are exposed to and receive lactation services from various provider types throughout their pregnancy, during the hospitalization associated with delivery, and during expected postpartum

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[3] *See also* Mar. 20, 2019 Lee Decl., Ex. A (Lee Expert Report), at 4-8 (establishing that Carroll and Endicott received network care); Souza Decl., Ex. C (Mar. 15, 2019 Marshall-Crim Dep.), at 27:18-36:21 (testifying regarding the inpatient and outpatient services available at Hartford Hospital); Souza Decl., Ex. D (Mar. 15, 2019 Hall Dep.), at 23:10-25:13, 84:24-85:2 (similar for free services at Poudre Valley Hospital); Souza Decl., Ex. E (Mar. 29, 2019 Keanna Dep.), at 20:17-22:2, 23:21-25:10, 37:2-38:18 (testifying regarding the pre-natal and post-partum services offered by ProHealth Physicians, a pediatric clinic); Mar. 19, 2019 Vasquez Decl., ¶¶ 4-7 (establishing that Hartford Hospital, Poudre Valley Hospital, and ProHealth Physicians are in-network providers, including for members of Carroll's and Endicott's plans).

[4] *See, e.g.*, 10 Cal. Admin. Code § 2240.1; 28 Tex. Admin. Code § 11.1607. Such laws may distinguish between different geographic regions within states, requiring, for example, a higher concentration of providers in urban, as opposed to rural, areas. *See, e.g.*, 28 Pa. Code § 9.679(d)-(e).

[5] *See, e.g.*, 10 Cal. Code Regs. § 2240.6 (identifying provider directory requirements); Cal. Health & Safety Code § 1367.27 (similar); 28 Pa. Code § 9.681 (similar); 45 C.F.R. § 156.230(b) (requiring Qualified Health Plans to provide various information about providers); 29 C.F.R. § 2520.102-3 (listing requirements applicable to summary plan descriptions for ERISA plans).

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1 visits. (Mar. 20, 2019 Lee Decl., Ex. A (Lee Expert Report), at 2-3, 8; *see also* Souza Decl., Ex. A
2 (Hanley Dep.), at 102:25-103:13; dos Santos Decl. ¶ 9.) Defendants direct members to network
3 providers, including through Defendants' provider directory, which is available online and in print.
4 (Mar. 18, 2019 Dietz Decl., ¶¶ 4-21.) Further, customer service representatives encourage members
5 to work with their primary care providers to obtain services. (Dkt. 161-2, Ex. 27 to Pls.' Original
6 Mot. for Class Certification, Member Services Breast Pump Benefit SOP, at UHC_003920.) If in-
7 network providers are unavailable within a certain distance of members' zip codes, depending on
8 their plan, members may be eligible to receive the in-network level of benefits for out-of-network
9 services through Defendants' "gap exception" process. (Mar. 20, 2019 Cappiello Decl., ¶¶ 4, 17, 24,
10 26; *see also, e.g.*, Pls.' Ex. 8 (CDG), at UHC_196572 (indicating that, in determining coverage, "the
11 member specific benefit plan document must be referenced"); Dkt. 106-4 (Hoy's benefit booklet), at
12 UHC_000908 ("[Y]ou may be eligible to receive Network Benefits from a non-Network
13 provider.").) Members may also appeal claim denials. (Mar. 19, 2019 Seay Decl., ¶ 8.)
14 Defendants identify the medical codes providers should select to obtain reimbursement for
15 preventive care, including lactation services. (Pls.' Ex. 8 (CDG), at UHC_196585-196586, 196610.)
16 Medical codes are the language used between providers and insurance/managed care companies to
17 communicate the services rendered for reimbursement purposes. (Pls.' Ex. 23 (D'Apuzzo Am.
18 Expert Report), ¶¶ 11, 17.) It is industry standard for insurers to provide coding guidance for
19 services, such as lactation services, where neither industry standard nor the law mandate the use of
20 particular codes, and there is thus no reasonable way to determine whether a lactation encounter
21 occurred. (*Id.* ¶¶ 17-35.) Without such guidance, insurers would not be able to readily identify
22 claims that need to be processed according to particular rules, such as network lactation claims. (*Id.*)
23 With respect to procedure-level codes, no industry standard has emerged regarding the codes
24 that denote lactation services. (*Id.* ¶¶ 14-15, 22-23.) In light of the preventive benefit at issue,
25 Defendants' procedure-level codes correspond to lactation classes and preventive counseling. (Pls.'
26 Ex. 8 (CDG), at UHC_196585-196586, 196610.) With respect to diagnosis codes, it is industry
27 standard that a provider will bill using the most-specific coding possible, which here means selecting
28

diagnosis codes that contain the word "lactation" in their descriptions. (Pls.' Ex. 23 (D'Apuzzo Am. Expert Report), ¶¶ 25, 31.) Nevertheless, Defendants allow providers to bill wide-ranging services—including those that treat ***conditions***—because certain procedure-level codes will process in Defendants' systems as preventive services regardless of the diagnosis code used.[6] (Pls.' Ex. 8 (CDG), at UHC_196585-196586 (codes do "not have diagnosis code requirements for the preventive benefit to apply"), UHC_196610 (same for S9443).) Because all but one of these procedure codes (S9443) could apply to a number of services, and numerous diagnosis codes say nothing on their face about lactation, determining whether claims involved lactation would require an individualized medical record review. (*See id.*; Pls.' Ex. 23 (D'Apuzzo Am. Expert Report), ¶ 31.)

If a provider deviates from Defendants' 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 an insurer's coding guidance for a specific service intends to seek reimbursement for some other service. (Pls.' Ex. 23 (D'Apuzzo Am. Expert Report), ¶¶ 23, 31.) Diagnosis codes do not help; while some diagnosis codes use the word "lactation" in their descriptions, many others do not. (*Id.* ¶ 31.) "[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.*) Defendants do not typically request or collect medical records for lactation services. (Mar. 19, 2019 Seay Decl., ¶ 4.)

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

Defendants' claims data confirms that members did not "stumble" across in-network providers as Plaintiffs' assert. (Renewed Mot. at 8.) To the contrary, thousands of members found and received lactation services from in-network providers for a variety of diagnoses and obtained coverage for those services without cost-shares, both across markets and over time. (dos Santos Decl., ¶ 9 & Ex. 2 thereto.) Approximately 72% of adjudicated claims billed since 2012 in

[6] Plaintiffs claim that "the CDG incorporates the preventive versus diagnostic care construct for CLS." (Renewed Mot. at 10-11.) But under the CDG, certain procedure-level codes will process as preventive ***regardless*** of the diagnosis code. Defendants' answers to interrogatories merely state that services "billed … in a manner not set out in the CDG … will be processed as non-preventive care." (Pls.' Ex. 7, at 7.)

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accordance with Defendants' coding guidance involved services rendered by network providers, and Defendants covered approximately 81% of those in-network claims and approximately 63% of all claims billed with Defendants' coding guidance (both in-network and out-of-network) without cost-shares.[7] (*Id.* ¶¶ 9(b)-(d).) OB/GYNS, pediatricians, and lactation specialists were responsible for 62% of total claims.[8] (*Id.* ¶ 9(e).) Additional members likely received lactation services through global billing, free services, or bundled post-partum wellness visits, which do not appear in Defendants' claims data in a manner that can be identified as lactation services. (Dkt. 173, Ex. A, at 16 n.17; *see also* Souza Decl., Ex. A (Hanley Dep.), at 172:24-173:14; Pls.' Ex. 23 (D'Apuzzo Am. Expert Report), ¶ 27; *supra* at n.3.) Further, some members unable to locate a network provider obtained gap exceptions, and others have successfully appealed claim denials. (Cappiello Decl., ¶¶ 17, 24, 26; Mar. 19, 2019 Seay Decl., ¶ 7-8.)

E. When Claims Are Not Fully Paid, Defendants' Remark Codes Initiate A Dialogue With the Member and Provider, Leading to Various Outcomes.

Defendants include remark codes in the Explanation of Benefits ("EOB") documents sent to members to provide information about how their claims are processed. (Pls.' Ex. 21 (Thompson Decl.), ¶¶ 5, 6.) The remark codes provide information to members in accordance with industry-standard language and initiate a dialogue between the member, the member's provider, and Defendants. (*Id.* ¶¶ 7, 14; *see also* Pls.' Ex. 23 (D'Apuzzo Am. Expert Report), ¶ 42; Mar. 19, 2019 Miller Decl., Ex. A (Miller Expert Report), at 2, 5, 9.) After receiving an EOB, members may consult their providers, benefit booklets, or customer service for additional information, and some members have had the denial decision adjusted. (Pls.' Ex. 21 (Thompson Decl.), ¶ 9; Dec. 11, 2018 Savercool Decl., ¶¶ 11-12.) The claim outcomes in each of these instances, and the financial impact

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[7] Pursuant to the Court's June 26, 2019 Order (Dkt. 218), Defendants produced additional claims data at UHC_198579-198580 for services rendered by out-of-network providers who are recognized in Defendants' systems as lactation specialists. Because that production is limited to ***out-of-network*** claims and involves different code sets, the calculations above do not take that supplemental production into account. Even considering the supplemental production in addition to claims billed in accordance with Defendants' coding guidance, approximately 62% of claims involved services rendered by network providers, and Defendants covered approximately 56% of all claims (both in- and out-of-network) without cost-shares. (dos Santos Decl. ¶ 12.)

[8] Plaintiffs' myopic focus on statistics involving only out-of-network claims is not warranted given that how payors, such as Defendants, treat such claims is dependent on the availability of network services, per ACA's clear rules. (*See* Renewed Mot. at 10); *see also* 29 C.F.R. § 2590.715-2713(a)(3)(i)-(ii).

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to the member, if any, are diverse and individualized. (Savercool Decl., ¶ 11.)

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

Plaintiffs here were members or beneficiaries of health benefit plans administered by one of the Defendants. (Dkt. 104-4 at 4.) Only Barber is a current plan member. (Mar. 20, 2019 Seay Decl., ¶ 8.) Each of these Plaintiffs received lactation services from out-of-network providers. (Dkt. 104-4 at 8-17.) The similarities stop there.

Condry sought services from an out-of-network lactation consultant after her network provider diagnosed her daughter with poor weight gain. (*Id.* at 9.) She did not attempt to locate other in-network providers or determine her lactation consultant's network status. (*Id.*) UnitedHealthcare Insurance Company denied her claim, explaining in the EOB "[t]his is not a reimbursable service" and "[t]here may be a more appropriate CPT or HCPCS code." (*Id.*) Condry understood that the lactation consultant had provided the codes on the bill but did not ask her for "more appropriate" codes. (*Id.*) She did not appeal or file claims for other services she received. (*Id.* at 9-10.)

Barber was seen by lactation consultants at the in-network hospital where she gave birth. (*Id.* at 15.) Without attempting to locate in-network care, she saw an out-of-network provider. (*Id.*) UnitedHealthcare Insurance Company denied her claim, explaining "[y]our plan does not cover this non-medical service or personal item." (*Id.*) Barber submitted an untimely appeal detailing her understanding of the denial reason. (*Id.*)

Endicott received lactation services prior to discharge from her in-network hospital. (*Id.* at 10; *see also supra* n.3.) Aware that in-network services were available, Endicott nevertheless located an out-of-network lactation consultant on the Internet and received services. (Dkt. 104-4 at 10.) After Endicott submitted a claim for reimbursement, UnitedHealthCare Services, Inc. asked her out-of-network lactation consultant to submit corrected claims with valid diagnosis codes, which the provider never did. (*Id.* at 11.) UnitedHealthCare Services, Inc. denied Endicott's claim, and although Endicott contends she appealed, she has no record of it. (*Id.*)

Carroll also received lactation counseling at her in-network hospital after giving birth to her daughter and continued to receive lactation services from hospital-based consultants following

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discharge. (*Id.*; *see also supra* n.3.) Nevertheless, Carroll received services from out-of-network providers. (Dkt 104-4 at 12.) When UMR, Inc. denied her claims, Carroll did not appeal. (*Id.* at 13.)

Bishop received in-network services from a lactation consultant during her hospital stay but decided to seek additional services out-of-network. (*Id.* at 13-14.) Bishop claims that she tried unsuccessfully to find an in-network provider on Defendants' website. (*Id.* at 14.) Bishop also claims that she spoke to customer service and was told that there were no in-network lactation providers. (*Id.*) Bishop attempted to obtain a gap exception but failed to submit her request in advance. (*Id.*) UnitedHealthcare Insurance Company denied her claim, explaining that "[t]his is not a reimbursable service" and "[t]here may be a more appropriate CPT or HCPCS code." (*Id.*) Bishop understood that her out-of-network provider selected the codes but did not ask the provider if there were alternative codes. (*Id.* at 14-15.) Bishop claims she submitted an appeal, but she has no record of it. (*Id.* at 15.)

Lastly, ***Hoy*** received in-network lactation services in the hospital after giving birth before seeking additional services out-of-network. (*Id.* at 15-16.) Hoy did not ask her in-network providers for a network referral but claims that she attempted to locate a provider on Defendants' website and was unable to do so. (*Id.* at 15.) Hoy failed to submit a claim for reimbursement for several months. (*Id.* at 16.) Ultimately, UnitedHealthCare Services, Inc. denied Hoy's claim, explaining that "[t]his is not a reimbursable service" and that "[t]here may be a more appropriate CPT or HCPCS code." (*Id.* at 16-17.) Hoy also understood that her provider supplied the codes at issue but never followed up. (*Id.* at 17.) Hoy submitted an appeal but did not address the coding issues identified in her EOB. (*Id.*)

G. Plaintiffs Sue for Damages Based on Claim Denials and Cost-Shares.

In their Second Amended Complaint, Plaintiffs allege that Defendants failed "to provide … in-network lactation service providers within a reasonable distance of the plan participants." (Dkt. 78 ("Second Am. Compl.") ¶ 212.) Plaintiffs also allege that Defendants utilized "a system … that fails to provide timely and substantive responses to requests for out-of-network benefits." (*Id.* ¶ 207.) Plaintiffs request damages and seek certification of classes under Rule 23(b)(2) and (b)(3), with no mention of 23(b)(1) or (c)(4). (*Id.* ¶ 184.)

H. The Court Conducts an Individualized Analysis at Summary Judgment.

On June 27, 2018, the Court issued an opinion and order on the parties' cross-motions for

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summary judgment. (Dkt. 146 ("Summ. J. Order").) With respect to Plaintiffs' ACA claims, the Court assessed the circumstances of each named Plaintiff, 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. (*Id.* at 3-5.) The Court granted summary judgment in Hoy's and Bishop's favor; granted summary judgment in Defendants' favor with respect to Barber and Condry; and denied summary judgment to both sides with respect to Endicott and Carroll. (*Id.*) The Court's grant of summary judgment in favor of Defendants with respect to Barber resulted in no active plan members having ACA claims. (Mar. 20, 2019 Seay Decl., ¶¶ 3-8.) With respect to Defendants' alleged claims processing deficiencies, the Court granted summary judgment in favor of the ERISA Plaintiffs (*i.e.*, all Plaintiffs but Carroll). (Summ. J. Order at 5-6.)

I. The Court Denies Plaintiffs' Original Motion for Class Certification.

On May 23, 2019, the Court denied Plaintiffs' original motion for class certification without prejudice. (Dkt. 213 ("Class Order").) The lactation classes consisted of "all people denied lactation coverage … whether in-network or out-of-network." (*Id.* at 2.) This was problematic, because "[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.* at 3.) Even limiting the lactation 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.*) There was no "evidence that UHC uniformly applied an unlawful policy to out-of-network claims." (*Id.* at 3-4.) The Court also observed that the named Plaintiffs lacked standing to seek prospective relief "because they [were] no longer … plan participants." (*Id.* at 4.) Further, the Court 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.* at 5.) With respect to the Claims Review Class, the Court explained that Plaintiffs sought "to certify an overbroad class" that included in-network claimants. (*Id.*) The Court also reasoned that "the plaintiffs provide[d] virtually no discussion of the relief they would seek on behalf of such a class." (*Id.*)

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J. Plaintiffs Seek Certification of Substantially Similar Classes Under 23(b)(1), (b)(2), and (c)(4) and Concurrently File a Motion to Intervene.

On September 9, 2019, Plaintiffs filed their renewed motion for class certification and a motion to intervene. In their renewed certification motion, Plaintiffs seek certification of the ERISA Plan Class, the Non-ERISA Plan Class, and the Claims Review Class (collectively, the "Classes"). (*See* Renewed Mot.) Plaintiffs now limit their Classes to out-of-network claimants, but they still attempt to expand the Classes by including, among others, members who never submitted a claim. (*Id.* at 14-15.) Plaintiffs contend that Defendants applied a "blanket policy" of imposing cost-shares on, or denying coverage for, out-of-network claims. (*Id.* at 1.) Plaintiffs also suggest that Defendants reimburse a limited set of billing codes. (*Id,* at 12.) 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 Defendants "reprocess" their claims "under a corrected standard." (*Id.* at 11.) In a footnote, Plaintiffs request certification of an "issue class" under Rule 23(c)(4). (*Id.* at 24 n.19.)

In their motion to intervene, Plaintiffs attempt to cure the named Plaintiffs' lack of Article III standing to obtain prospective relief by asking the Court to add Teresa Harris—a current beneficiary of an ERISA plan—as a named Plaintiff. (Dkt. 221.) As explained in Defendants' response, the Court should deny Plaintiffs' motion as untimely and prejudicial. (Dkt. 224.)

III. ARGUMENT

A. Plaintiffs Have the Burden to Meet Rule 23's Strict Requirements.

A plaintiff seeking class certification must satisfy all of the requirements of Rule 23(a) and at least one of the requirements 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), rather than (b)(3). Courts must scrutinize such classes to ensure that plaintiffs ***prove*** "that there

are ***in fact*** sufficiently numerous parties, common questions of law or fact, etc." *Dukes*, 564 U.S. at 350 (bolded emphasis added). Thinly veiled efforts to use Rule 23(b)(1) or (2) to obtain monetary relief while avoiding the express requirements of Rule 23(b)(3)—which protect the due process rights of the absent class members and the defendant—are discouraged. *Id.* at 360, 363; *see also Zinser v. Accufix Research Inst., Inc.*, 253 F.3d 1180, 1193 (9th Cir. 2001) (certification under Rule (b)(1) is "not appropriate in an action for damages"); *Philips v. Ford Motor Co.*, No. 14-cv-2989, 2016 WL 7428810, at *25 (N.D. Cal. Dec. 22, 2016) (same for (b)(2)).

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. "What matters to class certification … is … the ***capacity of a classwide proceeding to generate common answers apt to drive the resolution of the litigation***." *Id.* at 350 (bolded emphasis added). "Dissimilarities within the proposed class are what have the potential to impede the generation of common answers." *Id.*; *Mazza v. Am. Honda Motor Co., Inc.*, 666 F.3d 581, 588 (9th Cir. 2012).

a. The ERISA and Non-ERISA Plan Classes.

Plaintiffs do not and cannot satisfy commonality with respect to the ERISA and Non-ERISA Plan Classes, because Defendants' liability to each class member cannot be determined with common proof. *Dukes*, 564 U.S. at 350. As demonstrated by the Court's summary judgment and class certification rulings, determining Defendants' compliance with ACA class-wide would require a granular, fact-bound analysis. (Summ. J. Order at 3-5; Class Order at 3-4); *see also York v. Wellmark, Inc.*, No. 4:16-cv-00627, 2019 WL 1493715, at *4-6 (S.D. Iowa Feb. 28, 2019) (conducting similarly individualized analysis of lactation benefit and granting summary judgment).)

(1) Plaintiffs' Claim Regarding Out-Of-Network Services Does Not Establish Common Policies or Injuries.

Plaintiffs contend that Defendants violated ACA by applying a uniform policy of imposing cost-shares on, or denying coverage for, out-of-network lactation claims. (Renewed Mot. at 1.) This claim does not satisfy commonality. As a threshold matter, and as this Court held in denying

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Plaintiffs' original motion for class certification, there is no "meaningful evidence" supporting Plaintiffs' claim. (Class Order at 3-4.) To the contrary, the evidence shows that members unable to locate a network provider were directed to a network provider or, at least, able to obtain in-network coverage for out-of-network services through Defendants' gap exception and appeals processes; these were processes expressly laid out in members' benefit booklets and, in some cases, promoted by customer service when appropriate. *See supra* at 7; *see also* Souza Decl., Grp. Ex. F, at UHC_163822, UHC_172341, UHC_180379, UHC_180671, UHC_180992. Defendants therefore did not apply a "blanket policy" of excluding out-of-network claims from eligibility for coverage without cost-shares.[9] *See Dukes*, 564 U.S. at 355 (explaining that "[t]he only corporate policy" was the lack "of a uniform … practice that would provide the commonality needed for a class action"). Simply repeating the words "blanket policy" over and over does not constitute the necessary evidence of such a policy.

Even if there were evidence of a uniform policy, Plaintiffs have failed to establish a common injury among class members, as they must. *Thomasson v. GC Servs. Ltd. P'Ship*, 539 F. App'x 809, 810 (9th Cir. 2013) (commonality requires "significant proof that the entire class suffered a common injury"); *Ellis v. Costco Wholesale Corp.*, 657 F.3d 970, 981 (9th Cir. 2011) (similar); *see also* Souza Decl., Ex. G (Apr. 25, 2019 Class Hearing Tr.), at 14:3-15:2, 20:7-15 (Court recognizing that "there is very unlikely to be a common question susceptible to a common answer," as demonstrated by summary judgment ruling). As discussed above, the vast majority of women who submitted claims billed in accordance with Defendants' coding guidance received the services in-network and obtained coverage without cost-shares, both over time and across markets.[10] *See supra* at 8-9. Additional members likely received lactation services post-delivery and at wellness visits that were

[9] Plaintiffs repeatedly cite to the CDG to support their "blanket policy" theory. (*See, e.g.*, Renewed Mot. at 5.) But the CDG provides that, in determining coverage, "the member specific benefit plan document must be referenced." (Pls.' Ex. 8 (CDG), at UHC_196572.) Many benefit plans inform members of Defendants' gap exception process. (*See, e.g.*, Dkt. 106-4 (Hoy's benefit booklet), at UHC_000908.) Relatedly, the wide availability of network providers as demonstrated by the claims data shows that the "blanket policy" theory cannot be accepted without individual examination of whether each class member had a network provider available to that member.

[10] Even when expanded to other, not overtly lactation-related diagnosis codes, Defendants processed 78% of claims as in-network. (dos Santos Decl., ¶ 8 & Ex. 1 thereto.) Plaintiffs cite the same claims data to establish numerosity, thus acknowledging the breadth and reliability of this information. (Renewed Mot. at 14-15.)

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not billed individually or obtained free in-network services through hospital clinics. *See supra* at 9 & n.3. And Defendants covered without cost-shares the majority of all claims (both in-network and out-of-network) billed as described above. *See supra* at 9.

Thus, ***most*** members were aware of and able to obtain in-network lactation services without cost-shares or, at a minimum, in-network coverage for out-of-network services.[11] 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 cost-share was imposed or a claim was denied to determine, among other things, whether the member had an in-network provider available, and if so, whether there were any other reasons why the claim was denied or a cost-share imposed. Plaintiffs concede as much, arguing throughout their brief that lactation claims must be adjudicated "based on whether in-network CLS services were available or unavailable." (*See, e.g.*, Renewed Mot. at 1.)

First, the Court would need to determine whether each class member had a network provider available, and whether Defendants provided that member with sufficient information about that provider. (Summ J. Order at 3-5; *York*, 2019 WL 1493715, at *4-6.) The named Plaintiffs' circumstances demonstrate the individualized nature of this exercise. All Plaintiffs received in-network services, albeit from different providers and under unique factual circumstances. *See supra* at 10-11. While some named Plaintiffs claim that they received misinformation from customer service, this assertion requires the Court to examine each customer service call. Not all members had contact with customer service, but this analysis would need to be conducted for those who did.

This fact-bound and individualized exercise of determining the availability of network

[11] This is unsurprising, since lactation specialists classified internally with specialty code 380 (who Plaintiffs emphasize) are not the only in-network providers of lactation services, as this Court previously recognized. (Class Order at 4 ("providers … 'coded' … as lactation specialists … are not the only providers in UHC's networks that offer lactation services"); Mar. 19, 2019 Vasquez Decl., ¶¶ 8-10.) Plaintiffs argue that the Court granted summary judgment in Defendants' favor with respect to Barber and Condry only because they had 380 providers available. (Renewed Mot. at 8-9 & n.7.) But the Court denied Carroll and Endicott summary judgment as well, even though they received in-network services from non-380 providers. (Souza Decl., Ex. G (Apr. 25, 2019 Class Hearing Tr.), at 21:14-22:23; *see also* Lee Decl., Ex. A (Lee Expert Report), at 4-8.) Despite all of this, and the fact that Plaintiffs' experts agree that non-lactation specialists can and do provide the service (even if not <u>all</u> of them do), (*see, e.g.*, Pls.' Ex. 20 (Morton Expert Report), Plaintiffs continue to narrowly focus only on 380 providers as providers of lactation services. (*See* Renewed Motion at 8 n.7.)

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providers is rendered more complex by Plaintiffs' legal theories, which contend that Defendants deprived members of access to "in-network lactation service providers within a ***reasonable distance*** of" their homes. (Second Am. Compl. ¶ 212 (emphasis added)). Even assuming ACA incorporates this "reasonable distance" requirement, the Court cannot evaluate the extent to which Defendants complied with it across the Classes 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.4. 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 6 & n.5. Thus, identifying the standard for determining whether Defendants made members sufficiently aware of 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. (*See* Renewed Mot. at 8 (suggesting that there are '"material gaps in physicians' education, training and experience"' (quoting Pls.' Ex. 16 (Hanley Rebuttal Report), ¶ 5)).) 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 multi-faceted questions. *See Dukes*, 564 U.S. at 350.[12] Notably, Plaintiffs' "corrected standard" provides no mechanism for doing so. (*See* Renewed Mot. at 11-12.)

Third, the Court would need to analyze what efforts the member made to look for the service, including any communications with Defendants and the extent to which the member previously or subsequently obtained services from a network provider. (Summ. J. Order at 3-5; *see also York*, 2019 WL 1493715, at *4-6.) 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

[12] *See also Phillips v. Sheriff of Cook County*, 828 F.3d 541, 554-555 (7th Cir. 2016) (court would need to inquire into each class member's medical needs and the subjective quality of the treatment).

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the recommendation of a friend or family member. (Summ. J. Order at 3-5; *see also York*, 2019 WL 1493715, at *4-6.) 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.[13] *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 Defendants are unable to track claims payment or collection information. (Dec. 3, 2018 Seay Decl., ¶¶ 6-8; Dec. 3, 2018 Vasquez Decl., ¶¶ 6-9; Miller Decl., Ex. A (Miller Expert Report), at 11-12.) And, the Court would need to analyze any available defenses, including whether a claim was denied for reasons unrelated to the lactation benefit. (Pls.' Ex. 21 (Thompson Decl.), ¶¶ 18-26; Mar. 19, 2019 Klos Decl., ¶¶ 4-32; Mar. 20, 2019 Klos Decl., ¶¶ 4-7; Mar. 12, 2019 Thompson Decl., ¶¶ 4-46; Brewer Decl. ¶¶ 6-7.) The Court would also need to assess whether the member attempted to obtain a gap exception or appealed their claim. *See supra* at 7.

Plaintiffs cannot establish a common impact across the Classes with anecdotal opinions that some physicians do not have the requisite training to render lactation services, by citing out-of-context quotations from Defendants' emails, or by focusing on Defendants' out-of-network claims data—thereby ignoring that the vast majority of members were aware of and able to obtain in-network lactation services without cost-shares. (Renewed Mot. at 6, 8 & n.6, 10-11.) Plaintiffs go so far as to argue that individualized issues, such as the availability of network providers, are irrelevant, given their "blanket policy" theory. (*Id.* at 8.) That is not proof of commonality. *Dukes*, 564 U.S. at 350 ("the raising of common 'questions'—even in droves"—does not satisfy commonality). No common answers can be derived from this complex matrix of factual and legal questions.

(2) Plaintiffs' Effort to Expand the Classes Compounds the Individualized Inquiries.

Plaintiffs' attempt to increase the size of the Classes only compounds the individualized inquiries necessary to resolve the case on a class-wide basis. Most glaring is Plaintiffs' claim that Defendants adopted an unduly narrow set of billing codes for lactation services, and their

[13] Plaintiffs have previously asserted that this argument assumes "rampant insurance fraud by providers." (Dkt. 161 at 20.) It is well known, however, that waiver of cost-shares by providers is a regrettable but common practice. *See, e.g.*, *Kennedy v. Connecticut Gen. Life Ins. Co.*, 924 F.2d 698, 699 (7th Cir. 1991).

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accompanying effort to sweep in members whose claims were billed using codes other than those set forth in Defendants' coding guidance. Preliminarily, and as discussed further in section C.3 below, ACA does not require Defendants to adopt specific billing codes. As a result, the supposed harm Plaintiffs assert on behalf of the ERISA and Non-ERISA Plan Classes is simply a concoction Plaintiffs developed in an attempt to avoid denial of class certification. Plaintiffs' position is also misleading in that Defendants' coding guidance allows providers to bill for a full range of lactation services, including those relating to the treatment of conditions. *See supra* at 7-8.

Setting that aside, Plaintiffs' claim cannot be adjudicated on a class-wide basis because the evidence shows that thousands of providers were able to bill for a full range of lactation services using Defendants' billing codes, including diagnoses identified by Plaintiffs' coding "expert." (dos Santos Decl., ¶ 9 & Ex. 2 thereto; Pls.' Ex. 24 (Hanley Expert Report), at 4-8.) 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 using Defendants' coding guidance and whether the provider could have done so. Further, since ACA does 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 a claim subject to the class falls within its parameters. Such an 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. (Pls.' Ex. 24 (Hanley Expert Report), at 4-8.) The Court would thus need to examine each class member's treatment, including the underlying medical records (which Defendants do 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 Defendants would be

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entitled to present the defense that, in accordance with their discretion to identify codes that they would recognize as a particular covered service, they appropriately excluded the billing code(s) at issue from cost-share-free coverage. *See supra* at 5-6. 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. *See Doiron v. Conseco Health Ins. Co.*, 279 Fed. App'x 313, 316 (5th Cir. 2008) (classes included "policyholders who had claims denied for [other] reasons); Pls.' Ex. 21 (Thompson Decl.), ¶¶ 18-26. These individual issues are incompatible with Rule 23.

A similarly individualized analysis applies to Plaintiffs' claim that the Classes include members who did not submit claims ***at all***. (Renewed Mot. at 14-15.) 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. *See, e.g.*, *Davis v. AT&T Corp.*, No. 15-cv-2342, 2017 WL 1155350, at *2, 4 (S.D. Cal. Mar. 28, 2017) (rejecting "entirely different class" than that alleged in the Complaint). Plaintiffs' recent expansion of the Classes seeks to deprive Defendants of their 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 Defendants' supposed practices impacted them at all, let alone in a uniform manner. *See Dukes*, 564 U.S. at 350; *see also* Souza Decl., Ex. G (Apr. 25, 2019 Class Hearing Tr.), at 34:8-11 ("[H]ow does UnitedHealthcare figure out who to send a letter to[?]"). Even if these members could be located, the Court would need 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 Defendants' purported conduct.

These individualized issues go to the heart of the Court's commonality inquiry: namely, whether Plaintiffs have identified not just common questions, but the capability of the class action device to provide common answers through common proof. *Dukes*, 564 U.S. at 350. Plaintiffs' cited cases do not warrant certifying a class. Those cases involved challenges to policies that allegedly applied to ***every*** claim and, ***under the applicable substantive law***, uniformly injured ***all*** class

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members. *See, e.g.*, *Des Roches v. Cal. Physicians' Serv.*, 320 F.R.D. 486, 497-504 (N.D. Cal. 2017) (medical necessity guidelines uniformly injured class members); *Wit v. United Behavioral Health*, 317 F.R.D. 106, 127-29 (N.D. Cal. 2016) (same for coverage guidelines); *Escalante v. Cal. Physicians' Serv. d/b/a Blue Shield of Cal.*, 309 F.R.D. 612, 618 (C.D. Cal. 2015) (same for lumbar artificial disc replacement surgery exclusion). By contrast, here, Plaintiffs assert purported misconduct involving multiple Defendants and alleged policies and practices, across all states and over a broad time period. For example, putative class members' claims will process differently depending on (1) the medical codes their provider selects; (2) the provider type the class member seeks services from; and (3) whether the claim is submitted in accordance with applicable policies and procedures.[14] (*See, e.g.*, Pls.' Ex. 25 (Nonphysician Reimbursement Policy); Daubney Decl., ¶¶ 6-15.)

Even if Defendants' 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.[15] *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 as to the ERISA and Non-ERISA Plan Classes.

b. The Claims Review Class.

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.

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[14] Plaintiffs assert that Defendants cannot apply reimbursement policies, such as the Nonphysician Reimbursement Policy, to lactation claims (Renewed Mot. at 13 n.11), but nothing in ACA prohibits their application. *See* FAQs About Affordable Care Act Implementation (Part XII), at Q.19 (noting that reimbursement policies are outside HRSA Guidelines or regulations relating to ACA), https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs.

[15] Plaintiffs confuse ***damages*** for ***injury***, arguing that, in the cases they cite, courts certified classes even though all class members did not incur damages or the same amount of damages. (*See, e.g.*, Renewed Mot. at 17, 19 & n.16.) Even if variations in damages do not defeat certification, however, Plaintiffs must still identify a common ***injury***, which they have not done. *Thomasson*, 539 F. App'x at 810; *Ellis*, 657 F.3d at 981.

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(Renewed Mot. at 18.) The appropriate inquiry, however, is whether Defendants substantially complied with ERISA's "meaningful dialogue" standard, giving class members a full and fair review of claim denials. *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1032 (9th Cir. 2006); *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). Such a determination cannot be made on a class-wide basis because it entails an examination of each class member's circumstances, including the extent of any additional communications between the member and Defendants. *See, e.g.*, *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 mitigated by subsequent communications). Remark codes are designed to provide enough information for the member to understand the benefits determination and capitalize on other available resources. *See supra* at 9. The evidence shows this process works. Defendants' records indicate members routinely communicate with Defendants after receiving claim denials, including denials involving the remark codes at issue. (Savercool Decl., ¶ 11.) The experiences of each named Plaintiff show that members understand the basis for claim denials, often due to their or their providers' additional communications with Defendants.[16] *See supra* at 10-11.

Thus, the Court would need to examine the circumstances of each class member to determine ERISA compliance class-wide. At summary judgment, the record contained the full course of the named Plaintiffs' interactions with Defendants. Before extending that ruling to the class members, the Court would need to likewise assess each class member's interactions with the Defendants, rather than making class-wide assumptions. The Rules Enabling Act, 28 U.S.C. § 2072(b), requires that the same substantive requirements be applied to the class.

2. The Named Plaintiffs are Not Typical or Adequate Class Representatives.

"The test of typicality 'is whether [class] members have the same or similar injury, whether the action is based on conduct which is not unique to the named plaintiffs, and whether other class members have been injured by the same course of conduct.'" *Ellis*, 657 F. 3d at 984. "The adequacy-of-representation requirement 'tend[s] to merge' with the commonality and typicality criteria.'" *See, e.g., Amchem Products, Inc. v. Windsor*, 521 U.S. 591, 626 n.20 (1997); *see also Kandel v. Brother*

[16] Even Plaintiffs' expert, Dr. Lauren Hanley, admits she has participated in this "meaningful dialogue" process with at least one patient. (Souza Decl., Ex. A (Hanley Dep.), at 115:9-116:19.)

Int'l Corp., 264 F.R.D. 630, 634 (C.D. Cal. 2010).

For many of the same reasons Plaintiffs fail to establish commonality, they also fall short of satisfying typicality and adequacy. With respect to the ERISA and Non-ERISA Plan Classes, the varying circumstances of the named Plaintiffs' claims render Plaintiffs' typicality and adequacy arguments nonstarters. Further, Plaintiffs filed claims for benefits, yet they seek to represent members who never submitted a claim. Such individuals will necessarily require different proof and would be subject to unique defenses. Several Plaintiffs failed to exhaust their administrative remedies. Further, Bishop, Hoy, Endicott, and Carroll are subject to the defense of lack of standing. *See infra* at C.1. Plaintiffs' receipt of in-network lactation services further renders them inadequate (and atypical) representatives of those who did not.

With respect to the Claims Review Class, the member-specific analysis of whether a "meaningful dialogue" occurred means that the named Plaintiffs are neither typical nor adequate. For instance, and as discussed above, Barber indicated in her untimely appeal that she understood the basis for the denial at issue, so she cannot represent any actual or hypothetical class members who may not have received a full and fair review. Typicality and adequacy are lacking.

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

1. Bishop, Hoy, Endicott, and Carroll Lack Standing to Certify the ERISA and Non-ERISA Plan Classes Under Rule 23(b)(1) and (2).

Bishop, Hoy, Endicott, and Carroll are not current plan members and thus lack standing to represent the ERISA and Non-ERISA Plan Classes. (Mar. 20, 2019 Seay Decl., ¶¶ 3-7; Class Order at 4-5; *see also* Dkt. 163 at 24 (collecting cases).) Plaintiffs contend they have standing to seek retrospective relief, implicitly conceding they want money damages while impermissibly avoiding the requirements of Rule 23(b)(3). (Renewed Mot. at 24-25.) Plaintiffs' standing to seek retrospective relief is irrelevant to the applicable standing inquiry under Rule 23(b)(1) and (2).

Plaintiffs attempt to cure their lack of standing by filing their motion to intervene (Dkt. 221), but the Court should deny that motion as untimely and prejudicial. (*See* Dkt. 224.) Regardless, Plaintiffs concede that Harris is a beneficiary of an ERISA-governed plan, and, thus, even if the Court grants the motion to intervene, Harris would cure standing only for the ERISA Plan Class.

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Plaintiffs' failure to cure their standing woes warrants denial of certification.

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

Rule 23(b)(1)(A) "requires more … than a risk that separate judgments would oblige the opposing party to pay more damages to some class members but not to others." *Zinser*, 253 F.3d at 1193. At best, Plaintiffs' theories suggest that Defendants may be liable to some members of all three Classes but not others. *See Jimenez v. Domino's Pizza, Inc.*, 238 F.R.D. 241, 249-250 (C.D. Cal. 2006) (denying certification under (b)(1)(A) on this basis). Indeed, ***some but not all*** class members may be able to establish an ACA violation, or a deprivation of a full and fair review. Further, for the ERISA and Non-ERISA Classes, Plaintiffs' belated invocation of Rule 23(b)(1)(A) does not change the fact that they still seek significant monetary recovery and that Rule 23(b)(1)(A) is not an avenue to class certification in such circumstances. *Zinser*, 253 F.3d at 1193-94.

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

Rule 23(b)(2) requires that the relief be both (1) final and (2) appropriate. *Kartman v. State Farm Mut. Auto. Ins. Co.*, 634 F.3d 883, 892 (7th Cir. 2011). ***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." *See Jamie S. v. Milwaukee Pub. Sch.*, 668 F.3d 481, 499 (7th Cir. 2012); *see also Dukes*, 564 U.S. at 360-61; *Ellis*, 657 F.3d at 987; *Cholakyan v. Mercedes-Benz USA, LLC*, 281 F.R.D. 534, 560 (C.D. Cal. 2012). Even a systemic reform of Defendants' practices would not establish liability or remedies for any class, and Plaintiffs are seeking individualized damages. *Kartman*, 634 F.3d at 893. An injunction for the Claims Review Class would similarly initiate individualized claims decisions, as Plaintiffs concede. (Renewed Mot. at 14 (purported injunction "re-starts the time from which the class member can appeal").)

Second, Plaintiffs' proposed injunctions are not "appropriate." With respect to Plaintiffs' request that Defendants "reprocess" lactation claims under a single, "corrected standard," neither ACA nor HRSA impose such a standard. *See supra* at 5. Thus, "there is no independent cognizable wrong to support a claim for injunctive relief." *Kartman*, 634 F.3d at 886. Plaintiffs' focus on monetary recovery also precludes them from establishing irreparable harm. *Id.* at 892; *AA Suncoast Chiropractic Clinic, P.A. v. Progressive Am. Ins. Co.*, 938 F.3d 1170, 1179-80 (11th Cir. 2019). And

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Plaintiffs' request that Defendants reprocess claims under a "corrected standard" violates Rule 65(d), which requires that every injunction "state its terms specifically." *Kartman*, 634 F.3d at 893. Remarkably, the additional procedure-level codes (*i.e.*, medical coding) Plaintiffs propose as part of their supposedly "correct standard" are identified ***solely by Plaintiffs' counsel*** and without the support of expert testimony. (*See* Pls.' Ex. 32, at 7-9.) Plaintiffs also ask the Court to order Defendants to adopt additional diagnosis codes, but each of those codes can already be utilized consistent with Defendants' coding guidance. *See supra* at 8. Any request that Defendants be ordered to analyze provider availability for each and every member is moot, as Defendants' gap exception and appeals processes already take these issues into account. At bottom, and unlike *Wit* on which Plaintiffs rely, the Court here would be charged with crafting the supposed corrected standard "out of whole cloth." *Cf. Wit*, 317 F.R.D. at 138 (plaintiffs "pointed to several sets" of existing and generally accepted standards); *see also Martinez v. Brown*, No. 08-cv-565, 2011 WL 1130458, at *13 (S.D. Cal. Mar. 25, 2011) (injunction failed 23(b)(2) and 65(d) because "[t]he Court would be required to determine … what constitutes a 'reasonable' restriction").

Plaintiffs' request for injunctive relief for the Claims Review Class is similarly flawed. Plaintiffs seek an order that Defendants reissue EOBs that provide "a clear explanation as to … why the claim was denied." (Renewed Mot. at 14.) Such an injunction serves no purpose for members like Barber and Condry, whose claims were (indisputably) properly denied. *See supra* at 12. Regardless, Plaintiffs' request for revised EOBs constitutes ***retrospective***, not ***prospective*** relief, and the "injunction" is therefore not appropriate.[17] *See Kartman*, 634 F.3d at 892 (Rule 23(b)(2) allows only for "final injunctive relief or corresponding declaratory relief"); *see also* Renewed Mot. at 24-25. The Court should deny (b)(2) certification.

IV. CONCLUSION

The Court should deny Plaintiffs' renewed motion for class certification.

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[17] As an afterthought, Plaintiffs request certification of the ERISA and Non-ERISA Plan Classes under Rule 23(c)(4). (Renewed Mot. at 24 n.19.) Plaintiffs fail to develop their argument. *See Rahman v. Mott's LLP*, 693 Fed. App'x 578, 579-80 (9th Cir. 2017) (similar). Regardless, 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). Plaintiffs conceded that an issue class is not appropriate at the original hearing on class certification. (Souza Decl., Ex. G (Apr. 25, 2019 Class Hearing Tr.), at 38:6-9.)

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1 DATED: October 24, 2019 Reed Smith LLP
2
3 By: */s/ Rebecca R. Hanson*
4 Raymond A. Cardozo (SBN 173263)
Martin J. Bishop (admitted *pro hac vice*)
5 Rebecca R. Hanson (admitted *pro hac vice*)
Abraham J. Souza (admitted *pro hac vice*)
6
Attorneys for Defendants UnitedHealth Group Inc.,
7 UnitedHealthcare, Inc., UnitedHealthcare
Insurance Company, United
8 HealthCare Services, Inc., and UMR, Inc.
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