NO. 20-16823

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,

v.

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

Defendants-Appellants.

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

BRIEF FOR DEFENDANTS-APPELLANTS

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RULE 26.1 CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, Defendants-Appellants UnitedHealth Group Incorporated, UnitedHealthcare, Inc., UnitedHealthcare Insurance Company, United HealthCare Services, Inc., and UMR, Inc., by and through undersigned counsel, state as follows:

1. UnitedHealth Group Incorporated has no parent corporation. No publicly held corporation owns 10% or more of UnitedHealth Group Incorporated's stock.

2. UnitedHealthcare, Inc. is a wholly owned subsidiary of United HealthCare Services, Inc., which is a wholly owned subsidiary of UnitedHealth Group Incorporated.

3. UnitedHealthcare Insurance Company is a wholly owned subsidiary of UHIC Holdings, Inc., which is a wholly owned subsidiary of United HealthCare Services, Inc., which is a wholly owned subsidiary of UnitedHealth Group Incorporated.

4. United HealthCare Services, Inc. is a wholly owned subsidiary of UnitedHealth Group Incorporated.

5. UMR, Inc. is a wholly owned subsidiary of United HealthCare Services, Inc., which is a wholly owned subsidiary of UnitedHealth Group Incorporated.

Dated: December 28, 2020

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INTRODUCTION

The Employee Retirement Income Security Act of 1974 ("ERISA") requires an ERISA plan administrator to provide a full and fair review of a plan member's claim for benefits. In order to evaluate whether such a review occurred, courts must examine the course of communications between the member and the administrator. This appeal concerns whether, in the context of a putative class action, a district court can isolate one writing in the course of the communications between the administrator and the member, and find a full and fair review violation without addressing the rest of that course of communication. Under this Court's precedents and ERISA, the district court below applied an incomplete analysis to reach erroneous summary judgment, class certification, and injunctive relief rulings that each should be reversed.

This case arises out of provisions in the Affordable Care Act ("ACA") pertaining to lactation counseling. The ACA requires health plans to cover without cost-sharing "comprehensive lactation support services."[1] *See* 42 U.S.C. § 300gg-13(a)(4); HRSA

[1] The ACA defines "cost-sharing" as "deductibles, coinsurance, [and] copayments." 42 U.S.C. § 18022(c)(3)(A)(i). While there have been several putative class actions filed by the same plaintiffs' counsel against various payors based on the ACA's lactation services requirement, the district court below is the only one to have found any "full and fair" review issue. In addition to the summary judgment, class certification and injunction orders on the full and fair review claim, the district court denied United's motion to dismiss that claim at the pleading stage. (Order regarding Motion to Dismiss ("Dismissal Order"), Dkt. 68, 6-ER-1294 (Aug. 15, 2017).) By contrast, in *Briscoe v. Health Care Serv. Corp.*, Case No. 1:16-cv-10294 (N.D. Ill.), the district court dismissed a similar claim brought by these same counsel. *See Briscoe v. Health Care Serv. Corp.*, 281 F. Supp. 3d 725, 735 (N.D. Ill. 2017).) No class was certified in this *Condry* case, or in any of the other similar cases, with respect to any of the plaintiffs' claims regarding

Guidelines, https://www.hrsa.gov/womens-guidelines-2016/index.html. The ACA expressly provides that so long as plans have providers in their network who offer lactation services, the plans may require their members to obtain such services in-network and may deny coverage for, or impose cost-shares on, members who obtain such services out-of-network. 29 C.F.R. § 2590.715-2713(a)(3)(i)-(ii).

Plaintiffs Rachel Condry, Jance Hoy, Christine Endicott, Laura Bishop, Felicity Barber, and Rachel Carroll (collectively, "Plaintiffs") are current or former members or beneficiaries of plans administered by certain UnitedHealthcare entities (collectively, "United"). Five of these six Plaintiffs had an ERISA-sponsored plan (all but Carroll; the "ERISA Plaintiffs"). Plaintiffs filed this case contending that United violated the ACA when it denied coverage for, or imposed cost-shares on, lactation services that Plaintiffs had obtained out-of-network. *See, e.g.*, Second Am. Class Action Complaint ("SAC"), Dkt. 78, 6-ER-1281, ¶ 212 (Sept. 5, 2017).

Although not the focus of their original or amended complaints, the ERISA Plaintiffs also asserted United had deprived them of a full and fair review under Section 503 of ERISA, alleging United utilized "a system … that fails to provide timely and

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coverage of ACA lactation services. *See Briscoe*, Case No. 1:16-cv-10294, Dkt. 197 (denying motion for class certification); *York v. Wellmark, Inc.*, Case No. 4:16-cv-00627 (S.D. Iowa) (dismissing certain claims on pleadings; granting summary judgment for defendant on remaining claims), *aff'd, York v. Wellmark, Inc.*, 965 F.3d 633, 642 (8th Cir. 2020) (affirming judgment for defendant); *Ferrer v. CareFirst, Inc.*, Case No. 1:16-cv-02162 (D.D.C.) (settled prior to discovery).

substantive responses to requests for out-of-network benefits and/or appeals to denials of [such] requests." *See, e.g.*, 6-ER-1280 at ¶ 207.

That claim is the focus of this appeal and implicates the procedures that claims administrators, such as United, employ to efficiently communicate claims denials to plan members. Given the large volume of claims that administrators process, the industry has developed standard "remark codes"— brief statements of the reasons for a claim's denial—that plans use to initiate a dialogue with their members about a claims decision. The remark codes are intended to be part of a stream of information provided to members through which the basis of claims decisions are explained, including, among other things, benefits booklets, the plan's website, and communications with customer service representatives.

At summary judgment, the district court examined the ERISA Plaintiffs' full and fair review claim by focusing on the remark code United provided each plaintiff in its initial communication denying their claims. The court ruled those codes did not adequately explain the basis for the denial, but the court did not discuss the entire course of communications between United and each plaintiff or the uncontroverted fact and expert evidence that demonstrated that the remark codes were industry standard, understandable, and designed merely to initiate a dialogue with each plaintiff.

At the class certification stage, the district court correctly declined to certify the lactation claims class that was the plaintiffs' primary aim in this litigation. But the court compounded its earlier error on the full and fair review claim by certifying a remark

code class. This class certification ruling failed to follow this Court's precedent requiring an individualized inquiry into each putative class member's available course of communications with United.

The district court's summary judgment and class certification errors on the full and fair review claims also yielded an erroneous classwide injunction order that, if not reversed, will cause significant problems. United developed the remark codes at issue to conform to industry standards in communicating about denials with vast numbers of members in simple, efficient, and standardized ways. The codes serve merely to initiate a dialogue with the member and the record evidence shows the system works to generate a course of communication that serves the full and fair review goal. Based on the district court's own idiosyncratic reaction to the remark codes viewed in isolation, and without discussion of the full, available course of communication, that court has ordered United to comply with a burdensome "reprocessing" injunction. Absent a reversal, that injunction will require the sending of a letter to each class member regarding claims decisions that most members likely understood the first time around and that all members already had the opportunity to seek further dialogue on; moreover, many members now will likely be confused by the receipt of a new letter about a stale claim. Further, the language in that letter that the parties already drafted under court order is not substantially different than the remark codes themselves, and leaves members in substantially the same position they were in before this litigation.

None of this is warranted under the law and this Court's precedents. For these reasons, as established further below, this Court should reverse the portion of the judgment that grants summary judgment in favor of the ERISA Plaintiffs on the "full and fair" review issue and should reverse the associated certification of a full and fair review claims class and the related injunctive relief.

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. Defendants-Appellants timely filed their notice of appeal within 30 days after the judgment, on September 18, 2020, pursuant to Fed. R. App. P. 4(a)(1)(A). 6-ER-1297-1301.

ISSUES PRESENTED

1. Do this Court's precedents regarding whether a member of a health plan received a full and fair review for the purposes of ERISA require a district court on a summary judgment motion to examine the entire course of communications between a member and a health plan, or may the court instead isolate a single writing that is designed merely to initiate the dialogue with the member?
2. Do this Court's ERISA precedents permit a district court to certify a full and fair review claims class by examining only a single writing that is designed to initiate a dialogue between a health plan member and the plan, and without examining the course of communications between each member and her plan?
3. May a district court certify a class of individuals who allegedly did not receive a full and fair review when the evidence demonstrates that the circumstances of each class member would need to be examined to determine ERISA compliance class-wide?

4. May a district court order a health plan administrator to issue a new notice to an entire class of plan members who previously have had a benefits claim denied if the court has not examined the course of communication between each member and the plan regarding the prior claims denial to determine whether any members, in fact, did not receive a full and fair review, and if so, which ones?

LOCAL RULE 28-2.7 STATEMENT

In this brief, Defendants-Appellants cite 29 U.S.C. § 1133 and 29 C.F.R. §§ 2560.503-1(g) and (h). Relevant excerpts of these statutory and regulatory authorities are included in the Addendum.

STATEMENT OF THE CASE

A. ERISA Requires Plans To Provide A "Full And Fair Review" Of A Member's Claim, Which Entails A "Meaningful Dialogue" Between Plan And Member.

Section 503 of ERISA provides that plans must "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review." 29 U.S.C. § 1133(2) ("Section 503"). This right is not triggered until a participant submits a claim for benefits. *See* 29 C.F.R. § 2560.503-1(h)(2); *Tolle v. Carroll Touch, Inc.*, 23 F.3d 174, 181 (7th Cir. 1994). Once that occurs, Section 503's regulations require denials to contain certain elements, including "[t]he specific reason or reasons for the adverse determination" and "[a] description of the plan's review procedures." 29 C.F.R. § 2560.503-1(g)(1). Notices of denials of benefits are to be "written in a manner calculated to be understood by the participant." 29 U.S.C. § 1133(1).

In determining compliance with Section 503, the critical inquiry is whether the plan engaged in a "meaningful dialogue" with the member regarding the reasons for the denial. *Silver v. Exec. Car Leasing Long-Term Disability Plan*, 466 F.3d 727, 731 n.1 (9th Cir. 2006). While a plan may deny benefits that the plan does not cover, "it must couch its ruling in terms that are responsive and intelligible to the ordinary reader." *Booton v. Lockhead Med. Benefit Plan*, 110 F.3d 1461, 1465 (9th Cir. 1997). Failure to provide the specific plan provision will not, by itself, fail to provide full and fair review. *Morningred v. Delta Family-Care & Survivorship Plan*, 790 F. Supp. 2d 177, 194-95 (D. Del. 2011). A denial letter substantially complies with these requirements if it provides the claimant

with "a statement of reasons that, under the circumstances of the case, permitted a sufficiently clear understanding of the administrator's position to permit effective review." *Gravelle v. Health Net Life Ins. Co.*, No. C 08-04653 MHP, 2009 U.S. Dist. LEXIS 4929, at *23 (N.D. Cal. Jan. 23, 2009) (citing *Brogan v. Holland*, 105 F.3d 158, 165 (4th Cir. 1997)); *see also Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1032 (9th Cir. 2006) (same); *Koblentz v. UPS Flexible Emp. Benefit Plan*, No. 12-CV-0107-LAB, 2013 U.S. Dist. LEXIS 121389, at *11 (S.D. Cal. Aug. 23, 2013) (same).

B. When Claims Are Not Fully Paid, United's Remark Codes Initiate A Dialogue With The Member And Provider.

United includes remark codes in the Explanation of Benefits ("EOB") sent to members to provide information about how their claims are processed. 3-ER-517 ¶¶ 5, 6. United processes about one million healthcare claims on a daily basis and it is not feasible or necessary to provide a personalized explanation for each claim. *Id.* at ¶ 7. Accordingly, like all major health care insurers in the United States, United uses an automated process to generate EOBs in which its system selects from a set of standardized remark codes a code or codes that best matches the reason for the claim denial. 2-ER-301; 3-ER-517 ¶ 7.

Each of these remark codes are written to be short, understandable narratives and descriptions, providing high-level information for a member or provider. *Id.* at ¶ 7. For reasons of efficiency and functionality, the remark code is designed to provide

enough information to the member or provider to understand the basis for the benefit determination. 3-ER-517-518 ¶¶ 7-9.

In addition, members and providers have other resources available if they require more specific information about their claim, including the member's benefit booklet, United's websites, and its customer service representatives. *Id.* at ¶ 9; 2-ER-299 (United's expert noting that remark codes initiate a dialogue and that members and providers have these resources to consult as part of that); *see also,* 3-ER-533 ¶ 41 (same). In this way, United's remark codes initiate an individualized process that facilitates the member's understanding of United's adjudication of specific claims. 3-ER-518 ¶ 9.

United's remark codes are tethered or mapped to industry standard language authored and maintained by the Claim Adjustment Reason Codes ("CARCs") and Remittance Advice Remark Codes ("RARCs") Committees of the Centers for Medicare and Medicaid Services ("CMS"). *Id.* at ¶ 14, referring to http://www.wpc-edi.com/Codes. United's mapping process ensures the remark codes are consistent with health literacy, industry standards, and regulatory guidance. *Id.* at ¶ 15. As is demonstrated by the industry standard CARCs and RARCs themselves, the remark codes need to be short and concise so they can be used efficiently and effectively in automated systems. *Id.* at ¶ 14, referring to http://www.wpc-edi.com/Codes.

United's records from 2015-2018 indicate that members routinely communicated with United after receiving claim denials via the remark codes at issue.[2] 2-ER-325-326 ¶¶ 11-12. *Id.* at ¶ 12. These contacts show that members initiate dialogues with United, even when remark codes focus on issues that members are not typically familiar with, such as medical coding. *See infra* p. 19, note 3. As the record demonstrates below, the Plaintiffs themselves understood the substance of the remark codes and engaged, or could have engaged, in a similar dialogue.

C. The ERISA Plaintiffs Received A Full And Fair Review.

C.1 Condry And The First Remark Code At Issue In This Appeal

Condry sought services from an out-of-network lactation consultant on several occasions in 2015, but only sought reimbursement for a March 4, 2015 out-of-network service. 6-ER-1247-1248 ¶¶ 89, 91-92; 6-ER-1191. United denied her claim, explaining in an EOB that set forth **the first remark code at issue in this appeal**:

> "[t]his is not a reimbursable service" and that "[t]here may be a more appropriate CPT or HCPCS code that describes this service and/or the

[2] Members or their representatives contacted United with respect to: (1) 34% of claims denied with the code "[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 modifier or modifier combination is inappropriate"; (2) 35% of claims denied with the code "[t]his service is not separately reimbursable in this setting"; and (3) 59% of claims denied with the code "[y]our Plan does not cover this non-medical service or personal item." *Id.* at ¶ 11. In addition 20% of the members who received the remark code "[p]ayment for services is denied. We asked the member for more information and didn't receive it on time" had their claims adjusted after receiving their EOB. *Id.*

use of the modifier or modifier combination is inappropriate."

6-ER-1248 ¶ 90; 5-ER-941. United mapped this remark code to the CMS's CARC #8, which states: "The procedure code is inconsistent with the provider type/specialty (taxonomy)." 3-ER-519 ¶ 17(a); *see also* 2-ER-304 (United's expert agreeing the code maps to CARC #8).

Condry understood that this remark code referred to the medical billing codes her provider submitted to United for reimbursement. 4-ER-803-804 (82:3-83:18). Condry chose not to ask her provider for "more appropriate" codes in response to the EOB. *Id.* The EOB provided the address and timeframe for submitting appeals, but Condry did not appeal her denied claim. 5-ER-941; 6-ER-1248 ¶ 92.

C.2 Endicott And The Second Remark Code At Issue

Endicott received services from an out-of-network lactation consultant on September 23 and October 1, 2015. 6-ER-1256 ¶ 118; 6-ER-1192-1193. Endicott submitted a claim for reimbursement, and United sent Endicott copies of letters it mailed to her provider, asking the provider to submit corrected claims with valid diagnosis codes. 5-ER-894-910. When the provider failed to provide the requested information, United sent Endicott an EOB denying her claim, and including **the second remark code at issue in this appeal**, which explained:

"[w]e asked the member for more information and didn't receive it on time."

5-ER-913. This remark code was mapped to CARC #227, which states: "Information

requested from the patient/insured/responsible party was not provided or was insufficient/incomplete." 3-ER-519, ¶ 17(d); *see also* 2-ER-303 (United's expert agreeing this remark code maps to CARC #227). United also mapped remark code B5 to RARC #N706, which states: "Missing documentation." 3-ER-519 ¶ 17(d); 2-ER-303-304 (United's expert agreeing this remark code also maps to RARC #N706).

Endicott understood the remark code to mean that United "needed some information from [her provider] as far as codes . . . ." 4-ER-859 (163:20-24). Even though Endicott's claim remained incomplete due to the provider's failure to provide valid diagnosis codes, United made an exception and processed her claim, allowing an amount payable under her plan and factoring in her cost share obligations. 6-ER-1257 ¶ 121; 5-ER-916-921.

C.3 Bishop Received The Same Code As Condry

Bishop sought the services of an out-of-network lactation consultant on August 5, 2015. 6-ER-1260 ¶ 130. After Bishop submitted a claim for reimbursement, United sent Bishop an EOB denying the claim with the remark code "[t]his is not a reimbursable service" and "[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." 6-ER-1260 ¶ 131; 5-ER-949-959. This is the same remark code Condry received (*i.e.* the first remark code at issue in this appeal) and is mapped to CARC #8. *See supra,* at 12-13.

While Bishop testified she did not understand what a CPT or HCPCS code is,

she "trust[ed]" that her provider knew what codes they "should or should not use to describe a service." 4-ER-784 (119:3-7). Even though Bishop knew the remark code implicated the codes her provider selected, she chose not to ask her provider about those codes. *Id.* at 119:8-13. Bishop claims she submitted an appeal, but neither she nor United has any record of such an appeal. 4-ER-778 (14:11-24); 5-ER-947 ¶ 16 (noting that United has no such appeal on record, even though its business practice is to retain such documents as part of the member's administrative file).

C.4 Barber And The Third Remark Code At Issue

Barber saw an out-of-network lactation consultant in 2016. 4-ER-828-830 (87:24-89:2); 6-ER-1261 ¶¶ 136-137. After Barber filed a claim for reimbursement, United sent Barber an EOB that denied her claim, with a remark code that is **the third at issue in this appeal** and which explained

"[y]our plan does not cover this non-medical service or personal item."

5-ER-931. This remark code was mapped to CARC #202, which states: "Non-covered personal comfort or convenience services." 3ER-519 ¶ 17(b); *see also* 2-ER-303 (United's expert opining this remark code maps to a similar CARC, CARC #204, which reads "This service/equipment/drug is not covered under the patient's current benefit plan.").

Barber did not timely appeal, because she filed her appeal outside of the 180-day deadline in the plan's claims procedures. 5-ER-932 (noting Barber had 180 days from April 29, 2016 to appeal); 4-ER-833-834 (197:19-198:5) ("appeal" filed in 2017). In her

late appeal letter, Barber asserted that United had denied coverage on the ground that the service she had received was a parenting class, and thus was excluded from coverage under her plan, but she disagreed and noted that she had received lactation counseling. 4-ER-835. By interpreting United's remark code —"your plan does not cover this non-medical service or personal item"—as stating that she had received a parenting class, Barber manifested in her appeal that she understood the reason United had given for the denial, but simply disagreed with that reason.

C.5 Hoy Received The Same Remark Code As Condry And Bishop As Well As An Additional Remark Code, The Fourth At Issue

On September 10, September 28, and October 5, 2015, Hoy sought services from an out-of-network lactation provider. 6-ER-1250-1251 ¶¶ 97, 100; 4-ER-773 (124:9-24). Rather than file a claim for reimbursement in accordance with the terms of her benefit plan, Hoy claims she called customer service and asserted that United's purported failure to cover her out-of-network services constituted an ACA violation. 6-ER-1251 ¶ 101; 4-ER-862 (27:13-22) (Hoy knew her benefit booklet contained instructions for filing claims); 5-ER-1041-1043 (containing instructions for filing claims); 4-ER-865-866 (61:20-62:8) (Hoy acknowledging she thought her provider was supposed to submit the claims).

Hoy subsequently submitted a letter, which she characterized as an "appeal" even though she had neither submitted a claim nor received a written denial. 6-ER-1251 ¶ 102; 4-ER-867-868 (64:10-65:8) (noting Hoy could not point to a denial prior to her

October 23, 2015 letter). In her letter, Hoy asserted that ACA required full coverage of her claims because there were no network providers of breastfeeding support available to her. 5-ER-1102-1103. United acknowledged her letter and informed Hoy that it did not qualify as an appeal. 5-ER-1115-1120. United then sent letters to Hoy's lactation consultant, requesting diagnosis codes that were necessary to process it as a claim for benefits, to which Hoy's provider responded. 5-ER-1121-1125. Notwithstanding Hoy's failure to comply with the plan's claims procedures, United processed Hoy's claims and sent her EOBs denying them, with the same remark codes at issue in the Condry and Bishop claims (*i.e.*, the first remark code at issue). *See supra*, at CI.

Hoy also received an additional remark code, which is **the fourth at issue in this appeal**, and which stated:

"[t]his service code is not separately reimbursable in this setting."

4-ER-1170. This code is mapped to CARC #5, which states: "This procedure code/type of bill is inconsistent with the place of service," and to RARC #M77, which states: "Missing/incomplete/invalid/inappropriate place of service." 3-ER-519 ¶ 17(c); see also 2-ER-304 (United's expert agreeing this remark code maps to CARC #5).

Hoy testified that she understood the remark codes indicated that her claim was not reimbursable and that it referenced the coding used to bill the claim, yet Hoy never asked that provider for "more appropriate" codes to address the issue raised in her

EOB. 4-ER-774 (192:18-25) ("I can't give you more color than that. I mean it says it is not reimbursable."); 4-ER-869-870 (195:7-196:13) (claiming she did not know who provided the coding, but acknowledging her provider informed her about potential coding issues); *see also* 5-ER-1136-1164 (Hoy's appeal.) Hoy chose not to do so despite the fact that her provider warned her that claims are often denied because they contain incorrect codes and provided information to Hoy telling her to contact the provider for help in refiling claims, if necessary. 4-ER-870-871 (196:14-197:13); 2-ER-306.

Hoy submitted an appeal just days after the EOBs were issued. 6-ER-1251-1252 ¶ 104; 5-ER-1136-1164. Hoy did not address the coding issues raised in the EOBs, instead continuing to assert a violation of ACA, even though nothing in her EOB indicated that United had denied her claims because she was not entitled to coverage under the ACA. 5-ER-1126-1135. United acknowledged Hoy's letter and informed her that her letter did not "qualify as an appeal." 6-ER-1252 ¶ 107; 5-ER-1165-1172.

C.6 Expert Testimony Regarding Remark Codes

Palma D'Apuzzo and Dr. Henry Miller provided uncontroverted expert testimony that remark codes are designed to initiate a dialogue between the member and the health plan. 3-ER-533 ¶¶ 41-42; 2-ER-302, 306 (noting that the EOB includes directions to access United's website, or to call the customer service number provided on the member's ID card).

D'Apuzzo, a coding expert with certifications in medical coding and experience as a compliance auditor, testified that the remark code is designed to inform the

provider, *i.e.*, the person or entity that provides the medical codes on the associated claim form, about the reason why their coding is not being accepted. 3-ER-533 ¶¶ 41-42. Remark codes serve to inform the provider about a coding issue so that the provider has ample opportunity to review their claim submission and resubmit a corrected claim, if appropriate. *Id.* at ¶ 41. Although the provider assigns the medical coding associated with the claim, the patient receiving the EOB has an opportunity to contact her provider about the denial. *Id.* at ¶ 42. D'Apuzzo also noted that the provider often works with the member to address the concerns set out in a remark code to facilitate the claim getting processed and, therefore, paid. *Id.*

In short, D'Appuzo opined that for medical coding, the remark code and associated explanation provide the patient with information to query the health plan and/or provider for further clarification. *Id.* This makes sense because many members are likely to be laypersons with no medical coding knowledge; they will necessarily need to rely on the source of that coding – the provider – to remedy any insufficiencies identified by the remark code. The ERISA Plaintiffs did not controvert D'Apuzzo's testimony.

Dr. Henry Miller – who has 45 years of experience in the managed care industry and whose testimony was also uncontroverted – opined it is "typical for the member who receives a denial to contact his or her provider for more information about the reason for the denial," especially one that contains a technical reason, such as improper medical coding. 2-ER-306; 4-ER-665 (171:2-3.) Dr. Miller amplified D'Apuzzo's

opinion by stating that the provider has a "vested interest in resolving claims denials as well as familiarity with the language in the remark code statements." 2-ER-302. Dr. Miller noted that while the "typical insured" does not know what a CPT or HCPCS code or a "modifier" is in relation to the remark codes or EOB, the remark codes indicate to the member that there is a problem with the coding (*i.e.*, the wrong code was used) and that it is a provider issue that the member would naturally contact the provider about to see what it means. 3-ER-638-639 (64:3-67:4); 3-ER-652 (119:5-12) (noting that few people are involved in a claim – the member, the provider and the insurer; members therefore know who to contact about questions that arise with their claim).

Dr. Miller further opined that the particular remark codes at issue follow industry-standard language, as he was able to map them to CARCs and RARCs himself. 2-ER-303-304; 4-ER-641 (76:11-77:18). The comparison highlights that United's codes align with the CARCS and RARCs in both language used and volume of information. 2-ER-303-304.

Dr. Miller also concluded that the ERISA Plaintiffs had demonstrated that they understood the remark codes they received.[3] He understood that where the wrong

[3] Dr. Miller catalogued the reasons that demonstrated the ERISA Plaintiffs understood their codes. For example, he noted that Barber was able to translate the remark code, "your plan does not cover this non-medical service or personal item" to mean that United denied her claim because it had interpreted the service she received to be a parenting class, instead of lactation services. 2-ER-305 n.18. Dr. Miller further noted that Endicott had received the letters that United had sent to her provider asking for

coding had been provided, the Plaintiffs understood that the coding that was provided was not sufficient and that their providers had supplied it. 4-ER-660 (152:1-9); 4-ER-661 (157:7-18); 4-ER-664 (167:9-13) (only the provider can provide medical coding); 4-ER-664-665 (167:21-170:4) (noting that the member does not have to know about coding because the member expects that the provider – who provided the coding – does that.)

Dr. Lauren Hanley – an obstetrician/gynecologist and lactation consultant that the ERISA Plaintiffs hired – established that the purpose of remark codes is to provide information to members in accordance with industry-standard language and initiate a dialogue between the member, the member's provider, and United, allowing members to capitalize on available resources. 2-ER-257 (115:9-116:19). Dr. Hanley herself had participated in at least one such dialogue. *Id.*

D. The District Court Erroneously Granted Summary Judgment In Favor Of The ERISA Plaintiffs By Focusing On The Initial Communication From United Regarding The ERISA Plaintiffs' Claim.

After the district court dismissed some claims at the pleading stage, the parties cross-moved for summary judgment. Dkts. 104-4, 116-4, 146. The district court

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the provider to update the codes, indicating that she had the information she needed to perfect her claim. *Id.* Finally, Dr. Miller had reviewed Condry's, Bishop's, and Hoy's deposition transcripts and found they understood that their respective providers had supplied the procedure codes at issue to United; he concluded it was reasonable for them to follow up with the providers to get "more appropriate" codes to attempt to perfect their claims. *Id.*; *see also,* 2-ER-307.

construed the ACA regulations that permit a plan to deny coverage or impose cost shares on lactation services obtained out-of-network if the plan has an in-network provider to mean that Plaintiffs' ACA claims turned on whether each plaintiff had "meaningful access" to an in-network provider.[4] Order on Summ. J. ("SJ Order"), Dkt. 146; 1-ER-24, 26-27. This inquiry required an assessment of the circumstances of each named Plaintiff. *Id.* The court analyzed factors such as whether in-network providers were "nearby" to each plaintiff and whether each one attempted to locate in-network providers. 1-ER-25-27. Based on this individualized analysis, the district court reached different summary judgment outcomes based on the facts relating to each named Plaintiff.[5] *Id.*

With respect to the full and fair review claims in Count I, United submitted the full course of each ERISA Plaintiff's interactions (or potential for interactions) with United, in addition to evidence about how other United members reacted to and understood the four remark codes at issue. *See* 6-ER-1205-1206 & evidence cited; *see supra* Section CI.

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[4] As noted above, under ACA, only when a health plan does not have in its network a provider who offers lactation services must the plan cover out-of-network services without cost shares. 29 C.F.R. § 2590.715-2713(a)(3)(ii).

[5] Specifically with respect to the ACA claims in Count II, the district court entered summary judgment in favor of Bishop and Hoy and in favor of Defendants with respect to Barber and Condry. 1-ER-23. The court also found in favor of Defendants on Count IV (sex discrimination) and Count VI (unjust enrichment). 1-ER-29-30. The court denied summary judgment for both sides on: (1) Count III (joint liability); (2) Endicott's Count II claim (ACA); and (3) Carroll's Count V claim (ACA). 1-ER-27, 30.

Nevertheless, the district court granted summary judgment in favor of the ERISA Plaintiffs. The court focused only on the remark code language on the EOB that each Plaintiff received, did not discuss the additional evidence submitted by United that identified the entire course of interaction between each Plaintiff and United. 1-ER-28. The court ruled in a conclusory fashion—without discussing each Plaintiff's course or potential course of interaction with United—that the four remark codes "were written in a way that made them virtually impossible to understand." *Id.* The court did so even though the remark codes expressed the reasons for the denial. *Id.*

E. The District Court Erroneously Granted Class Certification On The Claims Review Class; Following Resolution Of Remaining Individual Claims, The Court Enters Judgment.

Following summary judgment, Plaintiffs moved to certify three putative classes, two pertaining to the ACA claims, and one—the Denial Letter Class—consisting of all members and beneficiaries of ERISA-governed plans who received out-of-network lactation services, had a claim denied, and received an EOB with one of the four remark codes identified in the summary judgment ruling. 4-ER-702-703. On May 23, 2019, the district court issued an order denying certification on all three classes. Original Cert. Order, Dkt. 213, 3-ER-535-541. With respect to the ACA classes, the court concluded (among other things) that Plaintiffs failed to present "adequate evidence that liability could be determined (or that any significant issues could be resolved) on a classwide basis." 3-ER-537. Regarding the Denial Letter Class, the court found that Plaintiffs sought "to certify an overbroad class," and that they had failed "to propose a form of

relief congruent with the summary judgment ruling." 3-ER-539-540.

Plaintiffs renewed their efforts to certify the classes, and the parties briefed the issues again. Pls.' Opening Brief in Supp. of their Renewed Mot. for Class Certification, Dkt. 222 (Sept. 9, 2019); Defs.' Resp. in Opp'n, Dkt. 248 (Oct. 24, 2019); Pls.' Reply, Dkt. 250 (Nov. 7, 2019). On December 23, 2019, the district court again denied certification of the ACA classes, relying on its individualized summary judgment analysis and finding, among other deficiencies, "the evidence undermines the plaintiffs' assertion that a uniform standard or approach existed with respect to coverage for out-of-network lactation services."[6] Renewed Cert. Order, Dkt. 262, 1-ER-15.

With respect to the Denial Letter Class, United again presented evidence of the ERISA Plaintiffs' and other United members' experiences with the remark codes, as well as evidence about how those codes are used in the industry. This evidence demonstrated why the district court needed to examine the circumstances of each class member to determine whether a meaningful dialogue was available to each member. *See supra* at 13, 14, 16, 17, 20 (noting that Barber was able to communicate back to United that she disagreed with its interpretation of her claim as one for a parenting class; that Endicott had received the letters sent to her provider asking the provider to update the coding; and that Condry, Bishop, and Hoy understood that their providers had

[6] As noted, the district court's denial of class certification is consistent with other courts' resolution of the other similar lactation-related putative class actions brought by these plaintiffs' counsel. *See supra* n.1.

provided the coding, but decided not to ask for a "more appropriate" code to use); *see also supra,* at 12 (demonstrating that between 2015 and 2018 United members or their representatives contacted United on many occasions to follow up the very same remark codes that the ERISA Plaintiffs had received, even though the codes focused on issues that members were not typically familiar with, such as medical coding).

United also explained that, at the summary judgment motion stage, the law required the court to assess each class member's interactions with United, rather than making class-wide assumptions on an incomplete record. Defs.' Resp. in Opp'n, Dkt. 248, 2-ER-221-222.

On December 23, 2019, the district court issued an order certifying the Remark Code Class. Renewed Cert. Order, Dkt. 262, 1-ER-12-22. Its class certification analysis was laced with the erroneous reasoning it adopted at summary judgment. The court focused solely on the text of the remark codes themselves, noting it had "ruled at summary judgment that United Healthcare … 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 court reasoned "[t]he plaintiffs now seek certification of a class … who received the same denial letters as the … named plaintiffs, with an eye towards a court order requiring United … to send class members new letters that explain the basis for denial in a comprehensible fashion." *Id.*

Although the district court acknowledged "it's safe to assume" that "some class members may have had subsequent communications with United … and those …

communications may have resolved the dispute between plan and participant," the court ruled such communications would "not change the fact that United['s] … denial letters … violated ERISA in the same way as to each participant." 1-ER-13. The court concluded "[a]n appropriate remedy … is to order United … to send a follow-up letter to each class member," and "[t]he new letter can be worded so as to emphasize that if a participant believes her dispute with the company was mooted by activity or communications subsequent to the … denial letter, she need not take further action." (*Id.*) The court stated that its summary judgment ruling dictated these conclusions, and that it would not revisit its ruling, telling United it was instead an issue for appeal. 2-ER-169 (121:8-10) ("[T]hat's something that you can take up to the Ninth Circuit."). The Court later indicated that "maybe I was incorrect, but I've made the ruling, and . . . there are consequences to that." 3-ER-602 (61:17-20.).

Following summary judgment and class certification, several claims remained unresolved: (i) Endicott's individual ACA claim under ERISA (Counts II and Count III); (ii) Carroll's individual ACA claim (Count V); and (iii) the ERISA Plaintiffs' claim under Count III regarding jointly liable under ERISA. The Parties agreed to dismiss Endicott's and Carroll's individual claims as the result of partial settlements. *See* Stip. Final J. & Order, Dkt. 288, 1-ER15 (Sept. 15, 2020). Those settlements expressly did not settle their class claims and the portions of their claims that the district court previously decided and which remain contested and subject to further appeals. 1-ER-7-8.

The district court entered final judgment in favor of Hoy and Bishop on their individual claims relating to Counts II and III and against Barber and Condry on those counts. 1-ER-6-7. The Parties agreed to stay execution of the payment ordered to Hoy and Barber. *Id.* Further, the court entered final judgment against Plaintiffs on Count IV (claim for sex discrimination). *Id.*

Lastly, the court entered final judgment in favor of the Denial Letter Class on Count I, finding that United violated ERISA and defining that Class as:

> All participants and beneficiaries, in one or more of the ERISA employee health benefit plans administered by Defendants in the United States, which provide benefits for healthcare services and for which claims administration duties are delegated to one or more of the Defendants, who received from August 1, 2012 to present, an explanation of benefits for Comprehensive Lactation Services rendered by an out-of-network provider, that included one or more of the following denial reasons (the "Remark Codes"):[7]
>
> (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 non-medical 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.")

1-ER-6.

[7] The class definition excluded United, its subsidiaries or affiliate companies, its legal representatives, assigns, successors and employees and the Court and all Court personnel involved in handling of this case.

The final judgment ordered United to send a follow-up letter ("Letter") to each member of the Denial Letter Class, "that explain[s] the basis for denial of the lactation claim in a comprehensible fashion (which would, in turn, allow participants to meaningfully assess whether to contest the denial)," and that is "worded so as to emphasize that if a participant believes her dispute with the company was mooted by activity or communications subsequent to the initial denial letter, she need not take further action in response to the new letter." 1-ER-6-7.

The court also ordered the parties to confer on the content of the Letter and to provide the court with competing versions if the parties could not agree on its contents. 1-ER-13. As a result of the court-ordered process, parties submitted competing versions of the Letter, including a version that showed which language the parties agreed to and which language was in dispute. 2-ER-44-48. In that version, the ERISA Plaintiffs substantially agreed to language to use to explain the remark codes. *Id.*

The Parties agreed to stay execution of the order directing United to send the Letter until after the Parties' appeals are fully resolved. 1-ER-7.

F. In The Final Judgment, The Parties Reserved Certain Rights To Appeal.

In the Final Judgment, the Parties expressly reserved their rights on appeal to challenge all rulings or orders in this case and agreed that "[i]f any aspect of a ruling or order is reversed or vacated on appeal, wholly or partially, [the] Stipulated Final

Judgment and Order shall be set aside to the extent inconsistent with any such decision on appeal or ruling of [the district court] on remand." 1-ER-5-6.

United thereafter appealed, and plaintiffs cross-appealed.

SUMMARY OF ARGUMENT

ERISA requires a health plan to explain the reason for its claims determination in a way that is adequate to explain the reason for the decision and to permit the member to pursue further review of the claim. This Court has held that to determine whether a plan has complied with this requirement, a court must assess the entire course of communications between the plan and the member to determine, under the circumstances of each individual case, if the plan engaged the member in, or the member had access to, a meaningful dialogue regarding the claims decision. However, this Court has not yet addressed how these principles apply when a party seeks to certify a class action to adjudicate a contention that a plan's communications to an entire class of members violated ERISA.

Given a plan's need to make quick and efficient determinations of the many claims for reimbursement it receives, it is standard in the managed care industry to have the plan's claim system generate a generalized notice of any claims denial that states the basis of the denial and invites the member to follow up. As uncontroverted fact and expert evidence demonstrated, such notices are intended to initiate a dialogue with the plan member, which should adequately explain the basis for the claims decision. Yet, in ruling on summary judgment, the district court departed from this Court's precedents

by focusing solely on the initial form notice provided to each ERISA Plaintiff, and basing its ruling solely on the court's subjective opinion that the notices were "virtually impossible to understand." The court did so even though the notices were not only understandable on their face, but unrefuted record evidence showed the ERISA Plaintiffs understood the notices and had the opportunity to engage in a meaningful dialogue with the plan after receiving their notice. Moreover, industry experts explained the reason why the notices read the way they did and why they were adequate as written.

For example, the district court found "impossible to understand" a notice that stated, "Your plan does not cover this non-medical service or personal item," even though that statement is understandable on its face, and record evidence showed the ERISA Plaintiff who received it (Barber) understood the denial was based on a particular exclusion in her health plan. Similarly, the court found "impossible to understand" a notice that stated, "We asked the member for more information and didn't receive it on time," even though the ERISA Plaintiff who received that remark code (Endicott) knew her provider had been asked for the information that was needed prior to the claims denial through the letters United had sent to her and her provider. The other two notices at issue indicated that "more appropriate" medical coding was needed to process the claim or that the coding used was inappropriate for use in the setting of the care provided. The ERISA Plaintiffs who received those codes (Bishop and Condry) understood that their providers furnished the medical coding questioned in the denials, yet they chose not to discuss the denials with those providers.

In short, all the remark codes were "reasonably calculated" under the circumstances to communicate the problem that caused the claim to be denied and the ERISA Plaintiffs understood that they had resources (their providers, their benefits booklet, United's website and its customer service representatives) to help them perfect their claims based on the information United had provided.

The district court's erroneous approach at summary judgment took on a new dimension when the court extended the error to certify a class, once again failing to consider the entire course of communications between each class member and the plans. Because this Court's precedents require inquiry into all of the communications between the plan and each class member, the court should have ruled that the required holistic examination cannot be conducted on a classwide basis.

The new dimension to these errors took an even more problematic turn when the district court granted injunctive relief to the class. Even though the court had not examined the course of communications between United and each member, and even though the court had acknowledged that such course may have sufficed for any given class member, the court nonetheless ordered United to send a new remark code letter to each class member that explained the basis for the claims denial in terms that were more to this court's liking. This injunction, if not reversed, would not only impose a substantial burden on United without delivering any corresponding benefit to the class members, but risks confusing class members by inviting them to resubmit claims for services provided years ago without any reason to believe any resubmitted claims will

yield a different outcome.

The decisions on summary judgment, on class certification, and on injunctive relief each should be overturned. Managed care companies, like United, need to balance their duty to explain their decision to members against the need to make efficient and timely benefits determinations. This Court's precedents that focus on the entire stream of communications between the plan and member strike the right balance in that they permit a plan to promptly send a concise notice stating the basis for a claims decision, among other things, while permitting the member to follow up with the health plan or provider. The summary judgment ruling erroneously criticized the notice, and the court mistakenly focused on the notice alone instead of conducting the more fulsome examination of the entire course of communication between the plan and member that this Court's precedents require. The court then replicated its erroneously truncated analysis on summary judgment in its ensuing class certification and injunctive relief rulings, so all three rulings must be reversed.

Reversing those rulings will correct errors that threaten to overly complicate health plan administration and produce other undesirable results. The rulings encourage class action lawyers to search for any single communication that they can claim is inadequate and demand class-wide adjudications of the adequacy of the isolated communication in the abstract. Such litigation, while unduly burdening plan administrators, would benefit only the class action lawyers and would not help the class. Such litigation would not ascertain whether the course of interaction with any given

class member and the plan, in fact, afforded a full and fair review. Worse still, injunctions like the one entered below could confuse and burden health plan members, who would receive new remark codes letters that would provide a redundant re-explanation of a previously denied claim and that would advise the member on how to resubmit an appeal even though there is no reason to believe any such appeal will yield a different claims outcome.

For all of these reasons, as explained further below, this Court should reverse the grant of summary judgment in the ERISA Plaintiffs' favor related to the remark codes and the order certifying a class on that same issue and should overturn the injunctive relief ordered as part of that ruling.

ARGUMENT

I. Standards Of Review

This Court reviews a denial of summary judgment *de novo*. *See Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130, 1138 (9th Cir. 2001), *citing Moran v. Washington*, 147 F.3d 839, 844 (9th Cir. 1998). This Court must determine whether the evidence, when viewed in a light most favorable to the nonmoving party, raises any genuine issues of material fact and whether the district court correctly applied the substantive law. *See id.*, *citing Berry v. Valence Tech., Inc.*, 175 F.3d 699, 703 (9th Cir. 1999). This Court also reviews *de novo* the district court's choice and application of the standard of review applicable to decisions of plan administrators in the ERISA context. *See*

Regula, 266 F.3d at 1138 (citing *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 797 (9th Cir. 1997)).

This Court reviews the decision regarding class certification for abuse of discretion. *See Lozano v. AT&T Wireless Servs. Inc.*, 504 F.3d 718, 725 (9th Cir. 2007), *citing Valentino v. Carter-Wallace, Inc.*, 97 F.3d 1227, 1234 (9th Cir. 1996). The district court abuses its discretion if its certification order is premised on impermissible legal criteria. *See Moore v. Hughes Helicopters, Inc.*, 708 F.2d 475, 479 (9th Cir. 1983).

Because the grant of injunctive relief followed directly from the summary judgment and class certification rulings, the standard of review of the injunctive relief order is a combination of of the above standards: the portion of the injunctive relief order that rested upon the summary judgment ruling is reviewed de novo, while the portion of the injunctive relief order that rested on the class certification ruling is reviewed for abuse of discretion.

II. This Court Should Reverse The Decision On Summary Judgment Because The District Court Applied The Wrong Standard To The ERISA Plaintiffs' Full And Fair Review Claims.

There is no genuine factual dispute that United complied with Section 503's requirements with respect to each Plaintiff. With respect to all the ERISA Plaintiffs, United provided notices that explained the reason for its denial of the claim for benefits that "permitted a sufficiently clear understanding of the administrator's position to permit effective review." *Koblentz*, 2013 U.S. Dist. LEXIS 121389, at *11, citing *Brogan*,

105 F.3d at 165 (noting that a denial letter substantially complies with these requirements if it provides the claimant with "a statement of reasons that, under the circumstances of the case, permitted a sufficiently clear understanding of the administrator's position to permit effective review."); *see also Chuck*, 455 F.3d at 1032 ("substantial compliance" is what section 503 requires). As a result, this Court should reverse the grant of summary judgment to the ERISA Plaintiffs on the remark code issue.

A. On De Novo Review, The District Court's Summary Judgment Order Cannot Be Reconciled With The Totality Of The Evidence Demonstrating Substantial Compliance With The Full And Fair Review Requirement

The district court was required to evaluate the entire course of communication between each plan member and United to determine whether a full and fair review occurred. *See Gravelle*, 2009 U.S. Dist. LEXIS 4929, at *23 (noting the appropriate question is whether the beneficiary was provided reasons for the denial that "under the circumstances of the case," permitted an effective review)); *see also Chuck,* 455 F.3d at 1032 (same); *Booton*, 110 F.3d at 1463 ("meaningful dialogue" is a "common sense standard"). Yet, the court only discussed the content of the remark codes and did not even mention any of the other evidence in the summary judgment record. 1-ER-28. Considering all the record evidence, the summary judgment ruling cannot withstand de novo review.

A.1 Barber Received A Remark Code That Was Clear On Its Face And Her Appeal Showed She Understood It

As noted, Barber received a remark code that was clear and understandable and stated in plain terms that United had concluded the service Barber had received was not a medical one: "[y]our plan does not cover this non-medical service or personal item." 5-ER-931. The code followed the industry standard CARC #202, which states: "Non-covered personal comfort or convenience services." *See supra at* 16.

Barber plainly understood that United was telling her the service was not a medical one because she filed an appeal that recognized and understood the reason given for the claims denial and she challenged that reason. Barber admitted in deposition testimony that she understood United's explanation that her plan does not cover "non-medical service[s] or personal item[s]" to say that United was not covering the service because it was a parenting class. 4-ER-826 (219:7-24); 5-ER-931. Her understanding of the reason for the denial demonstrates that Barber received an explanation that meets the ERISA regulation standards. *See Brogan*, 105 F.3d at 166 (noting that the member's subsequent actions demonstrated that he received a "sufficient explanation" of the defect and that the explanation, therefore "substantially complie[d] with the [ERISA] regulation's requirements").

Barber was able to determine what plan provision was at play and she was able to address that concern in her late appeal letter even though United did not point to the specific plan provision that related to the claim denial in the remark code. This is a

classic, objective example of a "meaningful dialogue" between member and health plan, demonstrating why the district court's decision was flawed and should be reversed. *See, e.g., Brogan*, 105 F.3d at 166 (noting that, while the plaintiff argued he was not given a sufficient explanation for the denial in that case, the court concluded "[b]ased on [his] subsequent actions," he was given the necessary information to perfect his claim); *see also Silver*, 466 F.3d at 731 n.1 (where the Ninth Circuit was "satisfied" that the denial letter in that case met the requirements set forth in the pertinent ERISA regulations and that it complied with the "common sense" requirement that plan administrators engage in a "meaningful dialogue" about the reasons for denying claims); *Siebert v. Cent. States, Se. & Sw. Areas Health & Welfare Fund*, No. 18 C 6681, 2020 U.S. Dist. LEXIS 195409, at *29 (N.D. Ill. Oct. 21, 2020) (no ERISA violation where the plaintiff had not received written notice of the denial of benefits because it was clear from his later appeal documentation that he was not harmed by lack of notice because he "knew and understood the basis for the decision and ran into no real difficulty challenging it, apart from the fact that the decisions ultimately went against him on the merits.").

Barber received a "full and fair" review under ERISA. *Id.*

A.2 Endicott Received A Remark Code That Was Clear On Its Face, And Other Evidence Also Established A Full And Fair Review

United sent Endicott a remark code that clearly advised her that United had denied her claim due to a failure to respond to a request for more information: "[w]e asked the member for more information and didn't receive it on time." 5-ER-913. This

remark code also was mapped to industry standard guidance, CARC #227, which states: "Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete." *See supra,* at 14. This message plainly advised Endicott that there was information that was missing that prevented United from processing her claim. Moreover, United had previously provided Endicott copies of the letters it had sent her provider, telling the provider – who supplied the coding on Endicott's claims – that the codes needed to be updated in order for the claims to be processed; Endicott's provider ignored those requests. 5-ER-913, 894-898, 899-910.

Thus, Endicott knew what information United needed from her provider to perfect her claim and cannot reasonably claim she could not understand the remark code she received on her EOB. *Booton*, 110 F.3d at 1463. This record easily satisfies the full and fair review standard. *Id.*; *see also Silver*, 466 F.3d at 731 n.1.

Inexplicably, however, the district court ruled that United had failed to provide Endicott with 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." 1-ER-28, citing 29 C.F.R. § 2560.503-1(g)(1)(iii). But the court's focus on the remark code goes astray because United not plainly told her that information was missing, through the letters it had sent her provider. 5-ER-913, 894-898, 899-910. Because the letters to her provider spelled out what United needed to process Endicott's claims, the letters and remark code met ERISA's requirements with respect

to "full and fair review." *Silver*, 466 F.3d at 731 n.1.

That United's correspondence prior to the remark code/EOB had asked Endicott's provider and not Endicott for this information is of no moment. Endicott was aware that United needed information regarding medical coding that Endicott herself would not have, but she also knew her provider could submit coding. The district court erred in focusing solely on the remark code on the EOB and in ignoring the course of communication between Endicott, her provider, and United, which clearly reveal Endicott knew what information was needed to perfect her claim and thus, a "meaningful dialogue" occurred. *Brogan,* 105 F.3d at 165 (no ERISA violation where denial "permitted a sufficiently clear understanding of the administrator's position to permit effective review"); *see also Chuck,* 455 F.3d at 1032 ("substantial compliance" is what section 503 requires). Under the circumstances, where Endicott had received the letters asking her provider for the needed information, there was meaningful dialogue and substantial compliance on United's part. Like with Barber, the "common sense" standard applies here, where Endicott knew what information she needed to provide United to perfect her claim in response to the remark code. *Silver*, 466 F.3d at 731 n.1; *Booton*, 110 F.3d at 1463.

A.3 Condry, Hoy, And Bishop Received A Remark Code That Clearly Advised That The Problem Was The Medical Codes Used In The Claim, And Other Evidence Further Establishes A Full And Fair Review

Condry's, Hoy's, and Bishop's notices plainly stated that the problem with the

claim was the medical codes used in the claim—"[t]here may be a more appropriate CPT or HCPCS code that describes this service"—as did the additional remark code that Bishop received (the last of the four codes at issue)—"[t]his service code is not separately reimbursable in this setting." 5-ER-1128, 1133, 1170, 957, 941. Condry and Bishop admitted in testimony introduced into the summary judgment record that each one understood that their lactation consultants had provided the codes submitted to United. 4-ER-783-784 (118:20-119:13); 4-ER-803-804 (82:19-83:8); 4-ER-869-871 (195:7-197:13). The remark codes thus sufficed because they advised each plaintiff of the type of additional information that might be needed to perfect their claims. The notice "permitted a sufficiently clear understanding of the administrator's position to permit effective review." *Brogan,* 105 F.3d at 165 (4th Cir. 1997); *Romanchuk v. Bd. of Trs.*, No. CV 15-08180-AB (KS), 2017 U.S. Dist. LEXIS 209636, at *22 (C.D. Cal. June 29, 2017, citing *Kludka v. Qwest Disability Plan*, No. 08-CV-01806, 2012 U.S. Dist. LEXIS 66857, at *5 (D. Ariz. May 14, 2012), *aff'd*, 581 F. App'x 633 (9th Cir. 2014) (noting that courts "generally find an administrator fails to comply with the dialogue requirement in situations where the administrator 'knew of specific information, but failed to notify the claimant of the need for the information'").

That United substantially complied with the full and fair review requirement for each plaintiff is further demonstrated by the uncontroverted facts and expert testimony that demonstrated that each of these remark codes correlated with industry-standard language held out by CMS and others and that the language in practice triggers a

meaningful dialogue between the plan and its members. *See supra* at 9-11 (cataloguing such evidence). United's experts agreed that members routinely reach out to their providers to get help with remark codes, particularly where medical coding is the root of the issue. *See supra,* at 21-23. Members are not expected to be able to provide new medical codes to solve insufficiencies identified by remark codes and it is reasonable to assume they would contact their providers – the source of the coding – to solve those problems. *Id.* Even the ERISA Plaintiffs' expert, Dr. Lauren Hanley, agreed that remark codes are just a means of initiating the dialogue between members or their providers and the health plan and had engaged in such a dialogue in her capacity as a provider. 2-ER-257 (115:9-116:19).

B. Plaintiffs' Arguments Below Were Erroneous

In the district court, the ERISA Plaintiffs asserted that United's remark codes did not specifically ask for the information needed to perfect their claims. 4-ER-755-756. This assertion is meritless. The remark codes they received clearly informed them that there may be a "more appropriate" code that could be used, and they clearly understood that their providers had selected the codes. Thus, it was reasonable for Condry, Bishop, and Hoy to ask their providers for a "more appropriate" code and engage in a further dialogue with United with that information. 2-ER-306 (United's expert noting that "[a]lthough the reference to the codes may seem somewhat technical, it is reasonable to expect that members will contact their providers in response to this denial reason."); 2-ER-307 (similar).

The ERISA Plaintiffs made an irrelevant argument below in relying on the fact that none of them had coding expertise. Although most plan members are likely not coding experts, their providers are required to use proper codes when submitting claims for reimbursement for services provided, and failure to use the proper codes entitled United to deny the claims and issue an EOB that succinctly indicated the problem was improper coding. United's remark code did so, and it could not offer more information about which codes the providers should have used because health plans do not select the codes that are submitted for reimbursement. This makes sense because the providers are best situated to determine what services they are entitled to perform and what services were actually provided during a particular visit. Thus, the ERISA Plaintiffs' providers were best situated to know which codes might be more appropriate.

Under the circumstances, United's explanation that different codes may be "more appropriate" was "reasonably clear" and sufficient to inform Plaintiffs of the type of additional information needed to perfect their claims. *See Gravelle*, 2009 U.S. Dist. LEXIS 4929, at *23 (citing *Brogan*, 105 F.3d at 165 (noting the appropriate question is whether the beneficiary was provided reasons for the denial that "under the circumstances of the case," permitted an effective review)); *see also Chuck,* 455 F.3d at 1032 ("substantial compliance" under the circumstances of the case is required); *Booton*, 110 F.3d at 1463 ("meaningful dialogue" is a "common sense standard"). Indeed, the record evidence demonstrated that other members who received the same codes contacted United (either personally or through a representative) to communicate with

United about their claims denied with those codes. *See supra* at 11-12.

Endicott argued that because the letters asking her provider for additional information that she received prior to receiving her EOB had indicated that she did "not need to respond or take any action," she was somehow prohibited from taking action as a result of the remark code she had received later in the EOB. Pls.' SJ Reply, Dkt. 123-4, 4-ER-756. That is irrational. Endicott was not limited in her ability to contact the provider after receiving the remark code and did so (but did not submit new codes nonetheless). 2-ER-305 n.18 (Endicott's testimony admitting she knew her provider had provided the codes and that she contacted her provider after receiving the remark code).

Barber argued that the remark code she received was "facially absurd" and "failed to suggest any means for Barber to 'perfect her claim.'" Pls.' SJ Reply, Dkt. 123-4, 4-ER-756. This argument is belied by the fact that Barber knew the remark code was referring to United's interpretation of her claim as a claim for reimbursement of a parenting class, and by her letter contesting the denial on this basis. *See supra*, at 16-17; *see also Coleman v. Am. Int'l Grp. Inc. Grp. Benefit Plan*, 87 F. Supp. 3d 1250, 1260-62 (N.D. Cal. 2015) (deficiencies in denial letter mitigated by subsequent communications).

C. That Plaintiffs Obtained A Full And Fair Review Is Further Shown By The Fact That The Relief They Requested Was Not Materially Different From The Review United Had Provided In The First Instance

There is another portion of the record below that further demonstrates that

United substantially complied with its full and fair review obligations and the district court reversibly erred in granting summary judgment on this issue: the injunctive relief that the ERISA Plaintiffs later contended should be granted was not materially different from the meaningful dialogue that United had made available to each ERISA Plaintiff in the first instance.

After the district court ordered the parties to meet and confer on the language of the Letter, which would be sent to the Denial Letter Class, the ERISA Plaintiffs agreed that certain language would suffice to explain the disputed remark codes. 2-ER-44-48 (containing version of the Letter that contains both parties' proposed language and the language the parties had agreed to). But, as demonstrated below, the language to which the ERISA Plaintiffs agreed is not materially different from United's original remark codes and did not materially change the class members' ability to engage in a meaningful dialogue with the plan. The similarity between the relief that the ERISA Plaintiffs agreed would suffice, and what United had provided to the class members in the first instance, shows two things that demonstrate the summary judgment below was reversible error:

(1) United's remark codes sufficed to initiate a meaningful dialogue, so the ruling that the remark codes violated ERISA was reversible error. Because United's original remark codes enabled each Plaintiff to initiate a meaningful dialogue just as well as the agreed language that Plaintiffs later conceded would satisfy United's obligations under ERISA, the district court erred in ruling the original remark codes were deficient; and

(2) it was also reversible error to focus only on the remark codes itself rather than the entire course of communication (or potential communication) between United and each plaintiff. Under the agreed language that Plaintiffs conceded would satisfy United's obligations under ERISA, each plan member still would need to engage in further dialogue with United if each one wanted to pursue the claim further. The language that the ERISA Plaintiffs agreed would suffice thus was not materially different from United's original remark codes in either one's capacity to produce a meaningful dialog, or in determining if a meaningful dialogue had in fact occurred based on either writing alone and both instead required consideration of the full dialogue.

In their request for injunctive relief, the ERISA Plaintiffs agreed the following language sufficed to explain why the claims of Condry, Bishop, and Hoy were denied:

> Your medical provider was not eligible to bill the medical procedure code used on Your Claim because the provider was not considered to be a physician or other qualified healthcare professional based on UnitedHealthcare's reimbursement policy entitled, "Nonphysician Healthcare Professionals Billing EM Codes," which is linked to below. Specifically, UnitedHealthcare will not reimburse CPT codes 99201-99499 (evaluation and management codes ("E/M Codes")) for nonphysician providers. **You or your provider must resubmit a corrected claim for lactation services you may have received (accompanied by information from the provider indicating the provider chose the coding) with a non-E/M procedure code that accurately identifies the service performed or an explanation from your provider that he or she is a physician or other qualified healthcare professional, for UnitedHealthcare to reconsider Your Claim**.

2-ER-40-41 (emphasis in original).

This proffered explanation is expressed in terms of medical coding and medical

issues that the average layperson would not know. Most tellingly, because the member cannot determine which code would solve the posited problem, this agreed to language still requires the member to consult with their provider to resolve the issue causing the claim denial. Accordingly, not only would this notice have been unwieldy if used in the initial remark codes sent to plan members, but even with this lengthy notice, the ERISA Plaintiffs will be left in the same position as they were with the original remark code itself – they have to go to the source of the medical coding – the provider – and ask that person to find "more appropriate codes" than were used on the initial claim for reimbursement. This demonstrates that United's remark code itself was "reasonably clear" and, therefore, substantially complied with ERISA.

Similarly, as a remedy for the remark code Bishop received that read "[t]his service is not separately reimbursable in this setting," the ERISA Plaintiffs agreed that United should send the following explanation:

> The service your medical provider rendered is part of a global service for which UnitedHealthcare provides reimbursement on a global basis; this means that your service was bundled with other services and reimbursed as a package. Pursuant to UnitedHealthcare's policies, the service you received cannot be separately reimbursed apart from this global, comprehensive reimbursement. For example, a claim for lactation services denied on this basis would likely be based on UnitedHealthcare's reimbursement policy entitled, Obstetrical Policy, Professional, Policy #019R0064A []. This policy states that all prenatal visits until delivery, which typically include 13 visits, an uncomplicated inpatient stay, and 6 weeks of routine postpartum care are included in the global delivery reimbursement. This policy is available online at https://www.uhcprovider.com/en/policies-protocols/commercial policies/commercial-reimbursement-policies.html.[8]

[8] The sentence that was in dispute in the Letter has been omitted. 2-ER-44-48.

2-ER-41 (providing the link).

This similarly leaves the member in the same position as she was with United's original remark code because she still has to go to the provider who provided the code to rectify the issue raised by United in the denial.

In their proposed Letter, the ERISA Plaintiffs also agreed the following language would suffice to explain the denial of Barber's claim: "[t]he service or medical item you received was not covered or reimbursed because it was not part of the benefits set out in your plan's benefit booklet." 2-ER-41. This is substantially the same as the original remark code itself—"[y]our plan does not cover this non-medical service or personal item." 5-ER-931. The language to which the ERISA Plaintiffs agreed thus further demonstrates that the original remark code at least substantially complied with ERISA.

The explanation that the ERISA Plaintiffs agreed would suffice to explain the denial of Endicott's claim likewise says almost the same thing as the original remark code itself. Specifically, the ERISA Plaintiffs agreed to tell members:

> UnitedHealthcare previously asked either you or your medical provider for information that was necessary to process Your Claim, but UnitedHealthcare did not receive it on time and denied your claim as a result. Prior to receiving the Explanation of Benefits denying Your Claim for this reason, you or your medical provider should have received a letter specifying the information that was requested.

2-ER-41.

Like the other examples discussed above, this language is substantially the same as what United already told Endicott, demonstrating that its original remark code

substantially complied with ERISA. Notably, Endicott understood that the letters she received prior to receiving her EOB with the remark code actually related to the remark code. 2-ER-305 n.18 (referring to Endicott's testimony noting that she contacted her provider about the letters after receving the remark code).

Because the language the ERISA Plaintiffs agreed would suffice as a remedy is materially similar to United's original remark codes, that agreed language is further evidence that its original remark codes sufficed to at least initiate a meaningful dialogue. And, because an ERISA full and fair review claim turns on whether a meaningful dialogue occurred, *Silver*, 466 F.3d at 731 n.1, and United's original remark codes sufficed to at least initiate such a dialogue, the district court reversibly erred in granting summary judgment on the full and fair review claim based solely on the original remark codes. Accordingly, this Court should reverse that summary judgment ruling.

III. The District Court Abused Its Discretion In Certifying The Denial Letter Class.

Because the summary judgment ruling pervaded and infected the ruling certifying a remark code class, reversal of the summary judgment on any of the above grounds alone warrants reversal of the class certification ruling and classwide injunctive relief that is premised on a valid class certification. The district court abused its discretion in certifying the Denial Letter Class for the additional reason that it improperly ignored the lack of commonality and that individual issues predominate, making the class device

inappropriate.

The Rules Enabling Act, 28 U.S.C. § 2072(b), precludes the use of the class action device to alter substantive law. *Ortiz v. Fibreboard Corp.*, 527 U.S. 815, 845 (1999) ("[N]o reading of the Rule can ignore the Act's mandate that rules of procedure shall not abridge, enlarge or modify any substantive right." (internal quotation marks omitted) (quoting *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 613 (1997)); *see also Dukes v. Wal-Mart Stores, Inc.*, 603 F.3d 571, 641 (9th Cir. 2010) ("A court must ensure that its certification of a class does not affect the substantive rights of either party."). Accordingly, to determine whether a class may be certified, a court must look to the inquiry that the underlying substantive law requires to establish an individual claim, and then determine whether that inquiry can be performed on a classwide basis through common proof. *See id.*

As noted, the appropriate inquiry to adjudicate a full and fair review claim is whether United substantially complied with ERISA's "meaningful dialogue" standard. *Chuck,* 455 F.3d at 1032; *Booton,* 110 F.3d at 1463. Thus, the proper inquiry requires examination of all circumstances of each claims denial to determine whether the totality of communications between the member and plan furnished a meaningful dialogue and achieved substantial compliance. *See Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 972-973 (9th Cir. 2006); *Coleman*, 87 F. Supp. 3d at 1260-62 (deficiencies in denial letter mitigated by subsequent communications); *Palmer v. Unum Life Ins. Co. of Am.,*, No. C04-2735 MJJ, 2005 WL 1562800, at *5 (N.D. Cal. June 24, 2005).

Such a determination cannot be made on a class-wide basis because it entails an examination of each class member's circumstances, including the extent of any additional communications between the member and United and providers. *See, e.g., Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 352 (2011)(commonality required to certify class is not present unless claims not only pose common questions, but those questions are amenable to common answers); *Thomasson v. GC Servs. Ltd. P'ship*, 539 Fed. App'x 809, 810 (9th Cir. 2013) (finding that class certification was inappropriate where individualized issues predominated); *Coleman*, 87 F. Supp. 3d at 1260-62 (deficiencies in denial letter mitigated by subsequent communications). Indeed, United's expert provided uncontroverted testimony that "[d]etermining whether a particular remark code was appropriate or inappropriate for a given situation or member would require an individual inquiry into the member's particular circumstances, including the service involved, the claim submitted, and any communications with the provider or [United] following the member's receipt of the EOB." 2-ER-299; *see also Brogan,* 105 F.3d at 165 (noting that that the sufficiency of a meaningful dialogue be adjudicated "under the circumstances of the case.").

In failing to appreciate the individualized issues and, instead, making assumptions based solely on the text of four remark codes, the district court erroneously allowed the Plaintiffs to avoid their Rule 23 burden based on assumptions untethered to class members' actual experiences—a tactic fundamentally inconsistent with Rule 23. As noted above, uncontroverted fact and expert testimony established that the purpose

of remark codes contained within an EOB form is to provide enough basic information for the member to *initiate* a meaningful dialogue that in its totality will enable the member to understand the benefits determination and to capitalize on other available resources. *See supra at* 10-11 including, but not limited to, 3-ER-533 ¶¶ 41-42; 2-ER-299, 302, 306; 3-ER-325-326 (115:9-116:19). The record evidence shows this process works as designed. United's records indicate members routinely communicate with United after receiving claim denials, including denials involving the remark codes at issue. *See supra* at 11-12 (citing, *e.g.*, 3-ER-518 ¶ 9; 2-ER-325-326 ¶¶ 11-12.) The experiences of each ERISA Plaintiff show that members understand the basis for claim denials, often due to their or their providers' additional communications with United. 2-ER-210-211, 222.

Thus, the district court's unsupported class-wide assumptions based solely on four remark codes that were designed solely to initiate a dialogue do not square with the record evidence of class member's actual experiences. To correctly adjudicate the full and fair review claims, individual assessments of each member's circumstances—including whether additional contact with United occurred or an appeal was filed—is required to determine whether the alleged procedural violation prevented a "meaningful dialogue," and whether United "substantially complied" with ERISA. *See Gravelle*, 2009 U.S. Dist. LEXIS 4929, at *23 (citing *Brogan*, 105 F.3d at 165 (noting the appropriate question is whether the beneficiary was provided reasons for the denial that "under the circumstances of the case," permitted an effective review)); *see also Chuck,* 455 F.3d at 1032 ("substantial compliance" under the circumstances of the case is what Section 503

requires); *Booton*, 110 F.3d at 1463 ("meaningful dialogue" is a "common sense standard").

The district court noted it was "safe to assume" some class members may have had subsequent communications with United, yet it found that was not a reason to deny class certification because United "engaged in the same conduct with respect to each of the proposed class members – sending a incomprehensible denial letter." Renewed Cert. Order, Dkt. 262, 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."). This approach altered the governing substantive law to accommodate the class action procedure—exactly what the Rules Enabling Act forbids.

The substantive law does not provide that a plan violates ERISA if a remark code, viewed in isolation, is deemed inadequate. Rather, the substantive law holds that an ERISA violation occurs only if the parties' entire course of communication fails to meet the "meaningful dialogue" or "substantial compliance" standards. *Silver,* 466 F.3d at 731 n.1; *Chuck,* 455 F.3d at 1032; *Abatie*, 458 F.3d at 972-973; *Coleman*, 87 F. Supp. 3d at 1260-62 (deficiencies in denial letter mitigated by subsequent communications). Accordingly, the district court could not properly adjudicate on a classwide basis whether a "meaningful dialogue" had occurred between each class member and the plan by evaluating solely the language of the remark codes alone, and without evaluating the ensuing dialogue between each class member and the plan. Therefore, the court

abused its discretion in ruling that the full and fair claim could be adjudicated on a classwide basis based on the remark codes alone.

At the summary judgment stage, the district court had before it in the record the entire course of communication between each ERISA Plaintiff and United and additional evidence and expert testimony. Although the court's summary judgment ruling only discussed the remark codes themselves and did not address any of the other record evidence, the record at least sufficed to permit the analysis that the governing substantive law required—*i.e.* whether a meaningful dialogue had occurred. At the class certification stage, by contrast, the district court did not even have any evidence of any of the communications between United and the putative class members, other than the remark codes themselves. The court accordingly not only did not conduct the appropriate inquiry, but it could not have done so.

Far-reaching consequences will follow if this Court does not reverse the class certification ruling. By permitting a facile way of certifying a class without engaging in the fulsome inquiry that the substantive law requires, the ruling, if not, reversed, invites a new wave of putative class actions that seek to isolate particular form notices without examination of the actual experiences of the individuals who received those notices. That is a recipe for costly litigation that will enrich lawyers, but will burden courts and plans, and ultimately the plan members themselves. *Koby v. ARS Nat'l Servs., Inc.*, 846 F.3d 1071, 1079 (9th Cir. 2017) (injunctive relief that required debt collector to make certain disclosures on voicemail messages for period of two years was "worthless to

most members of the class"); *In re Walgreen Co. Stockholder Litig.*, 832 F.3d 718, 724 (7th Cir. 2016) (a class action that "seeks only worthless benefits for the class" and "yields [only] fees for class counsel" is "no better than a racket" and "should be dismissed out of hand."); *In re Subway Footlong Sandwich Mktg & Sales Pracs. Litig.*, 869 F.3d 551, 556 (7th Cir. 2017) (same); *In re Dry Max Pampers Litig.*, 724 F.3d 713, 721 (6th Cir. 2013) (court found that website and labelling changes provided only rudimentary information and were of negligible value).

Accordingly, this Court should reverse the certification of the Denial Letter Class.

IV. Reversal Of Either The Summary Judgment Or The Class Certification Orders Compels Reversal Of The Injunctive Relief, Which Is Dependent On Those Rulings, And Other Reasons Further Warrant Reversal Of The Injunctive Relief

Because the injunctive relief order depended on the summary judgment and class certification rulings, reversal of either ruling requires reversal of the injunctive relief. But there are other reasons as well why the injunctive relief should be reversed.

As noted, the injunction imposes an unnecessary and undue burden on plan administrators without delivering corresponding benefits to the plan members because (a) the Letter ordered to be sent to the Denial Letter is not materially different from United's original remark codes, (b) there is no reason to believe sending of that Letter will change the outcome of any claim, but (c) the Letter is likely to confuse the plan members, who won't understand why they are getting a notice about a stale claim that

is redundant of one they received years ago. The unnecessary and undue burden on plan administrators is particularly troubling in light of the record evidence that EOBs and remark codes need to be short and concise to facilitate the automated systems that are essential to process the enormous number of benefits decisions that plans must communicate to members. *See* 2-ER-300-301 (discussing United's automated claims process and containing example of space constraint on EOB for remark codes); 3-ER-517 ¶ 7 (noting that remark codes are designed to be short).

Accordingly, the unwieldy Letter that would be sent to the class members not only is unlikely to help, and more likely to confuse, plan members, but it also is likely to create administrative problems because the Letter is so much longer than the short notices that the automated systems have been designed to transmit. Given that all of the industry standard remark codes that CMS has developed are short and concise, like United's remark codes, a notice of the proposed length here is problematic. Because there was no demonstrated need to send any new notice in the first place, the district court reversibly erred in awarding injunctive relief.

CONCLUSION

This Court should reverse the district court's grant of summary judgment in favor of the ERISA Plaintiffs on the remark code issue, the certification of the Denial Letter Class and the injunctive relief granted to that certified class.

Dated: December 28, 2020

Respectfully submitted,

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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UNITED STATES COURT OF APPEALS
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ADDENDUM

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29 U.S.C. § 1133. Claims Procedure

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.

29 C.F.R. § 2560.503-1(g) and (h)

(g) ***Manner and content of notification of benefit determination***.

(1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv), or with the standards imposed by 29 CFR 2520.104b-31 (for pension benefit plans). The notification shall 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;

(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;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan -

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(vii) In the case of an adverse benefit determination with respect to disability benefits -

(A) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
(i) The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
(ii) The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
(iii) A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the

plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(C) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and

(D) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section.

(viii) In the case of an adverse benefit determination with respect to disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner (as described in paragraph (o) of this section).

(2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this section is furnished to the claimant not later than 3 days after the oral notification.

(h) ***Appeal of adverse benefit determinations*** -

(1) ***In general.*** Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) ***Full and fair review.*** Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures –

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures -

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care

professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which -

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

CERTIFICATE OF SERVICE

Rachel Condry, et al. v. UnitedHealth Group, Inc., et al.,
Ninth Circuit No. 20-16823,
U.S. District Court for the Northern District of California, No. 3:17-cv-00183

I hereby certify that I caused the foregoing to be filed electronically with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on December 28, 2020.

I certify that all participants in this case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

/s/ Raymond A. Cardozo
Raymond A. Cardozo