No. 20-16823, No. 20-16857

In the United States Court of Appeals
for the Ninth Circuit

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

Plaintiffs- Appellees/Cross-Appellants,

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

Intervenor Plaintiff- Cross-Appellant,

v.

UNITEDHEALTH GROUP, INC.; UNITEDHEALTHCARE, INC.; UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTHCARE SERVICES, INC.; UMR, INC.,

Defendants- Cross-Appellants/Appellees.

On Appeal from the United States District Court for the Northern District of California, No. 3:17-cv-00183-VC (The Honorable Vince Chhabria)

PLAINTIFFS'-APPELLEES'/CROSS-APPELLANTS' OPENING BRIEF ON CROSS-APPEAL AND ANSWERING BRIEF ON APPEAL

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February 26, 2021

RULE 26.1 CORPORATE DISCLOSURE STATEMENT

Each Plaintiff Appellee/Cross-Appellant, namely Rachel Condry, Jance Hoy, Christine Endicott, Laura Bishop, Felicity Barber, Rachel Carroll and Teresa Harris, is a natural person. Accordingly, they are not subject to Federal Rule of Appellate Procedure 26.1 disclosure statement requirements.

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INTRODUCTION

At issue in this case and on appeal is the enforcement of the federally-created right vested in women to receive health care coverage without cost-sharing for comprehensive breastfeeding and lactation support services. Reversal of the portions of the district court's orders denying class certification and granting defendants summary judgment, which are on appeal by Plaintiffs and Intervenor Plaintiff, and affirmance of the portions of the district court's order granting class certification and judgment in Plaintiffs' favor, are consistent with this Court's and district courts' precedents, and will ensure that two federal laws remain effectual, and that insurers are held accountable and responsible for establishing policies and procedures that provide insureds with non-illusory, federally compliant health insurance coverage.

As part of the Affordable Care Act ("ACA"), Congress mandated that beginning in October 1, 2012 all non-grandfathered, non-federal health plans "must provide coverage…and may not impose any cost sharing requirements"[1] for certain enumerated women's preventive services. 42 U.S.C. § 300gg-13(a)(4). The women's preventive service at issue here is comprehensive breastfeeding and lactation support services ("CLS"), which are time-sensitive health services that (i) support the initiation and continuation of breastfeeding, and (ii) prevent the cessation of breastfeeding. 2-SER-72-

[1] The ACA defines "cost-sharing" as "deductibles, coinsurance, [and] copayments." 42 U.S.C. § 18022(c)(3)(A)(i).

73, 76-77[2]; 3-ER-489-490; 4-ER-712-713.

UnitedHealth Group, Inc. and its companies (collectively, "UHC")[3] established Preventive Care Services Coverage Determination Guidelines (the "CDG"). The CDG contained UHC's coverage policy for CLS, and it significantly restricted the CLS claims that were eligible for the cost-share-free coverage required by the ACA.

First, the CDG states "**Out-of-Network** preventive care services are not part of the [ACA] requirements." CLS claims were only eligible for coverage without cost-sharing if the services are provided from a network provider.

Second, the tools and resources used by UHC insureds to identify in-network providers, *e.g.* UHC's call center, on-line "provider finder" services and search engines, and provider directories, were useless in identifying which in-network providers, *if any*, for which UHC covered CLS claims without cost-sharing. This condition was internally acknowledged at UHC, and it was observed as unworkable and at odds with the ACA mandate, particularly because only in-network preventive care health services were eligible for ACA-coverage.

Third, for CLS, the CDG enumerated only a limited number of procedure and diagnoses codes that UHC deemed eligible to be covered without cost sharing. The CDG excluded codes that CLS providers, including lactation consultants, routinely used to

[2] References herein to Plaintiffs' Supplemental Excerpts of Record are "SER-__".
[3] "UHC" refers to UnitedHealth Group Inc., UnitedHealthcare, Inc., UMR, Inc., UnitedHealthcare Insurance Company, and UnitedHealthcare Services, Inc.

reflect that CLS had been rendered to patients. Thus, irrespective of whether the CLS provider was an in- or out-of-network provider, UHC's CDG provided coverage for its insureds for less than the full scope of CLS.

Fourth, when UHC notified insureds that their CLS claim was denied, UHC used denial explanations, four of which (the "Remark Codes") were not "written in a manner calculated to be understood by the [insureds]", nor "responsive and intelligible to the ordinary reader" as required by ERISA[4], 29 U.S.C. § 1133(1).

From the outset, Plaintiffs Condry, Hoy, Endicott, Bishop, Barber, and Carroll[5] and Intervenor Plaintiff Harris (each of whom are current or former members or participants in plans administered by UHC), have been challenging UHC's coverage policy for CLS. They challenge the CDG's exclusion of out-of-network claims and its failure to provide ACA coverage for *comprehensive* lactation services. Plaintiffs seek: an order holding that UHC violated the ACA with respect to providing CLS coverage under its CDG; and, further seeks the reprocessing, under an ACA-compliant policy, of all CLS claims that were not covered, in whole or part, by UHC. 3-ER-497-500; 4-ER-733. Plaintiffs also seek an order enjoining UHC's non-compliance going forward. *Id.*

Throughout the litigation, the district court identified the existence and import of the "overwhelming evidence" adduced about UHC's "horrible job" stating, for example,

[4] ERISA refers to the Employee Retirement Income Security Act of 1974.
[5] All Plaintiffs except Plaintiff Carroll had an ERISA-sponsored plan administered by UHC.

that "Again, and I mean, again, I think this this point cannot be emphasized enough. It seems pretty clear that [UHC] did a horrible job of complying with the ACA, and it seems pretty clear that in many instances [UHC] did not comply with the ACA." 2-ER-104; 1-ER-13-14. However, each time the district court castigated UHC for its "horrible job" in processing CLS claims, it refused to acknowledge and link that wrongful conduct to UHC's CLS policies and the CDG, ignoring overwhelming evidence of UHC's systemic and uniform policy failures. That judicial misstep was taken at summary judgment, and, as is evident from the lower court's orders, it infected and rendered erroneous the subsequent class certification rulings.

First, in the district court below, over Plaintiffs' objection, UHC moved and Plaintiffs' cross-moved for summary judgment, prior to the filing of any motion for class certification. 5-SER-963-964. The district court jettisoned that which the parties raised and argued in their papers concerning whether UHC's CLS policies complied with the ACA. 1-ER-146; 6-ER-1174; 4-ER-743; 4-SER-683. The district court embarked on an insured-centric inquiry, focused on what each Plaintiff did to secure CLS services and coverage. Ultimately, the district court entered summary judgment against Plaintiffs Condry and Barber, based on its inquiry as to whether in-network lactation consultants may have been "available" to them. 1-ER-26, 27. That "availability" inquiry, however, was irrelevant, because their CLS claims were not denied due to availability of an in-network provider, but as a result of UHC's blanket policy that out-of-network preventive services claims were *ineligible* for ACA coverage. And with respect to ACA cost-share-

free coverage the CDG language was unequivocal in its exclusion. Further, the unrebutted evidence demonstrated that UHC did not and could not identify to its insureds, including Plaintiffs, if and which in-network providers were available to provide ACA covered CLS. UHC could not even undertake to do the exercise the district court imposed on Plaintiffs. On summary judgment, the district court reviewed the ERISA Plaintiffs' explanation of benefits, and the four codes UHC used therein to convey the reason why UHC had denied CLS claims. After reading the facially incoherent and inapplicable reasons UHC used to deny the CLS claims, the district court properly entered judgment in favor of the ERISA Plaintiffs holding that UHC's Remark Codes violated ERISA's notice requirement, citing this Court's precedent, including *Booton v. Lockheed Med. Benefit Plan,* 110 F.3d 1461, 1465 (9th Cir. 1997). 1-ER-27-29.

Next, Plaintiffs twice sought certification under Fed. R. Civ. P. 23(a) and (b)(1) and/or (b)(2) of three classes of UHC insureds defined generally as: (1) UHC insureds whose CLS claims were not covered, in whole or part, by UHC (one class each for ERISA and non-ERISA insureds) (the "Claims Reprocessing Class"); and (2) UHC insureds in ERISA-governed plans who received from UHC one of four unintelligible and non-responsive Remark Codes when their CLS claim was denied (the "Denial Letter Class").[6] 3-ER-479-480; 4-ER-702-703.

[6] In the district court's second class certification order, 1-ER-12-13, it renamed plaintiffs' ERISA and Non-ERISA lactation services classes as the "Claims Reprocessing Class" and the claims review class as the "Denial Letter Class". Plaintiffs will use that terminology herein.

As to the Claims Reprocessing Class, the district court again, declined to acknowledge the CDG, despite the fact that Plaintiffs' claims and remedies were inextricably and necessarily linked to the health service coverage policy at issue – the CDG. For example, notwithstanding that it was an undisputed fact that the CDG was UHC's coverage policy for CLS, the district court inexplicably declared it *not* a "blanket policy" (2-ER-55, 59) and then erroneously held that UHC had no uniform standard or practice left for Plaintiffs to challenge class-wide. 1-ER-15. The district court again interjected caveats into UHC's CDG with respect to CLS coverage, including that the CDG language implies coverage depending on the availability of network CLS providers. 1-ER-14; 3-ER-537. That is not, however, what the policy states.

Consequently, the district court's orders denying certification of the Claims Reprocessing Class, are directly as odds with key legal precedent from courts within this Circuit certifying challenges to insurer coverage policies and seeking processing of health benefit claims under a revamped policy. Because of its faulty factual premise, the district court did not apply correctly such cases where claims, facts, legal issues, and relief analogous to those asserted by Plaintiffs are certified under Rule 23. 1-ER-13, 15; 3-ER-537-538. Driven by the same fundamental error of disregarding the CDG, contrary to this Court's precedent, the district court applied both a misplaced and an erroneous damages-like predominance analysis to Plaintiffs' claims, focusing on the outcome of UHC's adjudication of CLS claims instead of the CDG's directive and its applicability to all insureds' ACA-preventive services claims. 1-ER16-18; 3-ER-537-538. Despite

UHC's express policy denying coverage for out-of-network CLS, the district court refused to acknowledge that policy because UHC imposed cost-shares on 88%, but not 100%, of the out-of-network lactation claims, leading it to conclude no "uniform standard or approach existed." 1-ER-16-19. The district court applied a standard to the proposed Claims Reprocessing Class that does not reflect this Court's Rule 23 precedent.

Finally, the district court determined that UHC'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." 1-ER-14. Nevertheless, the district court held that Plaintiffs did not have standing to seek injunctive relief to enjoin ongoing CLS coverage failures, and denied Ms. Harris's, a then- and -current UHC insured, motion to intervene for purposes of class certification to satisfy the court's position on Plaintiffs' standing. 1-SER-2-3. Under the district court's construct, plaintiffs do not have standing because they are no longer insureds and that no one, including Ms. Harris, alleged an intent "to become pregnant again or use lactation services again" (1-ER-14; 3-ER-538-539; 2-ER-161). If that proposition stands, which it should not, a review of ongoing observable misconduct will plainly evade review and avoid prospective remedy.

Premised on its summary judgment order finding that the Remark Codes violated ERISA, the district court correctly certified the Denial Letter Class under Rule 23. 1-ER-12-13. The district court properly rejected UHC's request to overhaul this Court's holding in *Booton, supra,* and ERISA's notice requirements, and rejected UHC's

unsupported position that its facially unintelligible Remark Codes should instead be viewed or recast as just UHC initiating a dialogue with its insureds. As the Remark Codes convey UHC's reasons for the benefit *denial*, they must objectively comply with ERISA's notice requirement, and did not, as the court held.

In sum, the district court's orders challenged by Plaintiffs in this appeal are the consequence of the district court misapprehending the ACA and disregarding the substance of UHC's CDG and UHC's legal responsibility to establish ACA-compliant policies and coverage for its insureds nationwide, and the orders conflict with applicable legal precedent from this Court and other district courts within the Ninth Circuit.

Accordingly, Plaintiffs respectfully request this Court (i) reverse and remand the portions of the district court's (a) summary judgment order entering judgment against Plaintiffs Condry and Barber, (b) class certification orders denying certification of the Claims Reprocessing Class, and (c) order denying the motion to intervene; and (ii) affirm the district court's orders granting Plaintiffs summary judgment and the certification of the Denial Letter Class.

STATEMENT OF JURISDICTION

The district court had federal-question jurisdiction under 28 U.S.C.§ 1331. This Court has appellate jurisdiction under 28 U.S.C. § 1291 because the district court entered a final order and judgment on September 15, 2020. 1-ER-2-11. Plaintiffs-Appellees/Cross-Appellants and Intervenor Plaintiff-Appellee/Cross-Appellant timely filed their notice of appeal within 30 days after the judgment, on September 23, 2020, pursuant to Fed. R. App. P. 4 (a)(1)(A). 5-SER-965-969.

ISSUES PRESENTED

1. Whether the district court erred in granting summary judgment in favor of UHC, when the two Plaintiffs' claims challenged whether UHC's policies and procedures failed to comply with the ACA's mandate requiring UHC to provide coverage without cost sharing for comprehensive breastfeeding and lactation support and counseling ("CLS").

2. Whether base on this Court's precedent and the precedent of district courts within the Ninth Circuit, the district court's denial of certification pursuant to Rule 23(b)(2) was erroneous because the Plaintiffs' claim challenge to the legality of UHC's Preventive Service Coverage Determination Guidelines ("CDG"), at issue is whether the CDG violated the ACA preventive services coverage mandate for CLS, and Plaintiffs seek the reprocessing of the CLS claims under a corrected, legally compliant policy.

3. Whether the District Court erred by conducting a damages-like

predominance analysis in denying Rule 23(b)(2) certification, contrary to this Court's precedent.

4. Whether the District Court erred in denying, under Rule 23(b)(2), certification of classes comprised of insureds seeking to enjoin an insurer's illegal conduct and to secure the reprocessing of their medical claims, which classes are routinely certified under Rule 23(b)(2) by courts in the Ninth Circuit.

5. Whether the District Court erred in holding that Plaintiffs, who were not plan members at the time of the class certification hearing, did not have standing to enjoin UHC from its continued use of its non-ACA compliant policy, and further erred in denying an Intervenor the right to intervene for purposes of class certification to address the Court's position that the named Plaintiffs did not have standing.

6. Whether the district court can certify a class of individuals who received from UHC an explanation of benefits containing one of four standard denial codes, because the question and resolution of whether the denial codes are written in compliance with ERISA, in a manner calculated to be understood by the participant, does not require subjective or individualized inquiries as to each recipient.

LOCAL RULE 28-2.7 STATEMENT

In this brief, Plaintiffs cite 42 U.S.C. § 300gg-13(a)(4); 29 C.F.R. § 2590.715-2713(a)(3)(i)-(ii). Relevant excepts of these statutory and regulatory authorities are included in the Addendum.

STATEMENT AND COUNTER-STATEMENT OF THE CASE

A. The ACA Mandate and Scope of CLS

UHC is a diversified health care company in the business of insuring and administering health plans. 6-ER-1222; 5-SER-747.

UHC admits that they or their subsidiaries administer and underwrite health care plans that are subject to the ACA's preventive services requirements, including CLS. 5-SER-753. Each of the Plaintiffs' non-grandfathered, non-federal UHC plans require UHC to provide coverage for CLS as an ACA-mandated preventive services benefit. 6-ER-1186.

The coverage policy at issue here derives from a single source – the ACA – and it applies uniformly to all of UHC's non-grandfathered, non-federal health benefit plans. The ACA added Section 2713 to the Public Health Service Act (29 CFR 2590.715-2713) stating "[Non-grandfathered health plans] must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements...:

> (4) with respect to women, such additional preventive care and screenings…provided for in comprehensive guidelines supported by the Health Resources and Services Administration [HRSA]. . . ."

42 U.S.C. § 300gg-13(a)(4); 5-SER-743-744. The term "cost-sharing" "in general" includes "deductibles, co-insurance, copayments, or similar charges…." 42 U.S.C § 18022(c)(3)(A).

The ACA mandate was expressly identified as necessary to increase "access and

utilization" of preventive services, to address "underutilization of preventive services" and to "eliminate cost-sharing requirements, thereby removing a barrier that could otherwise lead an individual to not obtain such services." 2-SER-40-41.

Also, to ensure that access and utilization is established, the ACA includes a commonsensical directive to insurers: do not circumvent the ACA's mandate by not having in-network providers for the enumerated preventive services, and yet refuse to cover out-of-network preventive service claims. *See* 29 C.F.R. § 2590.715-2713(a)(3)(i)-(ii).

B. Comprehensive Lactation Support and Counseling Services

B.1. HRSA Guidelines

On August 1, 2011 and December 20, 2016, pursuant to 42 U.S.C. § 300gg-13(a)(4), HRSA adopted and released its guidelines, referenced above, the "HRSA Guidelines" for "[b]reastfeeding support, supplies, and counseling," which HRSA described as:

- "[c]omprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment", and

- "[c]omprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and the postpartum period to ensure the successful initiation and maintenance of breastfeeding"

2-SER-72-73; 2-SER-76-77. UHC admits that the applicable HRSA Guidelines for CLS are as stated above. 5-SER-744, 752).

B.2. The IOM and WPSI Reports

The HRSA Guidelines describe and mandate coverage of a comprehensive service with respect to breastfeeding support and counseling. The 2011 HRSA Guidelines were based on studies and recommendations of the independent Institute of Medicine ("IOM") as set forth in its report, Clinical Preventive Services for Women: Closing the Gaps. ("IOM Report") 5-SER-850, 873, 891. The IOM Report defined Preventive Health Services as "measures—including medications, procedures, devices, tests, education and counseling—shown to improve well-being, and/or decrease the likelihood or delay the onset of a targeted disease or condition." 5-SER-865. In addition, the IOM Report made the following pertinent points regarding CLS: "Contrary to popular conception, breastfeeding appears to be a learned skill and the mother must be supported to be successful. Nevertheless, a large gap exists in the area of providers discussing breastfeeding with patients prenatally and assisting with breastfeeding issues postnatally." 5-SER-891-892.

The 2016 HRSA Guidelines were based on the Women's Preventive Services Initiative 2016 Final Report ("WPSI Report", 2-SER-081), which states that "The IOM recommendation includes an ***explicit description of a [ ] comprehensive set of services***…" (Emphasis added). 2-SER-108; 5-SER-897-98.[7]

[7] That point is underscored by the following. The 2008 USPSTF recommendation on breastfeeding (4-SER-403), states that breastfeeding support includes "interventions…after birth to promote and support breastfeeding" and "Professional support" which "can include providing information about the benefits of breastfeeding, psychological support [ ] and direct support during breastfeeding observations (helping

Fundamentally, the IOM and WPSI Reports recognize an essential element to providing CLS preventive care coverage that UHC's policy ignores: (1) "mothers may have no means of identifying or obtaining the skilled support needed to address their concerns about lactation and breastfeeding" following discharge from the hospital and (2) "gaps existed between providers' intentions surrounding breastfeeding counseling and their training, experience and practice in supporting patients with breastfeeding." 5-SER-965.

C. UHC's CDG

UHC's coverage policies with respect the ACA preventive care services, including CLS, are contained in its Preventive Care Services Coverage Determination Guidelines (the "CDG"). 2-SER-12-13, 16. Per UHC, the CDG applies to all commercial plans, and are thus applicable to the plans attributable to all Plaintiffs. 4-SER-678-679.

C.1. UHC's Preventive Care Coverage

UHC's CDG states its CLS coverage policy clearly, unequivocally: "Out-of-Network preventive care services are not part of the [ACA] requirements." 3-SER-151.

In full, the CDG provides: [8]

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with the positioning of the infant and observing latching)…Sessions generally last from 15 to 45 minutes... Most successful interventions include multiple sessions and are delivered at more than 1 point in time." The HRSA Guidelines were not just repetitive of these USPSTF recommendations, but required comprehensive pre- and post-natal CLS. 4-SER-417 Ex. 28, 2/20/2013 FAQs, Part XII Q18, "…The HRSA Guidelines specifically incorporate comprehensive prenatal and postnatal lactation support, counseling, and equipment ...")

[8] At least as of January 2021, this language in the CDG has been replaced with the following statement:

> **Cost Sharing for Non-Grandfathered Health Plans**
> ….
> 2. **Out-of-Network** preventive care services are not part of the [ACA] requirements. Many plans do not cover out-of-network preventive care services. If a plan covers out-of-network preventive care services, the benefit for out-of-network is allowed to have member cost sharing. Please refer to the member specific plan document for out-of-network information.

3-SER-151.

In addition to expressly stating that out-of-network preventive care services are not part of the ACA preventive care coverage requirements, the CDG expressly states that, even if a health plan covered out-of-network services (separate from the ACA's requirement), the claim's status as "out-of-network" still trumps, and cost-sharing "is allowed", meaning, cost-sharing is imposed, contrary to the ACA. *Id.* Unequivocally, the CDG is clear; it did not provide for ACA-mandated coverage without cost sharing for out-of-network preventive services claims.

Per UHC, under its CDG "preventive services…will be eligible for coverage without cost-shares ***provided that such services are provided by a network provider***…" 2-SER-014 (emphasis added). UHC's 2014 "Preventive Care Services"

> "Under [the ACA], services obtained from an out-of-network provider are not required to be covered under a plan's preventive benefit, and may be subject to member cost sharing. Refer to the member specific benefit plan document for out-of-network benefit information."
> 1/1/2021 UHC Preventive Care Services CDG page 2, https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/preventive-care-services.pdf, *last visited 2-25-2021*.

The reversal of the district court's order is critical to prevent an insurer from taking license with writing and imposing this kind of vague and imprecise coverage policy.

"Snapshot" states "Under the health reform law, non-grandfathered health plans are required to cover women's preventive care services such as breast-feeding counseling. . . as long as they are received in the health plan's network." 3-SER-194. Under the "Lactation Support and Counseling" heading (pg. 2), it states "The health reform law does not require services outside of our network to be covered without cost-share." 3-SER-195. Likewise, UHC call centers informed insureds that only in-network benefits for CLS are covered. 3-SER-197.

C. 2. The CDG's Procedure and Diagnosis Codes for CLS

UHC states that its CDG "identifies certain procedure codes (and a diagnosis code for certain of those procedure codes) as those eligible for coverage without cost-shares when billed as described in the CDG and in accordance with Defendants' policies and procedures." 2-SER-012.

Current Procedural Terminology ("CPT") codes and Healthcare Common Procedure Coding System ("HCPCS") (numeric codes, collectively referred to as "procedure codes"), are how medical and evaluation and management services rendered to patients are reported and how providers and insurers communicate about such service rendered, without having to submit or review a patient's underlying medical records, as stated by UHC's proffered expert Ms. D'Apuzzo. 3-ER-523.

As Plaintiffs' expert, Dr. Hanley, an International Board Certified Lactation Consultant ("IBCLC"), and the founder of the Massachusetts General Hospital Lactation clinic for women and children, explained, International Classification of Diseases

("ICD") codes, sometimes called "diagnosis codes", are also used by providers to indicate the diagnosis of the conditions being evaluated and/or discussed with the patient during the visit. 3-SER-373. Like the procedure codes, the ICD codes enable providers and insurers to communicate without having to submit or review a patient's underlying medical records, per Ms. D'Appuzo. 3-ER-523.

The CDG identifies procedure codes and just one diagnosis code as eligible for coverage for certain of those procedure codes, as the codes eligible for the ACA-mandated coverage without cost-shares for CLS. 3-SER-188; 4-SER-420 (providing a description of the numeric procedure codes).

Plaintiffs asserted that, as grounded in the HRSA Guidelines (discussed *supra*), CLS means comprehensive lactation support, counseling and education services provided during the antenatal, perinatal, and the postpartum period, and the CDG's codes constituted coverage that was less than (or more restrictive than) what was required by the ACA-mandate.

UHC admits that the CDG excludes as eligible for coverage without cost sharing (pursuant to the ACA mandate), "breastfeeding services" that UHC determined "fall outside the scope of the preventive services". 2-SER-012.

Further, on its face the CDG does not include as eligible for coverage diagnoses codes that may be reasonably used by medical and non-medical providers to indicate that their encounter with a patient was for CLS. Plaintiffs' Expert, Dr. Hanley (4-SER-374-78) identified lactation and breastfeeding-related diagnoses codes.

Similarly, UHC's proffered expert Ms. D'Apuzzo, identified numerous other diagnoses codes that, on their face, describe lactation-related issues and breast issues, and that overlap with the diagnosis codes identified by Dr. Hanley. 3-ER-530-531.

In fact, effective January 1, 2020, UHC updated its preventive care services CDG, specifically to reflect some expanded coding for lactation counseling, adding both new procedure and nearly fifty (50) new diagnosis codes eligible for CLS coverage.[9] Many of the new diagnosis codes are the ones identified by Dr. Hanley and Ms. D'Apuzzo. These changes made in 2020 to the CDG, which were not identified as having been mandated by new regulatory guidance, demonstrate that the CDG policy on CLS coverage was fundamentally deficient when this Action was initiated and being prosecuted.

D. UHC Knew the Issues with and Harm Caused by its CLS Policy

UHC employed a Catch 22: establish a policy that wrongly states and provides that only in-network CLS claims are eligible for coverage under the ACA mandate, tell its members they could only receive the ACA benefit for CLS by using in-network providers, but UHC organizationally did not know which of its in-network providers would and did render CLS.

[9] *See,* UHC announcement, https://www.uhc.com/broker-consultant/ news-strategies/resources/2020-preventive-updates-to-coverage-determination-guideline; and page 47 of UHC's 1/1/2021 CDG, *https:*//www.uhcprovider.com/ content/dam/provider/docs/public/ policies/comm-medical-drug/preventive-care-services.pdf, *last visited 2/25/2021*.

This was not lost on UHC's employees. Ms. Naccarato, Director Member Services, stated that:

> We have tested multiple scenarios in the portal and we tried checking physicians/hospitals individual websites for searches. Sometimes we come up with it and sometimes we do not-the time it takes would be a considerable AHT buster. ..I think our only option is to call the members OBGYN to see if they have [a lactation specialist] on staff or one that they recommend. The big drawback is that the person they are using may not be INN.

(2-SER-215 at 114402-06). Further, as Ms. Proctor pointed out,

> ***The concern is access to care and how this is being addressed at UHC***. I did a national search on our directory and had very few hits across the country…Our communications say we have various in-network clinics[,] where are these clinics in the event the OB/GYNs and pediatricians are not providing the service? We provide very detailed info about breast pumps and how to access yet limited info on lactation support.

(2-SER-239 at 109546) (emphasis added).

On January 4, 2016 UnitedHealth Group's Chief Medical Officer, East Region from 2002 through 2016, Catherine Palmier, M.D. wrote, "***Unless we have some lactation consultants contracted*** we will have member dissatisfaction...***ob's and peds are not automatically skilled in lactation support***." (3-SER-244) (emphasis added). Dr. Palmier's points were the centerpiece of a UHC group discussion in mid-January 2016, as per Sharon Wakefield's 1/14/2016 notes: "**Issue:** Guidance requires insurers to provide a list of lactation counselors. Unless we have some lactation consultants contracted (*and searchable in the provider directory lists*) we will have member dissatisfaction. 'OB's and peds are not automatically skilled in lactation support. (Cathy Palmier 1/4/16)'" (3-SER-251) (emphasis in original).

Just as UHC internally recognized that its apparent assumption that obstetricians

or pediatricians would or could deliver CLS was baseless, that is something that has been further established through expert evidence. 3-SER-255 (Noting "the material gaps in physicians' education, training and experience regarding breastfeeding support and counseling [;] and [ ] an absence of coordinated care among providers during the post-partum period. [UHC's expert] implies that the hand-off of care from a hospital team or mid-wife to a pediatrician provides adequate and complete patient access to breastfeeding and lactation counseling; I disagree.").[10]

Under UHC's policy, UHC class members were stuck on UHC's proverbial merry-go-round: "What if the member is requesting a Gap exception stating there is no one in network to provide these services? ***We would not have a way to search for someone who can provide them."*** **2**-SER-204-206 (emphasis added).

Indeed, UHC's call center was telling members that only in-network CLS claims were eligible for coverage under the ACA mandate, but then telling them to go contact their network providers and not making insureds aware of the identity of any network provider that in fact provided CLS. 3-SER-197. Further compounding the problem UHC created for the Plaintiffs and its insureds, UHC's directive conflicts with its

[10] 2-SER-317 (Plaintiffs' expert Dr. Morton stated that, "Although some pediatricians or OB/GYNs may provide CLS, it is by no means the norm, the availability of [] [CLS] from OB/GYNs or pediatricians is inconsistent and sporadic at best. It is impractical and unrealistic to expect mothers to be able to determine which OB/GYNs, pediatricians or other primary care providers [] [in their health plan's network are providing] CLS" as a covered benefit, and such policy ignores many practical aspects of a physician's practice, including, among other things, that care is limited to established patients, and availability of appointments for new patients typically require lengthy wait times.)

definition of "Network", which acknowledges that providers are not "in-network" for any and all services.[11]

UHC could not identify network providers who provided CLS. First, UHC did not affirmatively determine or survey its network providers to determine if they were able to and would deliver CLS. 3-SER-303-304. Further, in response to Plaintiffs' request for the identity of every lactation specialist and lactation specialist group in UHC's network since October 2012, UHC responded that "[s]uch providers are identifiable in Defendants' systems by the specialty [code] '380"'. 2-SER-16-17. UHC admitted that only its network providers it internally identified by the specialty code number "380" have been electronically searchable as "Lactation Specialists" in UHC's provider directory since March 2014. 2-SER-018-019. As of August 2018, nationwide, from UHC's records, Plaintiffs' expert identified that UHC had only 122 unique in-network lactation specialists (and 22 unique terminated) identifiable as "lactation specialists". 4-SER-330. In addition, for 20 states, UHC's data reflected that it had no in-network providers identified during the Class Period as lactation specialists. 3-SER-335. Further, even viewing the data by the metropolitan statistical areas ("MSAs") where such identified lactation specialists were located, there were four or less providers identified

[11] "A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services….In this case, the provider will be a Network provider for the Covered Health Services…and a non-Network provider for other Covered Health services..." 3-SER-275; 3-SER-296.

per 1,000 live births, with most MSAs having less than one in-network provider per 1,000 live births. 3-SER-336-7.

The Departments of Health and Human Services, Labor, and the Treasury (the "Tri Departments") were charged with issuing regulations in several phases implementing the ACA. 2-SER-038.[12] The Tri-Departments' October 23, 2014 ACA Implementation FAQ #2 underscores why UHC's CDG violates the ACA: the imposition of cost-sharing on insureds is "premised on enrollees being able to access the required preventive services from in-network providers." 5-SER-663. UHC's CDG and its conduct with respect to CLS coverage are categorically at odds with that obvious, commonsense premise.

When it came to the ACA's preventive care coverage requirements, UHC pegged CLS as a way to minimize its financial risks associated with the ACA. 4-SER-682. To "minimize" the financial risk, UHC assumed **$0** incremental costs/financial impact ***specifically*** for breastfeeding support counseling services. 4-SER-648. At $0 financial impact, UHC coverage for CLS could not meet the ACA requirement expanding coverage for CLS. UHC could not meet its $0 financial impact assumption if it contracted

[12] The "[Tri] Departments [ ] released FAQs …to provide guidance related to the scope of coverage required under the recommendations and guidelines, including coverage of ….breastfeeding and lactation counseling…If additional questions arise regarding the application of the preventive services coverage requirements, the Departments may issue additional subregulatory guidance." 4-SER-675; *see Eternal Word TV Network, Inc. v. Sec'y of the U.S.HHS*, 818 F.3d 1122, 1179 (11th Cir. 2016) ("When Congress enacted the ACA it ceded broad authority to [the Tri-Departments, the] three Executive-branch administrative agencies to promulgate rules governing the availability of women's preventive health services in employer-sponsored health plans.")).

with lactation specialists and lactation specialist groups, and then identified to its members those lactation consultants, and established a CDG that correctly articulated the scope of CLS coverage under the ACA mandate.

E. UHC Did Not Provide Plaintiffs And Intervenor Plaintiff With Coverage For CLS That Complied With The ACA

Plaintiffs are participants and/or beneficiaries of employer healthcare plans ("Plans") provided and administered by UHC. 5-SER-745-747. All of the Plaintiffs' Plans, like all non-grandfathered, non-federal health plans administered by UHC, are covered by the ACA. 5-SER-753. Further, all of the Plans, except for Carroll's healthcare plan, are covered by ERISA. In addition, each Plaintiff's non-grandfathered, non-federal health Plans expressly provides that under the ACA, insureds will have coverage for the ACA-mandated preventive services benefit. 6-ER-1186.

It is undisputed that the CDG applies to all commercial plans, including the plans covering all Plaintiffs. 4-SER-678-679. And, it is undisputed that UHC's coverage policies with respect the ACA preventive care services, including the CLS services received by each Plaintiff and governing each Plaintiff's CLS claim denied by UHC, are contained in the challenged CDG. 4-SER-678-679.

The consequences of UHC's failures, starting with the fundamental (wrong) construct established by UHC in the CDG that out-of-network claims are not eligible for coverage without cost-sharing under the ACA, were foreseeable. Each Plaintiff wrongly incurred costs for CLS.

Plaintiff Carroll gave birth to her daughter at a hospital in Fort Collins, CO in

August 2015. Prior to receiving CLS, she searched UHC's website for providers of CLS, but no such providers were identified within a 100 mile radius of her home. 5-SER-815-816. Through her own independent research, she identified The Youth Clinic, which was a UHC network provider, but when she contacted them, they were only providing lactation services to established patients. 5-SER-919-921. Thereafter, Plaintiff Carroll received CLS from two providers, who were not in-network with UHC, on September 16 and 19, 2015, and November 2 and 14, 2015, respectively. 5-SER-829, 832, 846-848. Carroll submitted all four CLS claims, but was denied coverage and not issued any reimbursement from UHC, resulting in an out-of-pocket expenditure of $280. 5-SER-835, 838, 848. The first claim was processed at Plaintiff's out-of-network level of benefits (5-SER-835), and the three subsequent claims were denied on the basis that the "service is excluded by [her] health plan". 5-SER-838, 848. When Carroll contacted UHC to request information on submitting an appeal to challenge the wrongful denial of coverage (5-SER-906), the representative instructed her to locate the form online, but she could not find it. 5-SER-924-925.

Plaintiff Hoy gave birth to her son in September 2015 at a hospital in Montgomery County, PA. Before seeking CLS, she conducted an exhaustive search of UHC's website for CLS providers, but the closest provider was located over 30 miles away in Princeton, NJ. 5-SER-933, 961-962. When Plaintiff Hoy contacted UHC she was told that she was not eligible for coverage, (5-SER-962, that she would not be able to get an exception (a "GAP" exception) to secure coverage for out of network CLS

claims, and "to speak with the pediatrician, her doctor or hospital to see who they suggest and bill under their [in network] tax ID#." (*Id.*). Plaintiff Hoy received CLS from out-of-network providers on three occasions, September 10, September 28 and October 5, 2015, for $345. 5-ER-1127-28, 1132-1133, 1169-70. UHC denied Plaintiff Hoy's claims, issuing her EOBs that stated her CLS was "not a reimbursable service" and that "[t]here may be a more appropriate CPT or HCPCS code that describes this service and/or the use of the modifier or modifier combination is inappropriate." *Id.* Despite further efforts by Plaintiff Hoy, UHC told her that the letter she submitted (5-ER-1139-1162) did not "qualify as an appeal," and she was left responsible for the full amount of $345 for her CLS. 5-ER-1166.

Following the birth of her daughter in July 2015 at a Hartford, CT area hospital, **Plaintiff Endicott** sought to locate UHC in-network CLS providers. When she called UHC, she was told that "[t]here is no coverage for services billed by a lactation specialist…Lactation specialists are generally an exclusion." 5-SER-949. Moreover, UHC did not identify *any* in-network lactation specialist during the call. *Id.* After receiving CLS services on Sept. 23 and Oct. 1, 2015, at a cost of $255, Plaintiff Endicott submitted the two claims to UHC. 5-ER-897-898. UHC initially denied her claims on the basis that it "asked the member for more information and didn't receive it in time," (5-ER-912-913), which directly conflicted with UHC's letter previously sent to Endicott regarding her claims and instructing her that she did "not need to respond or take any action at this time." (5-ER-906)(stated in bold, "**For your information only – no action required**").

Ultimately, UHC reprocessed her claim, applied an "eligible expense amount" (essentially applied the cost to her non-network deductible), leaving Plaintiff Endicott responsible for the full $255 cost of the CLS. 5-ER-917-918.

Following the birth of her son in July 2015, **Plaintiff Bishop** sought coverage from UHC for CLS. Prior to receiving CLS, she conducted a "comprehensive" search on UHC's provider portal for trained providers of CLS, but she was not able to locate any providers, even after expanding the default mile distance. 5-SER-943-944. Bishop also called UHC's customer service, but the representative was unable to identify any in-network providers "who could help support [Bishop] with [her] lactation needs" 5-SER-938, 946-947. Despite other efforts to secure coverage, Plaintiff Bishop received CLS from an out-of-network provider on Aug. 5, 2015, and UHC denied the claim on Sept. 28, 2015 on the basis that "[t]his is not a reimbursable service. There may be a more appropriate CPT or HCPCS code that describes this service and/or the use of the modified or modifier combination is inappropriate." 5-ER-956-957. Plaintiff Bishop was denied coverage and not issued any reimbursement by UHC, resulting in an out-of-pocket expenditure of $130. *Id.*

Plaintiff Condry had a home birth on in February 2015 in Oakland, CA. Plaintiff Condry's midwives referred her to an out-of-network CLS provider for breastfeeding assistance, she submitted her claim for CLS services in the amount of $225, which UHC denied in full stating that her CLS "is not a reimbursable service. There may be a more appropriate CPT or HCPCS code that describes this service and/or the use of the

modifier or modifier combination is inappropriate." 5-ER-940-941. Plaintiff Condry also received CLS on two other occasions, March 19 and April 14, 2015, for $331 (6-ER-1248), deeming such efforts futile Plaintiff Condry did not submit those claims or further appeal the denial of her CLS denied claim. 5-SER-754. In total, Plaintiff Condry was held responsible for $556 for her CLS.

After the birth of her son in February 2016, at a San Francisco, CA hospital, **Plaintiff Barber** received two lactation consultations from an out-of-network CLS provider on Feb. 19 and 24, 2016, paying $345 and $245, respectively. 5-ER-929-934. UHC denied both CLS claims stating that her "plan does not cover this non-medical service or personal item." *Id.* In response to Barber's appeal, UHC issued her a letter stating that they "reviewed the claim and determined it was processed correctly. This service is not covered by the health benefit plan," thereby leaving Barber responsible for the $590 fee. 5-SER-759; 5-ER-929-934.

Intervenor Plaintiff Harris gave birth to her daughter in October 2016 at a hospital in Philadelphia, PA. Prior to receiving CLS, she contacted UHC to confirm the network status of a CLS provider in Abington, PA who her pediatrician recommended. 5-SER-776. However, the UHC representative was unable to confirm if the CLS provider was in-network, nor fulfill her request for a list of in-network CLS providers in the Philadelphia area. *Id.* Intervenor Plaintiff Harris received CLS from an out-of-network provider on Jan. 5 and 10, 2017, and UHC processed her claims by imposing cost-sharing, applying a portion of the first claim and the full amount of the second claim to

her deductible, leaving her responsible for full cost of $250. 5-SER-798-803. In response to her appeal (5-SER-790-793), UHC issued her a letter finding that Ms. Harris' CLS claims were "processed correctly." 5-SER-790.

Plaintiffs allege that Defendants have violated ERISA[13] and the Plan documents by not establishing policy and procedures to provide coverage as mandated by the ACA for CLS as a preventive service. 6-ER-1220, 1273, 1280-82.

Plaintiffs sought an order holding that UHC's CDG with respect to CLS coverage violated the ACA. 3-ER-497-500; 4-ER-733. On behalf of themselves and UHC insureds whose CLS claims were also not covered in whole or part, Plaintiffs sought an order requiring such CLS claims to be reprocessed under an ACA-compliant policy. *Id.* Plaintiffs also sought an order enjoining UHC from not complying with the ACA's CLS coverage mandate going forward. *Id.*

F. UHC's Denial Reasons Do Not Comply With ERISA

F.1. The Four UHC Remark Codes at Issue

After auto-processing the claim, UHC sends to its plan participants and beneficiaries claims outcome letters, which are sometimes referred to as Explanations of Benefits ("EOBs"), that include the remark codes. 3-ER-517.

[13] Under ERISA, health plan fiduciaries are obligated to administer private employer-provided plan benefits in accordance with the terms of the plan documents and applicable law. 29 U.S.C. § 1104(a)(1)(D). In administering plan benefits, fiduciaries must adhere to ERISA's strict duties of loyalty and care, including the obligation to act solely in the interests of the plan participants and/or beneficiaries. 29 U.S.C. §§ 1104(a)(1)(A)(i), 1104 (a)(1)(B).

Out of hundreds, only ***four*** of UHC's Remark Codes are at issue. One or more of the following Remark Codes were set forth by UHC as the reason why UHC ***denied*** the out-of-network lactation services claims:

1) Remark Code KM: "This is not a reimbursable service. There may be a more appropriate CPT or HCPCS code that describes this service and/or the use of the modifier or modifier combination is inappropriate."

2) Remark code I5: "This service code is not separately reimbursable in this setting."

3) Remark code 13: "Your plan does not cover this nonmedical service or personal item."

4) Remark code B5: "Payment for services is denied. We asked the member for more information and didn't receive it on time."

3-ER-479; 1-ER-28; Defendants-Appellants' Brief, Dkt. Entry 9 at 26.

ERISA expressly requires that when a claim for coverage of benefits is denied the written denial must "set[] forth the specific reasons for such denial" and be "written in a manner calculated to be understood by the participant." 29 U.S.C. § 1133 ("ERISA § 1133"); *see also* 29 C.F.R. § 2560.503-1(g). In full, ERISA § 1133 states as follows, providing two key requirements, in the conjunctive:

> In accordance with regulations of the Secretary, every employee benefit plan shall—
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of

the decision denying the claim.

Moreover, under *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…" From October 1, 2012 through December 31, 2018, UHC issued approximately 7,600 EOBs that included one of the Remark Codes as the reason for the denial of a CLS claim. The five ERISA Plaintiffs (*i.e.,* all Plaintiffs except Ms. Carroll), asserted that UHC violated ERISA when it denied their CLS claims by its failure to provide adequate notice through use of one or more of the four Remark Codes.

F.2. The Four Remark Codes are Not Understandable or Reasonably Clear Under ERISA

According to UHC, the four Remark Codes were purportedly "written to be short, understandable narratives and descriptions", because UHC's system is not "designed to extract the specific exclusion language from the member's specific plan to include in the remark code section of the EOB." 3-ER-517-518.

Moreover, the Remark Codes are developed by UHC's Remark Code Governance Team (3-ER-518), and UHC and its experts contend that they are "mapped to industry standard language." *Id.*

However, a review of the Remark Codes and the purported industry standard to which they were mapped, as set forth in ¶17 of the declaration of UHC employee Ms. Thompson, (3-ER-519), belie such contentions of clarity and consistency.

For example, with respect to Remark Code KM ("This is not a reimbursable service. There may be a more appropriate CPT or HCPCS code that describes this

service and/or the use of the modifier or modifier combination is inappropriate"), Ms. Thompson states that it was purportedly mapped to the code: "The procedure code is inconsistent with the provider type/specialty (taxonomy)." *Id.* The "industry standard" (even if it could) provides no safe harbor for UHC, as UHC's code is materially, substantively different, and, also, as the district court held, facially unintelligible.

Likewise, evidence obtained from UHC's proffered expert, Ms. D'Apuzzo, concerning Remark Codes, support the district court's summary judgment and class certification orders, and undermines UHC's arguments about the clarity and purpose of its Remark Codes. Throughout Ms. D'Apuzzo's Amended Expert Report, she routinely concludes that UHC's remark code language is consistent with industry practice or industry standard, but never cites to any comparable practice or standard from any other health plan. 3-ER-533. Yet, Ms. D'Apuzzo could not plainly explain why the Remark Codes were understandable or what was meant or intended by certain language in the Remark Codes.

For example, with respect to Remark Code KM ("This is not a reimbursable service. There may be a more appropriate CPT or HCPCS code that describes this service and/or the use of the modifier or modifier combination…"), Ms. D'Apuzzo acknowledged that the EOB did not state what is a CPT or HCPCS code (4-SER-580-581), and "an insured reading the EOB in its entirety would not know what CPT or HCPCS code was being referenced" (4-SER-582). With respect to Remark Code I5 ("This service code is not separately reimbursable in this setting"), Ms. D'Apuzzo stated

that the reference to "code" "could be CPT code….[b]ut above, on top they're taking about type of service office visits" (4-SER-583), and, she "believe[d] they are referencing above. I mean, without it saying CPT, I assume they're referencing what it states above." (*Id.*) And, with respect to the term "setting", "For [her], it means place of service", based on her industry knowledge." (*Id.*).

UHC offered incomprehensible reasons with their use of the four Remark Codes for denying Plaintiffs' claims.

F.3. The Revised Denial Reasons

Under the broad discretion of the district court, Plaintiffs are entitled to have UHC provide understandable explanations for the CLS denials that contained one or more of the four Remark Codes and, with that information in hand, the ability to resubmit a corrected claim. "Having found that the Plan violated [29 U.S.C. § 1133], the procedural requirements for notice of denial of benefits, the Court has some discretion in determining the appropriate remedy." *Schaub v. Consolidated Freightways, Inc. Extended Sick Pay Plan*, 895 F. Supp. 1136, 1145 (S.D. Ind. 1995). Here, Plaintiffs "may invoke section 1132(a)(3) to compel the plan administrators to establish claim procedures which comply with the ERISA regulations promulgated by the Secretary of Labor." *Arsenault v. Bell*, 724 F. Supp. 1064, 1068 (D. Mass. 1989).

The district court, in certifying the Denial Letter Class, ordered UHC to send a letter to each member of the Denial Letter Class "that explain[s] the basis for the denial of the lactation claim in a comprehensible fashion (which would, in turn, allow

participants to meaningfully assess whether to contest the denial)" (the "Remark Code Letter") 1-ER-67; 2-ER-39-43, 45-48.

The Remark Code Letter plainly informs each class member *why* she is receiving the notice, specifically that, (i) she had a claim for CLS denied by UHC since August 2012 to the present, (ii) it utilized the listed Remark Code, and (iii) the court has directed UHC to better explain the denial of her CLS claim. 2-ER-40, 45. The Remark Code Letter sets forth, for each Remark Code, a detailed revised description of the denial reason, and information as to how the class member can respond and possibly cure the reason why the claim was denied. 2-ER-40.

Ultimately, the parties substantially agreed to language to use to explain the Remark Codes used as the basis for denial of the insureds' out-of-network CLS claims. 1-ER-45-46. For example, for insureds who received the KM Remark Code - "There may be a more appropriate CPT or HCPCS code that describes this service and/or the use of the modifier or modifier combination" – they are now informed: (i) that their out-of-network claim was denied because their "provider was not eligible to bill the medical procedure code" that appeared on their claim; (ii) that a corrected claim needs to be resubmitted and how; and (iii) that the CDG identifies lactation services codes and are provided a link to the CDG. 2-ER-40-43, 44-47.

When the explanations in the Remark Code Letters are juxtaposed with the content of the original four Remark Codes, it just further affirms why the original Remark Codes were not written in a manner calculated to be understood by insureds and did not

afford insureds the opportunity to receive a full and fair review of the denials.

G. The District Court Erroneously Granted Summary Judgment In Favor Of UHC By Undertaking An Assessment of Each Plaintiff's Conduct In Place Of The Necessary, Foundational Inquiry Of Whether UHC Had Established ACA-Complaint Policies and Procedures for CLS Coverage Under Which Plaintiffs Were Insured

Over Plaintiffs' objections, UHC affirmatively sought to have summary judgment proceedings occur prior to the filing of any motion for class certification, and the parties cross-moved for summary judgment. 5-SER-963-964; 1-ER-146; 4-ER-743; 4-SER-683; 4-ER-736.

In their cross-motion for summary judgment, Plaintiffs presented the district court with fundamental evidence and law that formed the basis for Plaintiffs' lactation services claims, and on which they sought judgment: the ACA, its groundbreaking federal mandate that health plans nationwide provide coverage without cost-sharing for preventive health services including CLS, and UHC's policies and procedures, and conduct, in response thereto. 4-SER-683; 4-ER-736.

The foundational inquiry raised by Plaintiffs' claims and required to be resolved, so as to not have the tail wag the dog, was: Did UHC's coverage policies and procedures meet the ACA's requirements for CLS coverage? Plaintiffs presented evidence and argument as to why they did not, and UHC, which had filed the opening summary judgment brief, had presented its evidence and argument as to why it had. 6-ER-104; 4-SER-683-721;4-ER-736.

The district court, however, viewed the basis for entry of summary judgment

differently, focused not on UHC's general practices and whether the CDG was ACA-compliant, but on the Plaintiffs' conduct in seeking out CLS and whether the network lactation specialists were located proximate to each Plaintiff. 1-ER-26. The district court did not entertain whether UHC was even providing coverage consistent with the ACA. Nevertheless, the district court erroneously entered judgment in UHC's favor on Plaintiffs' Barber and Condry's claims, extinguishing without proper resolution the very crux of their claims against UHC. 1-ER-26.

H. The District Court Twice Erroneously Denied Class Certification of the Claims Reprocessing Class and Plaintiffs' Standing to Enjoin UHC's Illegal Policies

Thereafter, Plaintiffs twice sought certification under Fed. R. Civ. P. 23(a) and (b)(1) and/or (b)(2) of three classes of UHC insureds: two pertaining to Plaintiffs' ACA CLS coverage claims, the Claims Reprocessing Class; and, one pertaining to UHC's use of the four Remark Codes held by the district court to have violated ERISA at summary judgment (1-ER-27-29), the Denial Letter Class.

Relying on *Booton,* 110 F.3d at 1463, and the requirements of ERISA §1133, the district court granted certification of the Denial Letter Class, holding that as to the four Remark Codes: UHC's "denial letters as to these class members violated ERISA in the same way as to each participant"; UHC was required to send a letter to the members of the class "explain[ing] the basis for denial in a comprehensible fashion (which would, in turn, allow participants to meaningfully assess whether to context the denial)"; and certification was proper even if "some members of the class" may have resolved the

dispute between themselves and UHC, as the letter can be worded to address that circumstance. 1-ER-12-13; 1-ER-27-29.

As to the Claims Reprocessing Class, the district court twice denied certification under Rule 23. 1-ER-13-22; l-ER-535-540. At the crux of the district court's orders denying class certification of the Claims Reprocessing Class is the refusal to address Plaintiffs' claims from the standpoint which they were alleged: that UHC failed to have ACA-compliant coverage policies. Instead, the district court unilaterally deemed that the CDG was not a "blanket policy" (2-ER-55, 59), brushed aside consideration of UHC's CDG, and then erroneously held that UHC had no uniform standard or practice for Plaintiffs to challenge. 1-ER-15. That conclusion portends the outcome.

The district court's analyses and conclusion are irreconcilable with the undisputed facts and evidence presented by Plaintiffs: the CDG was UHC's ACA preventive services coverage policy for CLS, it's applied to all UHC plans governed by the ACA, and applied to both in- and out-of-network CLS. Plaintiffs challenge two primary aspects of the CDG: its exclusion of out-of-network CLS from eligible ACA coverage, and its limitation on the scope of CLS covered. The answers as to whether the CDG violates the ACA do not evoke individualized issues. The resolution of those questions – whatever that resolution may be - must be determined on the policy level, or, in other words, resolved on a class wide basis. The very nature of insurance coverage demands that common finding and application; coverage cannot be haphazard, uncertain, or discriminatory. The district court's erroneous supposition about the CDG tainted and precluded any

legitimate consideration under Rule 23 and this Court's precedent to which Plaintiffs were entitled.

Finally, while Plaintiffs' challenge to ongoing misconduct by UHC "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" (1-ER-14, emphasis added), the district court erroneously held that no Plaintiff had standing to enjoin UHC's continued use of its non-ACA compliant CDG and its ongoing CLS coverage failures. 1-ER-14; 3-ER-538-539.

The district court compounded the error with respect to its holdings concerning standing by denying Intervenor Plaintiff Harris her right to intervene for purposes of class certification, holding that, "[a]lthough she alleges that she was improperly denied coverage for out-of-network lactation services and that she continues to be a [UHC] plan participant, she includes no allegation about the likelihood that she will need lactation services in the future". 1-SER-003. The incongruity of the district court's holdings in the context of health insurance coverage is shown by the fact that just days after the court's class certification rule issued (1-ER-22), Plaintiff Condry again became insured by UHC effective January 1, 2020.

SUMMARY OF ARGUMENT

UHC makes a candid, material admission in its attempt to secure reversal of the district court's orders concerning the Remark Codes and Denial Letter Class. UHC asserts that the proposed Letter, that would be sent to the members of the Denial Letter

Class (ER-39-43), risks "confusing class members by inviting them to resubmit claims for [their out-of-network CLS] services…***without any reason to believe any resubmitted claims will yield a different outcome***." Defendants-Appellants' Brief, Dkt. Entry 9 at 26, 32 and 54 (emphasis added). This suggestion of a pre-ordained outcome shows that UHC is just giving lip service to its argument that the Remark Codes are intended to initiate a meaningful dialogue. That argument fails in the context of CLS coverage. The proposed Letter contains detailed, new explanations about the reasons UHC insureds were given for why the their out-of-network CLS claim was denied. Yet, by UHC's account, there is "no reason to believe any such appeal will yield a different claims outcome." *Id.* at 32.

Why? Because pertinent to both the Claims Reprocessing Class and Denial Letter Class, UHC's CLS coverage policies render the denials the outcome. This is consistent with the evidence, the CDG, and what Plaintiffs have asserted from the outset, but which the district court has erroneously stymied by its refusal to recognize or consider the overarching impact of the CDG. The CDG controls: it expressly excludes out-of-network CLS from ACA-eligible coverage, and it expressly limits the scope of CLS that it will cover without cost-sharing.

The district courts' opinions and orders have erroneously marginalized, disregard or misapprehend that what is at issue is a federal health care coverage law, the ACA, that UHC is required to implement across all its non-federal, non-grandfathered plans, nationwide, and that such implementation is contained in the CDG. 1-ER-19, 20. In a

rather striking instance of this, the district court expressed that "[i]ndeed, jumping through some extra administrative hoops to obtain out-of-network coverage is a familiar concept, at least for people accustomed to using health insurance." 1-ER-21. That is not only a highly problematic proposition, it is directly contrary to what the ACA mandated with respect to coverage for preventive health services, including CLS.

The district court's opinions and orders reflect a disregard or misunderstanding of the language in the CDG. As noted, the CDG mistakenly and unequivocally states that "out-of-network preventive care services are not part of the [ACA] requirement." (1-ER-14). It is a bit perplexing how, in light of the CDG language, the district court states that "[UHC] sometimes *miscommunicated* with participants who called to inquire about coverage *telling them that as a blanket matter that out-of-network services were not included*." 1-ER-12 (emphasis added). But, that is not a miscommunication, it *is* what the policy says and it is "a blanket matter". Similarly, in denying certification of the Claims Reprocessing Class, the district court wrote: "Several documents, such as the Coverage Determination Guide…stated that there was no obligation to cover out-of-network lactation services, which was true in situations where in-network services were available to the participant but false in situations whether in-network services were unavailable." 1-ER-14. That construct is not grounded in the FTC. 1-ER-14; 3-ER-537. The evidence (*supra)* was that UHC did not have available network providers who provided CLS. In addition, there is no evidence that availability is part of any construct employed or determination made by UHC. UHC did not adjudicate out-of-network CLS claims based on whether

in-network services were available or unavailable to the claimant; this is a practical fact that UHC cannot dispute yet the district court erroneously assumed UHC did or speculates it may have. UHC did not: adjudicate each out-of-network CLS claim by determining any in-network provider availability; it did not inform the insured that its claim was denied because UHC identified an available in-network provider; or it did not invite its insureds to demonstrate the negative, that is, that each insured did not have in-network lactation services available to them.

At bottom, as discussed *infra,* it was an abuse of the district court's discretion to deny certification to the Claims Reprocessing Class, when premised on the district court's implausible findings and unsupported inferences, concerning the CDG, which resulted in the district courts' failure to apply the correct, applicable Rule 23 legal principles. Similarly, on summary judgment, the district court extinguishing of Plaintiffs' Condry's and Barber's claim that UHC did not provide them with ACA-compliant policy, without assessing UHC's policies and conduct is an abuse of discretion.

The district court correctly holds UHC liable under ERISA for violating a critical, straightforward requirement that they inform insureds why their claims are being denied in an understandable manner. However, the district court's orders denying certification need to be overturned, so that the Plaintiffs and members of the Claims Reprocessing Class can proceed with the determination of whether the CDG violates the ACA, the resolution of which would apply to all of UHC's ACA-governed health plans and CLS claims.

ARGUMENT

I. Standards of Review

This Court reviews *de novo* the district court's orders granting summary judgment. *Edgerly v. City & Cty. of S.F.*, 599 F.3d 946, 953, 960 (9th Cir. 2010). Summary judgment is appropriate if "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). The deciding court must view the evidence, including all reasonable inferences, in favor of the non-moving party. *Cortez v. Skol*, 776 F.3d 1046, 1050 (9th Cir. 2015). "An issue of material fact is genuine if there is sufficient evidence for a reasonable jury to return a verdict for the non-moving party." *Id.* (*quoting Thomas v. Ponder*, 611 F.3d 1144, 1150 (9th Cir. 2010)).

This Court reviews the decisions denying class certification for abuse of discretion. *Sandoval v. Cnty. of Sonoma*, 912 F.3d 509, 515 (9th Cir. 2018) (denial of class certification). "A class certification order is an abuse of discretion if the district court applied an incorrect legal rule or if its application of the correct legal rule was based on a factual finding that was illogical, implausible, or without support in inferences that may be drawn from the facts in the record. . . ." *Sandoval*, 912 F.3d at 515 (citation and internal quotation marks omitted).

The district court's summary judgment order ("SJ Order") correctly entered judgment in favor of the ERISA Plaintiffs by holding that UHC's Remark Codes violated ERISA's notice requirement, citing this Court's precedent, including *Booton, supra*. 1-ER-27-29.

The Ninth Circuit Court of Appeals reviews "a district court's denial of a motion for intervention as of right *de novo,*" except for the issue of timeliness, which is reviewed for abuse of discretion. *Donnelly v. Glickman*, 159 F.3d 405, 409 (9th Cir. 1998). "In determining whether intervention is appropriate, we are guided primarily by practical and equitable considerations. *See* Fed. R. Civ. P. 24 (a)(2) advisory committee note ("if an [applicant] would be substantially affected in a practical sense by the determination made in an action, [the applicant] should, as a general rule, be entitled to intervene. . . ."). We generally interpret the requirements broadly in favor of intervention." *Id.*(citing *United States ex rel. McGough v. Covington Techs. Co.,* 967 F.2d 1391, 1394 (9th Cir. 1992) ("Generally, Rule 24(a)(2) is construed broadly in favor of proposed intervenors and we are guided primarily by practical considerations.") (internal quotation marks and citation omitted)).

A four-part test has been adopted by this circuit to determine whether applications for intervention as a matter of right pursuant to Rule 24(a)(2) should be granted:

> An order granting intervention as of right is appropriate if (1) the applicant's motion is timely; (2) the applicant has asserted an interest relating to the property or transaction which is the subject of the action; (3) the applicant is so situated that without intervention the disposition may, as a practical matter, impair or impede its ability to protect that interest; and (4) the applicant's interest is not adequately represented by the existing parties.

United States v. Stringfellow, 783 F.2d 821, 826 (9th Cir. 1986) *(*citing *Sagebrush Rebellion, Inc. v. Watt*, 713 F.2d 525, 527 (9th Cir. 1983); *County of Fresno v. Andrus*, 622 F.2d 436, 438 (9th Cir. 1980)).

II. The District Court Abused its Discretion in Denying Certification of the Claims Reprocessing Class

The district court abused its discretion in denying certification of the Claims Reprocessing Class pursuant to Rules 23(b)(1) and/or (b)(2). The district court's December 23, 2019 (1-ER-13-22, "December CC Order") and May 23, 2019 (3-ER-536-541, "May CC Order") class certification orders should be overturned for the following reasons.

A. In Denying Class Certification the District Court Erroneously Disregards Evidence and Decides the Merits of UHC's Policy

As discussed *supra,* the ACA required UHC to provide all of its insureds in non-grandfathered, non-federal health benefit plans with cost-share-free coverage of CLS. UHC's policy applied to every UHC non-grandfathered, non-federal plan nationwide and each class member's CLS claim, irrespective of whether it was an in- or out-of-network CLS claim.

The district court's class certification inquiry should have ended there, as required under Rule 23(b)(1) and/or (2). *See Mazza v. Am. Honda Motor Co.*, 666 F.3d 581, 588 (9th Cir. 2012) (The commonality prerequisite looks to whether the "claims 'depend upon a common contention' such that 'determination of its truth or falsity will resolve an issue that is central to the validity of each claim in one stroke.'") (quoting *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011)).[14]

[14] In Plaintiffs' initial motion for class certification, plaintiffs sought certification of both in-and-out-of-network CLS claims. In view of the district court's statement that "perhaps…the plaintiffs were too focused on getting the wrong classes certified (that is,

However, as discussed *supra in* Section H, the district court declined to certify the Claims Reprocessing Class, because it was disregarding: (i) UHC's CDG and its coverage policies (which are fundamental to UHC providing insureds ACA-compliant CLS coverage); and (ii) that the question of whether UHC's CDG and policies violate the ACA applies equally to each of the class members. Plaintiffs challenge two primary aspects of the CDG: its exclusion of out-of-network CLS from eligible ACA coverage, and its limitation on the scope of CLS covered. The answers as to whether the CDG violates the ACA do not evoke individualized issues. [15]

Likewise, the district court, contrary to the evidence, concluded that the CDG was not a "blanket policy" (2-ER-55, 59), and then erroneously held that UHC had no uniform standard or practice for Plaintiffs to challenge. 1-ER-15.

The district court erroneously ruled on the merits of UHC's policy. *Ellis v. Costco Wholesale Corp.*, 657 F.3d 970, 983 n.8 (9th Cir. 2011) ("The district court is required to examine the merits of the underlying claim …only inasmuch as it must determine whether

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classes which included people who were allegedly denied coverage in-network)" (3-ER-538), Plaintiffs left that issue for later appeal as to the Claims Reprocessing Class. Plaintiffs' renewed class certification motion sought certification of classes of UHC insureds who received CLS from out-of-network providers. 3-ER-479. The ACA mandate and the CDG apply to both in and out-of-network CLS claims. *See, e.g., Abdullah*, 731 F.3d at 957 (every question of law or fact need not be common to the class; all that Rule 23(a)(2) requires is a single significant question of law or fact).

[15] As Plaintiffs addressed with the district court (2-ER-188-189), there are no differing standards or an availability construct applicable to class members. UHC did not: adjudicate each out-of-network lactation services claim by determining any in-network provider availability; inform the insured that its claim was denied because UHC identified an available in-network provider; or invite its insureds to demonstrate the negative, that is, that each insured did not have in-network lactation services available to them. *Id.*

common questions exist; not to determine whether class members could actually prevail on the merits ..."). The district court stated "I don't read [the policy] as a statement that's contradictory to the requirements of the ACA." 2-ER-55.

Also compounding the errors is the district court's fundamental misunderstanding of the ACA. 2-ER-55. By law, the ACA is applicable to all non-grandfathered health plans, which is how Plaintiffs defined the class, discussed *supra*. Applicability of the ACA does not vary among UHC's plans "nationwide," or by "different employers," or "different geographic regions," contrary to the district court's speculation, which is not based upon any evidence or law. (*Id.*). That the district court's erroneous speculation alone would "defeat the motion for class certification" *(id.),* is basis alone for reversing the district court's orders.

Each time the district court ignored the CDG's express and ACA-non-compliant contents, the district court's analyses and holdings were erroneous.

B. The District Court's Summary Judgment Orders Directly Conflict with *Wolin* and *Parsons*

In both class certification orders, the district court erroneously interjected a damages-like predominance analysis to a proposed Rule 23(b)(2) class. 1-ER16-18; 3-ER-537-538. It is well-settled that the determination of certification under Rules 23(b)(1) or (b)(2) "does not require an examination of the viability or bases of the class members' claims for relief, does not require that the issues common to the class satisfy a Rule 23(b)(3)-like predominance test, and does not require a finding that all members of the class have suffered identical injuries." *Parsons v. Ryan,* 754 F.3d 688 (9th Cir. 2014).

Furthermore, this Court in *Wolin v. Jaguar Land Rover North America, LLC*, 617 F.3d 1168, 1173 (9th Cir. 2010) rejected the notions that (i) individual manifestations of a defect precluded resolution of the claims on a class-wide basis, or that (ii) "certification is inappropriate because [plaintiffs] did not prove that the defect manifested in a majority of the class's vehicles. . ." The Ninth Circuit adheres to a distinction, ignored by the district court, between challenging the predominance of common legal and factual issues, and addressing merits of the case. *Id.* Indeed, the Ninth Circuit's analysis in *Wolin* is equally applicable here, to wit: while "individual factors may affect premature tire wear," or applied here, affect the ultimate adjudication of a medical claim, "they do not affect whether the vehicles were sold with an alignment defect," or here, affect whether UHC's express policy that out-of-network lactation services were not eligible for ACA coverage violated the ACA. *Id.*

Also, the Ninth Circuit disfavors conflation of the challenged conduct with the conduct's ***consequences***. *See 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.").

Instead, in direct contravention of the foregoing authority, the December CC Order erroneously focused on and required such showings, while also recasting UHC's policy and Plaintiffs' claims to comport with the ultimate holding. In this regard, the December CC Order states that "if the uniform policy was to deny out-of-network claims

without regard to the availability of in-network services – why were 12 percent of the claims fully granted?" 1-ER-16-17; *see* 1-ER-16 ("varying results are the product of varying practices"). Notwithstanding that it was undisputed that 88% of the class' CLS claims were not paid in full (1-ER-16), amply satisfying any "manifestation of the defect" standard, a substantial part of the Order (1-ER-16-18) contains speculation about the 12% of claims that were "accidentally" paid that is unnecessary, irrelevant, and unsupported. If this Court's precedent had been properly applied, it would mandate a finding that individual factors do not affect whether UHC's policy denying coverage to out-of-network lactation services violated the ACA; and UHC's policy would not have been conflated with the consequence of that policy and the erroneous reliance on the consequence of UHC's policy that the claims were not even eligible for coverage.[16]

Instructive is Judge Spero's January 2020 Remedies Order in *Wit,* a case arising out of pervasive and long-standing violations of ERISA by United Behavioral Health ("UBH"), which denied mental health and substance use disorder treatment coverage using internal guidelines including CDGs and engaged "in this course of conduct deliberately, to protect its bottom line." *Wit v. United Behavioral Health*, No. 14-cv-02346-JCS, 2020 U.S. Dist. LEXIS 205426, at *7 (N.D. Cal. Nov. 3, 2020), *appeal pending, Wit, et al. v. United Behavioral Health,* No. 21-15193 (9th Cir). Pertinent here, in *Wit,* Judge

[16] A significant consequence of the Court's focus is that Plaintiffs' arguments and evidence, including the testimony submitted by Plaintiffs' experts, go largely unconsidered by the district court's December CC Order, *compare* 3-ER-478 and 2-ER-173, *with* the Order 1-ER-12, which is largely void of record and case references.

Spero held that,

> [f]irst and foremost, the injury that is the basis of Plaintiffs' claims was the adoption and use of flawed Guidelines in deciding whether Plaintiffs were entitled to coverage. As the Court explained on summary judgment, such an injury is cognizable under ERISA and consistent with existing case law, which does not require that Plaintiffs demonstrate that the flaws in UBH's Guidelines were the but-for cause of the denial of their benefits.

Id. * 25. Judge Spero also again rejects UBH's challenges to commonality and typicality, because it is not plaintiffs' burden to "prove *classwide* that UBH denied the class members' claim for benefits based on the specific criteria in the Guidelines that were found by the Court to be inconsistent with the generally-accepted-standard-of-care provision …" *Id.* at *24; *see also, Wit v. United Behavioral Health*, 317 F.R.D. 106, 127-129 (N.D. Cal. 2016)(common issues were found as to whether United's behavioral health coverage determination guidelines met generally accepted standards and whether it breached its fiduciary duty by using improper standards to assist in coverage determination.)[17]

C. The District Court's Class Certification Order Conflict with Analogous Decisions, Requiring Reversal

Having erroneously set aside the existence and import of UHC's policy and

[17] Likewise, in stark contrast to the district court's approach to wrongly shift the coverage burden onto Plaintiffs, in *Caldwell v. UnitedHealthcare Ins. Co.*, No. C 19-02861 WHA, 2021 U.S. Dist. LEXIS 16691, at *10-11 (N.D. Cal. Jan. 27, 2021), Judge Alsup cited to the *Wise v. Maximus Federal Services* decision by Judge Koh, "plac[ing] the burden of proof on UHC to show by appropriate studies that the [liposuction] procedure is *not* effective." *Citing Wise v. Maximus Fed. Servs.*, No. 18-CV-07454-LHK, 2020 U.S. Dist. LEXIS 145962, 2020 WL 4673152, at *11 (N.D. Cal. Aug. 12, 2020).

wrongly focusing on consequences of the policy, the district court misapplies precedent to erroneously hold that Plaintiffs "do [not] come close to proving that [UHC] failed to comply with the ACA in a uniform way."

To the contrary, UHC's policy and Plaintiffs' evidence met Rule 23(b)(2) certification standards as applied by other courts in the Ninth Circuit that grant certification of classes comprised of insureds seeking equitable relief to enjoin an insurer's illegal conduct and secure a reprocessing of medical claims under Rule 23(b)(2).

The commonality prerequisite looks to whether the "claims 'depend upon a common contention' such that 'determination of its truth or falsity will resolve an issue that is central to the validity of each claim in one stroke.'" *Mazza v. Am. Honda Motor Co.*, 666 F.3d 581, 588 (9th Cir. 2012) (quoting *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011)). The proposed common questions must be such that they will "generate common *answers* apt to drive the resolution of the litigation." *Mazza*, 666 F.3d at 588 (quoting *Dukes*, *supra*, 564 U.S. at 350). Following *Dukes* and *Mazza*, district courts in this Circuit have frequently found common issues in cases involving ERISA claims handling practices.

In *Trujillo, et al. v. UnitedHealth Group, Inc., et al.*, CV 17-2547, 2019 U.S. Dist. LEXIS 21927 (C.D. Cal. Feb. 4 2019), *app. petition dismissed,* No. 19-80017, 2020 U.S. App. LEXIS 364, at *1 (9th Cir. Jan. 7, 2020)), insureds alleged that "United has failed to ensure that benefit claim determinations are made in accordance with governing plan documents, failed to establish reasonable claims procedures, and failed to provide

adequate notice of adverse benefit determinations in violation of [ERISA]". *Id.* at *2. In *Trujillo*, the prosthetic coverage at issue is "based on an individualized assessment of the member's functional needs", and the coverage criteria are set out in UHC's CDG specific to prosthetics. *Id.* at *3. Further, in opposition to the *Trujillo* plaintiffs' revised proposed class definition, the defendants raised, as UHC does here, among other things, that: (1) coverage involved, for prosthetic devices, "a series of billing codes" and that a prosthetic limb will typically have ten to twenty different L-codes; and, (2) "providers sometimes ignore that guidance and use the miscellaneous codes….." (*Id.* at *4-5).

In *Des Roches v. Cal. Physicians' Serv.*, 320 F.R.D. 486 (N.D. Cal. 2017) plaintiffs alleged that defendants made use of "guidelines" which violated the terms of plaintiffs' health care plans, in that the guidelines were far more restrictive than generally accepted standards of care in determining medical necessity for mental health and substance abuse treatments. *Id.* at 491. The court rejected defendants' argument that "determining whether each class member's claim would have been granted under the proper Guidelines 'would require a highly fact-intensive inquiry of individual claims—which precludes class certification under Rule 23'" *id.* at 497, instead finding that, "even if the Guidelines ***were not dispositive in every case***, this does not change the fact that, assuming Plaintiffs' allegations are true, Defendants applied an incorrect standard in evaluating every class member's claims." *Id.* at 500 (emphasis added). Small variations are "not material to the theories upon which Plaintiffs' claims [were] based." *Id.* Rather, the "harm alleged []—the promulgation and application of defective guidelines to the

putative class members—is common to all of the [] class members." *Id.* (internal quotation omitted). *See Escalante v California Physicians Service dba Blue Shield of California,* 309 F.R.D. 612, 618 (C.D. Cal. 2015) (common issue found as to health plan's practice in denying claims for artificial lumbar disc surgery); *see, e.g, In re Conseco Life Ins. Co. LifeTrend Ins. Sales & Mktg. Litig.*, 270 F.R.D. 521, 529-30 (N.D. Cal. 2010) (holding commonality satisfied because "interpretation of the standard written policy language will present a question common to the class").

The Ninth Circuit has upheld commonality findings regarding less distinct practices than those presented here. *See Abdullah v. U.S. Security Assoc., Inc.*, 731 F.3d 952, 962-963 (9th Cir. 2013) (legality of employer's meal break practice was common issue that was "apt to drive the resolution of the litigation"); *see also Parsons, supra*, 754 F.3d at 679-680 (commonality existed as to adequacy of state's system of privatized health care for inmates that created a risk of substantial harm for all class members); *Jimenez v. Allstate Ins. Co.*, 765 F.3d 1161, 1165-1166 (9th Cir. 2014) (employer's practice of requiring unpaid off-the-clock overtime presented common issue).

Finally, the district court's orders also disregard that ERISA requires that, where appropriate, plan provisions must be "applied consistently with respect to similarly situated claimants." 29 C.F.R. § 2560.503-1(b)(5). Accordingly, if one court were to find that the terms of UHC's plans, and ERISA claim processing and notice rules, required UHC to act in a certain fashion, and another court found that those same terms and rules required UHC to act in a different fashion, UHC would face an "incompatible

standard of conduct." To avoid such a result, it was erroneous for the district court to decline certified pursuant to Rule 23(b)(1)(A). *Trullio,* at *21-22; *see also Hill v. UnitedhealthCare Ins. Co.*, 2017 U.S. Dist. LEXIS 218139, at *25-27 (C.D. Cal. Mar. 21, 2017) (finding individual inquiry into each patient's circumstances to determine whether lumbar procedure should be covered under patient's insurance was **unnecessary** where "the main issue of the case… challenges Defendant's policy on its face, not Defendant's individualized coverage decisions")(emphasis added).

D. The District Court Erroneously Precluded Plaintiffs' Ability To Seek Prospective Injunctive Relief

The district court's class certification orders erroneously precluded Plaintiffs' ability to seek prospective injunctive relief. 1-ER-14; 3-ER-538. In its order (3-ER-539), the district court holds that the it "disagrees" with *Johnson v. Hartford Casualty Ins. Co.*, No. 15-cv-04138, 2017 U.S. Dist. LEXIS 77482, at *31-32 (N.D. Cal. May 22, 2017).

However, based on the facts presented here, the district courts' order conflicts with *Johnson* and should be reversed.

Under *Johnson*, 2017 U.S. Dist. LEXIS 77482, at *31-32, a plaintiff harmed by an insurer has standing to pursue prospective injunctive relief, ***even if that plaintiff is no longer insured***. Like millions of UHC insureds nationwide, each Plaintiff, through a decision made by her employer (or a partner's/spouse's employer), may again become insured by UHC (as Plaintiff Condry did days after the issuance of the class certification order) and subjected to UHC's illegal conduct. Plaintiffs have a continued stake in the litigation and outcome. Plaintiffs are not clairvoyant, particularly about the future need

for medical services; yet, the district court calls on them to make necessarily speculative allegations about the need for such services. These facts demonstrate the soundness of the holding in J*ohnson,* and not as if what is at issue is a further purchase of, for example, a mislabeled food product.[18]

For these reasons, *Johnson* specifically counseled against the result the district court reaches, because it "create[s] a difficult situation for insureds" and undermines the purpose of insurance. *Johnson*, 2017 U.S. Dist. LEXIS 77482, at *31-32. In *Johnson,* the plaintiff had standing to pursue prospective injunctive relief because ***if*** *again* he was insured by Hartford, he "should be able to have confidence that Hartford will obey the law in the future if he shows that it is violating it now." *Id.* The court rejected Hartford's argument that Johnson who was not a policy holder was not "realistically" threatened by future harm just because he would (i) need to purchase insurance again from Hartford, and (ii) be so unlucky as to suffer another loss. *Id.*

III. This Court Should Reverse The Grant of Summary Judgment to UHC Against Plaintiffs Condry and Barber

By its summary judgment order, the district court extinguished Mses. Condry's and Barber's claims under Count II, in their entirety, without addressing UHC's CDG and without resolving several key disputed facts material to the parties' cross-motions. 1-ER-26. Mses. Barber and Condry moved for judgment on Count II and V, asserting that defendants did not provide them with coverage for CLS as required by the ACA. 1-

[18] 2-ER-160-161 (requiring that plaintiffs allege intent "to become pregnant again or use lactation services again").

ER-24.

The disputed facts at issue included whether UHC's coverage policies and procedures met the ACA's requirements for CLS coverage. Further, in their briefs, Plaintiffs presented evidence and argument about the express provisions in UHC's CDG concerning coverage for out-of-network CLS, and the scope of CLS identified as a covered benefit in the CDG; and, presented evidence as set forth *supra* in Sections B-D, demonstrating why UHC did not have ACA compliant coverage policies. In its brief, UHC presented its evidence and argument as to why its CDG complied with the ACA. 6-ER-104; 4-SER-683; 4-ER-736.

Notwithstanding the parties' arguments and evidence, the district court determined that UHC's policies and conduct were not at issue, and the district court did not make any findings or determinations as to whether UHC's CDG complied with the ACA. 1-ER-23-26. After focusing on what each *Plaintiff* did to secure CLS services and coverage, the district court entered summary judgment against Plaintiffs Condry and Barber on Count II because: they "did not attempt to look for an in-network" CLS provider, and UHC "had lactation specialists near these plaintiffs." 1-ER-26-27. The district court concluded that "On this evidentiary record, [UHC] had no obligation to cover out-of-network care." 1-ER-26. The district court does not provide any basis or support for: what standard the court used to determine what UHC's "obligation" was; how and why that standard was even met; and, how the district court addressed the evidence presented by Plaintiffs demonstrating UHC's failure to comply with the ACA

and ERISA. The district court erroneously entered judgment on Count I against Plaintiffs Barber and Condry, and that portion of the district court's summary judgment order should be reversed.

IV. The Court Should Affirm the Portions of the District Court's Summary Judgment and Class Certification Orders With Respect to the ERISA Plaintiffs' Full and Fair Review Claims

The district court did not abuse its discretion in certifying the Denial Letter Class, and there is no genuine factual dispute that UHC failed to comply with ERISA, by using the four standardized Remark Codes in the EOBs, that were not written in a manner calculated to be understood by the Plaintiffs, nor in a manner that the denials were reasonably clear, and there is no subjective standard or analysis required. Further, the district court's orders with respect the ERISA Plaintiffs' Full and Fair Review Claims, should be affirmed for the independent reason that UHC availed itself of the pre-class certification summary judgment proceedings, did not seek to overturn the summary judgment order, and has waived the right to object to class certification. The Court should affirm the portions of the district court's summary judgment orders and class certification orders with respect to the ERISA Plaintiffs Full and Fair Review Claims.

A. The Court Should Affirm the District Court's Orders Based on UHC's Waiver of the Right to Object to Class Certification Based on the One-Way Intervention Rule

In May 2017, UHC affirmatively sought to file a motion for summary judgment prior to class certification. In doing so, the Court held that UHC waived its right to object to class certification based on the one-way intervention rule. 5-SER-963-964

The District Court expressly held:

> "The defendant is affirmatively requesting a schedule in which the Court entertains cross-motions for summary judgment with respect to the named plaintiffs before entertaining a motion for class certification. This, by definition, is a waiver of the right to object to class certification based on the so-called one-way intervention rule." *Id.*

UHC took no exception and made no objection to that Order.

Then, on June 27, 2018, the district court granted summary judgment in favor of the Plaintiffs holding that the four Remark Codes violate ERISA. 1-ER-27-29. UHC, despite knowing that Plaintiffs would be filing a motion for class certification and the schedule for briefing, did not seek to overturn the district court's 2018 summary judgment order prior to such filing.

The one-way intervention rule, which UHC waived, exists solely to address the result of extending liability to class members if summary judgment is granted prior to class certification. *See Katz v. Carte Blanche Corp.*, 496 F.2d 747, 758–59 (3d Cir. 1974) ("The district court points out that if Katz' case went forward alone it would not be binding upon anyone other than Mr. Katz. That is only partly true. Judgment against Katz would not protect Carte Blanche against other class members, but judgment for Katz would bind Carte Blanche in suits by other class members") (cited by *Schwarzschild v. Tse*, 69 F.3d 293, 295 (9th Cir. 1995)).

UHC made a tactical decision to seek to avail itself of a pre-certification summary judgment procedure, and thereafter, in 2018, UHC did just that. *See Gessele v. Jack in the Box, Inc.*, No. 3:10-CV-960-ST, 2012 U.S. Dist. LEXIS 120377, 2012 WL 3686274, at *2

(D. Or. Aug. 24, 2012) ("by filing a motion for summary judgment prior to class certification, the defendant accepts the potential unfairness of one-way intervention").

Thus, UHC has already waived the very challenge it seeks to improperly raise now. *See, e.g. Flo & Eddie, Inc. v. Sirius XM Radio, Inc.*, No. CV13-5693 PSG (GJSX), 2016 WL 6953462, at *4 (C.D. Cal. June 16, 2016) ("…the Court already ruled that Defendant waived the protections of the one-way intervention rule by requesting early summary judgment briefing and consenting to litigating Plaintiff's motion for summary judgment before the certification stage.…").

Accordingly, the Court should affirm the portions of the district court's summary judgment orders and class certification orders with respect to the ERISA Plaintiffs Full and Fair Review Claims.

B. The District Court Applied the Correct Standards in Rendering its Decision on Summary Judgment and Class Certification as to the ERISA Plaintiffs' Full and Fair Review Claims.

The district court (1-ER-27) assessed the ERISA Plaintiffs' claims under ERISA § 1133(1) which provides:

> [E]very employee benefit plan shall – (1)…provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, ***setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant***…

Further, this District Court (1-ER-28) also cited to and relied on *Booton* which held:

> 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.

110 F.3d at 1463 (9th Cir. 1997) (emphasis added).

UHC finds no support for its position since neither *Chuck, infra, n*or *Coleman, infra,* address remark codes and the adequacy of the claim denials are not at issue in either case. In *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…" In *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1039 (9th Cir. 2006), 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.

Moreover, the district court's orders find further support in the express provisions of ERISA's regulations, specifically 29 C.F.R. § 2560.503-1(g)(1) ("ERISA § 503"). ERISA § 503 expressly provides that "notification of adverse benefit determinations" must, *inter alia*,

> set forth, in a manner calculated to be understood by the claimant—(i) The specific reason or reasons for the adverse determination; (ii) Reference to the specific plan provisions on which the determination is based; and (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

29 C.F.R. § 2560.503-1(g)(1), codified as 29 C.F.R. § 2560-503-1(f)(1) until 1/2001; (*see* 65 FR 70246-01 (11/21/2000)). Like ERISA § 1133(1) and *Booton,* there is nothing

unsettled about ERISA § 503. *See also Salomaa v. Honda Long Term Disabilit. Plan*, 642 F.3d 666, 680 (9th Cir. 2011) (an administrator does not do its duty under ERISA "by elaborating upon its negative answer with meaningless medical mumbo jumbo.")

Accordingly, the district court's findings are well grounded in the express, settled provisions within ERISA §§ 1133(1) and 503 and on *Booton*. Based on the settled law, the district court held that the Remark Codes were "written in a way that made [the denials] virtually impossible to understand." 1-ER-28.

UHC seeks a reversal that aims to nullify its fiduciary and statutory duties under ERISA through its assertion of a subjective, insured-by-insured assessment of whether a Remark Code was "written in a manner calculated to be understood by the participant", and reversal on the basis that the district court, purportedly, did not do such assessment. The district court, however, did precisely what was required.

UHC's contention that the district court's summary judgment order cannot be reconciled with the totality of the evidence and the experiences of each ERISA Plaintiff, is not supported by the record. It is based on UHC's *ipsit dixit*. The district court had before it and reviewed each one of the four Remark Codes, and held that each was "virtually impossible to understand." 1-ER-28. The extensive summary judgment record, however, does not alter or conflict with the necessary objective assessment that the district court undertook; and, even if they were relevant (and they are not), what Plaintiffs' contemporaneous experiences with the EOBs and communicating with UHC about their CLS claims show is that the Remark Codes are both impossible to understand

and useless. *See supra* Section E.

Whether a Remark Code is written in a manner calculated to be understood by claimants, which is the pertinent inquiry, is not, for example, dependent on the plan participant's level of education, her familiarity with medical terminology, her savvy in navigating insurance claim denials, or her ability to do extensive internet searches or comprehend medical coding manuals. ERISA also does not leave it to UHC to be the judge and jury over its ERISA compliance. Yet, in all practicality, UHC seeks that outcome, one that is contrary to the fundamental purpose of ERISA and ERISA's express procedural protections established for plan participants.

UHC often takes liberty with its characterizations of its Remark Codes (Br. at 40). For example, when referencing Remark Code KM, UHC often omits the remark code's use of the terms "CPT" and "HCPC". *Id.* Remark Code KM does not state that there may be a "'more appropriate' code", but instead "This is not a reimbursable service. There may be a more appropriate CPT or HCPCS code …". The recipients of the Remark Codes were not "clearly informed". (Br. at 40). Even Ms. D'Apuzzo, who UHC identified as one of its Remark Codes experts, could not explain how the Remark Codes were understandable or what they were intended to convey. With respect to Remark Code KM, Ms. D'Apuzzo acknowledged that the EOB did not state what is a CPT or HCPCS code SER-[201-1], 169:25-170:2], and "an insured reading the EOB in its entirety would not know what CPT or HCPCS code was being referenced." SER-[201-1]; *see also infra* Section F.2. The Remark Codes were self-evidently "written in a way that made

them virtually impossible to understand." 1-ER-28. It is plainly unreasonable for UHC to expect that its cryptic references to "service codes" and "CPT or HCPCS codes" could be viewed as an explanation "calculated to be understood" by a claimant. *See Salomaa*, 642 F.3d at 680 ("fooling someone unfamiliar with the medical terms with irrelevant medical mumbo jumbo violates the statutory duty to write a denial 'in a manner calculated to be understood by the claimant'").

If, after already denying their claims, UHC intended for Class members to then go ask their providers for more appropriate codes or information, then UHC should have said that; it did not. Indeed, a remark code that characterizes a medical service as a "non-medical service[s] or personal item[s]" is self-evidently ludicrous, provides no clarification as to how UHC reached that conclusion, and does not even offer any suggestions as to other information that may support challenging the denial. *See Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 870 (9th Cir. 2008) (finding benefits termination letter failed to establish a "meaningful dialogue" with claimant where it "notes merely that '[t]he medical information provided no longer provides evidence of disability that would prevent you from performing your job or occupation,' but does not explain why that is the case").

UHC's overstatements concerning the Remark Code Letter are neither persuasive nor grounded in reality. (Br. 42-27). UHC's comparisons of the Remark Codes to the information in the Remark Code Letter as "not materially different" (Br. at 42), "similar[]" (*id.* 43), and a concession by Plaintiffs, are readily belied by a review of the

Remark Code Letter versus the four Remark Codes. 2-ER-39-43, 45-48; *discussed supra* F.3. For example, as discussed *supra* F.3, for insureds who received the KM Remark Code - "There may be a more appropriate CPT or HCPCS code that describes this service and/or the use of the modifier or modifier combination" – they are now going to be given a link to the codes, informed that their out-of-network claim was denied because their "provider was not eligible to bill the medical procedure code" that appeared on their claim, and expressly told a correct claim needs to be resubmitted.

Thus, UHC's Remark Codes, *unlike the proposed Remark Code Letter,* do not describe "additional material or information necessary for [recipients] to perfect [their] claims and an explanation of why such material or information is necessary." 29 C.F.R. § 2560.503-1(g)(1). The Remark Code Letters affirm why the original Remark Codes were not written in a manner calculated to be understood by insureds and did not afford insureds the opportunity to receive a full and fair review of the denials.

Finally, the district court did not abuse its discretion in certifying the Denial Letter Class. 1-ER-12-13. In ruling on Plaintiffs' renewed motion for class certification, the district court correctly certified the Denial Letter Class pursuant to Rule 23(b)(2), 1-ER-12-13. As the district court recognized, the common contention for the Denial Letter Class is that each member was sent a claim denial letter from UHC that used one of four standardized reasons, called "Remark Codes," that were supposed to convey to the insured the reason why UHC denied their insurance claim.

The district court made a grounded determination that the claims of the Denial

Letter Class "depend upon a common contention of such a nature that it is capable of classwide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Wal-Mart,* 564 U.S. at 350. Here, the common contention is that the denial letters received by the Denial Letter Class members violated ERISA's requirement that the plan administrator write a denial in a manner calculated to be understood by the claimant. 1-ER-12.

The district court expressly concluded that "United Healthcare engaged in the same conduct with respect to each of the proposed class members—sending an incomprehensible denial letter." 1-ER-12-13.

Moreover, the district court did consider and make clear that UHC has no defense for its liability to the Denial Letter Class members. 1-ER-13. ("Although subsequent communications may have resolved disputes about benefits, it does not change the fact that United Healthcare's denial letters to these class members violated ERISA in the same way as to each participant").

V. The District Court's Order Denying Ms. Harris Her Right To Intervene Should Be Reversed

Based on the record before the district court (3-SER-429; 4-SER-421), the district court's order denying Ms. Harris' motion to intervene must be reversed. 1-SER-2. Under *United States ex rel. McGough v. Covington Techs. Co.,* 967 F.2d 1391, 1394 (9th Cir. 1992), "Generally, Rule 24(a)(2) is construed broadly in favor of proposed intervenors and we are guided primarily by practical considerations.") (internal quotation marks and citation

omitted)). Moreover, Ms. Harris sought to intervene when the need arose – at class certification. *See, e.g. Munoz v. PHH Corp.*, No. 1:08-cv-0759, 2013 U.S. Dist. LEXIS 106004, at *22-23 (E.D. Cal. July 26, 2013) (holding that intervention following the court's report and recommendation partially denying Plaintiffs' motion for class certification was appropriate to cure a deficiency); *Beach v. Healthways, Inc.*, 264 F.R.D. 360, 365 (M.D. Tenn. 2010) ("[I]t was not until the Court ruled on the motion for class certification that CLPF became aware of the need to intervene in this case."); *Shields v. Washington Bancorporation*, 1992 U.S. Dist. LEXIS 4177, at *2 (D.D.C. Apr. 7, 1992) (granting motion for intervention after Court denied class certification on adequacy grounds). Ms. Harris was intervening at an appropriate and necessary time, her documents had been promptly produced to UHC, and her claims mirrored those of an existing Plaintiff. The crux of the district court's denial though, is that Ms. Harris had not proposed an allegation that she intended "to become pregnant again or use lactation services again" (1-ER-14; 3-ER-538-539; 2-ER-161). Plaintiffs address why such holding in Section II.D, *supra*, as why that holding is erroneous.

CONCLUSION

Plaintiffs respectfully request this Court (i) reverse the portions of the district court's (a) summary judgment order entering judgment against Plaintiffs Condry and Barber, (b) class certification orders denying certification of the Claims Reprocessing Class, and (c) order denying the motion to intervene; and (ii) affirm the district court's orders granting Plaintiffs summary judgment and the certification of the Denial Letter

Class.

Respectfully submitted,

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ADDENDUM

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42 U.S.C. § 300gg-13. Coverage of preventive health services

(a) In general. A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—

> **(1)** evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
>
> **(2)** immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
>
> **(3)** with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
>
> **(4)** with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.
>
> **(5)** for the purposes of this Act [42 USCS §§ 201 et seq.], and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to deny coverage for services that are not recommended by such Task Force.

(b) Interval.

> **(1)** In general. The Secretary shall establish a minimum interval between the date on which a recommendation described in subsection (a)(1) or (a)(2) or a guideline under subsection (a)(3) is issued and the plan year with respect to which the requirement described in subsection (a) is effective with respect to the service described in such recommendation or guideline.

(2) Minimum. The interval described in paragraph (1) shall not be less than 1 year.

(c) Value-based insurance design. The Secretary may develop guidelines to permit a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs.

History

HISTORY:

Act July 1, 1944, ch 373, Title XXVII, Part A, Subpart II, § 2713, as added March 23, 2010, P. L. 111-148, Title I, Subtitle A, § 1001(5), 124 Stat. 131

29 C.F.R § 2590.715-2713 Coverage of preventive health services.

(a) Services —

****

(3) Out-of-network providers —

(i) Subject to paragraphs (a)(3)(ii) and (iii) of this section, nothing in this section requires a plan or issuer that has a network of providers to provide benefits for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider, or precludes a plan or issuer that has a network of providers from imposing cost-sharing requirements for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider.

(ii) If a plan or issuer does not have in its network a provider who can provide an item or service described in paragraph (a)(1) of this section, the plan or issuer must cover the item or service when performed by an out-of-network provider, and may not impose cost sharing with respect to the item or service.

(iii) A plan or issuer must provide coverage for and must not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible) for any qualifying coronavirus preventive service described in paragraph (a)(1)(v) of this section, regardless of whether such service is delivered by an in-network or out-of-network provider. For purposes of this paragraph (a)(3)(iii), with respect to a qualifying coronavirus preventive service and a provider with whom the plan or issuer does not have a negotiated rate for such service (such as an out-of-network provider), the plan or issuer must reimburse the provider for such service in an amount that is reasonable, as determined in comparison to prevailing market rates for such service.

****

Statutory Authority

Authority Note Applicable to Title 29, Subtit. B, Ch. XXV, Subch. L, Pt. 2590

CERTIFICATE OF ELECTRONIC SERVICE

I hereby certify that on February 26, 2021 I electronically filed the foregoing Brief for Plaintiffs, Intervenor Plaintiff- Appellees/Cross-Appellants with the Clerk of the Court of the U.S. Court of Appeals for the Ninth Circuit by using the Appellate CM/ECF system.

/s/ Kimberly M. Donaldson-Smith