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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

SOUTHERN DIVISION

DUAL DIAGNOSIS TREATMENT CENTER, INC., et al.,

Plaintiffs,

v.

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

Defendants.

Case No. SACV15−736 DOC (DFMx)

PLAINTIFFS' OPPOSITION TO DEFENDANTS' OMNIBUS MOTION TO DISMISS PLAINTIFFS' SECOND AMENDED COMPLAINT

Date: June 12, 2017
Time: 8:30 a.m.
Location: Courtroom 9D
Judge: Hon. David O. Carter

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INTRODUCTION

Defendants are free to design plans that do not cover out-of-network treatment at all, and they are likewise free to design plans that do not permit assignment of benefits. But they must disclose these facts to patients and providers up front. They may not lure providers into treating their insureds by offering assurances that services are covered or assignments are permitted and then, when it comes time to pay, do an about-face. Neither federal nor state law tolerates such conduct.

STATEMENT OF THE CASE

The Blue Cross Blue Shield Association and its 37 member companies (collectively "Blue Cross") provide or administer insurance for one in three Americans. Blue Cross is a dominant insurance player. Second Amend. Compl. ("SAC") ¶ 1. Sovereign is a leading provider of comprehensive addiction and mental health treatment services. SAC ¶ 206. At the center of this case are scores of patients (collectively, the "Former Patients") with plans insured or administered by Blue Cross who assigned their benefits to Plaintiffs ("Sovereign") in exchange for treatment. As alleged in the SAC and its Appendix of Patient Specific Allegations ("Patient Appendix"), three critical facts underpin Sovereign's claims in this case:

First, the Blue Cross Defendants told Sovereign that the benefits of the Former Patients were assignable. Sovereign had no choice but to rely on these representations: Sovereign had no access to plan documents and no way to know whether a particular plan contains an anti-assignment provision ("AAP"). *See, e.g.*, SAC ¶ 287.

Second, after extensive intake procedures, Sovereign obtained a valid assignment from each Former Patient *and* advised Blue Cross of the assignment in the proper manner on standard claim forms. SAC ¶¶ 233-36, 246, 250. As the Court addressed in its ruling on Defendants' first motion to dismiss, the assignments were of two kinds, Form A and Form B. Order Granting in Part Omnibus Mot. Dismiss at 6-10, ECF No. 1063 ("Omnibus Order"). While the language differs, both forms validly assigned at least the right to sue under ERISA to recover benefits. *Id.*

Third, without notice to Sovereign, Defendants sent benefit payments directly to Former Patients, regardless of whether the Former Patient's plan had an AAP. Because Defendants chose not to pay Sovereign directly in accordance with its assignments, Sovereign often did not receive any payment and incurred significant costs to collect from Former Patients. SAC ¶ 288.

Such conduct—which is part of a larger, coordinated effort by Blue Cross to undermine out-of-network providers, SAC ¶¶ 5, 257-261—is unfair and inequitable and violates ERISA and state law. Claim I seeks payment of benefits under 29 U.S.C. § 1132(a)(1)(B) with respect to those Former Patients whose plans do not contain an applicable AAP. For those Former Patients whose plans contain long-undisclosed AAPs, Claim II seeks appropriate equitable relief to remedy Defendants' misconduct and breach of duty. Specifically, Sovereign seeks to recover payment of benefits through the equitable remedies of reformation and estoppel under 29 U.S.C. § 1132(a)(3). Claim III seeks relief against the Blue Cross Defendants under California Unfair Competition Law, Cal. Bus. & Prof. Code § 17200 *et seq*. ("UCL"). Claim IV seeks relief under state law.

ARGUMENT

I. Claim I Should Not Be Dismissed

This Court has already recognized that Sovereign has a claim for payment of benefits for those patients associated with plans that lack applicable AAPs. Omnibus Order at 168-69. Sovereign restates that claim in Claim I of the SAC. Defendants nonetheless argue that Claim I should be dismissed because Plaintiffs have failed to notify them about which patient claims Plaintiffs "have collected full payment on." Defs.' Mem. at 17-18.

Defendants are confused. Plaintiffs are seeking to be paid for their services under Claim I because they have valid assignments under the governing policies. *No* Defendant sent Plaintiffs money directly—which is what a valid assignment, *as a matter of law*, obligates a debtor to do. Thus, with respect to every Claim I defendant,

Plaintiff has stated a valid claim. That in some circumstances Plaintiffs may have collected some money directly from a patient does not extinguish Plaintiffs' claims on the pleadings; some collection (even full collection, which has not occurred) would at best amount to an affirmative or equitable defense a defendant would have to prove on the facts.[1] Defendants cannot obtain dismissal by simply declaring that Sovereign may have recovered some of the money it was owed even though Defendants violated the assignments by sending the money to the wrong people.[2]

II. Claim II Should Not Be Dismissed

Defendants urge dismissal of Claim II on three grounds. According to Defendants: (a) the allegations of fraud and mistake in Claim II are pled with insufficient specificity, (b) the facts alleged in Claim II do not entitle Sovereign to reformation or estoppel, and (c) the Form A assignment (which pertains to some of the claims at issue in Claim II) did not assign the right to sue under 29 U.S.C. § 1132(a)(3) for reformation or estoppel. Defendants are wrong on all counts.

A. The Allegations In Claim II Are Pled With Adequate Specificity

As directed by the Court, Sovereign has supplied the "particularity in pleading the circumstances" that Fed. R. Civ. P. 9(b) requires for allegations of fraud or mistake. *Moore v. Kayport Package Express, Inc.*, 885 F.2d 531, 540 (9th Cir. 1989). The Patient Appendix provides a detailed account for each Former Patient. Each entry includes: all known information about the plan and the insurer or third-party administrator, the date Sovereign called the provider hotline to verify benefits, whether Sovereign was told

[1] *See, e.g., In re Garvida*, 347 B.R. 697, 705 (B.A.P. 9th Cir. 2006) ("Once there is a prima facie showing of an indebtedness or obligation to pay, the burden of proving the facts regarding payment is on the party who alleges payment, ordinarily the obligor or debtor.")

[2] As for Defendants' concern about "extra-contractual" damages: Plaintiffs only seek extra-contractual damages that arise out of any equitable or state-law relief that may ultimately be awarded. In any event, the scope of recoverable damages is no reason for dismissal.

that benefits were assignable, the date treatment began, and the fact that Sovereign billed using a standard form that indicated Sovereign sought payment as assignee.

Defendants call this exhaustively detailed pleading vague. Defs.' Mem. at 7. That is absurd. Sovereign has provided precisely what Rule 9(b) requires: the "time, place and nature of the alleged fraudulent activities." *Moore*, 885 F.2d at 540. The rule does not "require absolute particularity or a recital of the evidence, especially when some matters are beyond the knowledge of the pleader and can only be developed through discovery." 5A Charles A. Wright et al., *Federal Practice and Procedure* § 1298 (3d ed. 2017). Allegations are sufficient so long as they identify "the circumstances constituting fraud so that a defendant can prepare an adequate answer from the allegations." *Moore*, 885 F.2d at 540.

Tellingly, Defendants do not even suggest that they lack information needed to defend themselves. With the patient's identity and the dates for calls and service, Defendants can easily locate all of their relevant data to respond to Sovereign's claims—including call notes, recordings, claim submissions, and payment records. Because the "crux of the particularity requirement is that the plaintiff must provide the defendant with enough information to put the defendant on notice of the alleged misconduct," *Doran v. Wells Fargo Bank*, No. 1:11-CV-00132, 2012 WL 1066879, at *6 (D. Haw. Mar. 28, 2012), nothing more is needed to satisfy the rule. *See also Cincinnati Microwave, Inc. v. Wilson*, 705 F. Supp. 1453, 1457 (D. Nev. 1989) (well settled that fraud allegation "is sufficient if it identifies the circumstances constituting fraud so that the defendant can prepare an adequate answer from the allegations").

Defendants' pettifogging objections supply no basis for dismissal. For example, Defendants protest that Sovereign should have alleged the names of the individuals[3] who placed and answered the provider hotline calls, even though Defendants do not even claim to need more than date and patient name to retrieve their records of these

[3] The people involved typically do not even exchange full names.

routine interactions. Defendants also pick at Sovereign's diction, suggesting that "contact" and "learned" are somehow vague. Defs.' Mem. at 7-8. But the SAC repeatedly alleges that Sovereign staff called Blue Cross provider hotlines and were "informed that claims . . . were assignable." SAC ¶¶ 224-25, 287 & Patient Appendix; *see also* SAC ¶ 288 (alleging that plans' agents made material false representations that claims were assignable). And the allegations for each Former Patient are similar because they are based on standardized forms, not the unreliable memories of individuals who place dozens of calls a day and hundreds over weeks and months.

Finally, the Rule 9(b) standard is relaxed "as to matters within the opposing party's knowledge." *Moore*, 885 F.2d at 540. *See also, e.g.*, *Azurite Corp. Ltd. v. Amster & Co.*, 730 F. Supp. 571 (S.D.N.Y. 1990). When a plaintiff alleges corporate fraud, the plaintiff "will not have knowledge of all of the underlying facts." *Moore*, 885 F.2d at 540. For example, Sovereign cannot always identify which specific Blue Cross entity (home state or host) answered the provider hotline because Defendants' BlueCard arrangement shifts responsibilities between entities. *See* SAC ¶¶ 242-44. The critical requirement for pleading on information and belief under these circumstances is that Sovereign include "the facts on which the belief is founded." *Moore*, 885 F.2d at 540. That is what Sovereign has done. The SAC identifies the misrepresentations, explains Sovereign's practices and records, and provides all the information that reasonably can be supplied in these circumstances. Rule 9(b) does not require more.

B. The Facts Alleged In Claim II Entitle Sovereign To Equitable Relief

Sovereign's claim for equitable relief seeks redress for a pattern of misleading conduct by Defendants, namely false representations about the assignability of benefits. Equitable relief is appropriate and justified to remedy those misrepresentations. *See CIGNA Corp. v. Amara*, 563 U.S. 421, 440-41 (2011). Indeed, to enforce AAPs buried in complex, voluminous plan documents that Sovereign never had access to would contravene core equitable principles.

Defendants' attack on Claim II is premised on a critical misunderstanding of both Sovereign's claim and the law. They argue that Sovereign cannot "shoehorn equitable remedies" into a claim for benefits under 29 U.S.C. § 1132(a)(1)(B). Defs.' Mem. at 18. But Claim II seeks benefits through an award of equitable relief under § 1132(a)(3). The Supreme Court's landmark holding in *Amara* confirmed that traditional equitable remedies available under that section (including reformation, estoppel, and surcharge) may provide a basis for the award of benefits and similar make-whole relief. 563 U.S. at 438-442.

Because Sovereign seeks equitable relief consistent with *Amara*, a fuller discussion of that decision is useful. In *Amara*, the employer changed its pension plan and misrepresented those changes to its employees. After developing the new plan, the employer offered rosy assessments of it, saying some things that were not true and failing to tell employees of several ways the plan made them worse off. 563 U.S. at 424, 429. The district court remedied these misrepresentations by ordering, based on 29 U.S.C. § 1132(a)(1)(B), that the plan be reformed and employees be paid "appropriate benefits" consistent with the plan as reformed. *Id.* at 430-34.

When the case reached the Supreme Court, the Court adopted two key holdings. First, the Court held that § 1132(a)(1)(B) gave the district court authority to enforce the terms of the plan, not to change it. The Court rejected the federal government's argument that the district court was appropriately enforcing the terms of the (misleading) summary plan descriptions ("SPDs"). *Id.* at 435-37. ERISA distinguishes between the plan sponsor, who "executes a written instrument containing" the plan terms, and the plan administrator, who as fiduciary manages the plan and "provides participants with the summary documents that describe the plan." *Id.* at 435-37. Because "those two roles are distinct," the SPD does not set forth the terms of the plan. *Id.* at 438. Rather, consistent with 29 U.S.C. § 1022(a), the SPD provides information "*about* the plan." *Id.* at 436, 438.

Second, although declining to affirm under § 1132(a)(1)(B), the Court held that the relief awarded "closely resemble[d]" equitable remedies available under § 1132(a)(3). *Id.* at 440. Reformation, the Court explained, was a traditional power of an equity court, used to prevent fraud. *Id.* at 440-41. Further, "the District Court's remedy essentially held [the employer] to what it had promised"—an "aspect of the remedy [that] resemble[d] estoppel, a traditional equitable remedy." *Id.* at 441. Equitable estoppel places the "'person entitled to its benefit in the same position he would have been in had the representations been true.'" *Id.* (quoting J. Eaton, *Handbook of Equity Jurisprudence* § 62 at 176 (1901)). As for the district court's injunctions requiring payment of benefits consistent with the plan as reformed, the fact that "relief took the form of a money payment" did not remove it "from the category of traditionally equitable relief." *Id.* In short, the remedies entered by the district court fell within the "scope of the term 'appropriate equitable relief' in § [1132](a)(3)." *Id.* at 443.

Defendants' cramped view of Claim II ignores *Amara*, which "significantly altered the understanding of equitable relief available under" § 1132(a)(3). *Kenseth v. Dean Health Plan, Inc.*, 722 F.3d 869, 876 (7th Cir. 2011). Following *Amara*, courts have recognized that equitable relief may include payment of benefits or equivalent monetary compensation. *See, e.g.*, *Amara v. CIGNA Corp.*, 775 F.3d 510, 518-19, 523, 526 (2d Cir. 2014) (upholding, after remand, reformation of plan and award of monetary relief; noting that when "the plan is reformed . . . monetary benefits flow as a necessary consequence").[4] Sovereign likewise seeks make-whole relief under

[4] *See also Gearlds v. Entergy Servs., Inc.*, 709 F.3d 448, 452-53 (5th Cir. 2013) (holding that claimant's request for compensation in the form of lost benefits, based on breach of fiduciary duty and estoppel, was a viable claim for equitable relief); *McCravy v. Metropolitan Life Ins. Co.*, 690 F.3d 176, 180, 182-82 (4th Cir. 2012) (holding that surcharge and estoppel provided potential bases for award of "make-whole" monetary relief under (a)(3)); *Kenseth*, 722 F.3d at 883 (holding that, if plaintiff could show breach of fiduciary duty caused her damages, she "may seek an appropriate equitable remedy including make-whole relief in the form of money damages"); *Osberg v. Foot Locker, Inc.*, 138 F. Supp. 3d 517, 560 (S.D.N.Y. 2015) (holding that, to remedy ERISA

§ 1132(a)(3) that provides the benefits it was reasonably led to expect by Defendants' representations. That monetary relief flows as a "necessary consequence" from the equitable remedies of reformation and estoppel. *Amara v. CIGNA Corp.*, 775 F.3d at 440-41.

Sovereign has accordingly stated an ERISA claim for equitable relief. A pattern of false representations induced Sovereign's reliance and caused financial losses. The required elements for both reformation and estoppel are properly alleged. And the Ninth Circuit pension cases cited by Defendants do not hold otherwise.

Facts. Sovereign has no access to plan documents that include AAPs. To determine if claims are assignable, Sovereign reasonably asks the plan's agents when it verifies other aspects of coverage. *See* SAC ¶ 287 & Patient Appendix. Sovereign's employees were informed that claims were assignable and Sovereign, in turn, advised Defendants of patients' assignments on standard claim forms. SAC ¶¶ 239, 250, 287. In addition to misleading Sovereign about assignability at the outset, the Blue Cross Defendants interacted with Sovereign for other purposes, such as claims processing, all without informing Sovereign about AAPs. *Id.* ¶¶ 251-53.

These misrepresentations were not inadvertent or isolated oversights. The Blue Cross Defendants have an admitted policy of not honoring assignments to out-of-network providers, which furthers their objective to pressure out-of-network providers to join the Blue Cross network and accept lower rates. SAC ¶ 259. They paid patients directly even where plans did *not* contain AAPs—meaning they refused to honor assignments without any investigation into whether the plan documents supported their position. *Id.* ¶ 274. And they understood that misleading providers about assignability and failing to honor assignments leads to underpayment, because patients do not always forward benefits checks and are less likely to appeal denials. *Id.* ¶ 262. Indeed,

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violations and misrepresentations, "the Plan must be reformed to actually provide the . . . benefit that the misrepresentations inequitably caused Class members to reasonably expect").

Sovereign relied on these representations to its detriment. Sovereign took patients it would not have taken, lost opportunities to make alternate payment arrangements and help patients appeal benefit denials, and frequently was not compensated for its services. *Id.* ¶¶ 253, 288. In short, Defendants made false representations about plan terms that benefitted them and harmed Sovereign.

Reformation. Consistent with *Amara*, reformation is appropriate here to remedy Defendants' inequitable conduct. "While no 'single . . . statement accurately define[s] the equitable conception of fraud,' it generally consists of 'obtaining an undue advantage by means of some act or omission which is unconscientious or a violation of good faith.'" *Amara v. CIGNA Corp.*, 775 F.3d at 526. "The law is clear that equitable fraud does not require a showing of intent to deceive or defraud." *Osberg*, 138 F. Supp. 3d at 557.[5] Similarly, inequitable conduct "includes deception or even mere awareness of the other party's mistake combined with superior knowledge of the subject of that mistake." *Id.* at 558 (quotation omitted). Defendants' misrepresentations, which caused Sovereign's reasonable mistake about the assignability of benefits, warrant reforming the plans to remove the AAPs. That would put Sovereign in the position that Defendants' representations and conduct led it to expect. *See, e.g., id.* at 560 ("To remedy [the employer's] misrepresentations, the Plan must be reformed to actually provide the . . . benefit that the misrepresentations inequitably caused Class members to reasonably expect.").

[5] *See also Simmons Creek Coal Co. v. Doran*, 142 U.S. 417, 435 (1892) (inequitable conduct sufficient ground 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) ("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").

Following *Amara*, courts have recognized that reformation is available to redress misrepresentations about plan terms. The Eighth Circuit held that reformation was a potential remedy where an employer accepted an employee's application for life insurance and deducted premiums, without disclosing additional application requirements. *Silva v. Metropolitan Life Ins. Co.*, 762 F.3d 711, 721 (8th Cir. 2014). The Sixth Circuit, recognizing that post-*Amara*, "a material conflict between the SPD and the Pension Plan can give rise to a claim for equitable relief," directed a lower court to reconsider a retiree's claim for reformation and other equitable relief. *Pearce v. Chrysler Grp., L.L.C. Pension Plan*, 615 F. App'x 342, 346 (6th Cir. 2015). And, after remand, the Second Circuit held that reformation was proper in *Amara* itself. *Amara v. CIGNA Corp.*, 775 F.3d at 528-30. There, the court expressly rejected the argument that misrepresentations by the plan administrator in its description of the plan could not be grounds for reformation. *Id.* As the Second Circuit noted, the Supreme Court knew that the plan administrator proffered "misleading summary descriptions of the plan" and remanded specifically for the district court to determine whether the plan "could be reformed in order to remedy those falsehoods." *Id.* at 528.

Defendants' position—that misrepresentations made after plan documents are in place cannot serve as grounds for reformation—misconstrues inapposite cases (see below) and asks this Court to reject *Amara* and relevant post-*Amara* precedent. Defendants insist that reformation is only available where the plan itself contains an error, or "the actual plan document itself was wrongfully procured by fraud." Defs.' Mem. at 11-12. Neither of those things were true in *Amara*. There was no error or fraud in that plan. The misrepresentations came after the fact, in the SPD and other disclosures. *Amara*, 563 U.S. at 440 (reformation available to "remedy the false or misleading information" the employer provided). Indeed, that distinction underpinned the Court's holding: relief under 29 U.S.C. § 1132(a)(1)(B) is only available to *enforce* the plan, but equitable relief under 29 U.S.C. § 1132(a)(3) is available to remedy misrepresentations in disclosures "*about* the plan." *Id.* at 436, 438, 440.

This Court suggested reformation requires Sovereign to plead "facts that show that because of mistake or fraud, the plan terms do not reflect those the sponsor assented to or intended to impose." Omnibus Order at 19 n.9. But limiting reformation to ensuring that plan documents reflect the *employer*'s intent would make it virtually useless as a remedy for plan participants. That does nothing to address the harm caused when plans provide materially incomplete and inaccurate information to beneficiaries. It makes no sense to contend, as Defendants do, that reformation is not available where the "existence of a plan document necessarily preceded any alleged misrepresentation." Defs.' Mem. at 20. Because of the way ERISA plans work, the plan documents always exist *before* an employer makes representations—accurate or not—about the plan's terms. *See Amara*, 563 U.S. at 437 (noting that plan sponsor creates the plan and administrator provides information about the plan's terms). As the Second Circuit recognized, the Supreme Court adopted a broader understanding of reformation, grounded in contract and trust principles, that provides a remedy for beneficiaries misled about plan terms. *Amara v. CIGNA Corp.*, 775 F.3d at 524-25 & n.11. That is why, after remand, the Second Circuit held that the plan was properly reformed "to reflect the representations that defendants made to plaintiffs." *Id.* at 524-25. Reformation is simply not limited to determining whether the plan documents reflect the sponsor's intent. *See id.* at 524 n.11 ("Where consideration is involved in the creation of a trust and the settlor induces assent to the trust's terms by fraud or misrepresentation, the reasonable perceptions of the *beneficiaries* determine the nature of the reformation remedy.").

Estoppel. These same facts are also sufficient to support equitable estoppel, to hold Defendants "to what [they] had promised." *Amara*, 563 U.S. at 441. "An ERISA beneficiary may recover benefits under an equitable estoppel theory upon establishing a material misrepresentation, reasonable and detrimental reliance upon the representation and extraordinary circumstances." *Pisciotta v. Teledyne Indus., Inc.*, 91 F.3d 1326, 1331 (9th Cir. 1996). *See also Gabriel v. Alaska Elec. Pension Fund*, 773

F.3d 945, 955 (9th Cir. 2014) (traditional elements of equitable estoppel). Defendants' false statements about assignability were material, Sovereign's reliance was reasonable, and Sovereign was harmed. SAC ¶¶ 253, 288.

The SAC addresses any concern that Sovereign's earlier pleading did not allege required elements of estoppel or sufficient specifics for each patient. Omnibus Order at 18 & n.8. The Patient Appendix provides the requisite detail. The SAC also alleges that Sovereign lacked access to plan documents and fleshes out Sovereign's detrimental reliance by specifically alleging that, had Sovereign known the benefits were not assignable, it would either not have taken patients or made alternate payment arrangements. SAC ¶¶ 253, 288. Further, by pleading a pattern of false representations and inequitable conduct, the SAC adequately pleads any "extraordinary circumstances" necessary to support equitable estoppel. *See, e.g.*, *Pisciotta*, 91 F.3d at 1331.[6]

Defendants nonetheless argue that estoppel is simply not available as a remedy for a plan's material false statements about plan terms. Defs.' Mem. at 21-22. Just like their view on reformation, this unduly narrow understanding of estoppel misapprehends distinguishable cases and conflicts with *Amara* which approved equitable estoppel as a remedy for disclosures that misstated plan terms. 563 U.S. at 441. As the Supreme Court explained, estoppel "operates to place the person entitled

[6] Defendants' suggestion that each plan be viewed individually ignores reality. Blue Cross is a closely connected network, sharing provider networks and, through BlueCard, collaborating on benefit claims. *See* SAC ¶¶ 240-45, 257, 259-61. The SAC does not allege isolated incidents, but rather a coordinated BlueCard policy to disregard assignments to out-of-network providers—with the objective of pressuring those providers to accept lower in-network rates. *Id*. ¶¶ 257, 288. Defendants also contend that Sovereign's reliance was not reasonable because Defendants' misrepresentations and failure to honor assignments continued over a period of time. That is, Sovereign supposedly should have figured out sooner that the Blue Cross Defendants were providing false information—even though Sovereign had no access to plan documents and no reason not to trust Blue Cross to provide accurate information. Delays in processing health care claims are not uncommon, and Sovereign had no way of knowing that the clams were not paid because Defendants were not honoring Sovereign's assignments.

to its benefit in the same position he would have been in had the representations been true." *Id.* (quotation omitted). Defendants would edit that statement to add "so long as relief in no way conflicts with the plan documents." But those were not the Supreme Court's words and not the facts of *Amara*. Where estoppel applies, it *overrides* conflicting plan terms. *See, e.g.*, *McCravy*, 690 F.3d at 182-83 (estoppel available remedy where plan accepted 6 years of premiums and then disclaimed eligibility for life insurance after covered person's death); *Gearlds*, 709 F.3d at 452-53 (estoppel and surcharge viable claims where plan administrator mistakenly advised member that he was eligible for medical benefits with early retirement); *Silva*, 762 F.3d at 723-24 (estoppel potential remedy where plan deducted life insurance premiums and only advised that member's application was incomplete after member's death).

Gabriel *and* Skinner. Defendants place great weight on *Gabriel v. Alaska Electrical Pension Fund*, 773 F.3d 945 (9th Cir. 2014) and *Skinner v. Northrop Grumman Retirement Plan B*, 673 F.3d 1162 (9th Cir. 2012), as sharply constricting the scope of reformation and estoppel. But neither of those pension cases supports the pleading challenge advanced by Defendants here.

Most importantly, the plaintiffs in those cases *were not deceived or misled* by false representations. The question in *Skinner* was whether the SPD was sufficiently ambiguous that it conflicted with the plan. But the plaintiffs had not relied on the SPD and had themselves fully understood their benefits before retiring. *Skinner*, 673 F.3d at 1165, 1167 (explaining that plaintiffs (i) produced no evidence that the employer "materially misled its employees" and (ii) conceded that they could not show reliance). Likewise, the plaintiff in *Gabriel* knew the true facts about the plan *because he had received a letter explaining them*. He had been told—correctly—that he was not eligible to participate in the pension plan and his contributions had been returned to him. *Gabriel*, 773 F.3d at 950-51. Although decades later he applied for and received benefits for several years, he could not show "wrongful conduct" or reliance on the plan's subsequent error in granting benefits. *Id.* at 962.

It is not surprising that the Ninth Circuit would reject equitable claims sounding in misrepresentation for beneficiaries who actually knew the truth. But that, of course, is the opposite of what happened here—Sovereign has been in the dark from day one. And *Gabriel* and *Skinner* are further distinguishable still. Assignments are barred—by ERISA itself—in pension settings. 29 U.S.C. § 1056(d)(1). Thus, anyone seeking equitable relief must be an original beneficiary, and any such beneficiary-litigant is therefore *necessarily* entitled to the actual plan (as well as an explanatory SPD), 29 U.S.C. §§ 1024(b)(2), (b)(4). As a result, such a beneficiary's failure to consider contrary plan language may serve, in the pension setting, as a logical and equitable check on the reach of reformation and estoppel. Here, of course, Sovereign lacked access to the underlying plan; indeed, it was only after this Court ordered Defendants to produce the plan documents that some of them did so. Put differently, Sovereign was totally and uniquely vulnerable here: it had no alternative course, and no other source of information, *other than* Defendants' misrepresentations. Defendants cite no case, and Plaintiffs know of none, where defendants escaped liability in such circumstances. Or why that would even make sense.

Finally, in contrast to other cases cited by Defendants, this is not a circumstance where plaintiffs are seeking to use reformation or estoppel to make the plan pay "windfall" benefits it is not otherwise obligated to pay. *See Gabriel*, 773 F.3d at 963 (noting plaintiff sought relief that would deem "an ineligible person to be eligible for pension benefits").[7] While it would, indeed, stretch the bounds of equity (and perhaps

[7] Consider also *Greany v. W. Farm Bureau Life Ins. Co.*, 973 F.2d 812, 822 (9th Cir. 1992) (explaining that the "plaintiff cannot avail himself of a federal ERISA estoppel claim based upon statements of a plan employee which would enlarge his rights against the plan beyond what he could recover under the unambiguous language of the plan itself."). First, *Gabriel*'s discussion of *Greany* is dicta because, as the court recognized, the *Gabriel* plaintiff could not satisfy a critical traditional element of estoppel: ignorance of the true facts. The plan had told him he was not eligible and returned his contributions years earlier. *Gabriel*, 773 F.3d at 961. Second, *Greany* involved a case where the plaintiff was seeking to enlarge his financial entitlement. Whatever the reach of *Greany* in light of *Amara*, it does not mean that estoppel is inappropriate to ensure—

unfairly deplete plan funds) to award pension benefits to a person—like the *Gabriel* plaintiff—who made no contributions and never properly participated in the plan, the relief Sovereign seeks here is nothing like that. Sovereign asks only that the covered benefit be made to the proper recipient—the health care provider who treated the patients.

C. The Form A Assignments Authorize Claim II

The Form A assignment extends to this equitable claim to recover promised benefits. As this Court has held, the Form A assignment "manifests an intent to assign a claim for benefits and the right to sue for them under ERISA." Omnibus Order at 8. And in Claim II, Sovereign seeks "to recover ERISA benefits . . . under 29 U.S.C. § 1132(a)" through traditional equitable remedies of reformation and estoppel. SAC ¶¶ 287-88 (claiming the plans should be "equitably reformed and the anti-assignment provisions stricken," or in the alternative, based on estoppel, the plans should be held to their repeated representations that benefits were assignable). That is exactly what *Amara* contemplates and permits. As the Seventh Circuit put it, *Amara* "approved" the lower court's decision "to reform the terms of the plan and then *order the administrator to pay benefits* according to the reformed plan." *Kenseth*, 722 F.3d at 883.

Defendants are plainly wrong to assert that Form A did not assign *any* right to seek equitable relief.[8] There is no logic to construing an assignment of the right to sue for benefits as excluding an entire class of potential claims that could support recovery of those benefits. Defendants' reliance on the Court's earlier holding that Form A assignments did not assign a claim for breach of fiduciary duty or equitable relief, Omnibus Order at 8-10, 12-13, is misplaced. That holding was addressed to Sovereign's prior claim under § 1132(a)(2)—that Sovereign does not pursue here—for as is sought here—that payments actually owed under the plan be sent to the right address.

[8] Defendants do not dispute that the Form B assignments reach all of plaintiffs' claims. Defs'. Mem. at 10-11.

fiduciary breach premised on a violation of the "claim regulations." Omnibus Order at 12. *See also id.* at 13 n.5 (noting open question whether § 1132(a)(2) claims may be assigned). Because this Court construed the FAC to not have asserted § 1132(a)(3) claims for reformation and estoppel, Omnibus Order at 16-18, it has not yet reached the question of whether a Form A assignment encompasses those equitable claims.

It does. Previously, in addressing the scope of Form A, the Court relied on *Spinedex Physical Therapy USA Inc. v. United Healthcare*, 770 F.3d 1282, 1292 (9th Cir. 2014). *Spinedex* reasoned that with an assignment of benefits, "patients intended to assign . . . only their rights to bring suit for payment of benefits." *Id. See also* Omnibus Order at 8. Consistent with *Amara,* Claim II is a suit to recover benefits through traditional equitable remedies. The legal labeling of the claim is irrelevant to the patient's intent in making the assignment.[9] Patients do not distinguish between potential claims under § 1132(a)(1) and § 1132(a)(3)—not one patient in a thousand would even know such a distinction exists. What matters for these purposes is that Claim II seeks payment of benefits, as opposed to prospective injunctive relief, removal of the fiduciary, or other similar relief. Omnibus Order at 13 n.5, 16-17.

Defendants' supplemental cite (ECF No. 1124) to *DB Healthcare, LLC v. Blue Cross Blue Shield of Arizona, Inc.*, 852 F.3d 868 (9th Cir. 2017), does not support their unduly narrow reading of Form A. First, the *DB Healthcare* assignments were narrower, authorizing payment of benefits directly to the provider without using "the terms 'assign' or 'assignment.'" *Id.* at 876. Form A, in contrast, used the phrase "assignment of benefits" three times. Omnibus Order at 8. Second, the Ninth Circuit in *DB Healthcare* did not consider whether equitable claims seeking recovery of benefits, or similar make-whole relief, were within the scope of the assignment. As the Ninth Circuit explained, the equitable relief sought in that case (including declaratory judgment and damages) was aimed *not* at the plan's failure to pay benefits, but its

[9] The same reasoning applies to the unpublished case cited by Defendants, *Sanctuary Surgical Ctr., Inc. v. Aetna Inc.*, 546 F. App'x 846, 852 (11th Cir. 2013).

practice of recouping benefits already paid by offsetting later, unrelated payments for other patients. 852 F.3d at 877-78. The claim was a dispute over the terms of provider agreements, "not a suit to recover benefits under the ERISA plans." *Id.* at 877.

The critical question in assessing the scope of the assignment is the "intent of the parties." *Id.* at 876. Defendants offer no persuasive reason why a patient assigning benefits would intend to assign the right to sue to recover those benefits under one subsection of ERISA but not another. As the Court recognized, the assignment "does not appear to envision or reserve any role for the patients in securing these benefits." Omnibus Order at 8. The only reasonable reading of the assignment is that it extends to all potential claims for payment of benefits, without regard to the legal source of the claim.

III. Claim III Should Not Be Dismissed

Plaintiffs' UCL claim is simple. Blue Cross offers provider hotlines. SAC ¶¶ 224-25. It urges providers to call them to learn the material terms of patient policies so that they may act accordingly. Blue Cross thus induces providers to do business with it, in part, by representing that its provider hotlines are an accurate source of information. Instead, Blue Cross (1) offers hotlines that routinely provide false or misleading information and then (2) makes no effort to correct such information in subsequent interactions. As the SAC alleges, that conduct is unfair and unlawful. SAC ¶¶ 224-25, 287 & Patient Appendix. S*ee also* SAC ¶ 288 (alleging that plan's agents made material false representations that claims were assignable).

Sovereign is a victim of Defendants' unfair and unlawful conduct. Sovereign takes pains to collect accurate information from Defendants, including by calling provider hotlines. SAC ¶¶ 225-27. It then reasonably relies on that information. SAC ¶ 295. Sovereign specifically relied on Defendants' representations about assignability in accepting the Former Patients for treatment. SAC ¶ 297. And Sovereign

was harmed as a result: it rendered treatment without compensation, incurring collection costs, and lost the opportunity to appeal benefit denials. SAC ¶ 299.

Consider those Patients for which this Court held that the plan contained an AAP, i.e., the claims were not assignable. For those 76 patients, the SAC alleges (in the Patient Appendix) that Blue Cross falsely told Sovereign that benefits were assignable with respect to 44 of them, i.e., 56% of the time. Given the frequency of these errors, there is simply *no way* Blue Cross actually consulted the underlying policies (or used another reliable method) to check whether assignments were permitted. Obviously it is unfair to produce false information about an individual patient, but it is also unfair and unlawful to offer a system of provider hotlines that is so reckless in how it answers questions that wrong answers are produced more often than not. This is why Plaintiffs seek an injunction requiring all the Blue Cross Defendants to *consult* the policy in question before telling Sovereign whether benefits are assignable or not.

A. The SAC States A Claim For Relief Under The UCL

Defendants do not dispute that their conduct is unfair. They nevertheless attack Sovereign's UCL claim on both the "unfair" and "unlawful" prongs. Their arguments are meritless.

First, Defendants are simply wrong that Plaintiffs are foreclosed from invoking the UCL's "unfair" prong because they are neither consumers nor competitors of Defendants. It is well-established that health care providers may sue payers for unfair conduct. For example, in *Bell v. Blue Cross of California*, the health care provider plaintiffs challenged a payer's improper reimbursement practices. The court rejected Blue Cross's demurrer because "Blue Cross engaged in a business practice likely to deceive *the reasonable person to whom the practice was directed*." 131 Cal. App. 4th 211, 221 (2005) (emphasis added); *see also Coast Plaza Doctors Hosp. v. UHP Healthcare*, 105 Cal. App. 4th 693, 704-05 (2002).

As *Bell* recognized, the UCL is broadly available to those to whom an unfair practice is directed, not only competitors or consumers. Indeed, the Legislature

"intended by this sweeping language to permit tribunals to enjoin on-going wrongful business conduct in whatever context such activity might occur." *Cel-Tech Commc'ns, Inc. v. L.A. Cellular Tel. Co.*, 20 Cal. 4th 163, 181 (1999); *accord Kasky v. Nike, Inc.*, 27 Cal. 4th 939, 949 (2002) ("[T]he UCL sweeps within its scope acts and practices not specifically proscribed by any other law.").

Defendants' two cases do not support a competitor-or-consumer rule. Defs.' Mem. at 20. *Kasky* involved claims of false advertising against Nike brought by a consumer on behalf of the public; the court noted in passing that the UCL protects "both consumers and competitors." 27 Cal. 4th at 949. *Kasky* does not elaborate on this observation or suggest that the UCL's "unfair" prong is *limited* to consumers or competitors. *Almasi v. Equilon Enterprises* is also readily distinguished. Like *Kasky*, it did not involve a provider-payer dispute. *Almasi*, No. 5:10-CV-03458, 2012 WL 3945528, at *1-2 (N.D. Cal. Sept. 12, 2012) (describing dispute between gas station operators and lessor). And the *Almasi* court dismissed the UCL unfair conduct claim *on summary judgment*, noting that the plaintiffs failed to cite anything in the record showing a genuine dispute. *Id.* at *9. Plaintiffs' unfair conduct claim easily survives.

Second, Defendants also argue that Plaintiffs have failed to identify what was unlawful about their conduct. Defs.' Mem. at 19. Not so. "[V]irtually any state, federal or local law can serve as the predicate for an [unlawful] action under section 17200." *People ex rel. Bill Lockyer v. Fremont Life Ins. Co.*, 104 Cal. App. 4th 508, 515 (2002). "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 business practice and that at the same time is forbidden by law.'" *Anderson v. PHH Mortgage*, No. 8:12-CV-01192, 2012 WL 4496341, at *4 (C.D. Cal. Sept. 28, 2012) (quoting *Bank of the West v. Superior Court*, 2 Cal. 4th 1254, 1266 (1992)). Leading providers to believe provider hotlines are accurate and conscientiously administered when they are not

amounts to, at a minimum, negligent misrepresentation, constructive fraud, and fraud, as does actually misleading Sovereign with respect to individual patients.[10]

B. The UCL Claim Is Not Preempted By ERISA

Plaintiffs' UCL claim is directed at Defendants' pattern of misleading health care providers about Defendants' intentions with respect to payment for health care services. SAC ¶¶ 290-303. Sovereign asserts its own state-law rights against Defendants under the UCL. It is not standing in the shoes of the Former Patients nor seeking to enforce any right or remedy under ERISA (which are only available to beneficiaries and fiduciaries). And Sovereign does not seek any relief that would interfere with or alter the provisions of an ERISA plan.

The UCL claim is accordingly not preempted. The Ninth Circuit employs "a 'relationship test' . . . under which a state law claim is preempted when the claim bears on an ERISA-regulated relationship, e.g., the relationship between plan and plan member, between plan and employer, between employer and employee." *Paulsen v. CNF Inc.*, 559 F.3d 1061, 1081 (9th Cir. 2009). The relationship between plans and Sovereign is not regulated by ERISA.[11] ERISA "doesn't purport to regulate those relationships where a plan operates just like any other commercial entity." *Paulsen*, 559 F.3d at 1083; *Weaver v. Emp'rs Underwriters, Inc.*, 13 F.3d 172, 177 (5th Cir. 1994) ("[C]laims by a nonparticipant and nonbeneficiary to a plan do not affect the relationship between the traditional ERISA entities.").

Defendants wrongly contend that Sovereign's UCL claim "seeks to restructure

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[10] *See* Cal. Civ. Code § 1573 (defining constructive fraud); *Marolda v. Symantec Corp.*, 672 F. Supp. 2d 992, 997 (N.D. Cal. 2009) (defining fraud); *Fox v. Pollack*, 181 Cal. App. 3d 954, 962 (1986) (defining negligent misrepresentation).

[11] In its earlier decision, the Court suggested that Sovereign's claims were preempted because Sovereign did not have a contractual relationship with the plans. *See* Omnibus Order at 20 (citing *Cedars-Sinai Med. Ctr. v. Nat'l League of Postmasters of the United States*, 497 F.3d 972, 978 (9th Cir. 2007)). But a third party does not need to have a contract to sue a plan. State law may be a source of other protected rights and interests, such as laws regulating commercial practices generally.

the relationship between Defendants and their members." Defs.' Mem. at 22. In fact, the relief Sovereign seeks has nothing to do with the relationship between Defendants and plan members. Rather, Sovereign seeks prospective injunctive relief to stop Defendants from being dishonest *with Sovereign* about their intent to pay claims. SAC ¶ 302. Courts have recognized that analogous state-law claims by providers against insurers are not preempted by ERISA. *See, e.g.*, *Meadows v. Emp'rs Health Ins.*, 47 F.3d 1006 (9th Cir. 1995) (provider's breach of contract, estoppel, and negligent misrepresentation claims based on insurer's misrepresentation about coverage not preempted); *Hospice of Metro Denver, Inc. v. Group Health Ins.*, 944 F.2d 752, 756 (10th Cir.1991) (no preemption where provider's estoppel claim against insurer did not involve administration of ERISA plan, processing of covered claim, or rights of plan participant or beneficiary); *Mem'l Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 246 (5th Cir. 1990) (provider's claims against plan not preempted; noting that "[e]nforcing the allocation of risks between commercial entities that conduct business in a state is a classically important state interest"); *Hoag Mem'l Hosp. v. Managed Care Adm'rs*, 820 F. Supp. 1232, 1235 (C.D. Cal. 1993) (no preemption because state-law claims for misrepresentation of coverage did not involve administration of ERISA plan).

Like these providers, Sovereign has incurred significant financial harm from Defendants' misrepresentations over a series of commercial transactions. California law provides a remedy for this misconduct, and that remedy is not preempted by ERISA.

IV. Claim IV Should Not Be Dismissed

Claim IV of the SAC seeks relief under state law with respect to those plans not covered by ERISA. Defendants maintain that Claim IV "fails to allege sufficient facts that would give fair notice to Defendants about the legal claims at issue." Defs.' Mem. at 23. Defendants are wrong.

The facts of this case have been pled *exhaustively*.[12] Sovereign has alleged in great detail the established processes through which it obtains assignments, verifies benefits, contacts plans and their agents, treats patients, seeks payment, and receives payment or not. Sovereign has also alleged those facts with respect to each individual Former Patient, including the fact that Sovereign was not paid for services rendered. With respect to Claim IV Defendants, Plaintiffs incorporated all such allegations by reference, SAC ¶ 307, and also pled more specific allegations pertaining to the non-ERISA patients in the Patient Appendix.[13]

Upon those facts, Plaintiffs pled alternative theories of relief against Claim IV Defendants. Where the relevant policy lacks an AAP that applies to Sovereign, Sovereign can recover directly, as an assignee, under the contract of insurance.[14] Alternatively, where Defendants misled Sovereign about the existence of an AAP, Sovereign can recover under state law misrepresentation, state law reformation, or state law promissory estoppel.[15] *See, e.g.*, *R&B Auto Center, Inc. v. Farmers Grp. Inc.*, 140 Cal. App. 4th 327, 348-49 (2006) (reformation); *City of Atascadero v. Merill Lynch*,

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[12] Federal pleading requires *facts* sufficient to state a claim for relief. It does not require reference to any specific statutory provision or decisional law. *See Johnson v. City of Shelby, Miss.*, 135 S. Ct. 346 (2014).

[13] *See* Patient Appendix at 28 (Patient 23), 100 (Patient 74), 104 (Patient 77), 126 (Patient 106), 141 (Patient 112), 149 (Patient 118), 273 (Patient 202), 322 (Patient 239), 360 (Patient 267). To the extent a plan that Plaintiffs currently believe is an ERISA plan is in fact a non-ERISA plan, the allegations set forth in the SAC generally and in the relevant Patient Appendix entries are sufficient to plead state law claims against those Defendants.

[14] For example, under California law—which Defendants suggest governs this portion of the case, *see* Defs.' Mem. at 23-25—anti-assignment provisions of the kind are disfavored. *See Fluor Corp. v. Superior Court*, 61 Cal. 4th 1175, 1182 (2015). In any event, dismissal is not appropriate absent full briefing on governing state law regarding anti-assignment provisions.

[15] Promissory estoppel is a valid claim under state law. *Laks v. Coast Fed. Sav. & Loan Ass'n*, 60 Cal. App. 3d 885, 890 (1976). Sovereign's reference to "equitable estoppel," Defs.' Mem. at 25, does not bar them from seeking relief. Defendants misled Sovereign with respect to Patients 23, 74, 77, 106 and 267. *See* Patient Appendix at 28 (Patient 23), 100 (Patient 74), 104 (Patient 77), 134 (Patient 106), 360 (Patient 267).

Pierce, Fenner & Smith, 68 Cal. App. 4th 445, 482 (1998) (intentional misrepresentation); *Fox v. Pollack*, 181 Cal. App. 3d 954 (1986) (negligent misrepresentation). As Sovereign's ERISA claims satisfy federal pleading rules, so too do its state-law claims.[16]

Indeed, fairly read, Claim IV properly alleges state law negligent misrepresentation claims against even *ERISA* plans (and their associated Blues) for Patients wherein Sovereign was told benefits were assignable. Claim IV incorporates by reference all the facts pled in Claims I and II, and those facts—the same facts that support Sovereign's claim, *as assignee*, for equitable remedies under ERISA—also support an independent state-law claim, *as a provider*, for negligent misrepresentation. Here, Sovereign reasonably relied upon Defendants' false representations regarding assignability, and incurred financial losses as a result. *Small v. Fritz Cos., Inc.*, 30 Cal. 4th 167, 173-74 (2003) (explaining negligent misrepresentation as a common law tort that requires no showing of scienter or intent to defraud).[17]

A state-law tort claim of this kind is not preempted by ERISA, because it has nothing to do with the administration of an ERISA plan or the relationships among those regulated by ERISA. *See supra* at 20-21. Courts have routinely allowed these claims to redress false representations by insurers to health care providers.[18] And that

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[16] Defendants' unsupported suggestion that misleading a provider without access to the policy about material terms in the policy fails to satisfy state law on misrepresentation is wrong. *See* Defs.' Mem. at 24; *see supra* at 17-18 (explaining unlawful inducement to treat Blue Cross insureds through misleading provider hotlines).

[17] It is not necessary to show that the defendant knew the representation was false; it is enough to make the assertion with no "reasonable ground for believing it to be true." *Id.* (quotation omitted).

[18] *See, e.g.*, *Meadows v. Emp'rs Health Ins.*, 47 F.3d 1006 (9th Cir. 1995) (claim for negligent misrepresentation against insured concerning patients' insurance coverage not preempted); *Hoag Mem'l Hosp. v. Managed Care Adm'rs*, 820 F. Supp. 1232, 1235 (C.D. Cal .1993) (no preemption of hospital's state-law claims for misrepresentation of coverage); *Tenet Healthsystem Desert, Inc. v. Blue Cross of Cal.*, 245 Cal. App. 4th 821, 845 (2016) (false representations of coverage sufficient to plead claim for negligent misrepresentation). *Cf. See Marin Gen'l Hosp. v. Modesto & Empire Traction*

makes sense here as well: ERISA is not the final word on whether Defendants' pattern of misrepresentations *to providers* should go unchecked. Accordingly, the Court should either construe the SAC as stating a claim for negligent misrepresentation against the ERISA plan defendants and their associated Blues who misled Sovereign on assignability,[19] or grant leave to amend for Sovereign to add that claim, which is fully supported by the facts alleged.

V. Defendants Associated With 5 Of The 26 Contested Patients Are Properly Subject To Claims I Or IV; The Remaining 21 Are Dismissed Pending Appeal

Defendants claim that Sovereign has failed to assert claims for relief against 26 Welfare Plan Defendants, and seek their dismissal on this basis. Defs.' Mem. at 4-5.To clarify:

First, five Defendants were inadvertently omitted from lists in Claims I due to a scrivener's error. They are proper defendants because sufficient facts have been pled against them. *See generally* SAC & Patient Appendix at 68, 198, 272, 364, 370. As the Court recognized in the Omnibus Order, the plan Defendants associated with Patients 52, 152, 201, 269, and 273 are each properly subject to Claim I:

- **Patient 52:** The Court found that Plaintiffs had alleged compliance with a Conditional AAP. Omnibus Order at 73.
- **Patient 152:** The Court refused to dismiss on anti-assignment grounds due to discretionary language in the plan. *Id.* at 115.
- **Patient 201:** The Court refused to dismiss on anti-assignment grounds due to an enrollment fact dispute. *Id.* at 139.
- **Patient 269:** The defendant(s) associated with this patient did not seek dismissal pursuant to an AAP. *Id.* at 26 n.12.

Co., 581 F.3d 941 (9th Cir. 2009) (no complete preemption where relief arises from provider relationship and provider could not have brought claim under ERISA).

[19] This would be all patients for whom the Patient Appendix entries reflect that Sovereign was informed that benefits were assignable.

- **Patient 273:** The Court refused to incorporate documents associated with this patient. *Id.* at 165.

Second, there are 21 Defendants for whom (1) this Court has held that the anti-assignment provision reaches Sovereign and is enforceable, and (2) Sovereign does not possess documentary evidence that a plan affirmatively represented that benefits were assignable.[20] While Sovereign does maintain that *all* Defendants in this case, including these 21, are liable under ERISA (*see generally* Pls.' Opp. to First Omnibus Mot., ECF No. 834), this Court's previous order rejected any cognizable basis for relief against these 21 defendants. Sovereign respects the Court's rulings on those issues and only intends to challenge them, if necessary, on appeal.[21] As such, there are no live claims against these 21 Defendants.

CONCLUSION

For the foregoing reasons, Defendants' omnibus motion should be denied in its entirety.

Dated: May 8, 2017

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[20] There were also scrivener's errors associated with Patients 27, 137, 157, and 174. Their Patient Appendix entries erroneously allege that Sovereign's agents recorded a "Yes" entry next to the line "Assignable" on insurance verification forms. *See* Patient Appendix at 35, 175, 206, 235. Sovereign does not assert Claim II with respect to these patients.

[21] *See also* SAC at 59 n.1 (expressing Sovereign's intent to not re-litigate questions of law already resolved by the Court).