Docket No. 19-15074

In the

United States Court of Appeals

For the

Ninth Circuit

JOHN DOE, One, JOHN DOE, Two, JOHN DOE, Three, JOHN DOE, Four and JOHN DOE, Five, on behalf of themselves and all others similarly situated,

Plaintiffs-Appellants,

v.

CVS PHARMACY, INC., CAREMARK, LLC, CAREMARK CALIFORNIA SPECIALTY PHARMACY, LLC, NATIONAL RAILROAD PASSENGER CORPORATION, dba Amtrak, LOWE'S COMPANIES, INC. and TIME WARNER, INC.,

Defendants-Appellees,

CAREMARK RX, LLC and CVS HEALTH CORPORATION,

Defendants.

Appeal from a Decision of the United States District Court for the Northern District of California, No. 3:18-cv-01031-EMC · Honorable Edward M. Chen

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CORPORATE DISCLOSURE STATEMENT

Warner Media, LLC, successor in interest to Defendant-Appellee Time Warner Inc., makes the following disclosure**:**

Time Warner Inc.'s successor in interest is Warner Media, LLC, a direct wholly-owned subsidiary of AT&T Inc., a publicly traded corporation. AT&T Inc. has no parent company and, to the best of Warner Media, LLC's knowledge, no publicly held company owns ten percent or more of AT&T Inc.'s stock.

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INTRODUCTION

Plaintiffs/Appellants John Does One through Five ("Plaintiffs") appeal from the district court's decision granting a motion to dismiss filed by Defendant-Appellee Warner Media, LLC, as successor in interest to named defendant Time Warner Inc. ("Warner").[1] In their Corrected First Amended Complaint ("Amended Complaint" or "FAC"), Plaintiffs brought four counts against Warner stemming from the fact that, if a plan participant who needs specialty drugs and desires to pay "in network" prices for them under Warner's employee health benefit plan, he or she must obtain them through a Specialty Pharmacy Program operated by a CVS affiliate. Three of the claims against Warner were brought under the Employee Retirement Security Income Act ("ERISA"), as follows: (1) a claim seeking benefits under the plan (Count Five); (2) a claim asserting that Warner did not provide a full and fair review of the claim(s) for benefits (Count Six); and (3) a claim that Warner breached its fiduciary duties (Count Seven). Plaintiffs also asserted a separate count for a declaratory judgment (Count Eight).

The district court properly granted the motion to dismiss all of the claims against Warner, dismissing Count Five and Seven after finding that Plaintiffs could not prevail on a claim for benefits because the "benefit" they sought (the ability to

[1] Although Warner Media, LLC, is the correct party, Appellants have not substituted Warner Media, LLC in lieu of Time Warner Inc. This brief therefore will use "Warner" to refer to Warner Media, LLC, as successor in interest to Time Warner Inc.

"opt out" of the Specialty Pharmacy Program and obtain specialty drugs at in-network prices from a pharmacist of their choice) was not available under the Time Warner Group Health Plan, nor could Plaintiffs have been denied a full and fair review of a claim for a benefit the Plan did not provide. The district court also properly dismissed Count Six, finding that Warner was not acting as a fiduciary when it engaged in the sponsor activity of designing its health plan and therefore could not be liable for a breach of fiduciary duty or co-fiduciary liability. Further, because Plaintiffs had no valid claims for relief against Warner, the court correctly dismissed Count Eight seeking declaratory relief.

On appeal, Plaintiffs do not address any of the grounds on which the district court granted Warner's motion to dismiss. They do not appeal the district court's decision on three of the counts (Counts Six, Seven, and Eight), thereby abandoning those claims. They also do not challenge the district court's decision to grant the motion to dismiss without leave to amend. As to the remaining claim (Count Five), Plaintiffs make an entirely new argument concerning plan amendment that was never alleged in their Amended Complaint or even raised in opposition to the motion to dismiss. This Court should not consider Plaintiffs' new and unpreserved argument, and the district court's decision dismissing, with prejudice, all of the claims against Warner should be affirmed.

JURISDICTIONAL STATEMENT

The district court and this Court have jurisdiction over the federal claims asserted against Warner pursuant to Sections 502(e) and (f) of ERISA, 29 U.S.C. §§ 1132(e) and (f), and 28 U.S.C. § 1331. No state law claims were asserted against Warner.

Warner agrees with the statements of Plaintiffs regarding the finality of the order appealed from and other procedural matters.

ISSUES PRESENTED

I. Whether Plaintiffs, who fail to make any arguments on appeal directed to the district court's decision on Counts Six, Seven and Eight, have abandoned those counts on appeal?

II. Whether the district court's dismissal of the claims against Warner should be upheld on the grounds that the only argument made by Plaintiffs on appeal is unpreserved because it was neither properly raised in opposition to the motion to dismiss nor alleged in Plaintiffs' Amended Complaint, and should not be considered by this Court?

III. Whether the district court correctly determined that, because Plaintiffs seek benefits that are clearly not provided under the terms of the Time Warner Group Health Plan, Plaintiffs have no viable cause of action under ERISA § 502(a)(1)(B) for benefits allegedly due them?

STATEMENT OF THE CASE

I. The Time Warner Group Health Plan

Appellee Warner sponsors an employee benefit plan, the Time Warner Group Health Plan (the "Time Warner Plan"), for eligible employees and their dependents. (SER[2] 59, 67). The Time Warner Plan is a group welfare benefit plan governed by the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq*. ("ERISA"). A number of different types of health-related benefits are available to eligible employees under the Time Warner Plan, including vision, dental, and medical and prescription drug benefits. (*Id.*) Time Warner (or any successor, such as Warner Media, LLC) has the exclusive right to amend, modify, suspend or terminate the Plan, the medical and prescription drug program, or any coverage option offered under the Plan, in whole or in part, at any time and for any reason. (SER 83-84).

Eligible employees can elect to participate in all, some, or none of the benefits offered under the Time Warner Plan. (SER 59-60). For all of the years mentioned in the Amended Complaint, the Plan offered a choice of medical and prescription drug coverage options, including various Preferred Provider Organization (PPO) options as well as HMO options in particular regions (such as California). (SER 61; also Summary Plan Description ("SPD"), p. 2, SER 100;

[2] For purposes of this brief, "SER" refers to Appellees' Supplemental Excerpts of Record, while "EOR" refers to the initial Excerpts of Record filed by Appellants.

HMO Explanations of Coverage ("EOCs"), pp. 6-7, SER 185-186). The Plan also offered a Health Saving Account ("HSA"), available in connection with the PPO Plus and Health Savings HMO options, which enables participants to make pre-tax contributions to an account that can be used to pay for eligible health care expenses, including medical and prescription drug expenses, that might not otherwise be covered. (SPD, pp. 23-24, SER 121-122).

Although most hospital, surgical, other medical services, and prescription drugs are considered covered expenses under the PPO and HMO options of the Time Warner Plan, certain services and drugs are not covered, or are only partially covered, or are covered only when the participant uses an in-network provider. (SPD, pp. 24, 27-46, SER 122, 124-144; EOCs, pp. 20-60, SER 199-239). Further, some services and drugs are covered only when used for particular conditions and/or if particular procedures are followed (such as, for example, obtaining pre-certification or enrolling in a treatment program). (SPD, pp. 27-46, SER 125-144; EOCs, p. 19, SER 198).

Eligible employees who elect to obtain medical and prescription drug benefits under the Time Warner Plan can choose from among several PPO and HMO options available to them. (SPD, p. 2, SER 100). As is quite common in the health benefits arena, each of the available options includes one or more networks of participating providers for various services (physicians, hospitals, pharmacies,

etc.). (SPD, p. 39, SER 137 (referencing Anthem and CVS/Caremark networks for the PPO options); EOCs, p. 3, SER 182 (describing Kaiser Permanente/Plan providers for HMOs). Plan participants are free to obtain health care services from providers who are not in the network or HMO; however, it is generally advantageous for them to use in-network or HMO providers because it typically results in lower costs to the participant due to reduced rates and/or lower (if any) co-pays and deductibles. (SPD, pp. 2-5, 17-21, 39-44, SER 100-103, 115-119, 137-142; EOCs, p. 7, SER 120).

A CVS affiliate, CaremarkPCS, provided pharmacy benefit management services only for the PPO options under the Time Warner Plan. It did not provide pharmacy benefit management services for the HMO options under the Plan; instead, prescription drug services were offered through the HMO. (SPD, pp. 39-40, SER 137-140; *see also* EOCs, pp. 38-43, SER 217-222).

Beginning in 2016, Plan participants who elected one of the PPO options for which CaremarkPCS was the pharmacy benefit manager and who wanted to receive in-network pricing were required to obtain "specialty medications" through the CVS/Caremark Specialty Pharmacy Program (the "Program"). (FAC, ¶¶ 1, 9-12, EOR 16-17, 19-20; see also SPD, pp. 5, 39-43, 45, SER 103, 137-141, 143). This requirement did not apply to Plan participants who elected one of the HMO options. (SPD, pp. 2, 5, 39-40, SER 100, 103, 137-138).

Specialty medications are those that are often used to treat complex and chronic conditions; they tend to be more expensive and can require special storage (like refrigeration) or special administration (such as through an injection). (FAC, ¶ 94, EOR 48). Many HIV/AIDS medications are classified as "specialty medications" under the Program, as are a large number of other medications that have nothing to do with the treatment of HIV/AIDS. (FAC ¶ 94, EOR 48-71). The Program requirements applied to specialty medications across the board, including specialty medications for conditions such as high cholesterol and allergic rhinitis, not simply those medications used to treat HIV/AIDS. (*Id*.).

Through the Program, a designated specialty pharmacy fills the participant's specialty prescription and either delivers it to the address of the participant's choosing or sends it to a CVS retail pharmacy for pick-up. (FAC ¶ 1, EOR 16-17). One of the Plaintiffs allegedly is a participant in the Time Warner Plan and receives coverage for prescription medicines, including HIV/AIDS medications, through the Plan. (FAC ¶ 17, EOR 22). This Appellant voluntarily chose to enroll in the Time Warner Plan (either as an Eligible Employee or a dependent of one) and voluntarily chose the PPO option under which the CVS/Caremark Program for specialty medication prescriptions was in place.

II. Plaintiffs' Claims Against Warner

Plaintiffs contend that Warner violated ERISA because the Time Warner Plan requires participants to use the CVS/Caremark Program if they (a) elected coverage under the PPO option, (b) needed specialty medications, and (c) desired to pay in-network prices for those specialty drugs. Plaintiffs claim that the Plan illegally forces Plaintiffs either to pick up the specialty drugs at a CVS store, or to have them delivered to their home or workplace, but impermissibly prohibits them from "opting out" of the Program and utilizing their preferred retail pharmacy for obtaining their specialty medications at in-network prices. (FAC ¶ 196, EOR 94).

Although the operative Amended Complaint alleged eight causes of action, only four—Counts Five, Six, Seven, and Eight—were directed at Warner, as follows: (1) an ERISA claim seeking benefits allegedly due under the Time Warner Plan pursuant to ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (Count Five); (2) an ERISA claim for breach of fiduciary duty under 29 U.S.C. § 1132(a)(3) (Count Six); (3) an ERISA claim for failure to provide a "full and fair" review as required by 29 U.S.C. § 1133 (Count Seven); and (4) a claim for declaratory relief under the federal Declaratory Judgment Act (Count Eight). (FAC, EOR 94-103).

III. Procedural History

Plaintiffs commenced this action on February 26, 2018, when Plaintiffs John Does One through Four filed their initial complaint against the CVS Defendants, National Railroad Passenger Corp. d/b/a Amtrak, and Does 1-10 (who purportedly are officers or managing agents of the defendants responsible for supervision and operations of the Program at issue). Warner was not brought into this action until several months later, when it was served with the Amended Complaint in late June 2018. Another Plaintiff, John Doe Five, was added at or around this time, as was another employer/plan sponsor (Lowe's). The Amended Complaint did not specify which of the Plaintiffs allegedly participated in the Time Warner Plan,[3] although it can be ascertained from filings in the case that it was one of the original four named Plaintiffs (all of whom reside in California) and not John Doe Five.[4]

[3] In fact, as part of its ruling on the motions to dismiss, the district court determined that Plaintiffs had failed to meet the pleadings standards under Rule 8 of the Federal Rules of Civil Procedure because Plaintiffs failed to indicate which of the John Doe Plaintiffs was the participant in the Time Warner Plan and thus did not give Warner fair notice of the claims against it. (Order Granting Defendants' Motions to Dismiss ("Order"), EOR 212-213). Appellants do not challenge this ruling on appeal.

[4] In their brief, Plaintiffs confirm that John Doe Five is not a participant in the Time Warner Plan, but instead is a member of the Lowe's plan. (Appellants' Brief, p. 56). All of the other Appellants, including the one participating in the Time Warner Plan, reside in California, where the HMO option under the Time Warner Plan is available. (FAC ¶¶ 9-12, EOR 19-20).

IV. Warner's Motion to Dismiss

On August 10, 2018, Warner moved to dismiss all of the Plaintiffs' claims against it. (Docket, ECF # 113, EOR 10).[5] Warner moved for dismissal on the grounds that the Amended Complaint failed to comply with Rule 8 of the Federal Rules of Civil Procedure because it did not identify which Plaintiff was the participant in the Time Warner Plan, nor did the Amended Complaint allege specific allegations against Warner individually, thereby depriving Warner of fair notice of the claims against it. Further, because the claims against Warner were all linked to alleged deficiencies in the Program designed and administered by the CVS Defendants, if the claims against the CVS Defendants were dismissed the claims against Warner should be dismissed as well. (*Id.*).

Warner moved to dismiss Count Five of the Amended Complaint because the relief Plaintiffs sought—the ability to elect a PPO option, but opt out of the Program and be able to receive their specialty medications at in-network rates at the pharmacy of their choice—was not a benefit provided by the Time Warner Plan. Warner sought dismissal of the breach of fiduciary duty claims in Count Six because Warner's decisions regarding Plan design, such as determining which benefits to provide and under what terms, are sponsor functions, not fiduciary

[5] The remaining Defendants—the CVS Defendants along with Amtrak and Lowe's—also filed motions to dismiss all of the counts against them. (Docket, ECF # 87, 89, 97, EOR 8-9; Order, EOR 182).

functions. Moreover, Warner could not be liable for a breach of co-fiduciary duty because the CVS Defendants were not acting as fiduciaries in designing the prescription drug benefit Program and, even if they were, they did not breach their fiduciary duties because they simply enforced the terms of the Time Warner Plan as written. As to Count Seven, alleging failure to provide a full and fair review, Warner moved for dismissal because that statute is not a remedial statute and the claim was duplicative of other counts. Further, Warner was not responsible for the review of pharmacy benefit claims under the Time Warner Plan nor did Plaintiffs allege any factual allegations sufficient to establish that they were denied a "full and fair review" of any claim under the Plan. (*Id.*)

Count Eight failed to state a claim against Warner under the Declaratory Judgment Act because such a claim could not stand alone as it was contingent on the viability of at least one of the substantive causes of action and none of Plaintiffs' other counts could survive the motion to dismiss. (*Id.*)

Warner also moved for dismissal on the ground that, contrary to the Plaintiffs' allegations that they had no choice but to participate in the Program, this was not true for the Plaintiff who participated in the Time Warner Plan given that he resided in California and could choose an HMO coverage option that did not include the Program. As all of the claims against Warner were premised on the incorrect allegation that participants in the Time Warner Plan were forced to use

the Program, dismissal of those claims was warranted. Finally, Warner sought dismissal of Count Five on the ground that Plaintiffs' claims against Warner under 29 U.S.C. § 1132(a)(1)(B) were barred by the 90-day contractual limitations period of the Time Warner Plan. (*Id.*)

Plaintiffs filed oppositions to the motions to dismiss and all of the Appellees filed replies. (Docket, ECF # 115, 121; 118, 120, 125, 127, EOR 10-11). Oral argument on the motions was held on September 28, 2019 before Judge Edward M. Chen. (Docket, ECF # 138, EOR 12).

V. The District Court's Decision

On December 12, 2018, the district court entered its Judgment and Order Granting Defendants' Motions to Dismiss, dismissing all of the claims asserted in the Complaint, with prejudice and without leave to amend, as to all Defendants/Appellees including Warner. (Order, EOR 179-218). The district court dismissed Count Five (ERISA denial of benefits claim) without leave to replead, holding that Plaintiffs were required to, but had failed to, "identif[y] a specific term [of the Plan] that confers the benefits in question, as is required for such a Section 502(a)(1)(B) claim." (Order, p. 35, EOR 213 (quotation marks and brackets omitted)). The court noted that the Amended Complaint merely alleged that the Plan *previously* provided the benefit they wanted, but that plaintiffs "do not allege that … they are *still* entitled to the same benefit." (*Id.* (emphasis in original); *see*

also Id., pp. 24-25, EOR 202-203). The district court also rejected Plaintiffs' argument that Warner violated the ERISA "anti-cutback" rule, which precludes decreasing accrued benefits in a *pension* plan, because that rule does not apply to an employee *welfare* benefit plan like the Time Warner Plan. (*Id.*, pp. 35-36, EOR 213-214, quoting *Anderson v. Suburban Teamsters of N. Illinois Pension Fund Bd. Of Trustees,* 588 F.3d 641, 650 (9th Cir. 2009)).

The district court dismissed Count Six (ERISA breach of fiduciary duty) without leave to replead, holding that most of the acts that Plaintiffs alleged were in breach of fiduciary duty "relate to non-fiduciary plan design functions[,]" and therefore could not provide the basis for a breach of fiduciary duty claim. (Order, pp. 36-37, EOR 214-215). The district court also rejected as inadequate the few allegations Plaintiffs asserted that were not explicitly related to plan design. (*Id.* at 37-39, EOR 215-217).

The district court dismissed Count Seven (failure to provide full and fair review), holding that Plaintiffs did not allege such a claim against Warner (as opposed to the CVS Defendants). (Order, p. 39, EOR 217). Even if it were adequately pleaded, the claim failed for two reasons: "First, Plaintiffs are not entitled to the benefit of being able to opt out of the Program under their plans, so Plaintiffs cannot be denied a full and fair review of an opt-out request. Second, as

noted above, Plaintiffs have not identified any procedural defects in the opt-out process." (*Id.*).

Finally, the district court dismissed Count Eight (declaratory judgment) "[b]ecause Plaintiffs have not successfully stated claims for relief against Employer Defendants[.]" (*Id.*, p. 39, EOR 217).

Because the district court dismissed the counts against Warner on these grounds, it did not reach Warner's other arguments that the claims under ERISA § 502(a)(1)(B) were barred by the contractual limitations period and that the Time Warner Plan participant was not "forced" to use the Program as he contends, but had a choice and could have selected the HMO option that did not include the Program.

SUMMARY OF THE ARGUMENT

First, Plaintiffs do not challenge the district court's ruling dismissing Counts Six and Seven. Similarly, Plaintiffs make only a brief reference to a request for declaratory relief in the heading of their argument (Appellants' Initial Brief ("App. Br."), pp. 54-57), but do not provide any basis to overturn the dismissal of Count Eight. Plaintiffs therefore are deemed to have abandoned these claims on appeal, and the district court's ruling dismissing Counts Six, Seven and Eight should therefore be affirmed.

Second, regarding Count Five, Plaintiffs have not challenged the district court's decision. Specifically, they do not contend that the Amended Complaint alleges that the Time Warner Plan provides for the benefit that they seek. Nor do they contend that they can maintain their claim without identifying a specific term of the Time Warner Plan that conveys the benefit at issue. Rather, the only argument Plaintiffs advance is that they "never alleged that the Plans were validly amended," apparently to suggest the possibility that a prior version of the Time Warner Plan might govern their benefits and therefore, that their denial-of-benefits claim under Section 502(a)(1)(B) of ERISA should not have been dismissed. This argument was not raised as a substantive point in Plaintiffs' brief in opposition to Warner's motion to dismiss. Further, Plaintiffs never asserted in their Amended Complaint any issue concerning whether the Time Warner Plan was "validly amended" and no facts are alleged in the Amended Complaint to support such an assertion. Nor have Plaintiffs alleged what specific term in what prior plan purportedly entitles them to the benefit they seek. It is well-established, by United States Supreme Court and Ninth Circuit precedent, that a federal appellate court will not hear an issue raised for the first time on appeal. Accordingly, this Court should not consider Plaintiffs' unpreserved new argument and the district court's dismissal of Count Five should be affirmed.

STANDARD OF REVIEW

A district court's grant of a motion to dismiss is reviewed *de novo*. *Ebner v. Fresh, Inc.*, 838 F.3d 958, 962 (9th Cir. 2016). To survive a motion to dismiss, the complaint must contain sufficient "well-pleaded, nonconclusory factual allegation[s]," accepted as true, to state "a plausible claim for relief." *Ashcroft v. Iqbal*, 556 U.S. 662, 679–80, 129 S.Ct. 1937 (2009). A complaint is properly dismissed for failure to state a claim when it "lacks a cognizable legal theory and/or fails to allege sufficient factual allegations to support a cognizable legal theory." *Beckington v. American Airlines, Inc.,* 926 F.3d 595, 604 (9th Cir. 2019); see also *Turner v. City & Cty. of San Francisco*, 788 F.3d 1206, 1210 (9th Cir. 2015) ("Dismissal is appropriate if the plaintiff has not allege[d] enough facts to state a claim to relief that is plausible on its face.") (internal quotations omitted); *Lazy Y Ranch Ltd. v. Behrens,* 546 F.3d 580, 588 (9th Cir. 2008) (same, citing *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 127 S.Ct. 1955, 1974 (2007)); *Ebner*, 838 F.3d at 962-63 (same).

ARGUMENT[6]

I. Plaintiffs Have Abandoned Their Claims in Counts Six, Seven and Eight Because They Do Not Address Them on Appeal, and the District Court's Decision on These Counts Should Therefore Be Affirmed

It is well-established in this Circuit that, where a district court dismisses claims on specific grounds and an appellant does not challenge that determination on appeal, those claims are deemed to be abandoned. *Collins v. City of San Diego*, 841 F.2d 337, 339 (9th Cir. 1988); *United States v. Kama*, 394 F.3d 1236, 1238 (9th Cir. 2005) ("Generally, an issue is waived when the appellant does not specifically and distinctly argue the issue in his or her opening brief."); *Avila v. L.A. Police Dep't*, 758 F.3d 1096, 1101 (9th Cir. 2014) (same, quoting *McKay v. Ingleson*, 558 F.3d 888, 891 n.5 (9th Cir. 2009)); *N.A.A.C.P., Los Angeles Branch v. Jones,* 131 F.3d 1317, 1321 (9th Cir. 1997) (claims not raised by appellants on appeal are waived). *See also Staudenmaier v. Orange County Dept. of Education*, 656 F. App'x 360, 362 (9th Cir., Aug. 3, 2016) (unpub.) (Where district court had dismissed employee's ADA claim on ground he failed to exhaust and he did not challenge that determination on appeal, Court of Appeals declined to consider arguments regarding the merits of the claim); *Hanson v. La Flamme*, 761 F. App'x

[6] In addition to the arguments set forth herein, Warner also agrees with, and incorporates by reference herein, the similar arguments and case law cited in the other Defendants/Appellees' separate briefs explaining why affirmance on the denial-of-benefits claim is appropriate.

685, 689 (9th Cir. 2019) (unpub.) (Where appellant fails to address a ground for a district court's ruling, the appellant forfeits its consideration on appeal.).

The vast majority of the arguments advanced in Plaintiffs' 59-page appeal brief focus on their claims regarding the CVS Defendants. Indeed, the only argument concerning any of the claims against Warner (or the other employers, Amtrak and Lowe's) takes up fewer than three full pages toward the end of the brief, and is directed solely to Plaintiffs' claim for benefits allegedly due under Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1332(a)(1)(B), set forth in Count Five of the Amended Complaint. (App. Br., pp. 54-57). Counts Six and Seven are not mentioned at all, nor do Plaintiffs dispute the district court's grounds for its decision dismissing these claims with prejudice. Plaintiffs also fail to address the argument directed to Count Eight that the Declaratory Judgment Act does not provide an independent cause of action; the only reference to declaratory relief at all is in passing in the heading of their argument. By failing to address these counts in their brief, Plaintiffs have conceded the district court's rulings below dismissing those counts were correct and have waived the right to challenge them on appeal.

Plaintiffs also do not challenge the district court's denial of leave to amend their claims against Warner. Thus, as Plaintiffs have not raised this issue on appeal, it is waived. *See Galvani v. Tokio Marine & Nichido Fire Ins. Co., Ltd.*,

544 F. App'x 790, 791 (9th Cir. 2013) (finding appellant's challenge to district court's denial of leave to amend was waived when it was not raised in her initial brief on appeal); *In re VeriFone Sec. Litig.*, 11 F.3d 865, 872 (9th Cir. 1993) (failure to argument on appeal that leave to amend should have been granted warranted affirmance of dismissal). In any event, amendment would be futile as to the one count remaining on appeal, because the Time Warner Plan does not offer the benefit Plaintiffs seek.

The district court's dismissal of Counts Six, Seven and Eight should therefore be affirmed.

II. Plaintiffs Have Not Established that the Dismissal of Count Five Against Warner Was Incorrect, and This Court Must Not Consider the Unpreserved Argument Made For the First Time by Plaintiffs on Appeal Regarding this Count

A. Plaintiffs Do Not Challenge the District Court's Basis for Dismissing Count Five

The district court held, and Plaintiffs do not dispute on appeal, that "'[a] plaintiff who brings a claim for benefits under ERISA must identify a specific plan term that confers the benefit in question." (Order, pp. 24-25, EOR 202-203), quoting *Steelman v. Prudential Ins. Co. of Am.*, No. CIV S-06-2746 LKK-GGH, 2007 WL 1080656, at *7 (E.D. Cal. Apr. 4, 2007) (additional internal citations omitted); *see also Almont Ambulatory Surgery Center, LLC v. UnitedHealth Group, Inc.*, 99 F. Supp. 3d 1110, 1155 (C.D. Cal. 2015) (same)). This is a

consequence of the fact that an ERISA benefits case centers around, and is dependent on, the language of the plan**.** *CIGNA Corp. v. Amara*, 563 U.S. 421, 435-36, 131 S. Ct. 1866, 1876-77 (2011) ("§ 502(a)(1)(B) … speaks of '*enforcing*' the terms of the plan, not of *changing* them. … We have found nothing suggesting that the provision authorizes a court to alter those terms[.] (emphasis by the Court; brackets and quotation marks omitted). *See also Raygoza v. ConAgra Foods, Inc., Welfare Benefit Wrap Plan*, No. CV 15-013741-AB, 2016 WL 9454419 at * 5 (C.D. Nov. 4, 2016) ("a plaintiff must allege facts that establish the existence of an ERISA plan as well as the provisions of the plan that entitle [plaintiff] to benefits." (citations omitted)); *Forest Ambulatory Surgical Associates, L.P. v. United HealthCare Ins. Co*., 10–CV–04911–EJD, 2011 WL 2748724, at *5 (N.D. Cal. July 13, 2011) (court found "alleged violations [of ERISA] are insufficient without reference to the terms of the controlling plans" and plaintiff's failure to reference plan terms mandated dismissal). *See further* Order, p. 25, ER 203 (citing *Forest Ambulatory*).

The district court held, and Plaintiffs do not dispute, that the Amended Complaint did not allege that any term of the Time Warner Plan provides for the in-network community pharmacy benefit they seek:

> They are unable to point to any allegation in the complaint specifying which terms under their plans entitle them to such a benefit. Indeed, the complaint attributes the "designation of the community pharmacy as now being 'out-of-network'" to "Defendants' changes to Class

> Members' health plans' prescription drug benefit." [FAC] ¶ 197. Hence, their plans do not confer the benefit they seek. Indeed, their challenge is to the overall scope of the plan, not denial of benefits under the plan.

(Order, p. 24, EOR 202). Nowhere in their briefs below nor on appeal do Plaintiffs cite to any provision in the Time Warner Plan that provides the in-network community pharmacy benefit they claim they are entitled to, because such a provision does not exist. In fact, the allegations of the Amended Complaint state that Plaintiffs' benefit plans ***do not*** provide them a right to in-network prices on specialty drugs at the pharmacy of their choice. (FAC, ¶ 40, EOR 28; FAC, ¶ 197, EOR 94-95). Plaintiffs' failure to challenge the correctness of the district court's decision regarding Count Five means that this Court should affirm the dismissal.

B. The Only Argument Plaintiffs Make on Appeal Was Never Properly Brought Before the District Court or Even Alleged in the Amended Complaint

The district court's decision on Count Five also must stand because the argument Plaintiffs make on appeal was never raised below and should not be considered by this Court. As the United States Supreme Court has recognized, "[i]t is the general rule, of course, that a federal appellate court does not consider an issue not passed upon [by the district court] below." *Singleton v. Wulff,* 428 U.S. 106, 120, 96 S. Ct. 2868, 59 L. Ed. 2d 826 (1976), citing to *Hormel v. Helvering,* 312 U.S. 552, 556 (1941). The Ninth Circuit recognizes this rule. See, e.g., *Orr v. Plumb*, 884 F.3d 923, 932 (9th Cir. 2018) (noting the "usual rule" that arguments

raised for the first time on appeal "are deemed forfeited"); *In re Mort. Electronic Registration Systems, Inc.*, 754 F.3d 772, 780 (9th Cir. 2014) ("Generally, arguments not raised in the district court will not be considered for the first time on appeal."); *Smith v. Marsh*, 194 F.3d 1045, 1052 (9th Cir. 1999) (same). Further, "to have been properly raised below, the argument must be raised sufficiently for the trial court to rule on it." *Abogados v. AT&T, Inc.,* 223 F.3d 932, 937 (9th Cir. 2000) (internal quotations omitted); *In re E.R. Fegert, Inc*., 887 F.2d 955, 957 (9th Cir. 1989) (same); *Broad v. Sealaska Corp*., 85 F.3d 422, 430 (9th Cir. 1996) (same, citing *E.R. Fegert*). As this Court has observed, "[t]his rule serves to ensure that legal arguments are considered with the benefit of a fully developed factual record, offers appellate courts the benefit of the district court's prior analysis, and prevents parties from sandbagging their opponent with new arguments on appeal." *Dream Palace v. County of Maricopa*, 384 F.3d 990, 1005 (9th Cir. 2004).

This Court routinely declines to address issues that were not properly raised before the district court but presented for the first time on appeal. See, e.g., *Broad***,** 85 F.3d at 430 (declining to reach the merits of a due process claim raised for the first time on appeal); *Parsons v. Del Norte County*, 728 F.2d 1234, 1238-39 (9th Cir. 1984) (claim was not raised at trial, was not ruled upon in connection with other claims, and therefore would not be considered for the first time on appeal "since no substantial interest of justice calls for us to pass upon it.");

Intercontinental Travel Mktg. v. FDIC, 45 F.3d 1278, 1286 (9th Cir. 1994) (declining to address an argument not presented to district court in opposition to summary judgment).

This general rule has been applied in cases involving ERISA claims. For example, in *Noren v. Jefferson Pilot Financial Ins. Co*., 378 F. App'x 696 (9th Cir. 2010) (unpub.), the district court granted defendants summary judgment on a claim for disability benefits based on plaintiff's failure to file a required second internal administrative appeal. On appeal before this Court, the plaintiff argued that the plan waived the failure-to-exhaust defense because the plan failed to provide a reasonable claims procedure. This Court, in upholding the district court's decision, declined to address the plaintiff's new argument, stating:

> We need not determine if these violations amount to unreasonable procedures. Noren may have raised some of these violations before the district court, but she did not argue that the alleged violations excused her from exhausting her administrative remedies under 29 C.F.R. § 2560.503–1(l). As it is presented for the first time on appeal, this argument is waived. See *Singleton v. Wulff*, 428 U.S. 106, 120, 96 S.Ct. 2868, 49 L.Ed.2d 826 (1976).

378 F. App'x 696 at 698. *See also Jelinek v. Hewlett-Packard Co*., 89 F.3d 845 (table), 1996 WL 359470 at * 2 (9th Cir. 1996) (unpub.) (ERISA denial of benefits case; this Court declined to address on appeal an argument regarding the standard of review that plaintiff had not raised below, stating: "It is well-settled that claims may not be raised for the first time on appeal").

The only argument that Plaintiffs make on appeal concerning Count Five is a vague contention that their claim under ERISA § 502(a)(1)(B) should not have been dismissed because they never alleged or conceded that the Time Warner Plan was properly amended to include the Program. This issue was never raised before the district court below. Plaintiffs did not make this argument in their briefs in opposition to the Defendant/Appellees' motions to dismiss. (Opposition Briefs, SER 1-58). In addition, Appellees' purported "failure to properly amend the plans" argument was not addressed at all in the district court's decision—further proof that it was not raised sufficiently for the district court to rule on it. Because Plaintiffs are advancing this argument for the first time on appeal, it should not be considered and the district court's decision dismissing Count Five (along with the corresponding claim for any declaratory relief either under ERISA or through Count Eight) should be affirmed.

Plaintiffs appear to contend that they preserved this argument through a comment they made during oral argument concerning their fiduciary breach claim and plan design, during which they told the district court: "we have never alleged that the plans were validly amended to include the [P]rogram." (App. Br., p. 56; Transcript, p. 56, EOR 161). This remark, made in the context of discussion of an unrelated issue, cannot be construed as a sufficient presentation of the "failure to amend" argument to the district court. In any event, "[a]rguments raised for the

first time at oral argument are generally considered waived." *BSNF Railway Co. v. Oregon Dept. of Revenue,* 358 F. Supp. 3d 1129 (D. Ore. 2018); see also *EIJ, Inc. v. United Parcel Service, Inc.*, 233 F. App'x 600, 602 (9th Cir. March 28, 2007) (refusing to consider an argument on appeal where the appellant raised the issue for the first time in oral argument before the district court, finding that the argument was not properly raised either before the district court nor this Court).[7]

Beyond their failure to raise this issue in opposition to the motions to dismiss, Plaintiffs did not allege in the Amended Complaint that the Time Warner Plan was not (or may not have been) validly amended. Plaintiffs attempt to circumvent the absence of allegations in the Amended Complaint by stating that "they never alleged that the [Employer-Defendants'] Plans were validly amended[.]" (App. Br., p. 55). Plaintiffs claim that, in fact, "they alleged just the opposite[,]" because they alleged "that implementation of the Program 'caus[ed] a reduction in or elimination of benefits *without a change in actual coverage*[.]" (App. Br., p. 55, citing FAC ¶ 196, EOR 94 (emphasis by Plaintiffs)). That is not the "opposite." The "opposite" would have been an affirmative allegation in the

[7] While there are rare instances where an appellant is granted some small latitude in raising an argument that was not first presented to the district court, those instances are uncommon and extraordinary. The Plaintiffs here have not made any attempt in their brief to argue that they are due special consideration, which is hardly surprising given that they had every opportunity to present their argument below but failed to do so. Therefore, this Court should reject Plaintiffs' attempts to raise a new argument at this late date.

Amended Complaint that the Time Warner Plan was not validly amended to include the Program and that, accordingly, the Time Warner Plan actually authorizes Plaintiffs to procure specialty medications through community pharmacists on an in-network basis. The "opposite" would also include factual allegations to support that contention.

Such allegations appear nowhere in the Amended Complaint. The Amended Complaint does not even allege whether implementation of the Program as part of pharmacy benefit management under some of the Time Warner Plan's coverage options required a formal amendment of the Plan, let alone any factual allegations supporting Plaintiffs' new "failure to amend" theory. The absence of an allegation that the Time Warner Plan was validly amended is not at all the same as an affirmative allegation that the Time Warner plan was *not* validly amended. Where, as here, an appellant does not raise the issue in the complaint, the arguments on appeal "are barred." *Riggs v. Prober & Raphael*, 681 F.3d 1097, 1104 (9th Cir. 2012).

Indeed, scouring the Amended Complaint to find even a shred of support for their contention, Plaintiffs come up with only the fragment of a sentence cited above from one paragraph of the 235-paragraph complaint, asserting they alleged "that implementation of the Program 'caus[ed] a reduction in or elimination of benefits *without a change in actual coverage*[.]" (App. Br., p. 55, citing FAC ¶

196, EOR 94 (emphasis by Plaintiffs)). The identification of "isolated fragments" in a complaint is insufficient to preserve an issue for review. *Ecological Rights Found. v. Pac. Gas & Elec. Co.*, 713 F.3d 502, 511 (9th Cir. 2013). That is even more true here, where the paragraph upon which Plaintiffs rely (¶ 196) does not even contain the word "amend" or "amendment." Nor can that paragraph be interpreted to allege an improper amendment. Plaintiffs merely list various alleged "violations" by CVS and the Employer Defendants that purportedly "caused a reduction in or elimination of benefits without a change in actual coverage, as well as the failure to provide clear notice thereof." (FAC, ¶ 196, EOR 94). Improper amendment of the plans is not among the alleged violations. (*Id*.).

Moreover, as to the assertion that there was some kind of "violation" leading to reduction or elimination of benefits, that claim fails as a matter of law. Employers have broad leeway to design welfare benefit plans as they choose, and "are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." *M&G Polymers, USA LLC v. Tackett*, 135 S. Ct. 926, 933 (2015) (citations omitted); Order, p. 36, EOR 214). Warner expressly retained the exclusive right to amend, modify, suspend or terminate the Time Warner Plan, the medical and prescription drug program, or any coverage option offered under the Plan, in whole or in part, at any time and for any reason. (SER 83-84). Although Appellants contended below that benefits could not be reduced given

ERISA's rule prohibiting cutbacks to certain benefits, the district court properly held that this "anti-cutback" rule applies only to vested retirement benefits. Welfare benefits, including health benefits such as those at issue here, do not vest and the anti-cutback rule does not apply. (Order, pp. 35-36, EOR 213-214).

This Court has held that a complaint must contain sufficient factual allegations to support a valid claim; if it does not, it should be dismissed. For example, in *Austin v. University of Oregon,* 925 F.3d 133 (9th Cir. 2019), students suspended from the university challenged a district court decision dismissing, with prejudice, their Title IX claims based on sex discrimination and due process violations. In upholding the district court's decision, this Court noted that, even if the outcome of the university's administrative disciplinary procedure was erroneous as the students argued, dismissal would nevertheless be appropriate because the "complaint [was] missing any factual allegations that show that sex discrimination was the source of any error" in those proceedings. *Id.* at 1138.

Where, as here, the Amended Complaint is devoid of allegations that support the alleged claim, dismissal is proper. As stated in the Standard of Review section of this brief (*see infra* p. 16), in order to survive a motion to dismiss, the complaint must contain sufficient "well-pleaded, nonconclusory factual allegation[s]," accepted as true, to state "a plausible claim for relief." *Iqbal*, 556 U.S. 662 at 679-80; *Beckington,* 926 F.3d 595 at 604 (a complaint is properly dismissed for failure

to state a claim when it fails to allege sufficient factual allegations to support a cognizable legal theory). Plaintiffs bore the burden of alleging facts sufficient to show that they were entitled to relief. Fed. R. Civ. P. 8 and 12. They have not met this burden, nor can they. Indeed, Plaintiffs admittedly failed to allege sufficient facts in their Amended Complaint to support their argument on appeal and the district court's order of dismissal must therefore be affirmed.

CONCLUSION

For the foregoing reasons, the judgment of the district court dismissing all of the claims against Warner with prejudice was correct and this Court should affirm that order in all respects.

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(C) and Ninth Circuit Local Rule 32-1, I certify that:

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) and Ninth Circuit Local Rule 32-1 because, according to Microsoft Word, this brief contains 6,898 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionately spaced typeface using Microsoft Word Times New Roman 14-point font.

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STATEMENT OF RELATED CASES

There are no related cases of which Warner is aware.

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CERTIFICATE OF SERVICE

I hereby certify that on August 7, 2019, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

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