PETER K. STRIS (SBN 216226)
peter.stris@strismaher.com
BRENDAN S. MAHER (SBN 217043)
brendan.maher@strismaher.com
VICTOR O'CONNELL (SBN 288094)
victor.oconnell@strismaher.com
KRISTINA KOURASIS (SBN 291729)
kristina.kourasis@strismaher.com
THOMAS E. LOGAN (SBN 307193)
tom.logan@strismaher.com
STRIS & MAHER LLP
725 South Figueroa Street, Suite 1830
Los Angeles, CA 90017
Telephone: (213) 995-6800
Facsimile: (213) 261-0299

SETH ZAJAC (SBN 285718)
s.zajac@sovhealth.com
SOVEREIGN ASSET MANAGEMENT, INC.
d/b/a SOVEREIGN HEALTH GROUP
1211 Puerta Del Sol, Suite 280
San Clemente, CA 92673
Telephone: (949) 276-5553
Facsimile: (949) 272-5797

*Attorneys for Plaintiffs*
DUAL DIAGNOSIS TREATMENT
CENTER, INC., et al.

**UNITED STATES DISTRICT COURT**

**CENTRAL DISTRICT OF CALIFORNIA**

**SOUTHERN DIVISION**

DUAL DIAGNOSIS TREATMENT CENTER, INC., a California corporation, et al.,

Plaintiffs,

v.

BLUE CROSS OF CALIFORNIA d/b/a ANTHEM BLUE CROSS, et al.,

Defendants.

Case No. SACV15-736 DOC (RNBx)

**PLAINTIFFS' OPPOSITION TO DEFENDANTS' OMNIBUS MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT [ECF NO. 637]**

Date: April 18, 2016
Time: 8:30 a.m.
Location: Courtroom 9D
Judge: Hon. David O. Carter

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## INTRODUCTION

This case is about health insurance benefits regulated by the Employee Retirement and Income Security Act of 1974 ("ERISA"). Unlike ERISA pension benefits, ERISA health care benefits are freely assignable. The rationale is simple: by allowing health care providers to obtain assignments, they are more likely to treat beneficiaries. As numerous courts have observed, provider-assignees stand in the shoes of their patients and are therefore entitled to ERISA's protections.

Chief among those protections is that fiduciaries must, when faced with a benefits claim, carefully review the underlying ERISA plan documents, and either award benefits or provide the claimant with a timely and reasoned denial. Silence, or pro forma denials, are categorically barred. That has been the law for over four decades. What happened here—and what has been pled with great specificity—is that Defendants denied Plaintiffs' claims not only without providing any reasoned denial but also without consulting the relevant ERISA plan documents at all.

Defendants seek to excuse their misconduct by making one core argument in a variety of guises. They say Plaintiffs' assignments are not valid, and so they, as plan fiduciaries, were entitled to ignore Plaintiffs completely. According to Defendants, all of Plaintiffs' ERISA claims should be dismissed on that basis. On other grounds, Defendants seek to dismiss Plaintiffs' alternative state law claim.

As explained herein, Defendants are wrong. Some of their arguments misstate the relevant law. Some of their arguments misrepresent the allegations of Plaintiffs' complaint. And some of their arguments cannot be resolved without first evaluating hotly disputed questions of material fact. *None* of their arguments, however, can possibly justify dismissal of any of the claims pled in the First Amended Complaint ("FAC"). The motion to dismiss ("Omnibus Motion" or "MTD") should be denied in its entirety.

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**STATEMENT OF THE CASE**

The Blue Cross Blue Shield Association and its 37 member companies (collectively "Blue Cross") provide or administer health insurance for roughly one in every three Americans ("insureds"). FAC ¶ 1. Blue Cross is a dominant healthcare player with tremendous market share. *Id.*

Out-of-network providers, like Plaintiffs, are those providers who have no contractual relationship with Blue Cross. FAC ¶ 49. Instead, they offer their services in exchange for the right to seek reimbursement from Blue Cross for services rendered. FAC ¶¶ 49(a), 77(b). Providing healthcare services in exchange for the right of reimbursement from the patient's insurer has been a foundational component of healthcare delivery in America for decades.

Nothing requires Blue Cross or the ERISA plans Blue Cross administers ("ERISA Welfare Plans") (collectively, or in any combination, "Defendants") to offer health insurance that covers services from out-of-network providers. FAC ¶ 49(b). Rather, Defendants chose to write contracts offering that option; in exchange, insureds agreed to pay higher premiums. FAC ¶¶ 49(a)-(b); 77(a)-(b).

At the same time, Blue Cross strongly disfavors the use of out-of-network providers. FAC ¶¶ 2, 3, 77(a)-(b); 79. That is because such providers generally deliver more expensive services not subject to Blue Cross's negotiated network rates. FAC ¶¶ 49(a), 77(b). Rather than take the bitter with the sweet, Blue Cross has devised policies, which no other major insurer has adopted, to discourage out-of-network providers from accepting their insureds, and to force those providers to join the vast Blue Cross network. FAC ¶¶ 2, 3, 75, 77(a)-(b); 78, 79.

At issue here is Defendants' treatment of ERISA rights assigned by insureds to their providers. FAC ¶¶ 3-5. The FAC alleges that Blue Cross systematically refuses to pay providers directly when they submit assigned benefit claims for services rendered. FAC ¶¶ 3, 71(b). And to make matters worse, Blue Cross refuses

to comply with applicable law requiring communication with out-of-network providers who submit claims, including by failing to issue a written decision explaining the basis on which payment has been denied. FAC ¶¶ 71(a)-(e); 82-88. Instead, Blue Cross—after misleading providers about whether it will pay assigned claims, FAC ¶ 45(c)—later insists on paying millions of dollars in assigned benefits directly to patients, making it nearly impossible for providers to receive full payment. FAC ¶¶ 3, 71(a)-(e), 81.

Plaintiffs are healthcare providers that offer mental health and substance abuse treatment to patients. FAC ¶¶ 9-16, 24, 27, 28, 32, 41, 47, 56. Plaintiffs have no contracts with Blue Cross. FAC ¶¶ 2, 3, 49(c), 77. Instead, Plaintiffs determine that each patient is seeking treatment that is covered by her plan (a plan that is insured or administered by Blue Cross) and Plaintiffs obtain an assignment of rights from each insured before providing treatment. FAC ¶¶ 32, 40-48, 51-55, 97, 98, subpara. (a) of ¶¶ 101-366. After treatment is rendered, Plaintiffs seek reimbursement from Blue Cross. FAC subpara. (c) of ¶¶ 101-366. They do so by properly filling out and submitting the industry-standard form required by Blue Cross to present a claim, the UB-04. FAC ¶ 3-4, 64-68, 82, (c) of ¶¶ 101-366; 371.

For each claim submitted, Plaintiffs properly insert the letter "Y" in the box called "ASG BEN" on that form; in the medical billing industry, this is how a claimant indicates that it is seeking payment as a benefit assignee. FAC subpara. (c) of ¶¶ 101-366. Of the many hundreds of industry-standard claim forms Plaintiffs have submitted to Blue Cross, not once has Blue Cross *ever* responded with a request to review the underlying assignment of benefits. FAC ¶¶ 69-71, 83, 87. Nor has it *ever* written in response to explain the basis on which it has refused to pay Plaintiffs. FAC ¶¶ 70-71(a)-(d); 83, 87.

The patients in this case all received insurance through employer-sponsored plans subject to ERISA. FAC ¶¶ 4, 20, 22(1)-(158). Under ERISA, Plaintiffs seek to

enforce their valid assignments. FAC ¶¶ 5, 31, 95-366, 374. Defendants' failure to pay Plaintiffs for the medical services that they rendered is without basis in law or equity, and is therefore remediable under 29 U.S.C. § 1132(a).[1] Plaintiffs also seek injunctive and other non-monetary relief (pursuant to 29 U.S.C. §§ 1132(a)(2) and (a)(3)) to remedy Defendants' profound breaches of fiduciary duty. Defendants' flagrant and continuing failure to comply with ERISA's procedural obligations entitles Plaintiffs to a wide variety of important non-monetary remedies, including injunctive relief and fiduciary removal. FAC ¶ 379.[2] As an alternative to their ERISA theories, Plaintiffs assert that Defendants' practices constitute unlawful and unfair competition that is actionable under California Business & Professions Code § 17200 *et seq*. FAC ¶¶ 387-390.

## LEGAL STANDARDS

To avoid dismissal under Fed. R. Civ. P. 12(b)(6), a plaintiff must "allege 'sufficient factual matter . . . to state a claim to relief that is plausible on its face.'" *Pinnacle Armor, Inc. v. United States*, 648 F.3d 708, 721 (9th Cir. 2011) (quoting *Ashcroft v. Iqbal*, 556 U.S. 662 (2009)). A claim has "facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference

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[1] Plaintiffs' "FIRST CLAIM FOR RELIEF" is labeled as "(Against All Defendants—Seeking to Recover Benefits) (29 U.S.C. § 1132(a)(1)(B))." FAC ¶¶ 95-374. That label notwithstanding, the facts alleged under the first claim (and in the complaint overall), support monetary recovery not only pursuant to 29 U.S.C. § 1132(a)(1)(B) but also—to the extent necessary—pursuant to 29 U.S.C. § 1132(a)(3) under theories of reformation, estoppel, or surcharge. *See infra* 16-19, 29. Although Plaintiffs could, of course, seek leave to "relabel" (or otherwise amend) that claim, that is not necessary under the federal rules. Complaints are to be construed liberally, *Bouse v. Bussey*, 573 F.2d 548, 551 (9th Cir. 1977); complaints need not cite the correct statutory provision, *Johnson v. City of Shelby, Miss.*, 135 S. Ct. 346, 346 (2014); and labels are to be disregarded where justice requires, *Sateriale v. R.J. Reynolds Tobacco Co.*, 697 F.3d 777, 788 n.4 (9th Cir. 2012).

[2] Federal regulations require benefit denials (including *any* failure to pay) to be written, specific, and reasoned, and it is well-settled that failure to follow these regulations is illegal. FAC ¶¶ 5, 30, 85-88. Defendants were obligated to follow these regulations every time Plaintiffs asked to be paid, and there can be no doubt that Defendants were so obligated regardless of the ultimate merit of Plaintiffs' request. FAC ¶¶ 5, 30, 85-88. *See also infra* 20-21 (discussing this issue).

that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citing *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 556 (2007)).

A court must accept the well-pleaded factual allegations of the complaint as true and construe them in the light most favorable to plaintiffs. *Id.*; *see also OSU Student All. v. Ray*, 699 F.3d 1053, 1061 (9th Cir. 2012). Dismissal is proper only in the absence of a cognizable legal theory or sufficient supporting facts. *See Shroyer v. New Cingular Wireless Servs., Inc.*, 606 F.3d 658, 664 (9th Cir. 2010). Once the pleading standard has been met, "even if it strikes a savvy judge that actual proof of [the pled] facts is improbable, and that recovery is very remote and unlikely," the complaint should survive. *Twombly*, 550 U.S. at 556.

For a motion to dismiss on the pleadings, it is generally improper for the court to consider any material outside of the pleadings. *See Hal Roach Studios, Inc. v. Richard Feiner & Co.*, 896 F.2d 1542, 1555 n.19 (9th Cir. 1990). Under the "incorporation by reference" doctrine, a court may—but is not required to—look to documents beyond the pleadings only if the contents of the document are pled and no party questions the authenticity of the document. *Davis v. HSBC Bank Nev., N.A.*, 691 F.3d 1152, 1160 (9th Cir. 2012) (citing *Van Buskirk v. Cable News Network, Inc.*, 284 F.3d 977, 980 (9th Cir. 2002) and *Knievel v. ESPN*, 393 F.3d 1068, 1076 (9th Cir. 2005)). The Court should not consider agreements incorporated by reference when their completeness is in dispute. *See BJC Health Sys. v. Columbia Cas. Co.*, 348 F.3d 685, 688-89 (8th Cir. 2003) (given dispute over what constituted the complete contract, consideration of the offered documents was prejudicial error); *cf. McColgan v. Mut. of Omaha Ins. Co.*, 4 F. Supp. 3d 1228, 1232 (E.D. Cal. 2014) (denying request for judicial notice where plaintiff challenged authenticity and completeness of documents).

## ARGUMENT

### I. There Is No Basis to Dismiss Count I.

#### A. As the FAC Makes Clear, Plaintiffs Provided Services to Insureds in Exchange for the Valid Assignment of ERISA Rights.

While Plaintiffs take pride in their efforts to assist people struggling with chemical dependency or mental illness, they operate a for-profit business. Plaintiffs maintain facilities with qualified staff and other costly features, in exchange for payment. In the case of a patient with insurance, Plaintiffs agree to provide their services in exchange for the valid assignment of the patient's rights under ERISA. Securing and enforcing such assignments are critical to Plaintiffs' ability to receive payment. Thus, Plaintiffs are careful to verify insurance coverage and obtain valid assignments. FAC ¶¶ 40-46, 48, 51-55, 69-70.

Unlike pension benefits, ERISA permits assignments of health care benefits, including to providers. *Misic v. Bldg. Serv. Emps. Health and Welfare Trust*, 789 F.2d 1374, 1377 (9th Cir. 1986) (permitting assignments of ERISA benefit claims to providers). It is thus settled law in the Ninth Circuit that "[a] health care provider with an allegedly valid assignment" may sue for benefits under, and receive the protections of, ERISA. *Davidowitz v. Delta Dental Plan of Cal., Inc.*, 946 F.2d 1476, 1478 (9th Cir. 1991). Plaintiffs seek precisely that.

**1.** As a matter of course, Plaintiffs require all patients to execute an Assignment of Benefits that *expressly* assigns all her rights under ERISA, including the right to pursue claims under 29 U.S.C. §§ 1132(a)(1)(B) and (a)(3). *See* FAC, Ex. B ("Form B Assignment"). The Form B Assignment provides:

> I, Policyholder, irrevocably assign, transfer and convey to Provider the exclusive rights to benefits, insurance proceeds, or other monies otherwise due to me for services rendered by Provider ("Benefits") from my insurer, employee benefit plan, welfare benefit plan, government plan, tortfeasor or other liable third party ("Liable Third Parties"), and all administrative, arbitral, judicial or other rights I may have relating to the recovery of Benefits from Liable Third Parties, including but not limited to, my rights to . . . initiate and maintain

> arbitral or judicial proceedings to enforce . . . [ERISA], including, expressly, claims brought under ERISA §§ 502(a)(1)(B) and (a)(3), including claims predicated on a breach of fiduciary duty; Medicare and any other federal or state law . . . . I agree that any ambiguity regarding the scope of this Agreement shall be construed in favor of assigning Provider all rights that will assist it in recovering Benefits from Liable Third Parties.

*Id. See also* FAC ¶ 53.

The Form B assignment language is so comprehensive that Defendants concede it encompasses Plaintiffs' claims here. Defendants, however, attack the Form B Assignment by claiming it is so clear and broad as to be "unconscionable" and therefore invalid as a matter of law. MTD at 24-26. Defendants are wrong.

Unconscionable contracts must be grossly unfair both in the manner in which they were agreed to (procedural unconscionability) and in their terms (substantive unconscionability). *See, e.g.*, *Patterson v. ITT Consumer Fin. Corp.*, 14 Cal. App. 4th 1659, 1664 (1993). Nothing about the Form B Assignment is remotely unconscionable, and thirty years of precedent is in accord.

Plaintiffs begin with substantive unconscionability and common sense. Substantive unconscionability "involves contract terms that are so one-sided as to shock the conscience, or that impose harsh or oppressive terms." *24 Hour Fitness, Inc. v. Super. Ct.*, 66 Cal. App. 4th 1199, 1213 (1998). Assigning benefit rights to a provider is not substantively unconscionable *because doing so clearly advantages the patient*. As the Ninth Circuit has explained:

> Health and welfare benefit trust funds are designed to finance health care. Assignment of trust monies to health care providers results in precisely the benefit the trust is designed to provide and [ERISA] is designed to protect. Such assignments also protect beneficiaries by making it unnecessary for health care providers to evaluate the solvency of patients before commencing medical treatment, and by eliminating the necessity for beneficiaries to pay potentially large medical bills and await compensation from the plan.

*Misic*, 789 F.2d at 1377.[3]

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[3] Other courts agree. *See Cagle v. Bruner*, 112 F.3d 1510, 1515 (11th Cir. 1997) ("An assignment to a health care provider facilitates rather than hampers the employee's receipt of health benefits.") (quoting *Hermann Hosp. v. MEBA Med. &*

Despite these universally recognized advantages, Defendants assert unconscionability on the grounds that the Form B Assignment limits patient recourse against their plans. MTD at 26. Not only do Defendants provide no argument as to why that (supposed) negative rises to the level of unconscionable, they also ignore reality. Patients and the providers to whom they assign rights *have the same interests*: both want the patient to receive treatment expeditiously and both want to obtain insurer payment as conveniently as possible. And the patient, who assigns the right to payment for a service, does not *need* recourse against her plan because she has *already received* the service that the insurance covers.[4]

There is nothing unconscionable about assigning rights to a similarly interested party better situated to handle the demanding paperwork associated with obtaining benefits. That is why no court *anywhere* has ever held that an assignment of medical benefits to a provider substantively injures beneficiaries, let alone so much that such assignments are unconscionable. Indeed, if Defendants' radical position is correct, then federal courts have been sanctioning unconscionable contracts for decades. They have not. Defendants are wrong.[5]

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*Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988)); *Care First Surg. Ctr. v. ILWA-PMA Welfare Plan*, 2014 WL 6603761, at *9 (C.D. Cal. July 28, 2014) (holding that assignments "facilitate the receipt of health care benefits by beneficiaries") (internal quotation marks omitted).

[4] Of the three cases Defendants cite in support of their position: *Shroyer*, *v. New Cingular Wireless Servs., Inc.*, 498 F.3d 976 (9th Cir. 2007); *Nagrampa v. MailCoups, Inc.*, 469 F.3d 1257 (9th Cir. 2006); and *Aral v. Earthlink, Inc.*, 134 Cal. App. 4th 544 (2005). None involves anything remotely analogous to health care assignments.

[5] Nor is there anything procedurally unconscionable about Form B. Procedural unconscionability focuses on "oppression *i.e.*, inequality of bargaining power and absence of meaningful choice and surprise, *i.e.*, the extent to which the supposedly agreed-upon terms of the bargain are hidden . . . ." *Tiri v. Lucky Chances, Inc.*, 226 Cal. App. 4th 231, 245 (2014) (citations omitted). There is no oppression here. Prospective patients do not come to Plaintiffs for emergency services; they have every opportunity to obtain services elsewhere (*e.g.*, with in-network providers who do not require assignments). Nor is there surprise. The terms of Form B are presented unambiguously and transparently in a single-page document. *See* FAC, Ex. B. Defendants do not (and cannot) suggest otherwise.

**2.** For some patients, the FAC also alleges valid assignments on the basis of an (earlier) Assignment of Benefits form which provides, in pertinent part:

> I hereby authorize and request that payment of authorized insurance company benefits be made on my behalf directly to [Plaintiff entity] for the amount due to me for any medical or psychological/psychiatric treatment or services that are rendered to me by [Plaintiff entity].

FAC ¶ 53, Ex. A ("Form A Assignment"). Defendants characterize the Form A Assignment as a mere "authorization" for direct payment that assigns nothing. MTD at 7. Again, Defendants are mistaken.

Form A, titled "Assignment of Benefits," expressly and without reservation authorizes direct payments to Plaintiffs. The Ninth Circuit has held such language sufficient to constitute a valid assignment of a 29 U.S.C. § 1132(a)(1)(B) claim. In *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1292 (9th Cir. 2014), the Court considered an assignment that conferred upon the provider "the right to seek payment of claims directly from" the plans in question. Because such language indicated patients' intent "to assign . . . their rights to bring suit [under 29 U.S.C. § 1132(a)(1)(B)] for payment of benefits," the Ninth Circuit deemed it valid.[6]

No case cited by Defendants compels the opposite conclusion. In fact, Defendants' lead case—*MHA, LLC v. Aetna Health, Inc.*, 2013 WL 705612 (D. N.J. 2013), *abrogated in relevant part by N. Jersey Brain & Spine Ctr. v. Aetna, Inc.*, 801 F.3d 369, 371 n.1, 372-73 (3d Cir. 2015)—shows that Plaintiffs are right. In *MHA*

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[6] *See also Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Group, Inc.*, 99 F. Supp. 3d 1110, 1130 (C.D. Cal. 2015) (finding that agreements explicitly conveying "rights and benefits' under the relevant insurance policy" were valid assignments of 29 U.S.C. § 1132(a)(1)(B) claims); *Productive MD, LLC v. Aetna Health, Inc.*, 969 F. Supp. 2d 901, 915 (M.D. Tenn. 2013) (holding that language authorizing direct payment to provider constituted a valid assignment of the patient's right to sue for benefits). *Cf.* Am. Jur. 2d Assignments § 116 ("Use of the word 'assign' or 'assignment' is not essential . . . so the parties' failure to use the word . . . is not fatal to the conclusion that they intended an assignment.").

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*LLC*, a provider-assignee brought suit to obtain reimbursement under 29 U.S.C. § 1132(a)(1)(B). The basis for the assignment was the following language:

> I authorize payment directly to [provider] for hospital medical insurance benefits (from Medicare, Medicaid, commercial insurance, worker's compensation, auto insurance, etc.) that I may be entitled to for the charges of the care/treatment provided to me.

*Id.* at *4. The district court dismissed the suit, reasoning that the above "authorize" language was merely "an assignment of a right to payment" rather than an "assignment of plan benefits." Only the latter, it concluded, was sufficient to "permit a provider to sue under 502(a)." *Id.* at *7. The Third Circuit disagreed.

In *N. Jersey Brain & Spine Ctr.*, 801 F.3d 369, 370, the Third Circuit abrogated all lower court decisions distinguishing between a right to receive payment and a right to sue. In the words of the court of appeals:

> We hold that as a matter of federal common law, when a patient assigns payment of insurance benefits to a healthcare provider, that provider gains standing to sue for that payment under ERISA § 502(a). An assignment of the right to payment logically entails the right to sue for non-payment.

*Id*. In so concluding, the Third Circuit was approving decisions like *Premier Health Ctr., P.C. v. UnitedHealth Grp.*, No. 11-425 (ES), 2012 WL 1135608, at *7-8 (D. N.J. 2012). There, the district court explained that language requesting "direct payment" to the provider "vest[ed] in the assignee (the provider) the right to receive payment" and therefore "must logically include the ability to seek judicial enforcement of that right." *Id.*

In sum, both Form A and Form B both constitute valid assignments.[7]

[7] Defendants' litigation position is in tension with itself. On the one hand, Defendants argue that Form B is unconscionable because of its broad language. On the other, Defendants argue Form A does not qualify as an assignment because it lacks broad language. In Defendants' Kafkaesque world, apparently no provider assignment is valid under ERISA. That is clearly not the law.

**B. As the FAC Makes Clear, Plaintiffs Put Defendants on Notice of Their Valid Assignments.**

Faced with the pitch-perfect Form B Assignment, Defendants next assert that they were not required to pay Plaintiffs "because Plaintiffs did not provide sufficient notice of the alleged assignments' scope." MTD at 21. According to Defendants, Plaintiffs were required to provide a copy of each executed assignment. *Id.* at 22. Any alternative finding, they say, would "place the provider's interests above that of the member—a result anathema to ERISA's purpose." *Id.* at 23. Defendants offer three arguments in support. Each is meritless.

First, Defendants claim, without further elaboration, that the notice they received was not of an "assignment" because "[m]erely checking the box on a claim form is, at most, an assertion that some kind of patient signed form providing some form of authorization or direction exists." *Id.* at 22. That is plainly wrong as a matter of law. Courts routinely hold that UB-04 forms containing a "Y" in the "ASG BEN" field indicate valid ERISA assignments.[8] In resisting, Defendants should and do know better. As a member of the National Uniform Billing Committee, the organization that created and promulgated the UB-04 form, Blue Cross Blue Shield Association and its members are uniquely positioned to know the form and what it means. FAC ¶¶ 65-67. Defendants clearly understood the well-established meaning of "Y" in the "ASG BEN" field. And, in any event, Defendants' self-serving plea of ignorance is a fact-based contention that cannot be adjudicated at the pleading stage.

[8] *See, e.g.*, *Montefiore Med. Ctr. v. Teamsters Local 272*, No. 09 Civ. 3096(HB), 2009 WL 3787209, at *5 (S.D. N.Y. Nov. 12, 2009) (provider had standing as assignee to bring ERISA claim based solely on UB-04 form); *Paragon Office Servs., LLC v. UnitedHealth Group, Inc.*, No. 3:11-CV-2205-D, 2012 WL 1019953, at *4-5 (N.D. Tex. Mar. 27, 2012) (similar); *Spring E.R., LLC v. Aetna Life Ins. Co.*, No. 09-CV-2001, 2010 WL 598748, at *3-4 (S.D. Tex. Feb. 17, 2010) (similar); *N. Shore-Long Island Jewish Health Care Sys., Inc. v. Multiplan, Inc.*, 953 F. Supp. 2d 419, 434-36 (E.D. N.Y. 2013) (describing UB-04 form and "the telltale 'Y'" as indication of an assignment).

Second, Defendants claim that, even if they had actual notice, Plaintiffs were still required to give them a copy of each executed assignment. MTD at 22. Defendants cite no authority for their invented rule that one must present a signed agreement "in order to impose a duty on the obligor to render performance to it." MTD at 22. That is because, as Defendants know, the only authority on point is to the contrary. In *Metcalf v. Blue Cross Blue Shield of Michigan*, Blue Cross Blue Shield of Michigan and others argued that the plaintiff provider could not rely on assignments of which they did not receive copies. 57 F. Supp. 3d 1281, 1295 (D. Or. 2014). The court squarely rejected that argument, explaining:

> [A] debtor must honor an assignment upon receiving notice of the assignment. To be bound by the Assignments, the Plan did not need to receive copies of the actual assignments, but only notice that they existed . . . . Therefore, it is irrelevant whether Metcalf sent copies of the Assignments and Designations to the Plan.

*Id.*[9]

Third, Defendants resort to a misguided policy argument. They say honoring the "assignment" field on the UB-04 form "would subject payors to inconsistent and duplicative demands from purported assignees and assignors." MTD at 23. According to Defendants:

> Under Plaintiffs' theory, a payor presented with a checked box *must take a provider at its word that a valid and broad assignment was made and pay the provider in short order*, even while risking the ire of a patient who later files a suit under 29 U.S.C. § 1132(a)(1)(B) against the payor claiming that he never assigned any of his legal rights. . . .

*Id.* (emphasis added).

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[9] The *Metcalf* decision is particularly damning to the Blue Cross Defendants because BCBS Michigan had previously argued the exact same thing in a related case, lost for the same reasons, *and disregarded the court's legal conclusions*. *Id.* at 1290 (parties in previous case "strenuously disagree as to whether Metcalf is entitled to recover benefits which defendants have already paid to the Plan's participants after receiving notice of assignments"); *id.* at 1291 ("Convinced that this court reached the wrong decision in *Metcalf I*, defendants continue to disregard the assignments from the participants to Metcalf and pay benefits to the participants, rather than directly to Metcalf.").

That argument is disingenuous at best. As Defendants know, a payor who needs additional information to process a claim can simply ask for it before paying. Both ERISA and state law expressly give payors additional time under such circumstances. *See, e.g.*, 29 C.F.R. § 2560.503-1(f)(4) (process tolled until claimant responds to request for additional information); 10 Cal. Code Regs. § 2695.7(c)(1) (similar). Defendants never requested additional information from Plaintiffs about any assignment before choosing to dishonor it.

Even if the assignments were later held invalid, Defendants would have discharged their obligations by paying Plaintiffs. Indeed, it is black-letter law that any obligor who mistakenly pays an apparent obligee is protected "if he renders performance . . . without knowledge or reason to know that the appearance is false." Restatement (Second) of Contracts § 338 (1981).[10]

**C. No Defendant Is Entitled to Dismissal of Count I on Anti-Assignment Clause Grounds.**

Next, Defendants argue that "[a] substantial number of the underlying claims alleged in the FAC are barred by anti-assignment clauses contained in the ERISA plans." MTD at 16. Of course, no document including an anti-assignment clause was attached to the FAC. Numerous Defendants, however, have filed declarations with the Court attaching one or more documents that allegedly contain a valid and enforceable anti-assignment clause. *See* O'Connell Decl., Chart 1 (identifying, by

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[10] Defendants strain to avoid this conclusion by repeatedly citing a single 60-year-old case for the unremarkable proposition that an assignment protects an obligor from later claims by the obligee. *See, e.g.*, MTD at 22, 23 (citing *Cockerell v. Title Ins. & Trust Co.*, 42 Cal. 2d 284, 292 (1954)). In that case, there was no evidence that the purported assignor had any connection to the company that owned the note, meaning that there was no evidence that he had authority to act on behalf of the obligee. *Cockerell*, 42 Cal. 2d at 291-92. In any event, Plaintiffs' patients here executed clear and unambiguous assignments of their ERISA benefits, largely freeing Defendants of the risk of incurring their "ire" later on. Defendants' reliance on a footnote in *Brown v. Blue Cross Blue Shield of Tenn., Inc.* is accordingly misplaced. No. 1:14-CV-00223, 2015 WL 3622338, at *6, n.6 (E.D. Tenn. June 9, 2015), *appeal docketed*, No. 15-5739 (6th Cir. July 8, 2015).

name and ECF Number, each document filed by—or on behalf of—98 of the remaining 147 ERISA Welfare Plan Defendants).[11]

Defendants ask this Court to "incorporate by reference" these documents into the FAC. But this Court has no duty to consider documents that were not attached to the FAC, and it should decline to do so here. Their completeness is in dispute, and Plaintiffs cannot agree to their authenticity. *See Davis*, 691 F.3d at 1159-60. If this Court decides to consider these documents, however, none can possibly warrant the dismissal of Count I against *any* Defendant for two reasons:

1. *No Defendant has established that its anti-assignment provision is valid and enforceable against medical providers.*

Defendants explain at length the uncontroversial point that anti-assignment clauses in ERISA plans may be valid and enforceable. MTD at 16-18. What Defendants fail to mention, however, are any of the critical procedural requirements that must be established for a given anti-assignment clause to *in fact* be valid and enforceable. That is fatal to Defendants' position because *no* Defendant has met those requirements. *See* O'Connell Decl., Chart 2 (indicating which procedural flaws apply to each ERISA Welfare Plan Defendant):

*Requirement 1*. To be valid and enforceable, an anti-assignment provision must be found within the plan's written instrument that is mandated by ERISA. 29 U.S.C. § 1102 (plan must be "established and maintained pursuant to a written instrument"); *Holmes v. Colorado Coal. for Homeless Long Term Disability Plan*, 762 F.3d 1195, 1200 (10th Cir. 2014) (holding that "the requirements of an ERISA plan must be based on the terms of the plan document"). 124 of the 147 ERISA Welfare Plan Defendants have offered no written instrument containing an anti-assignment provision. *See* O'Connell Decl., Chart 2 (gray boxes) (identifying 50

[11] Plaintiffs named 157 ERISA Welfare Plans as defendants in the FAC. Ten of those defendants have since been voluntarily dismissed.

ERISA Welfare Plan Defendants who offered no documents *of any kind*); *id*. (column 1) (identifying an additional 75 who introduced no valid written instrument).[12]

*Requirement 2*. To be enforceable, an anti-assignment provision must not be contradicted by other language in the "written instrument." That means the *entire* written instrument must be introduced into evidence. 10 of the remaining 23 ERISA Welfare Plan Defendants fail this requirement. *See* O'Connell Decl., Chart 2 (column 2) (identifying 10 ERISA Welfare Plan Defendants who offered documents that make clear they are only *part* of the written instrument).

*Requirement 3*. To be enforceable, an anti-assignment provision must *also* be properly described in an ERISA-compliant summary plan description ("SPD"). 29 U.S.C. § 1022(a)-(b); 29 C.F.R. § 2520.102-3; *Osberg v. Foot Locker, Inc.*, No. 07 CIV. 1358 KBF, 2015 WL 5786523, at *29 (S.D.N.Y. Oct. 5, 2015) (reforming plan because of nondisclosure in an SPD). At least 65 of the 147 ERISA Welfare Plan Defendants offer no SPD. *See* O'Connell Decl., Chart 2 (column 3) (identifying 65 ERISA Welfare Plan Defendants who failed to offer an SPD).

*Requirement 4*. Any ERISA Welfare Plan Defendant seeking to interpose an anti-assignment provision as a defense must prove that it furnished the relevant SPD to the participant-assignee in compliance with 29 U.S.C. §§ 1022(a), 1024(b) and 29 C.F.R. § 2520.104b-1. Every one of the 148 ERISA Welfare Plan Defendants fails this requirement. *See* O'Connell Decl., Chart 2 (column 4).

[12] Some of these Defendants have introduced either a summary plan description ("SPD") or non-ERISA contract that contains an anti-assignment provision. Those documents, however, are of no help to Defendants because an anti-assignment provision must be included in the written instrument in order for it to be valid and enforceable. *See CIGNA Corp. v. Amara,* 563 U.S. 421, 438 (2011). The Ninth Circuit recently left open the controversial question of whether, in some cases, an "SPD [can serve] as the one and only formal plan document." *Prichard v. Metro. Life Ins. Co.*, 783 F.3d 1166, 1170 (9th Cir. 2015). But any Defendant that intends to press that position cannot possibly do so at this stage of litigation without sufficient discovery (to confirm the absence of other plan documents) as well as specific briefing on that complex legal question.

Even if one of the ERISA Welfare Plan Defendants could satisfy all of the procedural requirements set forth above, that Defendant would have to establish that its anti-assignment provision was not *substantively* deficient. That requires that the anti-assignment provision be "express." *Davidowitz*, 946 F.2d at 1481. And it requires that the provision clearly apply to the type of assignments at issue here.[13] As mentioned above, 98 ERISA Welfare Plan Defendants offer *some* document allegedly containing an anti-assignment provision. In 64 of those instances, however, the alleged anti-assignment provision does not unambiguously apply to Plaintiffs. *See* Stris Decl., Chart 3 (columns 2-4) (identifying three broad reasons why asserted language is substantively deficient).

2. *No defendant can possibly establish that its anti-assignment provision is enforceable against Plaintiffs.*

In the unlikely event that an ERISA Welfare Plan Defendant has offered documents that this Court believes establish the existence of a valid and enforceable anti-assignment provision as a matter of law, dismissal of Count I against such a Defendant would *still* be unwarranted here. As explained in detail below (*infra* 17-19), Plaintiffs have articulated a theory of fiduciary breach that—if successful—will justify reformation of the ERISA plans at issue (to excise any otherwise valid and enforceable anti-assignment provision) or equitably estop Defendants from asserting

[13] *See, e.g.*, *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 959 F.2d 569, 574-75 (5th Cir. 1992) ("Hermann II") *overruled on a different ground by Access Mediquip, L.L.C. v. UnitedHealthcare Ins. Co.*, 698 F.3d 229 (5th Cir. 2012) (en banc) (per curiam) (holding that a facially comprehensive anti-alienation clause was insufficient to bar *medical provider assignments*). *See also Abilene Reg'l Med. Ctr. v. United Indus. Workers Health & Benefits Plan*, No. 06-10151, 2007 WL 715247 (5th Cir. Mar. 6, 2007) (reaffirming the core holding of Hermann II); *Trueview Surgery Ctr. One L.P. v. OneSubsea LLC Comprehensive Self-Insured Welfare Benefits Plan*, No. 4:14-CV-2577, 2015 WL 4431408 (S.D. Tex. July 17, 2015) (discussing and applying Herman II); *Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Group, Inc.*, No. 14-02139 (Apr. 10, 2015) (ECF 1393) (same).

an anti-assignment clause defense.[14] For that reason, Count I cannot be dismissed against *any* Defendant.

In order to appreciate this point, a brief discussion of ERISA's reformation and equitable estoppel remedies is necessary. The United States Supreme Court recently made clear that misleading conduct on the part of fiduciaries, whether in the claim handling context or otherwise, entitles plaintiffs to pursue "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3), including the remedies of "reformation" and "estoppel." *CIGNA Corp. v. Amara,* 563 U.S. 421 (2011).

Reformation is an equitable remedy where the subject instrument—here, the relevant plan—is reformed to reflect the understanding of the misled party. *Id.* at 1879; 4 John N. Pomeroy, *A Treatise on Equity Jurisprudence* § 2097 (5th ed. 1941). Reformation is appropriate where the victimized party's misunderstanding results from the "fraud or inequitable conduct" of the defendant.[15] Inequitable conduct need not rise to the level of fraud.[16]

As the FAC alleges in great detail, Defendants' conduct here was profoundly inequitable and likely constitutes fraud. Defendants engaged in a scheme to take

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[14] Whether relief such as reformation or estoppel under 29 U.S.C. § 1132(a)(3) is conceived of as an interim step in vindicating a 29 U.S.C. § 1132(a)(1)(B) benefits claim, or as an alternative channel of relief, need not be resolved, as Plaintiffs holds both claims by express assignment and the FAC pleads the predicate facts to support either theory. *See supra* 4 n.1.

[15] *See, e.g.*, *Simmons Creek Coal Co. v. Doran,* 142 U.S. 417, 435 (1892) (fraud or inequitable conduct sufficient for reformation); *Home Owners' Loan Corp. v. Stevens*, 179 A. 330, 331-32 (1935) (same); *Heake v. Atl. Cas. Ins. Co.,* 29 N.J. Super. 242, 260 (N.J. Super. Ct. App. Div. 1954) *aff'd*, 15 N.J. 475 (1954) (same).

[16] *See, e.g., Nechis v. Oxford Health Plans, Inc.*, 421 F.3d 96, 103 (2d Cir. 2005) (recognizing conduct "violative of ERISA" as a basis for reformation); *Tokio Marine & Fire Ins. Co. v. Nat'l Union Fire Ins. Co*., 91 F.2d 964, 966 (2d Cir. 1937) (finding reformation in the aftermath of "a wrongful representation [that was] unmalicious and nonfraudulent"); *Esoldi v. Esoldi*, 930 F. Supp. 1015, 1021 (D.N.J. 1996) (explaining that "the fact that the [misunderstanding] was induced or contributed to in some way by the other party is generally sufficient to justify reformation"); 3 John N. Pomeroy, *A Treatise on Equity Jurisprudence* § 873 at 421 (5th ed. 1941) (observing that reformation-triggering conduct includes "obtaining an undue advantage by means of some intentional act or omission that was unconscientious").

advantage of Plaintiffs by not telling them (and, Plaintiffs intend to prove, in many cases affirmatively misleading them) that the patients at issue were members of plans with alleged anti-assignment provisions. *See, e.g.*, FAC ¶¶ 70, 71, 75, 76, 77, 80, 81. That misrepresentation impelled Plaintiffs to provide millions of dollars in services on the understanding they could collect directly from a responsible and liquid party. *See, e.g.*, FAC ¶¶ 5-374.

The frequency and consistency with which Plaintiffs were kept in the dark, at every possible stage, is no coincidence. The FAC provides detailed allegations about *hundreds* of claims. FAC ¶¶ 101-366. In discovery, Plaintiffs intend to present and uncover evidence—including records of phone calls with Defendants' representatives—to show that what happened here was widespread and intentional. At the pleading stage, there can be no doubt that what Plaintiffs have alleged, if proven, would constitute fraud or inequitable and misleading conduct sufficient to warrant reformation, nullifying the anti-assignment provisions Defendants claim justify dismissal of Count I.

The facts pled in the FAC also support holding Defendants *estopped* from relying on the anti-assignment provisions they refused to disclose for so long. "Equitable estoppel operates to place the person entitled to its benefit in the same position he would have been in had the representations been true." *Amara*, 563 U.S. at 441 (internal citations omitted). Estoppel requires a promise or misrepresentation by the defendant, reliance by the plaintiff, resulting injury, and injustice in permitting the defendant to not be held to its word.[17] Indeed, the nature of Defendants' misconduct—not only engaging in misleading representations and omissions over an "extended course of dealing," *Pell v. E.I. DuPont de Nemours & Co. Inc.*, 539 F.3d 292, 303-04 (3d Cir. 2008), but also taking precisely those misleading actions

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[17] *Schonholz v. Long Island Jewish Med. Ctr.*, 87 F.3d 72, 78-79 (2d Cir. 1996); *United States v. Georgia-Pac. Co.*, 421 F.2d 92, 96 (9th Cir. 1970).

that Defendants "should have expected to induce action or forbearance on the plaintiff's part," *Devlin v. Empire Blue Cross and Blue Shield*, 274 F.3d 76, 86 (2d Cir. 2001)—qualifies as the "extraordinary circumstances" under which courts often find estoppel. *See, e.g.*, *Productive MD, LLC v. Aetna Health, Inc.*, 969 F. Supp. 2d 901, 925 (M.D. Tenn. 2013) (insurer equitably estopped from contesting assignment of ERISA-governed claims).

Defendants spend several pages arguing that Plaintiffs cannot (as a matter of law) show waiver. MTD at 19-21. But waiver is a fact-based issue. Plaintiffs allege, among other things, that numerous Defendants *told* Plaintiffs that these claims were assignable. FAC ¶ 45. The idea that *telling* a Plaintiff that a claim is assignable, and then not raising the anti-assignment provision during a mandated claims regulation process (or otherwise), cannot qualify as an "intentional relinquishment of a known right" makes no sense. In any event, as Plaintiffs explained above, Defendants' conduct justifies the imposition of the equitable remedies of reformation or estoppel, which provide similar relief but do not depend on the voluntary relinquishment of a right. *See also* FAC ¶ 70 (seeking to set aside anti-assignment provisions by waiver, estoppel or otherwise).[18]

[18] As Plaintiffs explain in response to individual motions filed by a handful of Welfare Plan Defendants, plan defendants cannot escape liability by blaming Blue Cross. Important remedies that Plaintiffs seek—waiver, reformation, and estoppel—rest on the idea that, because of what transpired in the course of dealing between the parties, it would be inequitable to hold the victim to the terms of the underlying contract. This does not change if the a plan fiduciary used an agent (here, Blue Cross). Moreover, as the incredible scope of the misconduct makes clear—*i.e.,* Blue Cross denying hundreds of claims from one provider (and almost certainly thousands more across the country) without ERISA process, including where the plan did not bar assignments—there is essentially no chance that a prudent plan fiduciary could have missed what was systematically occurring. Such is directly actionable both as a failure of prudential oversight and through ERISA's co-fiduciary provisions. *See* 29 U.S.C. § 1105(a)(2) (a co-fiduciary is liable "if failure to comply with section 1104(a)(1) of this title . . . has enabled such other fiduciary to commit a breach").

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## II. There Is No Basis to Dismiss Counts II and III.

Plaintiffs assert two independent ERISA fiduciary claims (Counts II and III). The Omnibus Motion fundamentally misconstrues those Counts and, consequently, asserts bases for their dismissal that are easily rejected.

### A. Defendants Do Not Deny that They Are All ERISA Fiduciaries Bound to Follow Specifically Enumerated Claims Procedures.

To further its core purpose of ensuring that benefit promises are honored, ERISA contains procedures designed to ensure that claimants seeking benefits are treated fairly and transparently. Specifically, ERISA mandates that all plans "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. . . ." 29 U.S.C. § 1133 (authorizing the Secretary of Labor to promulgate regulations implementing this mandate).

The implementing regulations specifically require every ERISA plan to have "reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations. . . ." 29 C.F.R. § 2560.503-1(b). Those reasonable procedures must, *inter alia*, "not contain any provision, and not [be] administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits." 29 C.F.R. § 2560.503-1(b)(3). And they must also "contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents. . . ." 29 C.F.R. § 2560.503-1(b)(5).

The mandated procedures described above are designed to prevent plans from using silence or stonewalling to frustrate claimants. For example: when presented with any claim, a fiduciary who does not intend to pay *is required* to provide the claimant with written or electronic notification of the plan's "adverse benefit determination." 29 C.F.R. § 2560.503-1(j). And that notification must enumerate the

specific reason(s) for the adverse benefit determination, identify the specific plan provision(s) on which the adverse benefit determination is based, and describe the procedures for appealing the adverse decision. *Id.*

A fiduciary cannot sidestep the regulations by simply not issuing a decision *even if* it believes that the claimant is not an eligible beneficiary. Indeed, the term adverse benefit determination is specifically defined to include any "failure to provide or make payment (in whole or in part) . . . that is based on a determination of a participant's or beneficiary's eligibility. . . ." 29 C.F.R. § 2560.503-1(i)(4).

The upshot? When presented with any claim by an ERISA participant or beneficiary, fiduciaries *must* follow the above claims procedures. Not doing so is a breach of fiduciary duty that is remediable in a lawsuit that may be brought by the aggrieved participant or beneficiary. *See* 29 C.F.R. § 2560.503-1(l) (if a fiduciary does not comply with § 2560.503-1, the "claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue *any* available remedies under section 502(a)") (emphasis added).

**B. Plaintiffs Are Authorized to Assert Fiduciary Claims to Remedy Defendants' Flagrant Violation of the Claims Regulations and Related Duties.**

Plaintiffs unquestionably have standing to assert their ERISA fiduciary claims. As specifically alleged in the FAC, every insured to whom Plaintiffs provided services was an ERISA participant or beneficiary. FAC ¶ 20. And as specifically alleged in the FAC, Plaintiffs or their agents obtained an assignment from every single insured. FAC ¶ 53. Both the prior (Form A) and current (Form B) assignments used by Plaintiffs are attached as Exhibits A and B to the FAC.

As explained above (*supra* 6-7), the primary assignment involved in this litigation (Form B) expressly assigns to Plaintiffs the right to bring all benefit *and all fiduciary* claims. *See also* FAC, Ex. B (assigning "all" rights under ERISA, including claims "predicated on a breach of fiduciary duty"). Thus, it is beyond any

serious dispute that Plaintiffs have standing to assert any colorable fiduciary breach claim derived from an insured who signed the Form B assignment.[19]

As explained above (*supra* 9-10), the prior assignment used by Plaintiffs (Form A) expressly assigns to Plaintiffs the right to bring all benefit claims pursuant to 29 U.S.C. § 1132(a)(1)(B). As explained in detail below (*infra* 23-24), anyone with a colorable right to benefits under 29 U.S.C. § 1132(a)(1)(B) is expressly authorized by ERISA (defining "beneficiary") and its implementing regulations (defining "claimant") to bring a related fiduciary breach claim. Specifically: anyone whose colorable benefit claim is ignored (or otherwise mishandled) is authorized to sue under ERISA not only to recover the benefit *but also* to remedy the procedural misconduct of the fiduciary. That is precisely what Plaintiffs have done here. *See, e.g.*, FAC ¶¶ 4, 84-88 (pleading, in detail, the factual and statutory basis for Plaintiffs' standing to assert fiduciary breach claims).[20]

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[19] Defendants concede (as they must) that the Form B assignment was intended to assign all 29 U.S.C. § 1132(a)(3) fiduciary claims. Defendants insist, however, that because Form B's purpose is to ensure that Plaintiffs are "paid for [their] services," and to "recover[] Benefits," it was not intended to assign 29 U.S.C. § 1132(a)(2) claims. MTD at 11-12. But Defendants' lead case—*Klamath-Lake Pharm. Ass'n v. Klamath Med. Serv. Bureau*, 701 F.2d 1276 (9th Cir. 1983)—illustrates Defendants' flawed interpretation. At issue in *Klamath Lake* was the purported assignment of antitrust claims. The district court concluded that the initial paragraph of the assignment revealed the parties' intent to cover Sherman Act claims, but not *other* forms of antitrust claims. *Klamath-Lake*, 701 F.2d at 1283. The Ninth Circuit reversed, holding instead that the assignments effectuated a full assignment of *all* antitrust claims. *Id.* Thus, while it is true the judicial task for interpreting assignments is "to enforce the intent of the parties," *id.*, Defendants misapply that command here. To wit: the *Klamath Lake* Court *rejected* reading a snippet of text regarding the assignment's purpose as definitive, and instead insisted that "the [assignment] *must be read as a whole*." *Id.* (emphasis added). The court found implausible the argument that the assignors intended to reserve non-Sherman Act claims for later prosecution. *Id.* So too here. There is no reason whatsoever to conclude that assignor patients here sought to keep for themselves 29 U.S.C. § 1132(a)(2) claims when they specifically assigned "all" rights, including claims predicated on fiduciary breaches. Nor, for that matter, is there any reason to consider 29 U.S.C. § 1132(a)(2) claims somehow in tension with or unrelated to Form B's "purpose" of getting providers paid. *See, infra* 22-23 n.20.

[20] That makes good sense. Otherwise fiduciaries could disregard ERISA's claims processes and face no sanction. And, Defendants' suggestion notwithstanding, the removal of a fiduciary under 29 U.S.C. § 1132(a)(2) is directly related to ensuring fair and diligent claims handling—and therefore payment. The possible removal of

On this issue, Defendants insist that Plaintiffs reading of ERISA is wrong. Not so. As Defendants correctly note, the ERISA claims regulations provide that "'this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants *and beneficiaries* (hereinafter referred to as claimants)'" MTD at 27 (quoting 29 C.F.R. § 2560.503-1(a)) (emphasis added). What Defendants fail to note, however, is ERISA's definition of the term "beneficiary," which includes persons who *may* become entitled to benefits. *See* 29 U.S.C. § 1002(8) ("The term 'beneficiary' means a person designated by a participant . . . who is or *may* become entitled to a benefit thereunder.") (emphasis added); 29 U.S.C. § 1002(9) (defining "person" to include any "corporation").

For that reason, it is well-established that healthcare providers who submit claims pursuant to an assignment of benefits acquire the status of "claimants" under the claims regulations. *See, e.g.*, *Metcalf v. Blue Cross Blue Shield of Mich.*, No. 3:11-CV-1305-ST, 2013 WL 4012726, at *19 (D. Or. Aug. 5, 2013) (plaintiff-provider with assigned benefits deemed to have exhausted administrative remedies under 29 C.F.R. § 2560.503-1 due to defendant's unreasonable claim procedure; *Premier Health Ctr., P.C. v. UnitedHealth Grp.*, 292 F.R.D. 204, 224 (D. N.J. 2013) (concluding overpayment recoupment letters sent to plaintiff-provider violated 29 C.F.R. § 2560.503-1).

Defendants assert that assignee-providers are never entitled to the procedural protections of the ERISA claims regulations. MTD at 27-28. In support of that assertion, Defendants cite a DOL FAQ, *Grasso Enters., LLC v. Express Scripts, Inc.*, 809 F.3d 1033 (8th Cir. 2016), and *Pa. Chiropractic Ass'n v. Indep. Hosp. Indem. Plan, Inc.*, 802 F.3d 926, 928 (7th Cir. 2015). But none of those three authorities remotely supports Defendants' position.

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a fiduciary is a powerful tool, not only to promote the expeditious resolution of existing disputes but to ensure, moving forward, that new fiduciaries will not play games—thus making provider payment, where deserved, more likely.

The DOL FAQ makes a general observation about when and how a beneficiary might make someone *an authorized representative* to pursue a benefit appeal on a beneficiary's behalf.[21] It does not in any way represent the DOL's position on the *assignment* of claims either in this case or in general, nor is it an "interpretation" of how assignees fare under the claims regulations.

*Grasso* simply held that providers are not direct ERISA beneficiaries "in their own right." 809 F.3d at 1040. Indeed, the court held that providers holding assignments *were entitled* to pursue claims against plans, and *were entitled* to the protection of claims regulations, as well as remedies for their violation. *Id.* at 1039. And *Pa. Chiropractic* is completely irrelevant to the issue at hand. In that case, the plaintiffs had no assignments from patients, nor any relationship with any plan. They claimed they were beneficiaries based "on their contracts with an insurer [who was not an ERISA plan]." 802 F.3d at 928. The court disagreed, and said nothing to undermine the uncontroversial proposition that assignee-providers who assert claims are, indeed, claimants for purposes of ERISA's claims regulations.

In sum, Plaintiffs are unquestionably "claimants" for purposes of 29 C.F.R. § 2560.503-1. And, as noted above, 29 C.F.R. § 2560.503-1 expressly provides that any aggrieved claimant may bring a fiduciary breach claim under ERISA. *See* 29 C.F.R. § 2560.503-1(l) ("claimant shall be entitled to pursue *any* available remedies under section 502 of [ERISA] . . . .") (emphasis added).[22]

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[21] An authorized representative is different than an assignee. The former is someone who the beneficiary has named to communicate on her behalf with the plan regarding the claim. *Misic*, 789 F.2d at 1377, The latter is someone who is entitled *to themselves* receive benefits. 29 C.F.R. § 2560.503-1(b)(4); *Almont*, 99 F. Supp. 3d at 1143 (citing *Total Renal Care of N.C., L.L.C. v. Fresh Market, Inc.*, 2008 WL 623494, at *5-7 (M.D.N.C. Mar. 6, 2008) (authorized representatives sue "on behalf of" patients, whereas assignees file claims "in their own right"))

[22] None of the "assignment requires analysis of the intent of the parties" decisions cited by Defendants, MTD at 12-14 (discussing cases)—undermines the plain text of ERISA and its regulations discussed above. For example, the Ninth Circuit in *Spinedex Physical Therapy USA Inc. v. United Healthcare of Arizona, Inc.*, 770 F.3d 1282 (9th Cir. 2014) *cert. denied sub nom. United Healthcare of Arizona v. Spinedex Physical Therapy USA, Inc.*, 136 S. Ct. 317 (2015) certainly focused on whether the

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### C. Defendants' "Anti-Assignment" and "Full Payment" Arguments Have No Application to ERISA Fiduciary Claims.

3 To assert an ERISA benefits claim, a plaintiff must allege a *colorable benefit*
4 *entitlement*. *See, e.g.*, 29 U.S.C. § 1002(8) (a beneficiary includes anyone
5 "designated by a participant [who] may become entitled to a benefit thereunder"). In
6 order for that beneficiary to *win* the ERISA benefits claim, that plaintiff must prove
7 an *actual benefit entitlement*. *See* 29 U.S.C. § 1132(a)(1)(B).
8 In resisting an ERISA benefits claim, a defendant may advance arguments to
9 show why, under the terms of the plan, the claimant is not *actually* entitled to the
10 benefit sought. Those arguments may include: (a) the claimant was not an eligible
11 plan member during the relevant time; (b) the claimant seeks a benefit (e.g., an
12 experimental drug) that is not covered by the plan; (c) the claimant failed to satisfy
13 a condition (*e.g.*, the payment of a premium) of coverage; or (d) the claimant's
14 position depends on an assignment the plan's language specifically bars.[23]
15 In resisting Count I, Defendants have advanced this last (*i.e.*, anti-assignment
16 clause) argument. MTD at 16-18. As explained above, Plaintiffs vigorously contest
17 Defendants' position. *See supra* 13-16 (explaining that Defendants' anti-assignment
18 defense fails or, at a minimum, cannot be resolved at the pleading stage). But as
19 explained next, that defense (irrespective of its merits) has no possible bearing on
20 Counts II or III.
21 To assert an ERISA fiduciary claim a plaintiff must allege a *colorable benefit*
22 *entitlement*. That threshold requirement applies to both benefit and fiduciary claims.
23

24 parties intended to assign fiduciary claims. *Id.* at 1292. But that is because the only justification plaintiffs offered for being able to bring fiduciary claims was
25 contractual, and the Ninth Circuit concluded the narrow language of the assignment at issue was wanting. *Id.* The court was not asked to consider the argument Plaintiffs
26 present here.

27 [23] *See, e.g.*, *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 700 (7th Cir. 1991) (explaining that while an assignee is a beneficiary covered by ERISA the "assignee
28 cannot collect unless he establishes that the assignment comports with the plan").

When asserting an ERISA fiduciary claim, however, there is a second threshold requirement: a plaintiff must also allege a *colorable fiduciary violation* (*i.e.*, failure to comply with ERISA's benefit claims regulations).

In order for a beneficiary to *win* an ERISA fiduciary claim, that plaintiff must prove an *actual fiduciary violation.* But, unlike with an ERISA benefit claim, the plaintiff does *not* have any obligation to prove an *actual benefit entitlement.* Put another way: a fiduciary breach claim may succeed *even if* the plaintiff's benefit claim fails because a fiduciary has breached procedural duties or otherwise engaged in statutorily prohibited misconduct.[24] Put simply, all claimants are entitled to fair procedures—even claimants whose benefits claims are likely to fail on the merits. No ERISA decision has held to the contrary. The reason is obvious: transparent procedures ensure the system's legitimacy and promote efficiency.

This case is a perfect illustration. If fiduciaries of plans which expressly *authorize* medical provider assignments had made *any attempt* to follow ERISA's procedures, they would have realized that they could not deny Plaintiffs' claims on anti-assignment grounds. If fiduciaries of plans with ambiguous (or otherwise deficient) anti-assignment provisions, had made *any attempt* to follow ERISA's procedures, Plaintiffs would have been able to request missing documents and go through the statutorily-mandated (non-adversarial) administrative process that the United States Supreme Court has regularly noted is preferable to litigation. *Conkright v. Frommert*, 559 U.S. 506, 517 (2010) (discussing advantages of standard

[24] Imagine, for example, that a participant has paid premiums for a life insurance policy for years. Shortly before choosing to renew the policy for the coming year, the participant asks the plan when the renewal election is due. The plan deliberately misinforms the participant that the premium is due on January 31, instead of January 15 (the real due date specified in the plan). In reliance on the fiduciary's advice, the participant does not pay until January 31. When the participant dies later that year, and his beneficiary attempts to collect, that benefit claim would ultimately fail, because the premiums were not paid by the date the plan required. In such a case—where it is clear that the benefits claim will lose—the claimant is still entitled to seek a remedy for the *fiduciary misconduct*.

of deference in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *cf. Heimeshoff v. Hartford Life & Accident Ins. Co.*, 134 S. Ct. 604, 613-14 (2013) (explaining benefits of full-measure internal review process over extra time for judicial review); *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008) (noting favorably "the particular importance of accurate [administrative] claims processing" under ERISA).

And if fiduciaries of plans (if any) with valid and enforceable anti-assignment provisions had made *any attempt* to follow ERISA's procedures, Plaintiffs could have addressed the issue (certainly with assignor-patients still residing in Plaintiffs' treatment facilities) likely avoiding the unnecessary and significant injury caused by the previous misleading representations. FAC ¶ 71(e)(1)-(4) (detailing some of the ways in which Plaintiffs could have taken remedial or preventative action during the claims procedures but were deprived of the opportunity to do so by Defendants' failing).

Throughout the Omnibus Motion, Defendants imply that arguments about the merits of Plaintiffs' 29 U.S.C. § 1132(a)(1)(B) claim somehow undermine Plaintiffs' fiduciary breach claims. They do not. A merits objection to a 29 U.S.C. § 1132(a)(1)(B) claim does not authorize a fiduciary to ignore ERISA-mandated procedures or to otherwise engage in ERISA-prohibited misconduct. Specifically:

Defendants argue that all of Plaintiffs' ERISA claims (presumably including Counts II and III) must be dismissed where the applicable plans prohibit assignments. MTD at 16-21. That is simply false. The presence of an anti-assignment provision (even one that is, ultimately, deemed enforceable) does not mean Plaintiffs cannot *pursue* their benefit claims, and therefore cannot mean that Plaintiffs are not entitled to fair procedure. That, and other fiduciary misconduct (not any contractual entitlement) is the basis for Counts II and III of the FAC.

Defendants also seek to excuse their procedural misconduct by arguing that there was no "adverse benefit determination" because Defendants, in their view, directly paid the right parties, *i.e.*, the patients. MTD at 26-27. But as explained above (*supra* 21), any failure to pay Plaintiffs is squarely defined by the ERISA regulations as an adverse benefit determination. *See also* 29 C.F.R. § 2560.503-1(i)(4) (defining "adverse benefits determination"). Defendants conflate a benefit defense with a fiduciary defense. If Defendants were entitled to pay Plaintiffs' patients directly (they were not), then Plaintiffs' *benefit* claim may fail.[25] But, by failing to pay Plaintiffs, Defendants made an adverse benefits determination which triggered procedural obligations that Defendant willfully failed to perform. And that alleged failure states a textbook claim for fiduciary breach under ERISA.

**D. Defendants' Fiduciary Remedy Arguments Are Wrong.**

Defendants argue that the remedies sought by Plaintiffs under Counts II and III are unavailable. But Defendants misunderstand both what Plaintiffs seek and how 29 U.S.C. §§ 1132(a)(2) and (3) work.

*Plaintiffs may seek "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3) either as part of Count I or, if necessary, to obtain a direct monetary recovery.* As noted above (*supra* 17-19), misleading conduct on the part of fiduciaries, whether in the claim handling context or otherwise, entitles plaintiffs to

[25] To be clear: Defendants were *not* so entitled. Notice of an assignment charges the debtor with the obligation to make payment directly to the assignee. *Metcalf*, 2013 WL 4012726, at *15. And a debt is discharged only by payment to the assignee. *Id* at *16. Were that not so, assignments (in any setting) would be worthless in practice. The authorities cited by Defendants in support of the contrary position are cases in which participants' *own benefits claims* were considered resolved when the fiduciary chose to pay the benefits in question. MTD at 28-29. *See Filler v. Anthem Blue Cross*, No. CV 12-8960-CAS (JEMx), 2012 U.S. Dist. LEXIS 182356 (C.D. Cal. Dec. 17, 2012); *Silk v. Metro. Life Ins. Co.*, 310 F. App'x 138 (9th Cir. 2009); *Providence Health Plan v. McDowell*, 361 F.3d 1243 (9th Cir. 2004); *Lemons v. Reliance Standard Life Ins. Co.*, 534 F. App'x 162 (3d Cir. 2013); *Pakovich v. Verizon, Ltd. Plan*, 653 F.3d 488 (7th Cir. 2011). Obviously, those decisions do not support the argument that paying a third party extinguishes, in any way, the first party's claim.

pursue "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3), including the equitable remedies of "reformation" and "estoppel." *CIGNA Corp. v. Amara,* 563 U.S. 421 (2011). Reformation is appropriate "to remedy the false or misleading information [the fiduciary] provided." *Id*. at 1879. Estoppel holds a party to its words when others relied on them to their detriment. *Id*. at 1880. As explained in detail above (*supra* 17-19), the facts pled in the FAC will entitle Plaintiffs to both remedies here. In addition, a successful claim under 29 U.S.C. § 1132(a)(3) will entitle a plaintiff to directly "surcharge" the fiduciary for losses the beneficiary suffers because of a fiduciary's breach of duty. *Id.* at 1880. If necessary, that remedy will also be available here. Plaintiffs were owed fair and transparent treatment under the claims procedures. Had the Defendants complied, Plaintiffs would not have had to spend hundreds of thousands of dollars in time and effort to understand why they were not being paid for services that no one disputes they rendered in good faith. Defendants should be surcharged accordingly.

*Plaintiffs may seek important non-monetary "appropriate equitable relief" under 29 U.S.C. § 1132(a)(3).* As explained in the FAC, 29 U.S.C. § 1132(a)(3) permits the imposition of non-monetary, injunctive relief aimed at curbing a breaching fiduciary's violative conduct moving forward. Plaintiffs here seek a court order requiring Defendants to, when presented with a UB-04 form from Plaintiffs indicating an assignment, treat that claim as one entitled to the procedural protections of ERISA's claims regulations, as well as additional procedures to ensure Defendants hew to their general duties under ERISA. FAC ¶ 385; FAC at 280 (Prayer for Relief).

*Defendants' argument that* Varity Corp v. Howe*, 516 U.S. 489 (1996) forecloses any 29 U.S.C. § 1132(a)(3) relief is frivolous.* Defendants maintain that Count III fails because "Plaintiffs' claim for equitable relief does not allege an injury separate and distinct from the alleged misdirection of payment giving rise to

Plaintiffs' claim to recover benefits under 29 U.S.C. § 1132(a)(1)(B)." MTD at 30. That assertion is frivolous. The FAC contains detailed allegations of fiduciary breach (both misrepresentations and flagrant violations of ERISA's claims regulations). *See, e.g.*, FAC ¶¶ 69-72, 76, 81-88, 92, 93. Defendants' fiduciary misconduct caused an injury separate and distinct from the denial of benefits. *See, e.g.*, FAC ¶ 71. And as explained at length above (*supra* 16-19), the remedy available under 29 U.S.C. § 1132(a)(1)(B) may be wholly inadequate. In other words, reformation or estoppel under 29 U.S.C. § 1132(a)(3) may be needed in order to avoid an anti-assignment defense that would otherwise defeat Count I.

It is a bedrock principle of federal civil procedure that every plaintiff is entitled to plead alternative theories of relief. Fed. R. Civ. P. 8(a)(3) ("A pleading that states a claim for relief must contain . . . a demand for the relief sought, which may include relief in the alternative or different types of relief."); Fed. R. Civ. P. 18 ("A party asserting a claim . . . may join, as independent or alternative claims, as many claims as it has against an opposing party."). ERISA is, of course, no exception. *See, e.g.*, *Amara*, 563 U.S. at 438-45 (discussing the availability of relief under § 1132(a)(3) after concluding that no relief was available under § 1132(a)(1)(B)); *Silva v. Metro. Life Ins. Co.*, 762 F.3d 711, 725-28 (8th Cir. 2014) ("*Varity* does not limit the number of ways a party can initially seek relief at the motion to dismiss stage.") ("[A]t the motion to dismiss stage of litigation, we . . . hold that [Plaintiff] is allowed to assert liability under [§ 1132(a)(1)(B) and (a)(3)]."); *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 89 (2d Cir. 2001) (permitting both § 1132(a)(1)(B) and § 1132(a)(3) claims at the pleading stage).

*Plaintiffs' 29 U.S.C. § 1132(a)(2) claim does not fail as a matter of law as to the ERISA Welfare Plan Defendants.* Defendants argue that Plaintiffs' 29 U.S.C. § 1132(a)(2) claim—seeking to remove breaching fiduciaries—should be dismissed because it would be "illogical" for Plaintiffs "to sue the very plans on whose behalf

1 they supposedly seek relief for breach of fiduciary duty." MTD at 29.[26] Defendants
2 misstate the relevant law. Ninth Circuit authority allows Plaintiffs to name the plan
3 as a nominal defendant to the extent it effectuates attainment of the equitable relief
4 sought. In *Acosta v. Pacific Enters.*, 950 F.2d 611 (9th Cir. 1991), *amended on reh'g*
5 (Jan. 23 1992) , the court of appeal held that, while in some instances naming a plan
6 as defendant is not appropriate, that "does not inexorably lead to the conclusion that
7 a plan cannot be properly named in a suit alleging breach of fiduciary duty." 950
8 F.2d at 618. When doing so is a natural step in obtaining the sought relief, substance
9 trumps form. *See, e.g.*, *Solis v. Webb*, 931 F. Supp. 2d 936 (N.D. Cal. 2012) (citing
10 *Acosta* and holding that having the plan as defendant in a suit alleging breach of
11 fiduciary duty was permissible as a means of allowing plaintiff to obtain the
12 complete relief sought). Thus, Plaintiffs' naming plans as nominal defendants for the
13 sole purpose of removing a fiduciary is perfectly proper. Here, the profound failures
14 on the part of Defendants clearly justify fiduciary removal. Plaintiffs are confident
15 that discovery will confirm a sweeping range of fiduciary misconduct giving rise to
16 such a remedy.

17 **III. There Is No Basis to Dismiss Count IV.**

18 Defendants assert that Plaintiffs' alternative state law claim fails on the
19 pleadings for three reasons. None is a credible basis for dismissal.

20 Defendants first argue that "because Plaintiffs' claim under Section 17200 is
21 based on the same alleged [conduct] that forms the basis of Plaintiffs' claims under
22 ERISA, the state law claim must be dismissed for the same reasons. MTD at 31.
23 Defendants are confused. Even if this Court accepted one of Defendants' technical
24 "ERISA-specific" *defenses* (*i.e.*, Plaintiffs never became an ERISA claimant with
25

26 [26] Defendants cite two out-of-circuit district court decisions (*Kling v. Fidelity*
27 *Management Trust Co.*, 323 F. Supp. 2d 132 (2004) and *Steinman v. Hicks*, 252 F.
Supp. 2d 746 (C.D. Ill. 2003), *aff'd*, 352 F.3d 1101 (7th Cir. 2003)) for this
28 proposition. MTD at 29-30.

1 the statutory right to sue), the underlying *allegations of misconduct* in the FAC easily
2 state an independent claim under state law. And conspicuously absent from the
3 Omnibus Motion is any acknowledgment of the extensive details in the FAC
4 regarding how "the pattern and practice of the Blue Cross Defendants . . . has caused
5 Plaintiffs *to suffer direct and independent injury in violation of state law*." FAC ¶ 71
6 (emphasis added).

7 Defendants next argue that "Plaintiffs fail to state a Section 17200 [*sic*]
8 because the conduct alleged by Plaintiffs is neither unlawful, nor unfair, within the
9 meaning of the statute . . . ." MTD at 31. Not so.

10 As this Court has observed, the UCL defines "unfair competition" as "*any*
11 unlawful, unfair, or fraudulent business act or practice" and because it is written in
12 the disjunctive, "a practice is prohibited as unfair or deceptive even if not unlawful
13 and vice versa." *Valdez v. JPMorgan Chase Bank, N.A.*, No. EDCV 11-0935 DOC
14 (DTBx), 2012 WL 995278, at *10 (C.D. Cal. Mar. 20, 2012) (citing UCL and *Rubio*
15 *v. Capital One Bank*, 613 F.3d 1195, 1203 (9th Cir. 2010)) (internal quotation marks
16 omitted and emphasis added). The UCL affords standing to *any* private party who
17 has suffered injury and has lost money or property as a result of the unfair
18 competition. *See* Cal. Bus. & Prof. Code § 17204 (emphasis added).

19 *Unlawful.* Defendants argue that Plaintiffs have no claim under this prong
20 because the "FAC fails to allege a violation of any 'borrowed' law." MTD at 31.
21 Defendants are wrong. The extensive and detailed allegations in the FAC clearly
22 describe a business practice of Defendants that is forbidden by numerous California
23 laws.[27] Perhaps the simplest example is California's prohibition against constructive
24 fraud. *See, e.g.*, Cal. Civ. Code § 1573 ("Constructive fraud consists . . . in any
25

26 [27] "The 'unlawful' prong of the UCL borrows violations from other statutes or common-law causes of action and means 'anything that can properly be called a
27 business practice and that at the same time is forbidden by law.'" *Anderson v. PHH Mortgage*, No. SACV 12-01192-CJC, 2012 WL 4496341, at *4 (C.D. Cal. Sept. 28,
28 2012) (quoting *Bank of the West v. Super. Ct.*, 2 Cal. 4th 1254 (1992)).

breach of duty which, without an actually fraudulent intent, gains an advantage to the person in fault . . . by misleading another to his prejudice."). The FAC alleges every element of constructive fraud. *See, e.g.*, FAC ¶¶ 2, 3, 77, 78, 79, and 80 (summarizing the Blue Cross scheme); FAC ¶¶ 43, 45(c), 69, 70, and 71(a)-(d) (explaining the specific misconduct of Blue Cross); FAC ¶ 71(e) (explaining how Plaintiffs were misled to their prejudice by Blue Cross who, in turn, gained a significant advantage).[28]

*Unfair.* It is beyond any serious dispute that the behavior alleged in the FAC is "unfair" within the meaning of the UCL.[29] Misleading providers about the assignability of claims, refusing to consider those claims when later presented, refusing to consult the operative contracts governing the entitlement in question, and then sending the money to someone else—all in a bid to drive providers in-network—obviously qualifies as "unfair" under any test. *Cf. Smith v. Chase Mortg. Credit Group*, 653 F. Supp. 2d 1035, 1045-46 (E.D. Cal. 2009).[30]

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[28] The FAC's allegations also make out a claim for outright fraud. *See Marolda v. Symantec Corp.*, 672 F. Supp. 2d 992, 997 (N.D. Cal. 2009) (explaining elements of fraud are misrepresentation, knowledge of falsity, intent to induce reliance, justifiable reliance and damage). And they also likely constitute violations of numerous other California statutes. *See, e.g.,* Cal. Ins. Code § 10133 (prohibiting an insurer from attempting to control, direct and participate in the selection of the health facilities of its PPO members).

[29] The Supreme Court of California has long held that a broad conception of "unfair" is necessary to effectuate the UCL's purpose: "it would be impossible to draft in advance detailed plans and specifications of all acts and conduct to be prohibited . . . since unfair or fraudulent business practices may run the gamut of human ingenuity and chicanery." *Mosk v. Nat'l Research Co. Cal.*, 201 Cal. App. 2d 765, 772 (1962). *See also Kwikset Corp. v. Super. Ct.*, 51 Cal. 4th 310, 320 (2011) (UCL framed in "'broad, sweeping language'" to provide "courts with broad equitable powers to remedy violations").

[30] Defendants claim "unfairness" only refers to "conduct that relates to . . . a violation of any antitrust law or which threatens or harms competition." MTD at 31-32. But that is not what Defendants' sole case, *Cel-Tech Commc'ns, Inc. v. Los Angeles Cellular Tel. Co.*, 20 Cal. 4th 163 (1999), says. In *Cel-Tech*, the dispute was between direct competitors, so the Court accordingly explained what "unfair" would mean in *that* context, *i.e*, "[w]hen a plaintiff who claims to have suffered injury from a *direct competitor's* 'unfair' act or practice.") *Id.* at 187 (emphasis added). The *Cel-Tech* "rule" simply does not apply where, as here, the parties are not direct competitors.

Indeed, California courts routinely hold that disputes between independent providers like Plaintiffs and health plans and insurance companies like Defendants are properly litigated under the UCL. *See, e.g.*, *Coast Plaza Doctors Hosp. v. UHP Healthcare*, 105 Cal. App. 4th 693, 696, 705-06 (2002); *Bell v. Blue Cross of Cal.*, 131 Cal. App. 4th 211, 214-18 (2005). Nor is there any question that providers may having standing to bring such claims. *See Coast Plaza*, 105 Cal. App. 4th 693 at 205-06; *Bell*, 131 Cal. App. 4th 211 at 216-18; *In re Webkinz Antitrust Litig.*, 695 F. Supp. 2d 987 (N.D. Cal. 2010).[31] The FAC's allegations plainly state Plaintiffs' direct injuries, including lost money, as a result of Defendants' misconduct. *See, e.g.*, FAC ¶¶ 374; *Kwikset*, 51 Cal. 4th at 322-23, 326.

Finally, Defendants argue that Plaintiffs' statutory unfair competition claim is preempted by ERISA because it "necessarily relates to the ERISA-governed plans at issue." MTD at 32. Not so. Plaintiffs expressly assert their unfair competition claims in their own right—*i.e.*, as victims of Defendants' misleading conduct about the conditions under which providers qua providers would be paid—and *not* as an assignee of Defendants' insureds. FAC ¶ 388. It is well-established that ERISA does not preempt California unfair competition claims in which the provider sues "as a third party claiming damages, and not as an assignee of rights to benefits." *Cedars-Sinai Med. Ctr. v. Nat'l League of Postmasters of the United States*, 497 F.3d 972, 978 (9th Cir. 2007). Because such claims concern the relationships between providers and insurers (and not, in any meaningful way, the regulation of employee

[31] Defendants' suggestion that providers necessarily lack standing relies on two unreported decisions that lack persuasive weight. MTD at 32 n.10. In the unreported case *Centre for Neuro Skills v. Blue Cross of Cal.*, the Court dismissed *with leave to amend*, plaintiff's claim under the unfair prong of the UCL and *denied* the motion to dismiss plaintiff's claim under the unlawful prong. No. 1:13-CV-00743-LJ0-JLT, 2013 WL 5670889, at *1 (E.D. Cal. Oct. 15, 2013). And in *Almasi v. Equilon Enters., LLC*, plaintiffs had not identified any facts supporting their unfair competition claim. No. 5:10-CV-03458-EJD, 2012 WL 3945528, at *10 (N.D. Cal. Sept. 10, 2012) ("[P]laintiffs have failed to cite to any materials in the record demonstrating that a genuine dispute exists.") (on motion for summary judgment).

benefit plans), the involvement of a plan does not trigger ERISA preemption. *See Marin Gen'l Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009) (no preemption where provider sought relief based on its own relationship with ERISA plan); *Meadows v. Emps. Health Ins.*, 47 F.3d 1006 (9th Cir. 1995) (provider permitted to pursue state-law action).

**IV. Plaintiffs' Jury Trial Demand Should Not Be Stricken.**

Plaintiffs agree that none of its three ERISA claims (nor its UCL claim) is triable by jury. That does not mean, however, that the jury trial demand be stricken. The FAC's detailed factual allegations regarding the Blue Cross Defendants' pattern and practice of misconduct give rise to independent (*i.e.*, non-preempted) state-law claims such as constructive fraud. While those state-law claims may be borrowed as a predicate for Plaintiffs' statutory unfair competition claim (for which Plaintiffs do not seek a jury trial), those claims may *also* be asserted as independent bases for relief; if so, Plaintiffs are entitled to a jury trial. *Raedeke v. Gibraltar Sav. & Loan Ass'n*, 10 Cal. 3d 665, 671 (1974) (en banc) ("a suit to recover damages for fraud . . . is an action at law in which a right to jury trial ordinarily exists.") (citations omitted).[32]

**CONCLUSION**

For the reasons set forth above, the Court should deny Defendants' omnibus motion in its entirety.

[32] The Federal Rules require only that a complaint pleads facts sufficient to state a claim. *See supra* n.2. In any event, Plaintiffs request leave to re-plead should their complaint, in this respect (or any other raised by Defendants) be technically insufficient. In accordance with Fed. R. Civ. P. 15(a), the Ninth Circuit has long had a liberal policy favoring amendments. *DeSoto v. Yellow Freight Sys., Inc.*, 957 F.2d 655, 658 (9th Cir. 1992). *See also Manzarek v. St. Paul Fire & Marine Ins. Co.*, 519 F.3d 1025, 1031 (9th Cir. 2008) (leave to amend should only be denied if amendment is certain to be futile).

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**STRIS & MAHER LLP**

By: /s/ Peter K. Stris
Peter K. Stris

Attorneys for Plaintiffs
DUAL DIAGNOSIS TREATMENT CENTER, INC., et al.