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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

SOUTHERN DIVISION

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

Plaintiffs,

vs.

BLUE CROSS OF CALIFORNIA, dba ANTHEM BLUE CROSS, et al.,

Defendants.

Case No. 8:15-cv-00736-DOC-RNB

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF DEFENDANTS' OMNIBUS MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT

Date: April 18, 2016
Time: 8:30 a.m.
Location: Courtroom 9D

Judge: Honorable David O. Carter

Complaint Filed: May 8, 2015

[1] Exhibit A, attached hereto, identifies the individual defendants that are referred to collectively herein as the "Anthem Defendants."

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I. INTRODUCTION

The First Amended Complaint (the "FAC") filed by Plaintiffs Dual Diagnosis Treatment Center, Inc., *et al*. (collectively, "Plaintiffs") alleges that Defendants[2] improperly paid medical benefits to Defendants' members, who are alleged to be Plaintiffs' patients and participants or beneficiaries of health benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). Plaintiffs do not dispute that payments were made, but instead contend they should have received those payments directly. Based on this contention, Plaintiffs assert claims under ERISA to recover the benefits that Defendants allegedly previously paid to their members and to obtain equitable relief, as well as a claim under California Business and Professions Code § 17200.

With respect to Plaintiffs' claims under ERISA, it is well settled that health care providers, such as Plaintiffs, do not have direct statutory standing to bring claims under ERISA. Instead, Plaintiffs' rights under ERISA, if any, are purely derivative of their patients' rights and are limited to those rights that were expressly and knowingly transferred pursuant to a valid assignment. To this end, Plaintiffs' claims under ERISA are premised on Plaintiffs' allegation that Plaintiffs obtained valid "assignments of benefits" from their patients. The "assignments" of benefits alleged by Plaintiffs take one of two different forms: (1) an authorization and request that payment of insurance benefits be made directly to Plaintiffs, which is attached as Exhibit A to the FAC (the "Form A Assignment"); and (2) an express, though procedurally and substantively unconscionable, assignment of benefits, which is attached as Exhibit B to the FAC (the "Form B Assignment").

As an initial matter, Plaintiffs lack standing to assert their purported claims under ERISA on each of the following independent grounds:

- The Form A Assignments are nothing more than mere direct-payment

[2] Exhibit B, attached hereto, identifies the individual defendants that are referred to collectively herein as "Defendants" for purposes of this Motion and join in the filing of this Motion.

authorizations, which do not manifest any intent by Defendants' members to assign, convey, or otherwise transfer to Plaintiffs their legal rights to plan benefits or the ability to bring claims under ERISA.

- Even if construed as an assignment of benefits, as opposed to a mere direct-payment authorization, the Form A Assignment does not encompass the right to assert claims that seek the removal of ERISA plan fiduciaries (Count 2) or for equitable relief under ERISA (Count 3).
- The Form B Assignments, which are contracts of adhesion that are signed as a condition of receiving treatment by individuals that suffer from addiction and mental health issues, are procedurally and substantively unconscionable and, therefore, unenforceable as a matter of law.
- The Form B Assignment, by its terms, does not extend to claims that seek the removal of ERISA plan fiduciaries (Count 2).

Further, even if the Form A and Form B Assignments are determined by the Court to encompass Plaintiffs' claims under ERISA, Plaintiffs' ERISA claims would nevertheless fail as a matter of law for the following reasons:

- As to the many plans at issue that contain anti-assignment provisions, any purported assignment under those plans is void *ab initio* under well settled case law in the Ninth Circuit and, as a result, the anti-assignment provisions nullify the purported "assignments" on which Plaintiffs' ERISA claims are predicated.
- Plaintiffs confess that the only action they took to apprise Defendants of their purported "assignments" was to check a box on the claim forms they submitted to some Defendants, which, as a matter of law, does not constitute timely notice of the terms and scope of the purported assignments at issue such that Defendants were obligated to render performance to Plaintiffs directly rather than Defendants' members.
- Plaintiffs admit in their FAC that Defendants paid the applicable benefits to

the ERISA plan participants or beneficiaries that received services from Plaintiffs, and Plaintiffs do not plead facts establishing that Defendants were duty-bound to pay Plaintiffs instead.

Plaintiffs' claim under California Business and Professions Code § 17200 suffers from the same fatal defects as Plaintiffs' ERISA claims. Because Plaintiffs' claim under Section 17200 is premised on the same alleged "unlawful and unfair business practices" that form the basis of Plaintiffs' claims under ERISA, Plaintiffs' Section 17200 claim fails for the same reasons discussed above. Further, the FAC fails to identify any "borrowed" law or antitrust violation that can serve as a predicate for a Section 17200 claim. Finally, Plaintiffs' Section 17200 claim seeks the direct payment of plan benefits from Defendants pursuant to alleged assignments of those benefits executed by Plaintiffs' patients. Because Plaintiffs' Section 17200 claim indisputably relates to the ERISA-governed benefit plans at issue, Plaintiffs' Section 17200 claim is preempted by ERISA's express preemption provision, 29 U.S.C. § 1144(a).

The filing of the FAC follows Plaintiffs' voluntary amendment of their original Complaint in response to Defendants' first motion to dismiss. For the reasons summarized above, and those set forth in greater detail below, the FAC fails to cure the defects in Plaintiffs' original Complaint and should be dismissed in its entirety with prejudice.

II. SUMMARY OF ALLEGATIONS

Plaintiffs are health care providers that "provide in- and outpatient substance abuse and/or mental health treatment in California, Arizona, and Florida." [FAC., ¶ 9.] Plaintiffs allege that they provided health care services to plan participants and beneficiaries of employer-sponsored plans governed by ERISA. [*Id*. at ¶¶ 19-20.] Plaintiffs are "out-of-network" providers without preexisting contractual relationships with Defendants. [*Id*. at ¶ 2.] Defendants are alleged to be ERISA-governed employee benefit plans or to administer and/or insure the ERISA-governed plans at issue in Plaintiffs' FAC. [*Id*. at ¶¶ 20-22, 34(a),(b).] Plaintiffs allege that they obtain "valid

assignment of benefits […] from all patients before treating them." [*Id.* at ¶ 51.] According to Plaintiffs, "[t]he Assignments give [Plaintiffs] the right to be paid directly for any services rendered to patients, and also entitles [Plaintiffs] to assert patients' legal rights to recover benefits." [*Id.* at ¶ 52.] Plaintiffs' alleged "assignments" take one of two different forms: (1) an authorization and request that payment of insurance benefits be made directly to Plaintiffs, which is attached as Exhibit A to the FAC; and (2) an express assignment of benefits, which is attached as Exhibit B to the FAC. [*Id.* at Ex. A (Form A Assignment); Ex. B (Form B Assignment).] For each of the medical claims at issue in the FAC, Plaintiffs allege that the Defendants in the action improperly paid benefits to their members/insureds, rather than to Plaintiffs directly. [*Id.* at ¶ 3.]

Based on these allegations, Plaintiffs aver the following claims as to each Defendant: (1) to recover benefits pursuant to 29 U.S.C. § 1132(a)(1)(B); and (2) to remove the named fiduciary for each of the ERISA-governed plans at issue pursuant to 29 U.S.C. §§ 1132(a)(2) and 1109(a). In addition, Plaintiffs assert the following additional causes of action against the so-called "Blue Cross Defendants": (1) for declaratory and injunctive relief pursuant to 29 U.S.C. § 1132(a)(3); and (2) for violations of California Business and Professions Code § 17200. [FAC, ¶¶ 95, 375, 381, 387.]

III. LEGAL STANDARD

To survive a motion to dismiss for failure to state a claim under Rule 12(b)(6), a plaintiff must allege "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). "A claim has facial plausibility when the pleaded factual content allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 663 (2009). "[W]here the well-pleaded facts do not permit the court to infer more than the mere possibility of misconduct, the complaint has alleged - but it has not 'show[n]'-'that the pleader is entitled to relief.'" *Id.* at 679 (quoting Fed. R. Civ. P. 8(a)(2)). Courts are not bound to accept legal conclusions as true, and only a complaint that states a plausible claim for relief survives a motion to dismiss. *Id.* at 678-79. Plaintiffs must provide the

basis for their claimed entitlement to relief beyond mere labels and conclusions or formulaic recitation of the elements of the causes of action. *See Twombly*, 550 U.S. at 555-57. Conclusory statements, unlike proper factual allegations, are not entitled to a presumption of truth. *See Iqbal*, 556 U.S. at 681. Under this standard, a motion to dismiss should be granted where, as here, the complaint does not proffer enough facts to state a claim for relief that is plausible on its face. *See Twombly*, 550 U.S. at 558-59, *see also William O. Gilley Enters., Inc. v. Atl. Richfield Co.*, 588 F.3d 659, 667 (9th Cir. 2009) (confirming that *Twombly* pleading requirements "apply in all civil cases"); *Mendiondo v. Centinela Hosp. Med. Ctr.*, 521 F.3d 1097, 1104 (9th Cir. 2008); *Robertson v. Dean Witter Reynolds, Inc.*, 749 F.2d 530, 533-34 (9th Cir. 1984).

IV. PLAINTIFFS' CLAIMS SHOULD BE DISMISSED WITH PREJUDICE

A. Plaintiffs Lack Standing To Assert Certain Claims Under ERISA.

It is well settled that, in order to state a claim under ERISA, "'a plaintiff must fall within one of ERISA's nine specific civil enforcement provisions, each of which details who may bring suit and what remedies are available.'" *Spinedex Physical Therapy USA, Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1288 (9th Cir. 2014) (quoting *Reynolds Metals Co. v. Ellis*, 202 F.3d 1246, 1247 (9th Cir. 2000)). Plaintiffs' first claim for relief to recover ERISA plan benefits can be brought only by an ERISA plan participant or beneficiary. 29 U.S.C. § 1132(a)(1) (providing that a civil action to recover benefits may be brought by "a participant or beneficiary"). Plaintiffs' second claim for relief (to remove the named fiduciary for each of the ERISA-governed plans at issue) and third claim (for relief for declaratory and injunctive relief) may only be asserted "by a participant, beneficiary, or fiduciary," 29 U.S.C. § 1132(a)(2) and (a)(3).[3]

It is equally well settled that health care providers (such as Plaintiffs) are not "beneficiaries" within the meaning of ERISA and therefore do not possess direct statutory standing to pursue their claims under ERISA. Their standing, if any, is purely derivative of their patients' rights. In *Spinedex*, the Ninth Circuit held that Spinedex, a

[3] The Secretary of Labor may also pursue a claim under 29 U.S.C. § 1132 (a)(2).

health care provider that obtained an assignment of benefits from its patients, "cannot bring claims for benefits on its own behalf"; rather, "[i]t must do so derivatively, relying on its patients' assignments of their benefits claims." 770 F.3d at 1289 (citing *Misic v. Bldg. Serv. Emps. Health & Welfare Trust*, 789 F.2d 1374, 1377-79 (9th Cir. 1986) (per curiam)). In so holding, the Ninth Circuit confirmed that health care providers do not themselves become beneficiaries within the meaning of ERISA even with a valid assignment of benefits and, as a result, are not conferred with direct statutory standing to assert ERISA claims on their "own behalf." *See id.*; *see also Blue Cross of Ca. v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1047 (9th Cir. 1999) (concluding "that the fact that … medical providers obtained assignments of benefits from beneficiaries of ERISA-covered health care plans does not convert their claims into claims for benefits under ERISA-covered health care plans").

Other courts agree. *See, e.g., Rojas v. Cigna Health & Life Ins. Co.*, 793 F.3d 253, 257 (2d Cir. 2015) (holding that health care provider is "not a beneficiary as defined by ERISA and that its rights, if any, are limited by the assignments made by its patients."); *Sanctuary Surgical Ctr., Inc. v. Aetna, Inc.*, 546 F. App'x 846, 851 (11th Cir. 2013) (noting, in the context of a case where a health care provider possessed an assignment of benefits, that the "only parties with standing to sue a plan subject to ERISA under 29 U.S.C. § 1132 are 'participant[s],' 'beneficiar[ies],' 'fiduciar[ies],' and the Secretary of Labor" and holding that "[h]ealthcare providers fall outside this group"); *Borrero v. United HealthCare of N.Y., Inc.*, 610 F.3d 1296, 1302 (11th Cir. 2010) (holding that "[h]ealthcare providers may have standing under ERISA only when they derivatively assert rights of their patients as beneficiaries of an ERISA plan" and explaining that "[t]o sue derivatively, the provider must have obtained a written assignment of claims from a patient with standing to sue under ERISA"); *Hobbs v. Blue Cross Blue Shield of Ala.*, 276 F.3d 1236, 1241 (11th Cir. 2001) (same).

Because Plaintiffs are not beneficiaries within the meaning of ERISA, the inquiry becomes whether the forms that were allegedly executed by Plaintiffs' patients confer

derivative standing on Plaintiffs to assert the types of ERISA claims alleged in the FAC. For the reasons discussed below, where Plaintiffs' claims rest on the Form A Assignment, Plaintiffs lack derivative standing to assert any of the three ERISA claims alleged in the FAC. Further, under both the Form A and Form B Assignments, Plaintiffs lack derivative standing to assert a claim that seeks the removal of the ERISA plan fiduciaries and an order barring Defendants from serving as plan fiduciaries in the future.[4]

1. Plaintiffs Lack Derivative Standing Where Their Claims Are Premised On The Form A Assignment Because It Is Merely An Authorization For Direct Payment.

Plaintiffs assert that "[t]he Assignments give [Plaintiffs] the right to be paid directly for any services rendered to patients, and also [entitle Plaintiffs] to assert patients' legal rights to recover benefits[,] … includ[ing] the right to file claims and appeals … and to bring suit for violations of ERISA." [FAC, ¶ 52.] However, the actual language used in the Form A Assignment reveals that it is nothing of the sort. Instead, the Form A Assignment merely recites the patient's authorization for the provider to bill the payor directly, and for the payor, in turn, to issue payment directly to the provider on the patient's behalf at its discretion. Because the Form A Assignment does not actually assign any of the patients' legal rights, Plaintiffs lack derivative standing to pursue any ERISA claims based on those forms.

The Form A Assignment[5] states that the patient "authorize[s] and request[s]" payment of benefits directly to Plaintiffs:

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[4] Defendants note that the standing challenge they bring by way of this motion is not a dispute about whether the federal court properly has jurisdiction of the case given Plaintiffs' assertion of ERISA rights. Rather, Defendants' standing challenge is on the substantive merits of Plaintiffs' claims to ERISA rights given the scope of the assignments.

[5] While the document is entitled "Assignment of Benefits" it must be evaluated not by its header but by its terms – none of which provide Plaintiffs with any assignment of patient legal rights. *Brown v. Blue Cross Blue Shield of Tenn. Inc.*, No. 1:14-CV-00223, 2015 U.S. Dist. LEXIS 74306, at *8 n.3 (E.D. Tenn. June 9, 2015) (citing *United States v. Leslie Salt Co.*, 350 U.S. 383, 389 (1956)).

> I hereby authorize and request that payment of authorized insurance company benefits be made on my behalf to directly to DUAL DIAGNOSIS TREATMENT CENTER, INC. dba SOVEREIGN HEALTH OF CALIFORNIA for the amount due to me for any medical or psychological/psychiatric treatment or services that are rendered to me by DUAL DIAGNOSIS TREATMENT CENTER, INC. dba SOVEREIGN HEALTH OF CALIFORNIA.
>
> I authorize the holder of medical or other information to release the information needed or related to claims for services rendered to me by DUAL DIAGNOSIS TREATMENT CENTER, INC. dba SOVEREIGN HEALTH OF CALIFORNIA to any necessary government agency, including but not limited to the Social Security Administration; Health Care Financing Administration, and to any insurance payor or provider in regards to my claims.

[FAC, Ex. A (Form A Assignment).]

Conspicuously absent from the Form A Assignment is any language manifesting an intent to assign, convey, or otherwise transfer to Plaintiffs legal rights to the member's benefits – much less any ERISA causes of action. The absence of such language is fatal: "[i]t is essential to an assignment of a right that the obligee manifest an intention to transfer the right to another person [in a manner that is express and knowing]." *Tex. Life, Accident Health & Hosp. Serv. Ins. Guar. Ass'n v. Gaylord Entm't Co.*, 105 F.3d 210, 218 (5th Cir. 1997) (internal quotation marks omitted). The plain text of the Form A Assignment instead indicates that it is only a direct-payment authorization form, not an assignment of the patient's legal rights.

Other courts have properly held that direct-payment authorization forms do not confer standing upon providers to bring ERISA claims against payors. In *MHA, LLC v. Aetna Health*, No. Civ. A. 12-2984 (SRC), 2013 U.S. Dist. LEXIS 25743 (D.N.J. Feb. 25, 2013), another court held that virtually identical forms did not constitute an assignment. There, the form provided:

> I authorize payment directly to Meadowlands Hospital Medical Center 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 *13. It was thus "plain … that the quoted General Consent/Authorization language merely authorizes an insurer to make payments to MHA directly rather than through the patient as an intermediary." *Id.* at *14. The upshot was that "this authorization is precisely the kind" of document that is "insufficient to confer ERISA standing upon a provider," and so the court dismissed the provider's ERISA claims with prejudice. *Id.* at *15; *Brown*, 2015 U.S. Dist. LEXIS 74306, at *29 (similar); *Principal Mut. Life Ins. Co. v. Charter Barclay Hosp.*, 81 F.3d 53, 56 (7th Cir. 1996) (noting distinction between assignment and "mere[]… authorization for direct payment"); *Nat'l Med. Care v. United Health Care of Fla., Inc.*, No. 00-8160-Civ-Middlebrooks, 2001 U.S. Dist. LEXIS 26729, at *5-6 (awarding summary judgment to defendant-payor because plaintiff-provider failed to show that it possessed assignment).

The shortcomings of the Form A Assignment become clearer still when contrasted with what a real assignment looks like. *See, e.g., Care First Surgical Ctr. v. ILWU-PMA Welfare Plan*, No. CV 14-01480 MMM (AGRx), 2014 U.S. Dist. LEXIS 165744, at *39 (C.D. Cal. July 28, 2014) (internal quotations marks omitted) (emphasis added) (assignment conferred standing on plaintiff-provider to pursue ERISA claims; assignment stated, "I hereby *assign my right* to assert any and all causes of action for judicial review to [provider]… *My assignee may 'stand in my shoes',* [sic] as that phrase is understood under assignment law. I intend for my *personal standing under ERISA's disclosure and civil enforcement procedures* under 29 U.S.C. §§ 1024 and 1132 to be hereby *transferred to my assignee*, so that it may seek judicial review of denied claims and/or disclosure under 29 U.S.C. § 1132(a)(1)(B), 29 U.S.C. § 1132(a)(1)(A), and/or 29 C.F.R. 2560.503-1. This assignment specifically includes an *assignments of my rights to seek relief* as a claimant under 29 U.S.C. § 1132(c) and my rights to seek attorney fees under 29 U.S.C. § 1132(g)... The assignment of benefits and ERISA rights by me is complete: *I retain no interest in the benefits and/or rights due to me* under these claims for medical care and/or facility fees.").[6]

[6] The narrow scope of the Form A Assignment becomes even more apparent when

If a mere authorization for direct payment amounted to an assignment, plan participants unknowingly would be stripped of their statutory protections, contrary to ERISA's purposes. It is black-letter law that a valid assignment irrevocably transfers the whole of the interest or right assigned, extinguishing the assignor's interest: "if there is a valid assignment [of benefits to a healthcare provider], the [provider] becomes the only claimant because the original claimant gives up her claim by the assignment." *Hahnemann Univ. Hosp. v. All Shore, Inc.*, 514 F.3d 300, 308 n.5 (3d Cir. 2008). In other words, as a result of a valid assignment, the assignor loses all control over the subject matter of the assignment and all interest in the right-assigned. *Id.; see also Spinedex*, 770 F.3d at 1293 (holding that "[b]ecause [plan participants] assigned their right to seek payment from their Plans, they may not themselves seek payment of those claims"). This means, if a direct-payment authorization were held to constitute an assignment as broad in scope as Plaintiffs conclusory allege, then all plan participants or beneficiaries who sign authorizations like the Form A Assignment at issue here would have assigned away their entitlement to enforce any ERISA right, including prospective claims regarding the plan – even though the provider to whom the rights ostensibly were assigned might have no interest or personal stake in enforcing those rights. Consequently, "to allow a healthcare provider to assert ERISA claims outside the logical scope of an assignment from a subscriber would unknowingly deprive the subscriber of standing to assert those claims in the future." *Premier Health Ctr., P.C. v. UnitedHealth Grp.*, 292 F.R.D. 204, 219 (D.N.J. 2013). "Such a result would run contrary to the 'principal object of the ERISA statute which is to protect plan participants and beneficiaries,' such as spouses and dependents." *Id.* (alterations omitted).

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contrasted with the alleged Form B Assignment, which – unlike the Form A Assignment – seeks to "irrevocably assign, transfer and convey" the enumerated rights to Plaintiffs to the extent they relate to "the recovery of Benefits. [FAC, Ex. A (Form A Assignment); Ex. B (Form B Assignment).]

2. Plaintiffs' Form A And Form B Assignments Do Not Confer Derivative Standing On Plaintiffs To Bring ERISA Claims Seeking The Removal Of The Named Plan Fiduciaries Under 29 U.S.C. §§ 1132(a)(2) and 1109(a).

In Count 2, Plaintiffs seek "an order removing and dismissing the named fiduciaries" of the ERISA plans at issue and "permanently barring the Blue Cross Defendants from serving as fiduciaries for any of the Welfare Plan Defendants" under 29 U.S.C. §§ 1132(a)(2) and 1109(a). [FAC, ¶ 379.] Even assuming that the Form A Assignment allegedly obtained by Plaintiffs could be construed as assigning the patients' legal rights to benefits (which the actual text of the form forecloses), the Form A Assignment would not confer standing on Plaintiffs to assert ERISA claims that seek the removal of the plan fiduciaries or to seek an order permanently barring Defendants from serving as plan fiduciaries as a matter of law. [FAC, Ex. A (Form A Assignment).] Similarly, the Form B Assignment neither mentions, let alone assigns, the right to assert ERISA claims that seek the removal of the plan fiduciaries or an order permanently barring Defendants from serving as fiduciaries under 29 U.S.C. §§ 1132(a)(2) and 1109(a). As a matter of interpretation, the introductory paragraph of the Form B Assignment predicates the transfer of rights in each of the nine subparagraphs that follow as assigned to the extent they relate to "the recovery of Benefits." [*Id.*] The Form B Assignment reiterates this in the paragraph following the nine subparagraphs, which states that "the purpose of this Assignment of Benefits is to ensure that Provider is paid for services it has provided or will provide" and that the form "shall be construed in favor of assigning Provider all rights that will assist it in recovering Benefits." [*Id.*] Because claims that seek the removal of the plan fiduciaries involve remedies beyond the mere recovery of benefits, Plaintiffs' Second Count is not among the rights assigned by the Form B Assignment and should be dismissed.

As discussed above, the rights of health care providers under an assignment are limited to the language of the purported assignment and a court's task in analyzing the scope of an assignment is to "enforce the intent of the parties." *Klamath-Lake Pharm.*

Ass'n v. Klamath Med. Serv. Bureau, 701 F.2d 1276, 1283 (9th Cir. 1983); *Nat'l Reserve Co. of Am. v. Metro. Trust Co. of Cal.*, 17 Cal. 2d 827, 832 (1941) ("In determining what rights or interests pass under an assignment, the intention of the parties as manifested in the instrument is controlling."). "Assignment agreements are generally interpreted narrowly" and "the scope of an assignment cannot exceed the terms of the assignment agreement itself." *Sanctuary Surgical*, 546 F. App'x at 851-52 (citing *Tex. Life*, 105 F.3d at 218-19); *see also Rojas*, 793 F.3d at 258-59 (holding that health care providers have standing to assert claims under ERISA only if they are expressly assigned by their patients). The Ninth Circuit has reiterated that courts must look to the language of an ERISA assignment itself to determine the scope of the assigned claims. *See Eden Surgical Ctr. v. B. Braun Med., Inc.*, 420 F. App'x 696, 697 (9th Cir. 2011) (noting that the "question [was] whether the plan participants assigned Eden the right to sue for statutory penalties" and concluding that the language of the assignments did not encompass the right to bring claims under § 1132(c)). Under this standard, the Form A and Form B Assignments plainly do not confer standing to bring the type of ERISA claim asserted by Plaintiffs here.

Further, assignments that purport to convey standing to assert ERISA claims arising from an alleged breach of fiduciary duty are construed narrowly and are limited only to those rights that are expressly and knowingly assigned. *Sanctuary Surgical*, 546 F. App'x at 852 (holding that plaintiff's argument that an assignment of the rights to medical benefits confers standing to bring a breach of fiduciary duty claim under ERISA "stretches beyond its breaking point" because the assignment at issue "assigns only the right to receive benefits and not the right to assert claims for breach of fiduciary duty"); *Tex. Life*, 105 F.3d at 218 (holding that "only an express and knowing assignment of an ERISA fiduciary breach claim is valid" and noting that, "[b]ecause an assignment of a fiduciary duty breach claim affects all plan participants, and unsuccessful claims can waste plan resources ... these claims are not assigned by implication or by operation of law."); *Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 99 F. Supp. 3d

1110, 1130 (C.D. Cal. 2015) (holding than an assignment of "all rights and benefits under my contract with my INSURANCE COMPANY" does not manifest an intent to assign claims for breach of fiduciary duty under 29 U.S.C. § 1132(a)(2)); *In re WellPoint, Inc. Out-Of-Network "UCR" Rates Litig.*, 903 F. Supp. 2d 880, 892, 899 (C.D. Cal. 2012) (Gutierrez, J.) (holding that an assignment of benefits does not confer standing on a provider to bring a claim for breach of fiduciary duty under ERISA); *Via Christi Reg'l Med. Ctr., Inc. v. Blue Cross & Blue Shield of Kan., Inc.*, No. 04-1253-WEB, 2006 U.S. Dist. LEXIS 87194, at *19 (D. Kan. Nov. 30, 2006) (noting that the "scope of the assignment depends foremost upon the language of the agreement itself" and holding that hospital lacked standing to assert ERISA fiduciary breach claim because patient assigned only "medical benefits payable").

In *Spinedex*, the Ninth Circuit considered whether an assignment of the "RIGHTS AND BENEFITS" under an ERISA plan conferred standing on Spinedex, a health care provider, to bring a claim for breach of fiduciary duty against the claims administrator for the plans at issue. 770 F.3d at 1292. In response to Spinedex's argument that such an assignment encompasses all of the patient-assignor's "rights" under ERISA, including the right to bring a claim for breach of fiduciary duty, the Ninth Circuit held that "[i]t is essential to an assignment of a right that the [assignor] manifest an intention to transfer the right to another person." *Id*. (citing *Britton v. Co-Op Banking Grp.*, 4 F.3d 742, 746 (9th Cir. 1993) (internal quotation marks omitted)). The Ninth Circuit concluded that an assignment of the "RIGHTS AND BENEFITS" under an ERISA plan "nowhere indicates that, by executing the assignment, patients were assigning to Spinedex rights to bring claims for breach of fiduciary duty." *Id*. As a result, the Court ruled that "Spinedex has no right to bring claims for breach of fiduciary duty." *Id.* This reasoning applies with even greater force to Plaintiffs' claim under 29 U.S.C. §§ 1132(a)(2) and 1109(a), as the assignment forms alleged by Plaintiffs do not reference, let alone attempt to convey, the right to assert an ERISA claim *to remove the named ERISA plan fiduciaries* and the right to assert an ERISA claim that *seeks an order permanently barring Defendants from*

serving as fiduciaries. Plaintiffs therefore fail to allege any facts that could support a finding that the patient-assignors made an "express and knowing assignment" of these specific ERISA claims or that the plan members otherwise *intended* to assign those rights. *See Klamath-Lake Pharm. Ass'n*, 701 F.2d at 1283 (holding that the Court's task in interpreting the scope of an assignment is to "enforce the intent of the parties"); *Nat'l Reserve Co.*, 17 Cal. 2d at 832 (holding that the intention of the parties as manifested in the instrument is controlling); *see also* Restatement (Second) of Contracts § 324 (1981) ("It is essential to an assignment of a right that the obligee manifest an intention to transfer the right to another person without further action or manifestation of intention by the obligee."). Accordingly, Plaintiffs' claim under 29 U.S.C. §§ 1132(a)(2) and 1109(a) fails as a matter of law and should be dismissed with prejudice in its entirety.

3. The Form A Assignment Does Not Confer Derivative Standing On Plaintiffs To Bring An ERISA Claim For Equitable Relief Under 29 U.S.C. § 1132(a)(3).

Similarly, the Form A Assignment provides no indication that the Plaintiffs' patients intended to assign their rights to bring claims for equitable relief under 29 U.S.C. § 1132(a)(3). Thus, even if construed as an assignment (as opposed to a mere payment authorization), the terms of the Exhibit A Assignment Form do not convey the right to pursue equitable claims under ERISA. *See Sanctuary Surgical*, 546 F. App'x at 851-52 (rejecting a health care provider's claim that an assignment of the right to receive insurance benefits carries with it the ability to bring a claim under 29 U.S.C. § 1132(a)(3) and affirming the District Court's order dismissing plaintiff's 29 U.S.C. § 1132(a)(3) claim with prejudice under Rule 12(b)(6)); *Almont Ambulatory Surgery Ctr.*, 99 F. Supp. 3d at 1130 (holding than an assignment of "all rights and benefits under my contract with my INSURANCE COMPANY" does not manifest an intent to assign claims for equitable relief under 29 U.S.C. § 1132(a)(3)); *In re WellPoint*, 903 F. Supp. 2d at 895 (holding that an assignment that "expressly relate[s] to the right to receive benefits" does not confer standing on a provider to bring a claim under 29 U.S.C. § 1132(a)(3) and dismissing the claim under Rule 12(b)(6)).

By alleging that they assumed their patients' rights to assert equitable claims under ERISA, Plaintiffs are claiming that their patients have relinquished the right to subsequently assert such claims on their own behalf. *Spinedex*, 770 F.3d at 1293 (holding that "[b]ecause [plan participants] assigned their right to seek payment from their Plans, they may not themselves seek payment of those claims"); *Hahnemann*, 514 F.3d at 307 n.5 (citing *Principal Mut. Life Ins. Co. v. Charter Barclay Hosp., Inc.*, 81 F.3d 53, 55-56 (7th Cir. 1996)) ("[I]f there is a valid assignment the hospital becomes the only claimant, [because of] the original claimant having given up his claim by the assignment."). Plaintiffs' contention that they have standing to assert claims for declaratory and injunctive relief under ERISA based on the Form A Assignment runs contrary to the principal purpose of ERISA, which is to protect the rights of plan participants to the benefits they have been promised, not the rights of those who incidentally deal with an ERISA plan. *See Sharp Elecs. Corp. v. Metro. Life Ins. Co.*, 578 F.3d 505, 513-14 (7th Cir. 2009); *Clair v. Harris Trust & Sav. Bank*, 190 F.3d 495, 498 (7th Cir. 1999). This is especially true where, as here, a health care provider seeks to displace the plan participant's or beneficiary's right to bring a claim for equitable relief under 29 U.S.C. § 1132(a)(3), which is intended to be a "catchall" or "safety net" designed to offer appropriate equitable protection for violations not adequately remedied under other ERISA provisions. *Wise v. Verizon Commc'ns, Inc.*, 600 F.3d 1180, 1190 (9th Cir. 2010). If the Form A Assignment were considered to confer standing on health care providers to bring claims for equitable relief under 29 U.S.C. § 1132(a)(3), it would deprive the patient-assignor of a full array of equitable protections and place a provider's interest above that of the member. Such a result would be inconsistent both with the terms of the Form A Assignment alleged by Plaintiffs and with ERISA's central purpose of protecting plan participants and beneficiaries. Accordingly, Plaintiffs' third claim for relief should be dismissed with prejudice where it is premised on the Form A Assignment.

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B. Plaintiffs' Claims Must Be Dismissed Where The Applicable Plans Prohibit Assignments.

A substantial number of the underlying claims alleged in the FAC are barred by anti-assignment clauses contained in the ERISA plans (the Anti-Assignment Plans). [*See* Addendum of Anti-Assignment Plans and Relevant Anti-Assignment Provisions.[7]] The Anti-Assignment Plans expressly prohibit a plan participant or beneficiary from assigning plan benefits, and thus bar any attempt by Plaintiffs to sue on the basis of such assignments.

1. Well-Established Ninth Circuit Authority And Other Federal Court Decisions Have Unequivocally Upheld Anti-Assignment Clauses In ERISA-Governed Plans.

Under controlling Ninth Circuit precedent, anti-assignment clauses in ERISA plans are valid and enforceable. *Davidowitz v. Delta Dental Plan of Cal., Inc.*, 946 F.2d 1476, 1481 (9th Cir. 1991) (granting motion to dismiss providers' ERISA claims on the grounds that the plan's "non-assignment clause is legal"); *Spinedex*, 770 F.3d at 1296 (affirming summary judgment against provider's claims because "an anti-assignment provision in the [plan] prevented [the provider's] patients from assigning claims under that [p]lan."); *Long Beach Mem'l Med. Ctr. v. Cal. Mart Emp. Benefit Plan*, 1999 U.S. App. LEXIS 3346, at *2 (9th Cir. Feb. 22, 1999) ("Because this court has held that non-assignment clauses are valid under ERISA, the district court did not err by concluding that Medical Center failed to state a claim because it lacked standing."); *Eden Surgical Ctr.*, 420 F. App'x at 697 (same).[8] Indeed, courts in many other jurisdictions similarly

[7] Defendants contend that all plans with anti-assignment clauses should benefit from the enforcement of those clauses. Defendants reserve their rights under the applicable plan terms. Thus, to the extent that any plan is inadvertently not included in the list noted above, Defendants still reserve their rights of enforcement as to any anti-assignment provision related to their plans.

[8] *See also Quaresma v. BC Life & Health Ins. Co.*, 623 F. Supp. 2d 1110, 1128-29 (E.D. Cal. 2007) (dismissing for lack of standing healthcare provider's causes of action based on assignment because health care plan prohibited assignment of benefits); *Aviation W. Charters, Inc. v. United Healthcare Ins. Co.*, No. CV-14-00338-PHX-NVW, 2014 U.S. Dist. LEXIS 158859, at *6 (D. Ariz. Nov. 10, 2014) (because of plan's anti-assignment provision, "[a]ny purported assignment without consent is invalid for purposes of giving Plaintiff a federal cause of action under ERISA").

have held that anti-assignment clauses in ERISA plans are valid and enforceable. *See, e.g., Griffin v. Health Sys. Mgmt.*, No. 15-12138, 2015 U.S. App. LEXIS 22780, at *7-9 (11th Cir. Dec. 29, 2015); *LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores, Inc.*, 298 F.3d 348, 352 (5th Cir. 2002); *City of Hope Nat'l Med. Ctr. v. Healthplus, Inc.*, 156 F.3d 223, 229 (1st Cir. 1998); *St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield*, 49 F.3d 1460, 1464 (10th Cir. 1995); *Morlan v. Universal Guar. Life Ins. Co.*, 298 F.3d 609, 615 (7th Cir. 2002); *Physicians Multispecialty Grp. v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1295 (11th Cir. 2004); *Renfrew Ctr. v. Blue Cross & Blue Shield of Cent. N.Y., Inc.*, No. 94-CV-1527(RSP/GJD), 1997 U.S. Dist. LEXIS 5088, at *3 (N.D.N.Y. Apr. 10, 1997).

Because the Anti-Assignment Plans prohibit assignments and such clauses are valid and enforceable in ERISA plans, any purported assignment of benefits under these plans – irrespective of whether it is based on the Form A or Form B Assignment – is void *ab initio*. As an apparent afterthought, the FAC alleges that anti-assignment provisions are not enforceable under unspecified state insurance laws. [*See* FAC, ¶ 373.] This allegation, however, does not assist plaintiffs. State insurance laws do not regulate those Anti-Assignment Plans for which benefits are paid directly out of employer funds (so-called "self-funded" plans) because no insurance is involved at all. Moreover, to the extent Plaintiffs seek to apply these state laws to self-funded plans (the FAC does not so allege), those laws fall within ERISA's express preemption clause and cannot be "saved" from preemption as an insurance regulation because self-funded plans, like the ones at issue here, cannot be deemed to be insurers. *See FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990); *Med. Mut. of Ohio v. DeSoto*, 245 F.3d 561, 574 (6th Cir. 2001). There is no relevant state law that "is not preempted by ERISA" that could "bar" enforcement of anti-assignment provisions in self-funded plans.

Further, cases upholding anti-assignment clauses apply with equal force to fully insured plans as they do to self-funded plans. Plaintiffs do not even identify any states alleged to have laws that prohibit the use of anti-assignment clauses in health care plans.

Many states have expressly held that anti-assignment clauses are enforceable. *See, e.g.*, *Kohl v. Blue Cross & Blue Shield of Fla., Inc.*, 955 So. 2d 1140, 1144-1145 (Fla. Dist. Ct. App. 2007) (holding that an anti-assignment clause in a health insurance policy is valid and enforceable); *Obstetricians-Gynecologists, P.C. v. Blue Cross & Blue Shield of Neb.*, 361 N.W.2d 550, 556 (Neb. 1985) (upholding validity of nonassignment provision in health care contracts, noting that a "nonassignment clause is a valuable tool in persuading health care providers to participate in its physician's voluntary cost effectiveness program and accept set fees for health services, keeping health care costs down and passing that savings on to its subscribers"). Thus, Plaintiffs lack ERISA standing to pursue any claim for benefits under the Anti-Assignment Plans.

As set forth above, if Plaintiffs are to have any standing to pursue a claim for ERISA benefits, it can only be through the receipt of a valid assignment of benefits that is broad enough to encompass the claims asserted by Plaintiffs. [*See* Part IV.A.] However, each of the anti-assignment clauses contained in the Anti-Assignment Plans is valid and enforceable and nullifies each such purported assignment. Consequently, Plaintiffs cannot maintain an action to recover benefits allegedly due under any of the Anti-Assignment Plans. *Griffin*, 2015 U.S. App. LEXIS 22780, at *7-9, 12-13 (holding that anti-assignment provision in benefit plan "void[s]" assignment of benefits obtained by health care provider and affirming the dismissal of health care provider's claims under ERISA with prejudice); *Physicians Multispecialty Grp.*, 371 F.3d at 1296 (provider lacked standing to maintain ERISA action by virtue of a valid anti-assignment provision in the plan); *Quaresma*, 623 F. Supp. 2d at 1128-29 (dismissing a claim for benefits, in part, based on lack of standing); *Cohen v. Independence Blue Cross*, 820 F. Supp. 2d 594, 605-06 (D.N.J. 2011) (dismissing physician's ERISA claim for lack of standing because health plan included a non-assignment provision).

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2. Plaintiffs Have Failed To Allege Facts Demonstrating That Defendants Waived Their Right To Enforce The Anti-Assignment Provisions.

In apparent anticipation of a standing challenge based on the anti-assignment clauses, Plaintiffs allege that Defendants waived any right to enforce anti-assignment clauses in any plan at issue by failing to notify Plaintiffs of the clauses and assert the clauses as a basis not to pay Plaintiffs directly. [FAC, ¶ 373.] However, these allegations are insufficient to overcome the dispositive impact of the anti-assignment clauses upon their ERISA claims. "'Waiver' is the intentional relinquishment of a known right." *Alocozy v. U.S. Citizenship & Immig. Servs.*, 704 F.3d 795, 797 (9th Cir. 2012); *see also Griffin*, 2015 U.S. App. LEXIS 22780, at *11-12 (holding that "[w]aiver is the voluntary, intentional relinquishment of a known right") (citing *Witt v. Metro. Life Ins. Co.*, 772 F.3d 1269, 1279 (11th Cir. 2014). Here, the FAC is devoid of any allegation that any Defendant intentionally relinquished a known right, and thus, the waiver allegations are deficient. Indeed, waiver allegations similar to those alleged in the FAC have been held to be insufficient as a matter of law.

In *Almont Ambulatory Surgery Center,* several health care providers argued that defendants waived their right to rely on the plans' anti-assignment provisions because such provisions were not asserted by defendants during the claims administration process as a reason to deny benefits or otherwise. *See* 99 F. Supp. 3d at 1140. The court disagreed. Because the plans in question allowed providers to act as the patients' authorized representatives when submitting claims or appeals, defendants could have understood that providers were proceeding in their capacity as the patients' authorized representatives, rather than assignees of their patients' plan benefits. Thus, defendants' failure to raise the anti-assignment clauses during the administrative claims process, as alleged in the complaint, did not rise to the level of an intentional relinquishment of any known rights pertaining to the anti-assignment clauses. *Id.* at 1143-1147. As a result, to the extent plaintiffs' claims arose under plans with anti-assignment clauses, such claims were dismissed because the proffered assignments could not confer standing on the

providers to bring ERISA claims. *Id.* at 1147; *see also Spinedex*, 770 F.3d at 1296 (holding insurer did not waive anti-assignment clause by failing to raise it in the administrative claims process).

In *Griffin*, the Eleventh Circuit recently reached the same conclusion. *Griffin*, 2015 U.S. App. LEXIS 22780, at *3-5, 11-12. The provider in that case alleged that she submitted two claims to the defendant for services that she provided to defendant's member/insured. *Id*. at *3-4. After the claims were denied, the provider filed separate level one administrative appeals for both claims with the defendant based on the allegation that the claims were underpaid and "demanded that [the defendant] notify her whether the Plan contained an anti-assignment clause, warning that if it failed to do so, she would argue in litigation that the anti-assignment clause was unenforceable." *Id*. at *4. Following defendant's denial of both first level appeals, the provider filed a level two administrative appeal for each claim. *Id*. The defendant denied one of the appeals and did not respond to the other, nor did the defendant disclose that the plan had an anti-assignment provision. *Id*. Based on these allegations, the provider contended that the defendant waived its ability to rely on the anti-assignment provision in the plan because the defendant "failed to disclose the anti-assignment term." *Id*. at *10-11. The Eleventh Circuit rejected the provider's argument, holding that the defendant could assert defenses based on the anti-assignment provision in the lawsuit because the defendant's conduct did not amount to the intentional and voluntary relinquishment of its rights under the anti-assignment provision. *Id*. at *12. Because the provider's 29 U.S.C. § 1132(a) claim was premised on an assignment of benefits, the Eleventh Circuit affirmed the dismissal of the provider's ERISA claim with prejudice. *Id*. at *12-13.

Plaintiffs' waiver allegations are similar to those held to be insufficient in *Almont Surgery Center* and *Griffin* and are thus equally deficient. Moreover, Plaintiffs' waiver argument is based on a contrived "duty to notify" that does not exist. A payor cannot be required to inform providers that their claimed assignments are not valid under the applicable plans because the existence of an anti-assignment clause in a plan means that

the payor owes procedural duties only to plan members. Plaintiffs' allegation that paying a patient directly where a plan bars assignments nevertheless somehow constitutes an "adverse benefit determination" to the provider ignores the legal force and effect of the anti-assignment clause, and, if accepted, would expand the Anti-Assignment Plans' procedural obligations in precisely the way the anti-assignment clauses were intended to foreclose. [FAC, ¶ 84.] Where assignments are not permitted, the provider has no rights under the ERISA plan at all; the plan is not required to render any notice to the provider because the provider is not a beneficiary. *See, e.g., Riverview Health Inst., LLC v. Med. Mut. of Ohio*, 601 F.3d 505, 521-22 (6th Cir. 2010). Consequently, the Anti-Assignment Plan Defendants are entitled to enforce the anti-assignment clauses, and Plaintiffs' claims against these parties are thus foreclosed.

Because each of the Anti-Assignment Plans contains a valid and enforceable clause precluding assignments to providers like Plaintiffs, the forms that Plaintiffs allege they obtained from their patients are null and void. Consequently, irrespective of the many other defects in Plaintiffs' FAC, Plaintiffs' cannot maintain this ERISA action against the Anti-Assignment Plan Defendants, and their claims should be dismissed with prejudice.

C. Each Of Plaintiffs' Claims Must Be Dismissed Because Plaintiffs Do Not Allege That They Gave Sufficient Notice Of The Terms Of The Purported Assignments To Defendants.

Even if Plaintiffs had obtained valid assignments of their patients' benefits under plans that do not contain anti-assignment provisions, Plaintiffs' claims would nevertheless fail as matter of law because Plaintiffs did not provide sufficient notice of the alleged assignments' scope. Thus, Defendants were not required to pay Plaintiffs rather than Defendants' members.

Each claim asserted by Plaintiffs is predicated on the assertion that they provided "notice" to Defendants that Plaintiffs' patients assigned their legal rights to plan benefits to Plaintiffs. In support of this assertion, Plaintiffs allege that the claim form they use to submit claims for reimbursement to Defendants "includes a field […] in which the provider indicates whether it has received an assignment of health care benefits from the

patient" and that each of the claim forms that were submitted to Defendants indicated that Plaintiffs "received an assignment of health care benefits" from their patients. [FAC, ¶¶ 69-70.] Critically, however, Plaintiffs' FAC does not allege that Plaintiffs ever furnished Defendants with a copy of the executed "assignment," or otherwise presented information to Defendants identifying which rights, if any, were purportedly assigned to Plaintiffs. Indeed, Plaintiffs candidly acknowledge that the only indication they provided to Defendants that a patient assigned benefits was by indicating "Y" or "N" in "field 53," labeled "ASG BEN" on the claim forms. [FAC, ¶ 69; *see id.* ¶ 70.] Plaintiffs do not allege that they provided Defendants with any documentation supporting their assertion that these "assignments" were actually made or otherwise describe the basis for or terms of the purported "assignments." Thus, the checked boxes on the claim forms are the sole basis on which they assert that the "Blue Cross Defendants [were] informed of [*sic*] and on written notice that [Plaintiffs were] assignee[s]." [FAC, ¶ 72.] This slender reed collapses under the weight Plaintiffs put on it – particularly given the fact that different "assignment" forms were apparently used by Plaintiffs.

To enforce an assignment, California law "requires that the evidence of assignment be clear and positive to protect an obligor [here, a payor] from any further claim by the primary obligee [here, the member]." *Cockerell v. Title Ins. & Trust Co.*, 42 Cal. 2d 284, 292 (1954); *see also Superior Energy Servs., LLC v. Cabinda Gulf Oil Co.*, No. C 13-2056 PJH, 2013 U.S. Dist. LEXIS 172878, at *18-23 (N.D. Cal. Dec. 6, 2013) (insufficient evidence of assignment). A provider's action of merely checking the "assignment" box on a claim form neither provides evidence nor puts a payor on notice of a valid assignment or its terms, and, thus, cannot require a payor to pay benefits directly to the provider. Instead, the provider must provide the signed assignment form to the payor in order to impose a duty on the obligor to render performance to it. Merely 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. It does not allow a payor to determine whether the language of the form truly effects a transfer of the

patient's legal rights under the applicable plan.

This is of particular significance in the health care context, as cases are legion in which courts have found so-called "assignments" to be nothing of the sort because their language simply *authorizes* the insurer to pay benefits directly to the provider on the member's behalf. [*See* Part IV.A.1.] A checked box provides no notice of the nature of the alleged "assignment" and fails to inform the reader that what Plaintiffs call assignments are really mere authorizations of direct payment. While a payment authorization *allows* a payor to render payment to the provider, it does not mandate it. Instead, the payor's payment obligation is discharged when it renders payment to either the provider or its members.

Merely checking the "assignment" box on a claim form does not shift a payor's performance obligation because doing so would subject payors to inconsistent and duplicative demands from purported assignees and assignors. 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 to the provider. This is untenable, in no small part because the provider is the entity that has within its possession all evidence of the purported assignment. Moreover, it places the provider's interests above that of the member – a result anathema to ERISA's purpose. *See Brown*, 2015 U.S. Dist. LEXIS 74306, at *17 n.6 (reasoning that permitting a provider to pursue ERISA claims on the basis of ambiguous assignments allows the provider to elect whether to hold the form out as an authorization of direct payment or, where it believes the patient will not pay, to divest the member of his or her ERISA rights by asserting the forms as assignments). That is why, as the California Supreme Court explained in *Cockerell*, "[i]n an action by an assignee to enforce an assigned right,… the measure of sufficiency requires that the evidence of assignment be clear and positive *to protect an obligor from any further claim by the primary obligee*." 42 Cal. 2d at 292 (emphasis added).

Plaintiffs' alleged representation on their claim forms that they had obtained some form of assignment or authorization from their patients was insufficient to establish "clear[ly] and positive[ly]" that their patients' plan rights had been transferred. This is particularly true given the significantly different "assignment" forms Plaintiffs admit are involved in this action.[9] Thus, the FAC fails to allege any facts that can conceivably support Plaintiffs' claims for alleged violations of ERISA, and each claim fails as a matter of law on this separate ground as well.

D. The Terms Of The Form B Assignment Are Unconscionable And, Therefore, Unenforceable.

In the context of this lawsuit, the terms of Plaintiffs' Form B Assignment are unenforceable as a matter of law because they are unconscionable. *See Nagrampa v. MailCoups, Inc.*, 469 F.3d 1257, 1280 (9th Cir. 2006) ("It is well-established that unconscionability is a generally applicable contract defense…"). California Civil Code section 1670.5 provides:

> If the court as a matter of law finds the contract or any clause of the contract to have been unconscionable at the time it was made the court may refuse to enforce the contract, or it may enforce the remainder of the contract without the unconscionable clause, or it may so limit the application of any unconscionable clause as to avoid any unconscionable result.

Cal. Civ. Code § 1670.5(a). "[U]nconscionability has both a procedural and a substantive element, the former focusing on oppression or surprise due to unequal bargaining power, the latter on overly harsh or one-sided results." *Armendariz v. Found Health Psychcare Servs., Inc.*, 24 Cal. 4th 83, 114 (2000) (internal quotation marks omitted). However, the more procedurally unconscionable a contract term is, the less evidence of substantive

[9] The lack of notice afforded to Defendants is compounded in instances where the patient claims at issue were not submitted by any of the Plaintiffs in this action. For many of the underlying patient claims, the services were apparently rendered and billed by Medical Concierge, Inc. ("Medlink"), a third-party identified in the FAC as an entity that is "licensed to operate and maintain an adult residential facility ("ARF") for ambulatory mentally ill adults [FAC, ¶ 17], under Medlink's federally-issued National Provider Identifier. [*See, e.g.*, Declaration of Greg Armknecht ("Armknecht Decl."), ¶¶ 8, 10-13, 18, 22, 25.] For such claims, Plaintiffs have not (and, indeed, cannot) plausibly state a claim for relief based on the contention that payment should have been rendered to Plaintiffs under an assignment of benefits when Plaintiffs were not identified as either the rendering or billing health care provider to Defendants in the first instance.

unconscionability is required to conclude the contract term is unenforceable, and vice-versa. *Id*.

This Form B Assignment is procedurally unconscionable because it is a contract of adhesion signed by Plaintiffs' patients, often in a vulnerable state, who lack meaningful bargaining power. "Under California law, [a] contract of adhesion is defined as a standardized contract, imposed upon the subscribing party without an opportunity to negotiate the terms." *Shroyer v. New Cingular Wireless Servs., Inc.*, 498 F.3d 976, 983 (9th Cir. 2007) (internal quotation marks omitted). "The California Court of Appeal has held that [a] finding of a contract of adhesion is essentially a finding of procedural unconscionability." *Nagrampa v. MailCoups, Inc.*, 469 F.3d 1257, 1281 (9th Cir. 2006) (internal quotation marks omitted). Here, Plaintiffs cannot dispute that the Form B Assignment is, contractually speaking, adhesive. First, Plaintiffs recognize that the Form B Assignment is just that, a form. [*See* FAC, ¶ 53.] Second, Plaintiffs allege that they "obtained" an assignment of benefits "from **all patients** before treating them." [FAC, ¶ 51 (emphasis added)]. Thus, patients seeking treatment from Plaintiffs must either sign an assignment form, or forego Plaintiffs' services. Such "take it or leave it" terms signal "quintessential procedural unconscionability." *Aral v. Earthlink, Inc.*, 134 Cal. App. 4th 544, 557 (2005). What makes the Form B Assignment all the more adhesive is that the patients must accept the Form's terms "before treatment" when they are suffering from addiction and mental health issues. [FAC, ¶ 51.] Accordingly, under the circumstances alleged in the FAC, the Form B Assignment is so procedurally unconscionable that it cannot be enforced as a matter of law.

Even if the Form B Assignment were not sufficiently procedurally unconscionable to render it unenforceable, the terms of the Form B Assignment are also substantively unconscionable. A contract is substantively unconscionable when it is unjustifiably one-sided to such an extent that it "shocks the conscience." *Chavarria v. Ralphs Grocery Co.*, 733 F.3d 916, 923 (9th Cir. 2013). "A determination of substantive unconscionability involves whether the terms of the contract are unduly harsh or

oppressive." *Grabowski v. C.H. Robinson Co.*, 817 F. Supp. 2d 1159, 1173 (S.D. Cal. 2011) (internal quotation marks omitted). The Form B Assignment is unduly harsh and oppressive because it purports to irrevocably convey a substantial portion of the patients' rights under their health benefit plans to Plaintiffs without any meaningful limitation – including their rights to assert ERISA claims that fundamentally restructure their plan benefits and plan terms. [FAC, Ex. B (Form B Assignment).] Thus, Plaintiffs' patients would have essentially ***no*** recourse under their plans in connection with Plaintiffs' services, including the right to recover benefits and the right to seek equitable relief, which unreasonably and unexpectedly elevates the rights of Plaintiffs over that of the plan members. *See Altman v. PNC Mortg.*, 850 F. Supp. 2d 1057, 1081 (E.D. Cal. 2012) (quoting citation omitted) ("The substantive element turns on allocation of risks between the parties, and therefore that a contractual term is substantively suspect if it reallocates the risks of the bargain in an objectively unreasonable or unexpected manner to constitute a one-sided result without justification for it.") This lack of available remedies is particularly troubling given that the Form B assignment does not mention – let alone constitute – a waiver of Plaintiffs' patients' obligation to pay the provider for the services. The Form B Assignment's allocation of substantially all of the plan member's rights and benefits to the providers under circumstances in which the provider may still hold the plan member liable for payment is substantively unconscionable and contrary to the purpose of ERISA. As a result, the Form B Assignment is unenforceable and each claim predicated on the Form B Assignment necessarily fails as a matter of law.

E. Plaintiffs' ERISA Claims Suffer From Other Defects.

1. Plaintiffs Fail To Allege Cognizable Procedural Violations Under ERISA.

In addition to claiming that Defendants made benefit payments to Plaintiffs' patients that belonged to Plaintiffs directly, Plaintiffs complain that Defendants' alleged conduct constituted an "adverse benefit determination" under the Department of Labor's ("DOL's") Claims Procedure Regulation, 29 C.F.R. § 2560.503-1, *et seq*. [FAC, ¶ 82.]

This contention goes nowhere.

ERISA Claims Procedure Regulation applies only where there is an adverse benefit determination as to the ERISA plan participant or beneficiary. 29 C.F.R. § 2560.503-1(a) (providing 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)"). As set forth above, Plaintiffs are not beneficiaries within the meaning of ERISA as a matter of law. [*See* Part IV.A.] Accordingly, the inquiry becomes whether Defendants' alleged conduct constitutes an adverse benefit determination as to Plaintiffs' patients, who are alleged to be ERISA plan participants or beneficiaries. Yet, the FAC concedes that Defendants did, in fact, pay the applicable benefit for the claims at issue by mailing the payment directly to the ERISA plan participants and beneficiaries. [*See* FAC, ¶ 72.] Thus, both under ERISA's Claims Procedure Regulation and as a matter of common sense, there was no "adverse benefit determination." It is undisputed that Defendants allowed and paid the applicable benefit on the claim to the only parties with a legal entitlement to same – the ERISA plan participants or beneficiaries. *See* 29 C.F.R. § 2560.503-1(m)(4). Accordingly, each claim alleged by Plaintiffs in their FAC fails as a matter of law and should be dismissed with prejudice.

Even assuming that there was an "adverse benefit determination" as to Plaintiffs' patients (which is not the case), Plaintiffs would not be entitled to any of the notice and appeal rights under ERISA's Claims Procedure Regulation and would not have the ability to pursue a claim based on any alleged failure by Defendants to afford Plaintiffs notice and appeal rights. [*See* FAC, ¶¶ 80-86.] Under the DOL's interpretation of its own regulation, "[a]n assignment of benefits by a claimant is generally limited to assignment of the claimant's right to receive a benefit payment under the terms of the plan [and typically] are not a grant of authority to act on a claimant's behalf in pursuing and appealing a benefit determination under a plan." *See* FAQs About The Benefit Claims Procedure Regulation at B-2, http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html

(last visited Jan. 22, 2015). In other words, health care providers, such as Plaintiffs, are not entitled to receive notice or a right to an administrative appeal under the Claims Procedure Regulation in instances where the providers obtain mere assignments of benefits. *Id.*; *see also id* at B-3 (confirming that an individual or entity is an "authorized representative" for purposes of ERISA's Claims Procedure Regulation only where "a claimant clearly designates an authorized representative to act and receive notices on his or her behalf with respect to a claim"). The Supreme Court and the Ninth Circuit instruct that an agency's interpretation of its own regulations is "'controlling unless' plainly erroneous or inconsistent with the regulation." *Resisting Envt'l Destruction on Indigenous Lands v. U.S. Envt'l Prot. Agency*, 716 F.3d 1155, 1165 (9th Cir. 2013) (quoting *Auer v. Robbins*, 519 U.S. 452, 461 (1997)). The DOL's interpretation at issue here is a written document discussing ambiguities in the agency's own ERISA regulation and is entitled to deference. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833-34 (2003) (holding that "[d]eference is due" to the Department of Labor Claims Procedure Regulation Frequently Asked Questions website). Thus, to the extent that Plaintiffs' claims are predicated on any allegation that Plaintiffs were due notice and appeal rights under ERISA's Claims Procedure Regulation, any such claim fails as a matter of law. *Grasso Enters., LLC v. Express Scripts, Inc.*, No. 15-1578, 2016 U.S. App. LEXIS 346, at *14 (8th Cir. Jan. 11, 2016) (holding that health care providers are not beneficiaries as ERISA uses that term and are thus "not entitled to the procedures established by § 1133 and the [Claims Regulation]"); *Pa. Chiropractic Ass'n v. Indep. Hosp. Indem. Plan, Inc.*, 802 F.3d 926, 928 (7th Cir. 2015) (same).

Second, Plaintiffs' claims each fail as a matter of law on the independent ground that the rights that a health care provider can assert under ERISA based on an assignment can never exceed the rights belonging to the ERISA plan participant or beneficiary. *Spinedex*, 770 F.3d at 1289; *Misic*, 789 F.2d at 1377-79. When, as the FAC admits, the Defendants in the action paid the ERISA plan participants and beneficiaries for the services at issue, those payments extinguished any claim for benefits that could be

asserted by Plaintiffs' patients. *See Filler v. Anthem Blue Cross*, No. CV 12-8960-CAS (JEMx), 2012 U.S. Dist. LEXIS 182356, at *25 (C.D. Cal. Dec. 17, 2012) (Snyder, J.) (holding that "because plaintiffs do not dispute that all of the benefits owed pursuant to the ERISA plan at issue have already been paid in full, plaintiffs will clearly be unable to state a cognizable claim for ERISA benefits under section 502(a)"); *see also Silk v. Metro. Life Ins. Co.*, 310 F. App'x 138, 139-40 (9th Cir. 2009) (finding that a claim for benefits became moot after the defendant paid the benefits); *Providence Health Plan v. McDowell*, 361 F.3d 1243, 1248 (9th Cir. 2004) (holding that a claim for unpaid benefits under ERISA does not "relate to" the terms of an ERISA plan where the ERISA benefits have already been paid); *Lemons v. Reliance Standard Life Ins. Co.*, 534 F. App'x 162 (3d Cir. 2013) (claim that benefits were arbitrarily terminated rendered moot when benefits were reinstated after lawsuit was filed); *Pakovich v. Verizon, Ltd. Plan*, 653 F.3d 488, 492 (7th Cir. 2011) (holding that an ERISA benefit claim is moot after the payment of ERISA benefits). Because the rights of Plaintiffs to assert claims under ERISA are derivative of the rights of Plaintiffs' patients and are necessarily limited by the terms of the acknowledgement forms they received from their patients, the payment to Plaintiffs' patients extinguished any claim to recover benefits against Defendants.

2. Plaintiffs' Second Count For Breach Of Fiduciary Duty Under 29 U.S.C. § 1132(a)(2) Fails As A Matter Of Law As To The ERISA Plan Defendants.

A claim arising from the alleged breach of fiduciary duty is necessarily derivative in that it is brought on behalf of the ERISA plan. *See Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985). As it relates to the ERISA plan Defendants, Plaintiffs seek to sue the very plans on whose behalf they supposedly seek relief for breach of fiduciary duty. This is illogical, and the ERISA plan Defendants are therefore entitled to dismissal with prejudice. *See, e.g., Kling v. Fid. Mgmt. Trust Co.*, 323 F. Supp. 2d 132, 147 (D. Mass. 2004) (holding that a suit under 29 U.S.C. § 1132(a)(2) is necessarily on behalf of the plan and thus the plan cannot be a defendant to such suit); *Steinman v. Hicks*, 252 F. Supp. 2d 746, 756 (C.D. Ill. 2003) (plan was "entitled to a summary judgment because it

cannot be named as a defendant in a suit in which it must be considered to be the plaintiff"). Thus, Plaintiffs' claim to remove the allegedly breaching plan fiduciaries fails as a matter of law and should be dismissed with prejudice.

3. Plaintiffs' Third Count For Equitable Relief Under 29 U.S.C. § 1132(a)(3) Fails Because It Seeks Relief That Is Not Appropriate Under ERISA.

As to Plaintiffs' claim under 29 U.S.C. § 1132(a)(3), the Supreme Court has held that equitable relief under 29 U.S.C. § 1132(a)(3) is only "appropriate" where Congress did not provide adequate relief elsewhere in the statute. *Varity Corp. v. Howe*, 516 U.S. 489, 515 (1996). Thus, the Ninth Circuit has denied plaintiffs relief under 29 U.S.C. § 1132(a)(3) "where another section of ERISA already provided them with an adequate remedy." *Bowles v. Reade*, 198 F.3d 752, 760 (9th Cir. 1999). Significantly, a plaintiff need not have already received relief under another section of ERISA to be precluded from seeking relief under 29 U.S.C. § 1132(a)(3). Instead, where relief is available elsewhere in ERISA, relief under 29 U.S.C. § 1132(a)(3) is not "appropriate" and is thus barred. *See Bowles*, 198 F.3d at 760; *Mondry v. Am. Family Mut. Ins. Co.*, 557 F.3d 781, 805 (7th Cir. 2009); *Wise v. Verizon Commc'ns, Inc.*, 600 F.3d 1180, 1190 (9th Cir. 2010). Here, 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). Therefore, ERISA's "catchall" provision is not available as a source of relief. *Wise*, 600 F.3d at 1190; *Rochow v. Life Ins. Co. of N. Am.*, 780 F.3d 364, 372 (6th Cir. 2015) (holding that relief under 29 U.S.C. § 1132(a)(3) is not available "irrespective of the degree of success obtained on a claim for recovery of benefits under § 502(a)(1)(B)" unless the claimant has alleged "an *injury* separate and distinct from the denial of benefits or where the remedy afforded by Congress under §502(a)(1)(B) is otherwise shown to be inadequate"); *Sleep Lab at W. Houston v. Tex. Children's Hosp.*, No. Civ. A. H-15-0151, 2015 U.S. Dist. LEXIS 70889, at *28 (S.D. Tex. June 2, 2015) (holding that "claims for money damages under § 1132(a)(1)(B) arising from wrongful denial of benefits cannot coexist with claims for

equitable relief under § 1132(a)(3).").

F. Plaintiffs' Fourth Count For Alleged Violations Of Business And Professions Code § 17200 Fails As A Matter Of Law.

Plaintiffs' Fourth Count for alleged violations of California's Business and Professions Code § 17200 fails as a matter of law for two principal reasons. First, because Plaintiffs' claim under Section 17200 is based on the same alleged "unlawful and unfair business practices" that form the basis of Plaintiffs' claims under ERISA, Plaintiffs' Section 17200 claim fails for each of the reasons set forth above. [*See* FAC, ¶ 389 ("By virtue of the misconduct complained of above, the Blue Cross Defendants have engaged in unlawful and unfair business practices…").]

Second, Plaintiffs fail to state a Section 17200 because the conduct alleged by Plaintiffs is neither unlawful, nor unfair, within the meaning of the statute and therefore does not fall under the prohibitions of Section 17200. As to the unlawful prong, a plaintiff must show that the defendant's business practice violated a "borrowed" law. *Davis v. HSBC Bank*, 691 F.3d 1152, 1168 (9th Cir. 2012) ("To be 'unlawful' under the UCL, the advertisements must violate another 'borrowed' law.") (citing *Cel-Tech Commc'ns., Inc. v. L.A. Cellular Tel. Co.*, 20 Cal. 4th 163, 180 (1999) ("[S]ection 17200 'borrows' violations of other laws and treats them as unlawful practices that the unfair competition law makes independently actionable.")); *Khan v. CitiMortgage, Inc.*, 975 F. Supp. 2d 1127, 1145 (E.D. Cal. 2013) ("Where a plaintiff cannot state a claim under the 'borrowed' law, she cannot state a UCL claim either.") Because the FAC fails to allege a violation of any "borrowed" law, Plaintiffs' Fourth Count does not satisfy the "unlawful" prong of Section 17200. With respect to the unfair prong, a plaintiff must demonstrate that the "conduct [] threatens an incipient violation of an antitrust law, or violates the policy or spirit of one of those laws because its effects are comparable to or the same as a violation of the law, or otherwise significantly threatens or harms competition." *Id.* (quoting *Cel-Tech*, 20 Cal.4th at 187). As applied here, the FAC fails to allege any conduct that relates to – let alone constitutes – a violation of any antitrust law or which

threatens or harms competition. As a result, Plaintiffs fail to state a claim for relief under either the unlawful or unfair prongs of Section 17200.[10]

Third, in spite of Plaintiffs' assertion that they are bringing a claim under Section 17200 "in their own right, and not based on the assignment of benefits they received from the Former Patients," the crux of Plaintiffs' Section 17200 claim (as well as the entire FAC) is that Defendants unlawfully paid ERISA plan benefits to Plaintiffs' patients, rather than Plaintiffs directly, pursuant to an alleged assignment of benefits. [FAC, ¶ 3.] Thus, Plaintiffs' Section 17200 claim necessarily relates to the ERISA-governed benefit plans at issue and is preempted by ERISA's express preemption provision. ERISA's central purpose is to "provide a uniform regulatory regime over employee benefit plans" which is in part accomplished by "expansive pre-emption provisions." *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 208 (2004) (quoting 29 U.S.C. § 1001(b)). In furtherance of this objective, 29 U.S.C. § 1144(a) provides that state laws that "relate to" an employee benefit plan are preempted:

> (a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter ***relate to*** any employee benefit plan described in section 1003 (a) of this title and not exempt under section 1003 (b) of this title. This section shall take effect on January 1, 1975.
>
> ….
>
> For the purposes of this section (1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.

[10] Plaintiffs' claim under Section 17200's unfair prong should be dismissed for the independent reason that as providers, Plaintiffs are neither consumers nor competitors of Defendants and thus lack standing to state a claim under the unfairness prong. *See Ctr. for Neuro Skills v. Blue Cross of Cal.*, No. 1:13-cv-00743-LJO-JLT, 2013 U.S. Dist. LEXIS 148432, at *26-27 (E.D. Cal. Oct. 15, 2013) (dismissing UCL claim by providers asserting ERISA claims where the providers were neither consumers nor competitors of Blue Cross or the ERISA plans); *Almasi v. Equilon Enters., LLC*, No. 5:10-cv-03458 EJD, 2012 U.S. Dist. LEXIS 128623, at *9 (N.D. Cal. Sept. 10, 2012) (dismissing UCL claim where plaintiffs were neither consumers nor competitors of defendant).

29 U.S.C. § 1144(a), (c) (emphasis added). A law "'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). In determining whether a claim has a "connection with" an ERISA plan, courts are instructed to "look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *Cal. Div. of Labor Standards Enf't v. Dillingham Constr., Inc.*, 519 U.S. 316, 325 (1997) (internal quotation marks and citation omitted). Courts also look to "whether the state law encroaches on relationships regulated by ERISA, such as between plan and plan member, plan and employer, and plan and trustee." *Blue Cross of Cal.*, 187 F.3d at 1053. "Any regulation of the relationship is basis enough for preemption." *Gen. Am. Life Ins. Co. v. Castonguay*, 984 F.2d 1518, 1522 (9th Cir. 1993). Here, Plaintiffs' Section 17200 claim necessarily relates to the ERISA-governed benefit plans at issue because Plaintiffs are seeking the direct payment of their patients' plan benefits from Defendants pursuant to alleged assignments of plan benefits by their patients. [FAC, ¶ 3.] Plaintiffs' Section 17200 claim also seeks to restructure the relationship between Defendants and their members as it relates to the member's entitlement to receive the payment of benefits directly. [*Id.*] As a result, Plaintiffs' Section 17200 claim clearly falls within the preemptive scope of ERISA's express preemption provision, and Plaintiffs' Section 17200 claim should be dismissed with prejudice.

Finally, Defendants note that in the event that the Court finds that Plaintiffs stated a claim under 29 U.S.C. § 1132(a)(1)(B), Plaintiffs' Section 17200 claim is also completely preempted by ERISA's civil enforcement provision. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 946 (9th Cir. 2009) (internal quotation marks omitted) ("a state-law cause of action is completely preempted if (1) an individual, at some point in time, could have brought [the] claim under ERISA § 502(a)(1)(B), and (2) where there is no other independent legal duty that is implicated by a defendant's actions"); *Aetna Health, Inc.*, 542 U.S. at 209 ("[a]ny state-law cause of action that

duplicates, supplements, or supplants the ERISA civil enforcement remedy" is preempted because it "conflicts with the clear congressional intent to make the ERISA remedy exclusive").

G. Plaintiffs' Demand For A Jury Trial Should Be Stricken.

Plaintiffs' FAC includes a demand for a jury trial. [FAC, p. 281:2.] However, the Ninth Circuit has held that "in ERISA actions there is no independent constitutional or statutory right to a jury trial." *Nevill v. Shell Oil Co.*, 835 F.2d 209, 213 (9th Cir. 1987). Similarly, there is no right to a jury trial for Plaintiffs' claim for violations of California Business and Professions Code § 17200 because the only relief afforded under the statute is equitable. *Hodge v. Superior Court*, 145 Cal. App. 4th 278, 284-85 (2006). Because all of Plaintiffs' purported claims are brought under ERISA and Business and Professions Code § 17200, Plaintiffs' demand for a jury should be stricken from the FAC.[11]

V. CONCLUSION

For the reasons set forth above, the Defendants respectfully request that the Court dismiss each and every claim averred in Plaintiffs' FAC without leave to amend.

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[11] Fed. R. Civ. P. 12(f) allows the Court to "strike from a pleading… any redundant, immaterial, impertinent, or scandalous matter." Fed. R. Civ. P. 12(f).

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Filer's Attestation: Pursuant to Local Rule 5-4.3.4(a)(2)(i), Eileen R. Ridley hereby attests that concurrence in the filing of this document and its contents was obtained from all signatories listed.