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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

TERESA HARRIS, on behalf of herself and all others similarly situated,

Intervenor Plaintiff,

v.

UnitedHealth Group Inc.; UnitedHealthcare, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Services, Inc.; and UMR, Inc.,

Defendants.

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

PLAINTIFFS' AND INTERVENOR PLAINTIFF'S REPLY BRIEF IN FURTHER SUPPORT OF MOTION FOR CLASS CERTIFICATION

Date: November 21, 2019
Time: 10:00 am
Place: Courtroom 4

Honorable Vince G. Chhabria

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes/Other Authorities

Plaintiffs, Rachel Condry, Jance Hoy, Christine Endicott, Laura Bishop, Felicity Barber, and Rachel Carroll, and Intervenor Plaintiff, Teresa Harris (collectively, "Plaintiffs"), hereby submit their Reply in Further Support of their Motion for Class Certification and the Memorandum of Points and Authorities in Support (Dkt. No. 222, "Plaintiffs' Motion" or "Mot."); and in Reply to Defendants' Response in Opposition to Plaintiffs' Renewed Motion for Class Certification (Dkt. No. 248, "UHC's Opposition" or "Opp."). In support of Plaintiffs' Motion, Plaintiffs filed the Declaration of Kimberly Donaldson-Smith (Dkt. No. 222-1, the "KDS Decl.").

I. INTRODUCTION

UHC's Opposition reads as if Plaintiffs simply refiled their prior Class Certification Motion, ignoring that Plaintiffs' Motion specifically addresses the issues raised in the Court's May 23, 2019 Order re: Class Certification ("CC Order," Dkt. 213, at 1). UHC's myopic approach is telling and ultimately unpersuasive. The ACA mandate was unquestionably directed to insurers and health plans.[1] Despite this plain fact, in its Opposition, UHC, as it has done with its Policy[2], continues its wholly dismissive treatment of comprehensive breastfeeding and lactation support services ("CLS") coverage. In its Opposition, UHC flouts fundamental concepts of health insurance coverage and its responsibilities under the ACA mandate and asks the Court to countenance those actions. Most fundamentally, UHC does not dispute that since the start of the Class Period its Policy has been, and remains, that out-of-network ("OON") CLS claims ***are not eligible*** for ACA coverage without cost-sharing, in contravention to the mandates of the ACA. UHC's CLS coverage Policy is reflected in its Preventive Care Services Coverage Determination Guideline (the "CDG"), which states clearly UHC's incorrect position that "Out-of-Network preventive care services ***are not part of the [ACA] requirements***." (KDS Decl., Ex. 8 (the CDG) at pg. 2 (emphasis added); KDS Decl., Ex. 7; UHC

[1] The ACA requires that plans "***must provide coverage*** for all of the following items and services, *and* ***may not impose any cost sharing requirements***…" (42 U.S.C. § 300gg-13, emphasis added). Insurers cannot circumvent the ACA's mandate by not having in-network providers for the enumerated preventive services. (*See* 29 C.F.R. § 2590.715-2713(a)(3)(i)-(ii).)

[2] UHC's Policy is that "preventive services…will be eligible for coverage without cost-shares ***provided that such services are provided by a network provider***…" (KDS Decl., Ex. 7, UHC Rog. Resp. No. 3 (emphasis added)). Also, under UHC's Policy, even if a health plan covered OON services generally, the claim's status as "out-of-network" still trumps, and cost-sharing "is allowed", meaning, ***cost-sharing is imposed***. (*Id.*)

Rog. Resp. No. 1.)

By uniformly excluding OON CLS claims from eligibility for the ACA-mandated benefit, UHC has violated the ACA. The OON CLS claims of Plaintiffs and UHC insureds have been adjudicated under this non-ACA compliant policy. As set forth in Plaintiffs' Motion, of the 33,000 OON CLS Claim Lines produced, 88% were denied or had cost-sharing imposed, resulting in over $1.1 million of cost-share imposed and over $3.4 million of billed charges denied. *See* Mot. at 10. Despite its attempt to stick its head in the sand, UHC cannot avoid the fact that "the Court could award classwide relief by requiring the company to reprocess all claims previously denied pursuant to that noncompliant policy, ***even if some claims were granted pursuant to that non-compliant policy (and even if some claims would still be denied pursuant to a compliant policy)***." (CC Order at 3 (emphasis added)).

In its Opposition, UHC ignore, and asks the Court to ignore, its Policy, the ACA coverage requirement, and the injury to Class members and instead attempts to focus the argument on the availability of lactation services. UHC's argument is a litigation-driven, after-the-fact fabrication underscoring the reality that UHC is mired in its own disingenuous world. UHC insists that certification should be denied because "availability" of an in-network CLS provider will be an essential inquiry. This is simply untrue. Not a single OON CLS claim was adjudicated, denied, or had cost-sharing imposed because of "availability" of an identified in-network CLS provider. UHC did not request (or provide the opportunity for) that any insured demonstrate that in-network CLS was, or was not, available to her. UHC's coverage of CLS was not based on member specific circumstances, but rather on its Policy that OON CLS was never eligible for ACA coverage. UHC's Opposition is, in fact, an exercise in revisionist history. UHC seeks the Court's endorsement of the imposition on insureds of an after-the-fact, self-serving "availability" standard that UHC itself never embraced. This highlights the limited utility of a summary judgment ("SJ") procedure focused on individual plaintiffs in a class action context. The Court's SJ decision did not address UHC's uniform, deficient CLS coverage policies which are at the nucleus of Plaintiffs' Class Certification Motion. *See* Mot. at 16. UHC's employment of SJ presented a fiction that bore no relationship to the reality of the adjudication of OON CLS claims that were routinely denied using inscrutable Remark Codes that had

nothing to do with "availability" of in-network lactation providers.

Similarly ineffectual is UHC's response concerning the certification of the Claims Review Class. Utilizing boilerplate hypotheticals and conjecture about breastfeeding mothers' conduct, UHC reiterates its already-rejected arguments that because Remark Codes are (purportedly) intended to ***start*** a dialogue (notwithstanding the fact that they convey ***denial*** of a claim), one must look at what occurred after receiving the claim denial. (*See* SJ Order, Dkt. 146, at 5-6.)

Tellingly, UHC does not refute the facts that are actually relevant to class certification: the existence of the CLS policy; the substance and applicability of the policy to all members of the ERISA and Non-ERISA Classes and its OON CLS claims; the substance of the four Remark Codes; and, that UHC routinely denied and imposed cost-sharing on OON CLS claims. UHC has not rebutted Plaintiffs' argument that the determination of whether UHC's CLS Policy violates the ACA and its use of the four Remark Codes can and must be determined on a classwide basis. Plaintiffs have demonstrated that certification of the Classes is proper under Rule 23.

II. UHC'S POLICY AND CONDUCT APPLY AND MUST BE REMEDIED CLASSWIDE

The conjecture, speculation and strawman arguments that permeate UHC's Opposition (Sections II and III) are not grounds on which certification of the Classes can be denied. They fall flat in contrast to Plaintiffs' renewed Class Certification Motion, which addresses each of the Court's prior concerns: (a) the Classes are redefined to include only UHC insureds who received OON CLS (*see* CC Order at 2-3, 5); (b) Plaintiffs demonstrate that liability can be resolved on a classwide basis (*see id.* at 3-4), as it is undisputed that UHC's Policy was that OON CLS claims were not eligible for coverage without cost-sharing (*see* Mot. at Section III.A), it was under that policy that OON CLS claims were adjudicated without regard to whether in-network CLS was available to an individual claimant (*see id.* at Section III.C), and injury from UHC's deficient policies resulted (*see id.* at Sections III.B and IV); (c) Teresa Harris has sought to intervene in this action, and has standing to seek prospective relief (*see* CC Order at 4-5); (d) Plaintiffs demonstrated standing to seek an order remedying UHC's past violations (*see id.* at 5; *see also* Mot. at Section VII); and (e) Plaintiffs explain the relief sought for the Classes, describe what the "corrected standard" looks like, and explain why the remedies should be considered for Class certification under Fed. R. Civ. P 23(b)(1)-(2). (*See* CC

Order at 5, 6; *see also* Mot. at Section V.)

A. UHC's Conjecture About Breastfeeding Mothers is A Red Herring

UHC asserts that a "range of individualized issues" are at play. (Opp. at 4, 17-18, 22-23.) UHC speculates about "socioeconomic, workplace, cultural and other factors" as going to whether, and what type, of lactation assistance women need or want. (*Id*. at 5.) UHC's argument makes no sense. Each Class member ***did*** receive lactation services, but because of UHC's failure to establish a proper OON CLS coverage policy, their claims were not covered by insurance, as required by the ACA.

UHC's use of such boilerplate characterizations, which can be argued about and applied to the rendering and receipt of any type of medical services, are unpersuasive. UHC seeks to obfuscate that it is the insurer's responsibility to establish and follow effective, sound, legal, and, here, ACA-compliant medical insurance coverage policies, procedures and infrastructure, under which insurance claims can be adjudicated consistent with the law. That responsibility exists irrespective of why an insured did or did not seek a medical service. UHC does not (and cannot) establish policies and adjudicate insureds' claims based on the mindset and deliberations of insureds.

In its CDG, UHC states clearly and unequivocally that: "Out-of-Network preventive care services ***are not part of the [ACA] requirements***." (KDS Decl., Ex. 8 at pg. 2.) In the CC Order, the Court stated that "[i]t appears…that UHC's approach to compliance with the Affordable Care Act's lactation coverage mandate was disinterested and haphazard…" (CC Order at 4.) To the contrary, the evidence clearly establishes that UHC's approach to OON CLS coverage was neither disinterested nor haphazard: it was fundamentally and uniformly wrong. Contrary to UHC's conjecture, Policy applied to every OON CLS Claim. (*Cf.* UHC Opp. at 20-21.) The cases relied upon by UHC do not dictate a contrary result: In contrast to the situation presented here, in *Graddy v. BlueCross BlueShield of Tenn*., 2010 U.S. Dist. LEXIS 14896, at *23-26 (E.D. Tenn. Feb. 19, 2010), there was no uniform coverage policy to deny claims for experimental or investigative therapies for autism, but rather highly individualized determinations were required to assess medical necessity. In *Dennis F. v. Aetna Life Ins*., 2013 U.S. Dist. LEXIS 137849, at *12-13 (N.D. Cal. Sep. 25, 2013), unlike here, entitlement to coverage turned on a ***medical necessity*** determination with respect to the treatment

proposed. Similarly, in *DWFII Corp. v. State Farm Mut. Auto. Ins. Co.*, 271 F.R.D. 676, 683-84 (S.D. Fla. 2010), providers' entitlement to reimbursement required evidence that the treatments were "medically necessary" and that the provider billed reasonable amounts pursuant to Florida's No-Fault statute.

B. UHC Raises Merits Arguments About the Scope of the CLS Benefit

UHC contends that the ACA and HRSA do not elaborate on what constitutes CLS, and it therefore has discretion on how to implement the CLS benefit. (Opp. at 5-6, citing to 29 C.F.R. § 2590.715-2713(a)(4)). That is a merits argument. Even if relevant, its resolution applies classwide; it goes to the illegality of UHC's Policy, which is applicable to all members of the Classes, and UHC's treatment of Class members' OON CLS claims. Substantively, though, the assertion is misleading. The ACA and HRSA require "coverage" and state the frequency, method, treatment (*i.e.* comprehensive) and setting for CLS. (*See* Mot. At 3-4.) The application of any "reasonable medical management techniques" is only permitted to the extent that the treatment is "not specified in the relevant recommendation or guideline," and, even if the ACA and HRSA guidelines did not specify the CLS treatment (which they do), Section 2713(a)(4) requires any applied medical management to be reasonable, and based on "***relevant clinical evidence" and on "established …techniques."*** UHC's after-the-fact attempt to argue that the scope of its CLS coverage was appropriately limited is a merits argument and is inappropriate for consideration at the class certification stage.[3]

C. UHC Has Not "Established A Network of Providers"

UHC contends that it has "***thousands*** of in-network providers of lactation services." Opp. at 6-7 (emphasis added). That contention remains just as misleading and baseless as when it was first argued in UHC's Motion to Dismiss. Despite repeating the assertion, UHC has ***never*** demonstrated that it has thousands of in-network lactation providers.

Absent specific CLS training and the ability and willingness to provide office or home visits

[3] UHC's litigation arguments, like its conduct since the start of the Class Period in 2012, directly contravene the ACA's mandate to address "access and utilization of these services" and "underutilization of preventive services" due to "market failures" identified as "***plans' lack of incentive to invest in these services.***" (KDS Decl., Ex. 1, 75 FR 41726 at 41730, Table 1, and at 41731 (emphasis added)).

of sufficient duration, physicians and their staffs cannot be assumed to be providing CLS, but that is exactly the ***assumption*** that UHC has always made and which UHC asks the Court to accept without question.[4] UHC also resorts to its rejected view of CLS as limited to services provided by hospital staff, which is directly contrary to the scope of CLS, as stated by HRSA. (*See* Opp. at 6, fn. 3 (citing to the declarations UHC propounded from hospitals and their designees, but never demonstrating that these providers were identified by UHC to members as network CLS providers)).[5]

Indeed, when Plaintiffs asked UHC to identify every lactation specialist and lactation specialist group in UHC's network during the Class Period, UHC responded that, "[s]uch providers are identifiable in Defendants' systems by the specialty '380.'" (KDS Decl., Ex. 7; UHC Rog. Resp. No. 6.) But, importantly, when asked what actions UHC took to provide its insureds with the ability to identify the in-network "providers of lactation and breastfeeding services, support and counseling" (so, the question was ***not*** limited by the terms "lactation specialist," "lactation specialist group" or "380"), UHC ***did not*** provide the names of ***any*** other network providers. (*Id.*; UHC Rog. Resp. No. 12 (referencing its Responses to Rogs. 7 and 9, which do not provide the identity of ***any*** network CLS provider)).[6]

Further, as summarized and depicted in the Report of Daniel McGlone (KDS Decl., Ex. 22) and the maps attached thereto (*id.* at Ex. 22-A), as of the date of the production, UHC had only 122 unique in-network lactation specialists ***nationwide*** (and 22 unique terminated). (KDS Decl., Ex. 22 at 6.) In addition, in 20 states, UHC had ***no*** in-network providers identified during the Class Period as

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[4] UHC's reliance on Dr. Lee (Opp. at 6, fn. 3) is unpersuasive. The Court has already held that Dr. Lee provides "***little or no opinion relevant to this [class] certification decision***." *Condry, et al. v. UnitedHealth Grp., Inc., et al.*, 2019 U.S. Dist. LEXIS 106254, at *12 n.2 (N.D. Cal. May 23, 2019) (emphasis added).

[5] In fact, Poudre Valley Hospital, Hartford Hospital and ProHealth Hospital – which UHC contends were in-network in Plaintiffs' Carroll's and Endicott's plans – were not identified to those Plaintiffs when they affirmatively sought the identity of in-network providers from UHC. (*See* Opp. at 6, fn. 3).

[6] These interrogatory answers all reaffirm the existence of and UHC's reliance on its wrong Policy that OON CLS was not eligible for ACA-mandated preventive coverage; according to UHC, the interrogatories "reflect the manner in which Defendants identify in-network providers for their members and insureds", which is to direct them to "ask their network provider." (KDS Decl., Ex. 7 Rog Resp. No. 7.) Likewise, when asked to identify the "Documents relating to the 'availability of ***providers of lactation counseling services*** in Defendants' networks" (again, without regard to the term "lactation specialist"), UHC referred "Plaintiffs to their responses to Interrogatories Nos. 6, 7 and 9, which only refer to the "380" lactation specialists. (*Id.*, Rog. Resp. No. 13) (emphasis added).

lactation specialists. (*Id*. at 11.) Further, even viewing the data by the metropolitan areas where UHC did identify lactation specialists, there were four or less providers identified per 1,000 live births, with most areas having less than one provider per 1,000 live births. (*Id.* at 13.)

D. "Gap Exceptions" or After-the-Fact Appeals Processes

UHC also frequently references its purported "gap exceptions" and asserts that members may also appeal the claim denials *after* UHC improperly denies or applies cost-sharing to an OON CLS claim.[7] (*See* Opp. at 7, 15.)

The use of "gap exceptions" does not rectify UHC's failure to follow the ACA. First, by its own admission, UHC's "gap exception" does not equate to ACA-mandated preventive care coverage. In other words, the "gap exception" cannot negate or remedy UHC's Policy that OON CLS claims are not eligible for ACA-mandated preventive care coverage. In this regard, UHC states that the "gap exception" process is plan dependent ("depending on their plan") and members then "may be eligible to receive the in-network level of benefits for out-of-network services…" (Opp. at 7). There are at least two material differences between the ACA-mandate and UHC's gap exceptions: (1) the ACA is not plan dependent, and (2) the ACA entitles one to coverage without cost-sharing, which is not the same as the in-network level of benefits. Tellingly, UHC does not contend as much.

Second, the use of a gap exception and after–the–fact appeals processes flies in the face of the ACA preventive care mandate. It discourages insureds from seeking out the preventive service by imposing a financial barrier that the ACA intended be removed. UHC's argument further evidences its persistence that, absent judicial intervention, it will continue to require insureds to jump through administrative hoops in violation of the ACA-mandate. UHC's stance exemplifies why its Policy must be addressed for all insureds, retrospectively and prospectively, classwide.

Even UHC concedes that the Policy and gap exception put its members on a proverbial merry-go-round with no hope of relief: "What if the member is requesting a Gap exception stating there is

[7] UHC should be abashed to make such frequent reference to its gap exception policy. Aside from the time sensitive nature of CLS and the inherently cumbersome process of UHC's gap exception policy, UHC's proffered evidence amounts to a meager 600 approved gap requests for the entire nation from 2012 through part of 2018 (*see* Cappiello Decl. (Dkt. 239) at ¶¶ 17, 27) or an average of ***two*** granted gap exceptions per state per year. (Contrary to the Cappiello Decl. ¶ 26 statement that data was for 2015 to 2018, the supporting documentation covers 2012 – 2018.)

no one in network to provide these services? ***We would not have a way to search for someone who can provide them.***" (KDS Decl., Ex. 11, UHC_056770, 056772, 056774 (emphasis added)).

E. UHC's Reference to its CDG is Misplaced and Actually Supports Class Certification

UHC misfires in its reliance on its CDG's billing codes for CLS. (*See* Opp. at 7-8, 19-20.) The adequacy or inadequacy of UHC's billing codes – another inappropriate merits argument[8] – requires resolution on a classwide basis. Indeed, UHC's arguments support that very conclusion. UHC points out: "[i]t is industry standard for insurers to provide coding guidance for services" and "[w]ithout such guidance, insurers would not be able to readily identify claims that need to be processed according to particular rules, such as network lactation claims under ACA." (Opp. at 7.) Plaintiffs agree. The challenged UHC billing code guidance, as it exists and as altered by any ruling here, governs coverage for every CLS claim. The CLS billing codes apply classwide. UHC's CDG for CLS (like any other covered service) does not and could not hinge on an individual Class member's circumstances.

In addition, UHC's arguments about "medical records" are unconvincing because UHC auto-adjudicates its claims. (*e.g.*, Opp. at 3, 8, 19.) As Ms. Seay, UHC's employee, states, "Claims for health care services, including lactation services, are typically auto-adjudicated (*i.e.*, they are not reviewed clinically for medical necessity) by UHC for all commercial plans barring any irregularity, such as fraudulent billing by a provider. As a result, UHC does not typically request or collect medical records for lactation services." (Dkt. 237, Seay Decl. at ¶ 4.) And, as UHC admits, its CDG purportedly permits the use of procedure codes even absent a reference to any diagnosis code with the word "lactation." *See* Opp. at 8:2-6. UHC adjudicates its claims, without medical records, but, rather,

[8] "[W]hether or not Plaintiff can prevail on the merits is a different question from whether class treatment of Plaintiff's claims is appropriate." *Datta v. Asset Recovery Sols., LLC*, 2016 U.S. Dist. LEXIS 36446, at *17-18 (N.D. Cal. Mar. 18, 2016); *see also e.g., Edwards v. First Am. Corp.*, 798 F.3d 1172, 1178 (9th Cir. 2015) ("A court, when asked to certify a class, is merely to decide a suitable method of adjudicating the case and should not turn class certification into a mini-trial on the merits.") (internal quotation marks omitted); *Schlaud v. Snyder*, 785 F.3d 1119, 1125 (6th Cir. 2015) ("Whether a class should be certified and whether the claims raised by that class have any merit are two different questions."); *Ellis v. Costco Wholesale Corp.*, 285 F.R.D. 492, 507 (N.D. Cal. 2012) ("A district court must resolve factual disputes necessary to class certification, but the court should not turn the class certification proceedings into a dress rehearsal for the trial on the merits.") (internal quotation marks and alterations omitted).

based on procedure and diagnosis codes, it cannot selectively point to a lack of medical records to justify actions related to CLS. Moreover, the ACA does not give insurers the means to deny or not adjudicate CLS claims based on a purported need to review medical records.[9]

Further, as Plaintiffs' Motion detailed, reviewing the CDG codes in the context of the 33,000 OON CLS Claim Lines supports the conclusion that UHC's CDG does not capture the full scope of CLS services being rendered. (Motion at Section IV.C.) Over 16,800 of the OON CLS Claim Lines utilized codes that were not included as part of UHC's CDG for CLS coverage. *Id.* Of those, 92% had cost-sharing imposed or had their claims denied entirely. As a result, Class members incurred over $640,000 in cost-sharing payments, and over $1.5 million for bills that were denied entirely. This Court previously recognized the import of the "erroneous 'preventive/diagnostic care construct.'" (CC Order at 4.) What the foregoing shows is: (i) the magnitude of the OON CLS claims submitted by CLS providers who utilized CPT and ICD codes that do not appear in UHC's CDG; and (ii) the CDG, whether viewed as a "preventive/diagnostic care construct" or otherwise, does not capture the CLS services being rendered.

The ACA-compliant CLS standard for billing codes will not be satisfied by UHC's

[9] If, even after UHC's CDG is expanded to comply with the ACA, UHC needs to review medical records or gather information from patients and providers, including objective data to reprocess claims, that does not defeat class certification. *See Ballas v. Anthem Blue Cross Life & Health Ins. Co.*, 2013 U.S. Dist. LEXIS 199523, at *35-36 (C.D. Cal. Apr. 29, 2013) ("The court can, if it finds Anthem's reliance on a blanket policy…a breach of fiduciary duty, remand all class members' claims to the plan administrator for reevaluation…This would not require any individualized determinations by the court.") (citing *Saffle v. Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 460-461 (9th Cir. 1991); *see, e.g. Josephat v. St. Croix Alumina, LLC*, 2000 U.S. Dist. LEXIS 13102, at *39 (D.V.I. Aug. 7, 2000) (recognizing "the existence of individual issues such as the medical histories of each potential class member," but finding that the individual issues did not "predominate over the common issues such as Defendants' liability"); *Whitney v. Khan*, 2019 U.S. Dist. LEXIS 38288, at *17 (N.D. Ill. Mar. 11, 2019) (finding class certification appropriate where potential class members could be identified based on objective data in medical records); *see also Rikos v. Procter & Gamble Co.*, 799 F.3d 497, 525-526 (6th Cir. 2015) (finding class ascertainable where it "can be discerned with reasonable accuracy using Defendants' electronic records…, though the process may require additional, even substantial, review of files") (emphasis omitted), *cert. denied*, 136 S. Ct. 1493, 194 L. Ed. 2d 597 (2016). *Phillips v. Sheriff of Cook County*, 828 F.3d 541, 554-555 (7th Cir. 2016), cited by UHC Opp. at fn. 17, is inapposite. In *Phillips*, decertification occurred because the defendant fixed its policies to align with national standards resulting in there "no longer [being] a single identifiable remedy that could help all class members." *Phillips*, 828 F.3d at 548-549.

application, retrospectively or prospectively, of its CDG to all improperly processed OON CLS claims. (Motion at Section V, addressing CC Order at 5-6.) CLS means comprehensive lactation support, counseling and education services provided during the antenatal, perinatal, and the postpartum period. Whether one characterizes UHC's CDG as reflective of a diagnostic/preventive construct, or a failure to cover the full scope of ACA and HRSA-mandated CLS, the ACA-compliant standard must include the additional CPT and ICD codes identified by Plaintiffs and their experts. (*See* KDS Decl., Ex. 24, Table 1 in Dr. Hanley's Amended Report;[10] KDS Decl., Ex. 32 (compilation of the CPT Codes, by number and description)).

At bottom, in UHC's words, the "guidance" for it to "identify claims that need to be processed according to particular rules, such as network lactation claims under ACA" applies to all Class members such that certification of the ERISA and Non-ERISA Classes is warranted and, in fact, required. (Opp. at 7.)

F. UHC's Reference to In-Network Claims Data is Irrelevant

It is telling that UHC resorts to use of its ***in-network*** CLS claims data (Opp. at 8-9, 15-16, 19, "over time and across markets"). As Plaintiffs' Motion stated, of the 33,000 OON CLS Claim Lines produced, 88% were denied or had cost-sharing imposed, resulting in the imposition of over $1.1 million of cost-share payments and over $3.4 million for billed charges denied entirely. (*See* Mot. at 10.) Aware that the analysis confirms that UHC improperly denied and imposed cost-sharing on a vast majority of the OON claims, all UHC can muster in response is an odd and inapposite characterization of Plaintiffs' analysis as "myopic." (Opp. at 9, fn. 9). Further, UHC admits that the additional claims data produced for OON providers "who are recognized in Defendants' systems as lactation specialists" shows the vast majority of those claims were denied or had cost-shares imposed. (*Id*. at 9, fn. 7.) What UHC cannot escape is the established truth that "the Court could award classwide relief by requiring the company to reprocess all claims previously denied pursuant to that noncompliant policy, ***even if some claims were granted pursuant to that non-compliant policy (and***

[10] A majority of Dr. Hanley's are diagnosis codes that Defendants' expert, Ms. D'Apuzzo identifies in her Report (KDS Decl., Ex. 23) as diagnosis codes that describe lactation-related issues (*id.* at 8, fn. 2); and, diagnosis codes that relate to breast issues but, in her opinion, "not lactation issues overtly" (*id.* at 9, fn. 3).

even if some claims would still be denied pursuant to a compliant policy)." (CC Order at 3 (emphasis added)).

Thus, UHC's reference to its in-network CLS claims is unhelpful to its position. Perhaps more importantly, the existence of the in-network claims leads one to wonder why UHC did not mine the claims data, identify in-network CLS providers, determine their qualifications and availability, and readily provide that information to insureds. The unrefuted evidence is that UHC did none of these commonsensical things to provide its insureds with access to in-network CLS providers.

G. UHC's Availability Presumption Fails

Contrary to the baseless impression UHC seeks to create in this litigation, its Policy was that OON CLS were not eligible for the ACA benefit. If, as UHC now asserts, its contorted "availability" construct (*see* Opp. at 16, 22-23) is to even be considered in the context of class certification, that position necessarily requires that UHC had undertaken such analysis in its OON CLS claim adjudication. UHC did not even hint at making such an analysis. UHC is unilaterally imposing a contrived standard on OON CLS claims that it did not use.[11] UHC did not give (and was incapable of giving) "availability" as a reason for a claim's outcome. Having eschewed any consideration or reference to availability of an in-network provider as part of its claims' adjudication process, UHC cannot now seek to defeat class certification on that basis. Indeed, if "availability" were a reason for UHC to properly deny ACA-mandated coverage, it was obligated to convey that reason, with appropriate detail, to insureds when claims were processed. *See e.g., Trujillo, et al. v. UnitedHealth Group, Inc., et al.*, 2019 U.S. Dist. LEXIS 21927, at *2 (C.D. Cal. Feb. 4, 2019) (insurers must establish reasonable claims procedures and provide adequate notice of adverse benefit determinations); *see also* 29 U.S.C. 1133(1). In practice, UHC did not convey any such reasons. UHC did not, and could not, determine "availability," so as to allow it to deny an OON CLS claim on that ground, as demonstrated by the unrefuted evidence. (*See* Mot. at Section III.B). UHC circumvented the inquiry with its policy (*see* Mot. at Section III.C) and now seeks to avoid class

[11] *See* Plaintiffs' Motion at Section III.B, UHC knowingly put insureds into the proverbial Catch 22: tell its members they could only receive the ACA benefit for CLS by using in-network providers, when UHC organizationally did not know which of its in-network providers would and did render CLS, and UHC did not identify any such in-network providers.

certification (and liability) based on a fictional "availability" requirement.

H. Definition of the Classes

Contrary to UHC's Opposition (Opp. at 20), the inclusion of persons who never submitted claims is not an expansion of the Classes. Plaintiffs have always asserted that UHC's policies deterred the submission of OON CLS claims, and inclusion of such persons in the Classes is not difficult. *See* Mot. at 15 and fn. 13; *see also Kumar v. Salov N. Am. Corp.*, 2016 U.S. Dist. LEXIS 92374, at *6 (N.D. Cal. July 15, 2016) (finding class members ascertainable despite defendant's arguments that class members would have to self-identify and show "what they paid, where they purchased it, and how many times, plus whether they saw and were deceived" by a product's label). In their SAC, Plaintiffs' ACA Class included "[a]ll persons who…are or were participants in or beneficiaries of [ ] health plan[s]…administered by Defendants [ ], who did not receive full coverage and/or reimbursement for [CLS]." (Dkt. No. 78, at 60.) Similarly, Plaintiffs' Lactation Services Class included "[a]ll participants and beneficiaries in one or more of the ERISA employee health benefit plans administered by Defendants [ ] for which Defendants fail and refuse to provide payment or reimbursement for [CLS] without cost to such participants and beneficiaries." *Id*. The definitions expressly include all persons whose CLS claim was not covered, regardless of whether their claims were submitted.

Likewise, UHC's argument (*see* Opp. at 11, Section II.G) fails to the extent it relies on variance in the contours of the Classes between the operative complaint and class motion. *See e.g,. Brown v. Hain Celestial Group, Inc.*, 2014 U.S. Dist. LEXIS 162038, at *17 (N.D. Cal. Nov. 18, 2014) ("Courts, including those in the Ninth Circuit regularly allow class definitions to be adjusted over the course of a lawsuit."); *Sandoval v. Cnty of Sonoma*, 2015 U.S. Dist. LEXIS 55571, at *4 (N.D. Cal. Apr. 27, 2015) (allowing plaintiffs to seek class certification of a narrowed putative class without needing to amend the complaint).

I. The Claims Review Class and the Remark Codes

UHC again asserts that the remark codes "provide information to members in accordance with industry-standard language and initiate a dialogue…" (Opp. at 9-10, 21-22, 23.) The Court has already held that the four Remark Codes were "written in a way that made [the denials] virtually

impossible to understand." (SJ Order at 5-6.) Specifically, the Court stated that "[w]hen denying a claim for benefits, the defendants are required under ERISA to 'provide adequate notice . . . setting forth the specific reasons for such denial.' 29 U.S.C. § 1133; *see also* 29 C.F.R. § 2560.503-1(g)." (SJ Order at 5.) It is not enough for Remark Codes to give a patient a general idea that there is something wrong with their claim, ERISA specifically requires that participants and beneficiaries be informed in writing of the ***precise*** reasons for their claim denials and a reasonable opportunity for a "full and fair review" of those denials. *See Booton v. Lockheed Med. Ben. Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997) ("If benefits are denied in whole or in part, the reason for the denial must be stated in reasonably clear language, with specific reference to the plan provisions that form the basis for the denial…There is nothing extraordinary about this; it's how civilized people communicate with each other regarding important matters."); *see also Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 680 (9th Cir. 2011) (an "administrator does not do its duty under [ERISA] by saying merely 'we are not persuaded' or 'your evidence is insufficient'"). UHC's use of remark codes was uniformly deficient, individual inquiry into events subsequent to the issuance of the deficient remark codes is irrelevant.[12]

Finally, UHC's "diverse financial impact" argument with respect to the Claims Review Class is unavailing at the Class certification stage and ignores the uniform relief of reprocessing sought in this action. (Opp. at 9-10.)

III. STANDING

UHC concedes that the involvement of Ms. Harris cures any issue of Article III standing with respect to prospective relief for the ERISA Class. (*See* Opp. at 4, 23.) As her filings state, Ms. Harris is currently insured by UHC, and UHC applied cost-sharing to both of her OON CLS claims. Ms. Harris has standing to seek prospective relief. (*cf.* CC Order at 4-5).

[12] The cases cited by Defendants are inapposite, as neither involves remark codes and the adequacy of the claim denials are not at issue. *Coleman v. Am. Int'l Grp., Inc.*, 87 F. Supp. 3d 1250, 1260 (N.D. Cal. 2015) (the insurance company repeatedly notified the insured that she needed to provide specific evidence that her physical ailments were disabling and preventing her from working to which the insured responded that she "understood the need to show that she was physically disabled."); *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1039 (9th Cir. 2006) (holding that a plan's failure to inform a claimant that the claim had been finally denied did not preclude the running of the ERISA statutory limitation to bring suit).

Further, contrary to UHC's position, Plaintiffs have standing to seek an order remedying UHC's past violations. (*See* CC Order at 5.) UHC does not challenge that courts certify classes awarding the precise relief sought here. *See Trujillo*, 2019 U.S. Dist. LEXIS 21927 at *9-10; *Des Roches v. Cal. Physicians' Serv.*, 320 F.R.D. 486, 508 (N.D. Cal. 2017); *Saffle*, 85 F.3d at 456 (an ERISA Plan participant or beneficiary may bring a claim for arbitrary and capricious denial of benefits based on an injury other than the actual denial if the process by which a coverage determination was made was defective); *Ballas*, 2013 U.S. Dist. LEXIS 199523 at *35-39 (certification appropriate based on a requested injunction requiring the defendant to reprocess class members' claims under a different policy). Plaintiffs have (1) alleged an injury in fact, in the form of a deprivation of the health insurance benefits to which they allege they were entitled; namely, the consideration of their OON CLS claims as eligible for the ACA-mandated preventive care coverage; (2) there is a causal connection between their injury and the conduct complained of; namely, UHC's Policy that OON preventive care services are not part of the ACA requirements; and (3) it is likely, as opposed to merely speculative, that this injury will be redressed by the order Plaintiffs seek. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992) (internal quotation marks omitted). Finally, in certifying a class under Rule 23(b)(1) and 23(b)(2), the court in *Wit v. United Behavioral Health*, 317 F.R.D. 106, 132 (N.D. Cal. 2016), rejected the defendant's argument that because some of the named plaintiffs are no longer members of its insurance plans, they do not have standing to seek injunctive or declaratory relief.

IV. RULE 23(b) IS SATISFIED

UHC's argument that Plaintiffs have not satisfied the prerequisites of Rule 23(b) is unpersuasive. (*See* Opp. at 23-25.) Plaintiffs could not have been clearer that they seek relief under (b)(1) and (b)(2) and do not seek monetary damages. Plaintiffs outlined the proposed relief in their Motion.[13] (*See* Mot. at Section V, 11-14.)

Disregarding case law from this Circuit and citing back to the individualized issues addressed

[13] "[P]laintiffs are not 'required to come forward with an injunction that satisfies Rule 65(d) with exacting precision at the class certification stage.'" *Wit*, 317 F.R.D. at 138 (quoting *Parsons v. Ryan*, 289 F.R.D. 513, 524 (D. Ariz. 2013), aff'd, 754 F.3d 657 (9th Cir. 2014)).

supra and in Plaintiffs' Motion, UHC cites to a Seventh Circuit opinion, *Kartman v. State Farm Mut. Auto. Ins. Co.*, 634 F.3d 883 (7th Cir. 2011).[14] *Kartman*, however, is distinguishable in several material respects. In *Kartman*, the Seventh Circuit, addressed the merits of plaintiffs' claim rather than Rule 23 issues and determined that Indiana law did create a duty for insurers to examine all hail-damaged roofs pursuant to an identified uniform standard, and that State Farm had an ad hoc method for determining coverage for hail-damaged roofs. 634 F.3d at 889-91.[15] The court in *Wit* highlighted that distinction, stating that "[t]he situation here differs from *Kartman* in that Plaintiffs are asserting claims to obtain injunctive relief based on an injury that is distinct from the actual denial of benefits and that is cognizable under ERISA…" 317 F.R.D. at 138.[16] Also, as noted *supra*, contrary to UHC's claim, Plaintiffs are seeking the usual remedy sought in analogous cases.[17]

V. CONCLUSION

Based on the foregoing and Plaintiffs' Motion and opening Memorandum, Plaintiffs respectfully request that the Court certify the Classes as defined in their Motion, under Federal Rules of Civil Procedure 23(b)(1) and (b)(2), or, in the alternative, Rule 23(c)(4).

Dated: November 7, 2019

CHIMICLES SCHWARTZ KRINER & DONALDSON-SMITH LLP

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[14] UHC also relies on *Kartman* in asserting that certification under (c)(4) is not proper as to the ERISA and Non-ERISA Plan Classes. In *Kartman*, (c)(4) certification was not sought (634 F.3d at 886), and as discussed, material factual and legal distinctions exist between *Kartman* and Plaintiffs' claims. Also, unlike here, in *Kartman* the "particular standard State Farm used to evaluate policyholders' hail damage ***is <u>not</u> an element of any case presented by these plaintiffs*** for final injunctive relief", which fact would not favor (c)(4) certification. (*Id.*) (emphasis added). Notably, the *Kartman* court did state that "[i]n some circumstances, the applicable standard of care might be a proper separable issue." (*Id.*)

[15] *Cf., N.B. v. Hamos*, 26 F. Supp. 3d 756, 774 (N.D. Ill. 2014) (where plaintiffs' claims would require policy modifications and such policy changes were generally applicable, and therefore would benefit all class members, certification under 23(b)(2) was appropriate).

[16] *C.f., Breedlove v. Tele-Trip Co.*, 1993 U.S. Dist. LEXIS 10278, at *25-26 (N.D. Ill. July 26, 1993) ("Several cases hold that certification of an ERISA claim is proper under Rule 23(b)(2) where monetary relief, in conjunction with injunctive relief, is sought.").

[17] *Morgan v. Laborers Pension Trust Fund*, 81 F.R.D. 669, 681 (N.D. Cal. 1979) ("Courts are not precluded from certifying a class under [] 23(b) merely because plaintiffs have included a request for monetary damages in their complaint."); *Des Roches*, 320 F.R.D. at 509-10 (Plaintiffs' requested reprocessing injunction meets the requirements of Rule 23(b)(2). Such injunction would apply to the class as a whole and would not require the court to engage in individual determinations of class members' claims.).

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I hereby certify that on November 7, 2019, I served the foregoing **PLAINTIFFS' AND INTERVENOR PLAINTIFF'S REPLY BRIEF IN FURTHER SUPPORT OF MOTION FOR CLASS CERTIFICATION** on the following counsel of record via email:

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