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

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

PLAINTIFFS' REPLY MEMORANDUM OF LAW IN FURTHER SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

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I. INTRODUCTION

Defendant Health Care Service Corporation's ("HCSC") Opposition (Dkt. 163, "Opp." at 1) ignores that Plaintiffs' renewed Motion (Dkt. 143) and Memorandum in Support (Dkt. 145, 148, "Memo") specifically address each issue raised in the Court's 1/21/2020 Order re: Class Certification ("CC Order, Dkt. 138).[1] HCSC's posturing does not alter the fact that Plaintiffs did not simply refile their prior Class Certification Motion.

Plaintiffs' renewed motion seeks certification pursuant to Rule 23(a), (b)(1) and (b)(2), not (b)(3), of narrowed Classes and sub-Classes. *See* Motion, and Memo at 2, Section III. The Class members are limited to: HCSC insureds who submitted claims for out-of-network comprehensive breastfeeding and lactation support services ("CLS") but whose claims were denied or had cost-sharing imposed (*c.f.* CC Order at 12); and, HCSC insureds who submitted claims for in-network CLS that did not include one of the procedure codes from HCSC's policies and were denied or had cost-sharing imposed (*c.f. id.* at 10). The narrowed Classes involve common issues, proof, and injury, each of which is directly tied to the ACA's mandate and to HCSC's written policy on ACA-mandated preventive care coverage. Furthermore, contrary to HCSC's argument, Plaintiffs have articulated the precise, targeted relief to which they are entitled, *see* Memo at Section III, which is based on a finding that HCSC's policy violated the ACA.

HCSC persists in its wrong, self-serving characterizations of the ACA, its conduct, and Plaintiffs' claims. HCSC's tactic, however, is unpersuasive. It fails to alter the fact that the ACA requires coverage of preventive services by health plans, and that, throughout the Class Period, HCSC's challenged policy applicable to each Class member has been that out-of-network CLS

[1] Exhibits referenced herein are attached to: (a) the Donaldson-Smith Declaration [Dkt. 146-147, 149, "Decl. Ex."]; and, (b) HCSC's Appendix [Dkt. 161-162, 164-165, "HCSC App."].

claims are not covered. HCSC chose to operate its health plan under a defective policy that fails to provide coverage for out-of-network claims and the full scope of CLS, which contravenes the ACA's coverage mandate and puts the onus of trying to secure cost-share-free coverage on the insured. The determination of whether HCSC's policy complies with the ACA necessarily applies to each Class member throughout the Class Period.

Moreover, throughout its Opposition, including with respect to its commonality challenge (Opp. at 1, 11-13, 15-19, 22-23), HCSC spills much ink relying on decisions from *Condry, et al., v. UnitedHealth Group Inc., et al.,* and *York, et al., v. Wellmark, Inc., et al.* Those decisions are not new. HCSC already provided those decisions to the Court prior to the issuance of its CC Order. Also, those decisions are not applicable to the facts here nor support the result HCSC urges.

Further, as it did in its prior opposition, HCSC points to irrelevant and unsupported merits arguments and conjecture about breastfeeding mothers' conduct and relies on the existence of its own administrative barriers to claim that certification is precluded (a perverse result, indeed, if countenanced). In reality, though, each Class member received CLS, but was subjected to and had her claim adjudicated by HCSC under a facially wrong, express policy that only in-network CLS claims were covered and pursuant to HCSC's failure to establish procedures and infrastructure to provide the ACA-mandated CLS coverage.

At bottom, HCSC does not refute the facts that are relevant to class certification: the existence of the CLS policies; the substance and applicability of those policies to all members of the Classes and their CLS claims; and, that HCSC denied and imposed cost-sharing on CLS claims. HCSC has not rebutted Plaintiffs' argument that the determination of whether HCSC's CLS policies violate the ACA can and must be determined on a classwide basis. Plaintiffs have demonstrated that certification of the Classes is proper under Rule 23.

II. REPLY ARGUMENTS

A. HCSC Has A Uniform CLS Policy That Applies to Each Class Member

HCSC's Opposition rests on a false premise: that there is no uniform policy. *See, e.g.* Opp. at 15. The fact is, however, since 2012 HCSC has had a written policy governing each class member's health plan and her CLS claims. Throughout the Class Period, HSCS's CLS policy was set forth in its "[redacted]", which stated that [redacted] Decl. Ex. 19 at 1-2. As of July 2017, the CLS policy was set forth in HCSC's "[redacted]", which states, [redacted] *See*, Decl. Ex. 20 at 1, 17. HCSC cannot dispute the existence, content and applicability to the Plaintiffs' claims of the challenged policies.

B. The ACA Mandates Preventive Care Coverage of CLS

HCSC misstates the ACA's directive. The ACA did not state that "health plans [ ] cover ***in-network*** preventive lactation support and counseling services without cost-shares…" nor "allow health plans to impose cost-shares on, or deny coverage for, out-of-network services so long as the member had a network provider available." Opp. at 1 (emphasis added). Rather, the ACA mandates coverage of preventive services by health plans; the express language of the ACA states 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. HCSC's recasting of

the ACA defies the plain language of the ACA and seeks to skirt fundamental responsibilities of health insurance coverage, to shift both financially and structurally HCSC's coverage responsibilities for CLS onto the insured. It is undisputed that throughout the Class Period HCSC's written policy has been, and remains, that out-of-network CLS claims are not covered unless "you go to a trained, network provider" and submit a bill that reflects one HCSC's limited procedure codes. The determination of whether such policy complies with the ACA applies to each member of the Classes throughout the Class Period. There is no evidence that HCSC deployed an ACA-compliant policy or applied a different policy than the foregoing policies to each class member.

Relatedly, HCSC tries to distract from the existence of its policy and its failure to provide preventive care "coverage" for CLS, by changing the proposed narrative to what was paid. There is, of course, an important distinction between "Payment" and "Coverage". A purported payment does not equate to ACA-compliant coverage, nor does payment transform illegal CLS policies and conduct into ACA-compliant policies and conduct. Furthermore, notwithstanding HCSC's argument, its position is unpersuasive and factually unsupported; the CLS claims were not paid in full. Plaintiffs' analyses of the CLS claims data revealed that HCSC [redacted].[2] *See* Memo at 8-9, and footnote 15.

C. HCSC Misstates The Class Members' and Plaintiffs' Experiences

HCSC does not, and cannot, contend that the Plaintiffs and their CLS claims were subject to differing policies from those of the members of the Classes. *C.f.* Opp. at 9-10. HCSC aims to avoid scrutiny of its non-compliance by broadly arguing that HCSC's liability pivots on the

[2] HCSC's employee reached the same conclusions: [redacted] HCSC App. Q, Bourgeois Decl. ¶¶ 6, 7, 9.

individualized knowledge or conduct of each Plaintiff or insured. That proposition is unfounded. It is HCSC's policy and conduct at issue. HCSC did not identify any of the Plaintiffs' providers or facilities, or any other network provider of CLS to insureds. As the Plaintiffs and any other class member would have encountered, no network CLS providers were located through HCSC because HCSC had [redacted] (Decl. Ex. 16, Benner at 2; Memo at 8). HCSC admitted that all insureds [redacted]" Decl. Ex. 16, Benner at 1(b). And, as discussed *supra*, HCSC's policy was that only in-network CLS claims would be eligible for ACA-preventive care coverage.

HCSC's passing argument, HCSC Opp. at 23, about Plaintiffs Briscoe and Magierski is incorrect; both exhausted their administrative remedies. Briscoe testified that [redacted] HCSC App. R at 136:9-139:8; Decl Ex. 7, Briscoe Rog. 8 at 14-15. Similarly, Magierski testified that she appealed [redacted] HCSC App. S at 96:18-100:15; Decl Ex. 8, Magierski Rog. 8 at 14-15. Second, exhaustion of remedies is futile when claim denials are based on an established policy. *See Stanek v. AT&T*, 1997 U.S. Dist. LEXIS 3716, at *17-18 (N.D. Ill. Mar. 27, 1997).

HCSC argues (Opp. at 4) that members seek CLS based on their personal preference. First, there are two wholly separate, basic events: the selection of a provider and the identification of

providers that are in-network whose services will be covered by insurance.[3] In the context of the ACA preventive care mandate, an insurer's identification of in-network providers is critical to insureds being able to either (i) access the no-cost benefit from such in-network providers, or, (ii) be informed that their out-of-network CLS claims should be submitted to the insurer and covered without cost-sharing. [redacted]. Decl. Ex. 26 at HCSC_0097040-41. Likewise, HCSC's arguments (Opp. at 8) about any requirement for individual medical record review does not preclude certification. The resolution of liability is directed at HCSC's, not the insureds', conduct.

HCSC did not adjudicate CLS claims based on whether in-network services were unavailable to claimants. HCSC did not inform insureds that claims were denied or had cost-sharing applied because HCSC identified available in-network providers. HCSC did not ask the insureds to demonstrate that they did not have an in-network CLS provider available before denying a claim or imposing cost-sharing. HCSC could not point to specific in-network CLS providers as the reason for denying claims. HCSC's CLS policies were not based on member specific circumstances. Rather, HCSC established its policies that applied to all class members and their CLS claims. Those policies must be addressed, and remedied, class-wide.

D. HCSC Raises Merits Arguments

HCSC again raises merits arguments in defense of its challenged policies and conduct. *See*

[3] Contrary to HCSC's argument, [redacted]

Opp. at Section II.[4] HCSC seeks to have the Court at the class certification stage legitimize the very policies and conduct that are at issue. As Plaintiffs' Memo discussed, Plaintiffs' experiences are consistent with what Plaintiffs uncovered in discovery as the systemic, egregious consequences flowing from HCSC's policy that out-of-network claims and claims without HCSC's enumerated Procedure Codes were not eligible for cost-share-free CLS coverage. *See* Memo at Section II.

i. What Constitutes CLS

HCSC contends (Opp. at 4) that the ACA and HRSA do not elaborate on what constitutes CLS, and it therefore has discretion on how to implement the CLS benefit (citing to 29 C.F.R. § 2590.715-2713(a)(4)). That is a merits argument. Even if relevant, its resolution applies classwide; it would go to the illegality of HCSC's CLS coverage policies applicable to all members of the Classes and the treatment of their 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* Memo at Section II.A. 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"***. HCSC's after-the-fact attempt to argue that its CLS policies were appropriately limited in scope is a merits argument.[5]

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[4] In conducting the Rule 23 analysis, "the court should not turn the class certification proceedings into a dress rehearsal for the trial on the merits." *Messner v. Northshore Univ. HealthSystem,* 669 F.3d 802, 811 (7th Cir. 2012). As the Court held,"[a]t summary judgment, the parties can address the precise legal contours of the ACA's coverage requirements." (12/4/17 Order, Dkt. 50, at 13).

[5] HCSC's litigation arguments, like its conduct during the Class Period, 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***". Decl. Ex. 1, 75 FR 41726 at 41730, Table 1, and at 41731 (emphasis added).

ii. Network of CLS Providers

HCSC argues (Opp. at 5-6) that it has "established a network of providers." HCSC's Opposition asserts (as HCSC did in its motion to dismiss filings) that it has thousands of in-network providers of lactation services. *Id.* at 5. HCSC does not have thousands of trained CLS providers. HCSC has never identified by name every provider in its network since August 1, 2012 who it contends offered or offers in-network CLS. Instead, HCSC now cites to the declarations and deposition testimony it propounded from hospitals and their designees, *see* Opp. at fn. 4. Critically, HCSC never demonstrates that these facilities and providers were identified by HCSC to insureds by name (provider or facility name) as network CLS providers. HCSC is simply relying on hospitals and the in-hospital breastfeeding services offered primarily at the time of delivery. Also, the testimony of the hospital designees undermines HCSC's characterizations about its CLS coverage, its claimed "established" "network", and insureds' ability to know about and access all CLS at no-cost from providers.[6] HCSC also ignores the fact that the circularity and futility of HCSC's stance about having thousands of unidentified network providers was, during the Class

[6] ***See,* HCSC App. G: Delay Tr.** at 38:12-39:13, Of the four St. John's locations, only one provides breastfeeding support services; *Id.* at 127:19-128:14, 164:8-12, Pamphlets and materials advertising St. John's breastfeeding support services are not publicly available; not accessible by mothers who don't deliver at St. John's. ***See,* HCSC App. J: McConville Tr.** at 29:25-30:8, Benefis only has 1 IBCLC on staff per day; *Id.* at 93:16-94:7, Benefis' informational brochures about the breastfeeding support services it offers are not available on its website. ***See,* HCSC App. F: Deschamps Tr**. at 74:17-76:9, Community Medical Center (CMS) only has 2 IBCLC's on staff to meet all of the hospital's breastfeeding counseling needs; *Id.* at 100:1-13, CMS's IBCLC's have an enormous workload, seeing 40 patients per week; ***See* HCSC App. I: Chamblin Tr.** at 57:16-18, DuPage does not offer in-home consultations; *Id.* at 60:3-5, DuPage does not offer post-discharge breastfeeding classes; *Id.* at 59:13-16, HCSC's Provider Finder does not list DuPage's IBCLCs; *Id.* at 68:19-69:2, Chamblin does not know how BCBSIL insureds can identify that she provides breastfeeding support services on provider finder. ***See,* HCSC App. K: Meadows Tr.** at 116:14-16, Methodist does not offer in-home consultations; *Id.* at 111:13-22, Methodist's pamphlets informing mothers about services are only distributed within the hospital; and, *Id.* at 112:5-8, Methodist's designee testified that the only way for mothers to access its informational pamphlets is by visiting one of its facilities. ***See* HCSC App. H: Houchins Tr.** at 93:15-20, Northwest's support group started in 2017; *Id.* at 96:7-10, Northwest does not offer in-home consultations.

Period, [redacted][7]

iii. Waiver or After-the-Fact Appeals Processes

HCSC relies on its purported "waiver" and after-the-fact processes (appeals and claims adjustment processes) insureds are supposed to use. Opp. at 2, 6, 18, 24, and fn. 12. HCSC is asking the Court to ignore facts and reality. *First*, such position flies in the face of the ACA preventive care mandate; among other things, it discourages insureds from seeking out the preventive service by imposing the financial barrier that was to be removed. HCSC's stance exemplifies why its policies must be addressed for all insureds, retrospectively and prospectively, classwide. *Second*, HCSC's employee, [redacted]. *See* HCSC App. M at ¶8.[8] *Third*, HCSC's position is that care is available from network providers. Therefore, its suggestion that insureds can secure a waiver, or even a successful appeal or adjustment is pointless and futile. *Fourth*, HCSC's Opposition at 6 references the information its CSRs provide to insureds (*i.e.* to go back to their primary care providers) and to the [redacted]. HCSC ignores that insureds are looking to identify and obtain services from *in-network* providers, as HCSC directs. And, it ignores that the fundamental role of an insurer is

[7] As [redacted] *See* Decl Ex. 26 at HCSC_0097043.

[8] Ms. Cress [redacted]

to identify its in-network providers from whom insureds can secure services, which is particularly critical to the purpose and implementation of the ACA preventive care mandate.

E. HCSC Seeks a Legally Erroneous Application of Rule 23

Aside from HCSC's arguments about "individualized issues" being factually unfounded, HCSC's assertion that its liability cannot be determined with common proof is unsupported. Opp. at 14-22. *See A.F. v. Providence Health Plan*, 300 F.R.D. 474, 477, 481 (D. Or. 2013) (certifying a class of persons who were denied treatment based on a plan exclusion of a particular treatment for autism because, among other reasons, "all class members have in common the issue of whether the [exclusion] violates state or federal law").

What HCSC improperly seeks is to have the Court conflate the challenged conduct – the policy- with the conduct's consequences. *See, e.g., Keegan v. Am. Honda Corp.* 284 F.R.D. 504, 530 (C.D. Cal. 2012) ("defendants repeatedly 'confuse[ ] the defect at issue . . . with the consequences of that defect'…The Ninth Circuit disfavors this type of mingling of issues, and requires that courts accept plaintiffs' theory of relief as it is stated."). HCSC's Opposition is replete with argument and references to the consequences of HCSC's policy (*e.g.* that some persons may have had CLS paid for by HCSC and HCSC's after-the-fact conduct in responding to insureds and HCSC's ultimate treatment of their submitted claims).

Plaintiffs' legal theory is grounded on HCSC's policy. HCSC's strategy to try to reframe the issues for the purpose of opposing certification is often deployed by defendants in opposition to class certification, and rejected. As Judge Gettlemen did in *Lacy v. Dart*, No. 14 C 6259, 2015 U.S. Dist. LEXIS 56625, at *10-14 (N.D. Ill. Apr. 30, 2015), the Court should reject HCSC's typicality and commonality arguments that are based on feigned arguments about individual evaluations. As the court in *Lacy* explained:

> Plaintiffs and the putative class allege that courthouse ramps, holding cells, and transport vans are not compliant with the ADA and Rehabilitation Act and that defendants have not provided adequate accommodations to overcome this non-compliance. Because plaintiffs, along with prospective class members, each use a wheelchair and attend court in at least one of the six courthouses at issue, they experience the same structural barriers and accommodations defendants allegedly provide. As such, plaintiffs' claims arise from the same events and course of conduct that gives rise to the claims of the other class members, and are based on the same legal theories.
>
> As discussed previously, the putative class members are already identified as qualified for protection under the ADA because they are regarded as disabled or have a history of impairment. Defendants' argument that plaintiffs must show that they are qualified to make use of the "services, programs and activities in question" is nonsensical, because plaintiffs have a constitutional right to attend their court proceedings.

Id. at *13-14. The court then concluded: "Plaintiffs' claims do not require an individual evaluation of plaintiffs' disabilities or the accommodations allegedly provided, ***but rather ask the court to determine whether courthouse facilities and defendants' actions comply with federal statutes***." *Id.* at *14 (emphasis added). The court's sound approach and rationale in *Lacy* applies equally here to Plaintiffs' claims and readily dispenses with HCSC's arguments. *See also, McReynolds v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 672 F.3d 482, 488-91 (7th Cir. 2012) (finding commonality despite the fact that defendant's policies were carried out in different offices, by different managers, and an individualized determination as to which class members were actually adversely effected would still be required); *Dunn v. City of Chicago*, 231 F.R.D. 367, 372 (N.D. Ill. 2005)("[t]he variations identified by defendant in the actual treatment of certain detainees . . . do not eliminate the common nucleus of fact.").

Likewise, the Ninth Circuit recently considered and rejected a similar tactic espoused by Nissan in opposing class certification and reversed the district court's denial of class certification on such grounds. In *Huu Nguyen v. Nissan N. Am., Inc.*, 932 F.3d 811, 819 (9th Cir. 2019), the Ninth Circuit held that "Nissan and the district court mischaracterized Plaintiff's theory as being centered on performance issues, rather than the defective system itself." The Ninth Circuit also

noted that the plaintiff argued "under [his] theory, the *defect* exists—and must be remedied—whether or not the *symptoms* have manifested yet." *Id.* at 822.

This Action is grounded in HCSC's wrong, non-ACA compliant policy that applied to each member of the Classes and is based on the ACA's mandate which must be established and applied uniformly and correctly to each HCSC insured requiring Rule 23 certification. *See Sherman v. Township High School District 214*, 540 F. Supp. 2d 985, 993 (N.D. Ill. 2008) (certifying class under 23(b)(1)(A) because injunctive relief requested regarding constitutionality of application of state law needed to be affected statewide to avoid incompatible standards across school districts); *Chi. Teachers Union, Local No. 1 v. Bd. of Educ.*, 797 F.3d 426, 441 (7th Cir. 2015)(Certification under Rule 23(b)(2) requires that "the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole."). *See* Plaintiffs' Memo at Section III and IV.

F. HCSC's Reliance on Condry is Misplaced and Unpersuasive

HCSC's legal argument relies heavily on decisions from *Condry, et al., v. UnitedHealth Group Inc., et al.*, and *York, et al., v. Wellmark, Inc., et al.* *See* Opp. at 1, 11-13, 15-19, 22-23. Those are not new decisions and HCSC provided them to the Court in connection with its opposition to Plaintiffs' initial Motion for Class Certification, including as supplemental authority, *see* Dkt. 131 filed on December 30, 2019 prior to the Court's issuance of the CC Order. Moreover, HCSC's propositions sought to be applied in this Action are not supported by those decisions.[9]

[9] HCSC's Opp. at fn. 20, also cites to the settlement in *Ferrer v. CareFirst, Inc.*, Case No. 1:16-cv-02162 (D.DC) for the proposition that HCSC's "current" list of CLS codes is similar to CareFirst's CLS codes. HCSC is incorrect. First, it was only beginning in July 2017, over six months after this Action was filed, that HCSC added some of the referenced codes. Second, unlike CareFirst's policy which provides that "non-physician providers may bill the [codes]" (HCSC App. X, Dkt. 30-1, at 90-104), HCSC's policy is [redacted] (Decl. Ex. 14, Janulis at 6). Thus, except for the code

Fundamentally, unlike UnitedHealth and Wellmark, HCSC did not seek pre-class certification summary judgment as to any of the individual plaintiffs. Now, HCSC tries to improperly bootstrap those proceedings (involving different cases, plaintiffs, and insureds) here. Substantively, HCSC is wrong that those decisions support the presence of "individualized issues". The *Condry* summary judgment order affirmed that, with respect to the ACA's "requirement that health insurers provide coverage" for CLS, it requires providing meaningful access by insurers, "[i]llusory or de minimus access is not sufficient…." *Condry*, No. 17-cv-00183, 2018 U.S. Dist. LEXIS 111233, at *4 (N.D. Cal. June 27, 2018). Also, in *Condry*, United's provider directory actually identified an in-network provider by name and specifically as a "lactation specialist" who was proximate to two plaintiffs, both of whom resided in the San Francisco-area; that circumstance (not present here) was relied on by the *Condry* court in issuing the summary judgment opinion as to those two plaintiffs. *Id.* at *8-9.

Further, the class certification decision in *Condry v. Unitedhealth Grp., Inc.*, No. 17-cv-00183-VC, 2019 U.S. Dist. LEXIS 220287 (N.D. Cal. Dec. 23, 2019) ("*Condry* CC Order") did not (erroneously so) address United Healthcare's express written policy that out-of-network lactation claims were not eligible for the ACA-mandated coverage. *See id.* at * 7-8 (ignoring United's policy and erroneously discussing the consequences of United's failure to have an ACA-compliant polices and coverage for CLS).

Next, HCSC's reliance on *Condry* CC Order's statements about the percentage of paid lactation claims is misplaced and in contravention of fundamental class certification principles. *See e.g., Pella Corp. v. Saltzman*, 606 F.3d 391, 394 (7th Cir. 2010) (holding that the possibility

[redacted] *See* HCSC App. C (HCSC Rebuttal Report at ¶43). This alone is a material difference between the two lists.

of including people who have not been injured by defendant's conduct does not preclude class certification "because at the outset of the case many members may be unknown, or the facts bearing on their claims may be unknown"); *Wolin v. Jaguar Land Rover N. Am., LLC*, 617 F.3d 1168, 1173 (9th Cir. 2010) (rejecting the notion that individual manifestations of a defect precluded resolution of the claims on a class-wide basis). In *Wolin*, the Ninth Circuit concluded that the district court "erred when it concluded . . .that certification is inappropriate because [plaintiffs] did not prove that the defect manifested in a majority of the class's vehicles. . . ." *Wolin*, 617 F.3d at 1173. *See also*, Section II.E, *supra.*

Finally, contrary to HCSC's standing arguments (Opp. at 23, *citing to Condry*), Plaintiff Magierski, who is and has been at all relevant times insured under an HCSC health plan subject to the ACA's preventive services requirements, has Article III standing to seek injunctive relief.[10] *See* Dkt. 57, HCSC Answer, at ¶110. Indeed, Plaintiff Magierski testified about the ongoing impact of HCSC's non-compliant lactation policy, [redacted] *See* HCSC App. S, Magierski Tr. at 40:7-43:3.[11]

[10] As of the date that the *Condry* CC Order was issued on Dec. 23, 2019, none of the six named plaintiffs were insured under a health benefit plan administered or underwritten by defendants. But this factual distinction between the two cases is not the principal reason the Court should choose not to follow the *Condry* CC Order with respect to Plaintiffs' standing to seek injunctive relief here. It is repugnant to the notion of a court doing equity, as is being requested here, to conclude that it is helpless to enjoin and impose corrective measures. *Compare Condry* CC Order at *6 ("United Healthcare's misconduct, which appears to be ongoing, would presumably support a classwide claim for prospective relief—specifically, an injunction requiring the company to adopt reforms to better ensure coverage for lactation services in the future") *with Laurent v. PricewaterhouseCoopers LLP*, No. 18-487-cv, 2019 U.S. App. LEXIS 38178, at *3-4 (2d Cir. Dec. 23, 2019) (on appeal the Second Circuit vacated and remanded the district court's holding, finding that "reformation of the plan and the recalculation of benefits in accordance with the reformed plan" is an equitable remedy under ERISA).

[11] In certifying a class Rule 23(b)(1) and (b)(2) class, the court in *Wit v. United Behavioral Health*, 317 F.R.D. 106, 132 (N.D. Cal. 2016), rejected defendant's argument that because some of the named plaintiffs were no longer members of its insurance plans, they do not have standing to seek injunctive or declaratory relief. *See also Ladegaard v. Hard Rock Concrete Cutters, Inc*., No. 00 C 5755, 2000 U.S. Dist. LEXIS

G. Plaintiffs Satisfy 23(b)(1) and (b)(2)

HCSC's response regarding (b)(1) and (b)(2) certification is limited (Opp. at 23-24). HCSC relies on *Kartman v. State Farm Mut. Auto. Ins. Co.*, 634 F. 3d 883 (7th Cir. 2011) (Opp. at 14, 24-25). *Kartman*, however, is distinguishable in several material respects. In *Kartman*, the Seventh Circuit, addressing the merits of the plaintiffs' claim rather than Rule 23 issues, 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. *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). In contrast, the ACA creates an actual, specific duty and statutory requirement directly governing CLS coverage. And, HCSC has, of course, policies specific to CLS preventive care coverage. Also, Plaintiffs are seeking the usual remedy sought in analogous cases. *See Wit*, 317 F.R.D. at 138 ("The 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…").

III. CONCLUSION

Based on the foregoing and Plaintiffs' Opening Brief, Plaintiffs respectfully request that the Court certify the proposed Classes under Rules 23(a), (b)(1) and (b)(2).

DATED: March 17, 2020

17832, at *19 (N.D. Ill. Nov. 30, 2000) (holding that former employee had standing to seek injunctive relief because he possessed the "same interest and suffered the same injury as the other class proposed class members, whether former or current"); *Walker v. Bankers Life & Cas. Co.*, Civil Action No. 06 C 6906, 2007 U.S. Dist. LEXIS 73502, at *17-18 (N.D. Ill. Oct. 1, 2007)(same).

CHIMICLES SCHWARTZ KRINER & DONALDSON-SMITH LLP

By: */s/ Kimberly Donaldson-Smith*
Nicholas E. Chimicles (admitted *pro hac vice*)
Kimberly Donaldson Smith (admitted *pro hac vice*)
Stephanie E. Saunders (admitted *pro hac vice*)
361 W. Lancaster Avenue
Haverford, PA 19041
(610) 642-8500
NEC@Chimicles.com
KMD@Chimicles.com
SES@Chimicles.com

Proposed Class Counsel
Paul D. Malmfeldt, Esq.
BLAU & MALMFELDT
566 West Adams Street, Suite 600
Chicago, Illinois 60661-3632
Phone: (312) 443-1600
Fax: (312) 443-1665

Jonathan W. Cuneo (to seek admission *pro hac vice)*
Pamela B. Gilbert (to seek admission *pro hac vice)*
Monica E. Miller (to seek admission *pro hac vice)*
Katherine Van Dyck (to seek admission *pro hac vice)*
CUNEO GILBERT & LADUCA, LLP
4725 Wisconsin Ave. NW, Suite 200
Washington, DC 20016
Phone: (202) 789-3960
Fax: (202) 789-1813

Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I, Kimberly M. Donaldson Smith, an attorney, hereby certify that on March 17, 2020, I electronically filed a true and correct copy of the foregoing document with the Clerk of the Court using the CM/ECF system. Participants in the case who are registered CM/ECF users will be served by the CM/ECF system.

/s/ Kimberly M. Donaldson-Smith
Kimberly M. Donaldson-Smith