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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. SACV 15-00736 DOC (DFMx)

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

Date: June 12, 2017
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 Second Amended Complaint (the "SAC") 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 that they should have received those payments directly. Based on this contention, Plaintiffs assert two claims under ERISA to recover plan benefits and a claim under California Business and Professions Code § 17200 (the "UCL"). As to the handful of claims that arise from services provided to members of non-ERISA plans, Plaintiffs also allege various state law claims, including breach of contract and misrepresentation.

As an initial matter, Plaintiffs' SAC is fatally vague, devoid of facts and necessary details. First, it fails to allege any facts or claims against twenty-six welfare plans named as Defendants in the action. These welfare plan Defendants, as a result, lack fair notice about Plaintiffs' theory of liability, and the claims against them should be dismissed with prejudice. Second, Plaintiffs have failed to plead with particularity their Second Claim under ERISA and Third Claim for alleged violations of the UCL. Specifically, Plaintiffs have not alleged any of the required specific details supporting their general theory of fraud and misrepresentation on which their Second and Third Claims are based. Rather, Plaintiffs have only alleged, "upon information and belief" and without any factual support, that they were misled by unspecified oral representations purportedly made by unidentified representatives of Defendants to Plaintiffs or their agents.

Even if Plaintiffs' averments survive the requirements of Rule 8 and Rule 9(b), their Second and Third Claims still fail on each of the following independent grounds:

- The remedies of reformation and equitable estoppel are not available under an ERISA

[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.

claim to recover benefits (Claim 2);

- The Form A Assignments that Plaintiffs rely on to seek equitable relief do not manifest any intent by Defendants' members to assign, convey, or otherwise transfer to Plaintiffs their right to seek equitable relief (Claim 2);
- Plaintiffs' claim for reformation under ERISA impermissibly relies on an alleged after-the-fact statement to alter the anti-assignment provisions ("AAPs") and, in any case, fails to present a plausible inference of fraud (Claim 2);
- Plaintiffs' claim for equitable estoppel under ERISA would enlarge Plaintiffs' rights beyond the scope of the AAP (Claim 2);
- Plaintiffs' claim for equitable estoppel under ERISA fails to allege reasonable reliance on purported misrepresentations and "extraordinary circumstances" that justify application of equitable estoppel (Claim 2);
- Plaintiffs' UCL claim fails to (a) identify a borrowed law, (b) plead any fraudulent conduct with particularity, and (c) allege that Plaintiffs are a proper party to pursue relief for allegedly unfair conduct as a competitor or consumer of Defendants (Claim 3); and
- Plaintiffs' UCL claim is preempted by ERISA because it seeks to challenge Defendants' administration of, and the direction of payment under, ERISA-governed benefit plans.

Further, Plaintiffs' request for extra-contractual damages in their First and Second Claims under ERISA fail as a matter of law. Moreover, as to certain patient claims for which the Court declined to enforce the AAPs in connection with the first Omnibus Motion to Dismiss, Defendants are renewing their request that the Court enforce the AAPs where Defendants have a good faith basis for believing that the supplemental declarations and addenda submitted herewith address the Court's concerns during the prior round of briefing. Based on these supplemental submissions, each of Plaintiffs' claims – including their First Count under ERISA – should be dismissed with prejudice. Finally, as to the handful of claims that arise from members of non-ERISA plans,

Plaintiffs' Fourth Claim fails to allege any facts that can plausibly support their various state-law claims. For these reasons, the SAC fails to cure the defects in Plaintiffs' First Amended Complaint and should be dismissed in its entirety with prejudice.[3]

II. SUMMARY OF ALLEGATIONS

Plaintiffs are health care providers that "provide in- and out-patient substance abuse and/or mental health treatment in California and Arizona." [SAC ¶ 10.] Plaintiffs allege that they provided health care services to plan participants and beneficiaries of employer-sponsored plans governed by ERISA, "except for a handful of plans and policies" that are not governed by ERISA. [*Id*. at ¶¶ 19-20.] Plaintiffs are "out-of-network" providers without preexisting contractual relationships with Defendants. [*Id*. at ¶¶ 2, 231.] Defendants are generally alleged to be ERISA-governed employee benefit plans or entities that administer and/or insure the ERISA-governed plans at issue in Plaintiffs' SAC. [*Id*. at ¶¶ 20-22, 158.] Plaintiffs contend that they obtain "valid assignment of benefits […] from all patients before treating them." [SAC ¶ 233.] According to Plaintiffs, "[t]he Assignments give [Plaintiffs] the right to be paid directly for any services rendered to patients, and also entitle[s] [Plaintiffs] to assert patients' legal rights to recover benefits." [*Id*. at ¶ 234.] 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 SAC; and (2) an express assignment of benefits, which is attached as Exhibit B to the SAC. [*Id*. at Ex. A (Form A Assignment); Ex. B (Form B Assignment).] For each of the medical claims at issue in the SAC, Plaintiffs allege that the Defendants in the action improperly paid benefits to their members/insureds, rather than to Plaintiffs directly. [*See, e.g., id*. at ¶¶ 5, 256, 263.] For some of the underlying patient claims, Plaintiffs also contend that Defendants misled Plaintiffs into believing that Plaintiffs' patients were "members of plans where assignment was permitted." [*Id*. at ¶¶ 263, 283.]

[3] The legal standard governing Rule 12(b)(6) motions to dismiss is set forth at pages 4-5 of the Court's Order Granting In Part Omnibus Motion to Dismiss.

Based on these allegations, Plaintiffs aver one or more claims to recover ERISA benefits against Defendants pursuant to ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). [SAC ¶¶ 278-89.] As to the so-called "Blue Cross Defendants," Plaintiffs also assert a claim for alleged violations of California Business and Professions Code § 17200. [*Id*. at ¶¶ 290-306.] Finally, as to the "Non-ERISA Plan Defendants and the Associated Blue Cross Defendants," Plaintiffs purport to allege various "state law claims," including "misrepresentation" and "breach of contract." [*Id*. at ¶¶ 307-316.]

III. PLAINTIFFS' CLAIMS SHOULD BE DISMISSED WITH PREJUDICE

A. Plaintiffs Fail To Allege Facts And Claims Against Twenty-Six Named Welfare Plan Defendants.

Rule 8 requires that a complaint give the defendants fair notice of the factual basis for a plaintiff's claims. *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). In particular, Rule 8 requires that a plaintiff identify "specific Defendants who are liable for each particular claim." *Curry v. FPC Lompoc Med Director*, No. CV 16-7523 AB (SS), 2016 WL 6781113, at *2 (C.D. Cal. Nov. 16, 2016) (dismissing complaint because plaintiff broadly alleged wrongdoing by a general administration without identifying individuals who specifically harmed him or linking "the particular Defendants to particular claims"). Plaintiffs, however, have failed to give fair notice to twenty-six welfare plans[4] identified in the SAC because none of the claims in the SAC are asserted against these defendants. Plaintiffs have accordingly not apprised these defendants of the grounds for relief.[5]

Plaintiffs' SAC asserts four claims for relief. Of these four claims, only Claims One and Two to recover ERISA benefits are asserted against the ERISA-governed welfare plans named as Defendants. [SAC ¶¶ 278-289.] Nonetheless, Plaintiffs have not alleged that the twenty-six welfare plans committed any wrong, let alone alleged any

[4] Exhibit C, attached hereto, identifies the twenty-six welfare plans. Defendants note that Plaintiffs and Defendants have met and conferred regarding this issue and are close to resolving it as to twenty-three of the welfare plans discussed herein.

[5] Additionally, Plaintiffs have likewise failed to assert their ERISA claims as to certain underlying patient claims.

facts against them. Claim One enumerates patients for which there is no allegedly applicable AAP. [SAC ¶ 280(a)-(b).] Claim Two does the same for plans that Plaintiffs thought were assignable as a result of alleged misrepresentations by Defendants. [SAC ¶ 283.] But Plaintiffs do not identify any patients associated with the twenty-six welfare plans in either claim. Accordingly, neither claim is brought against any of the twenty-six welfare plan defendants. In violation of Rule 8, the SAC is bereft of any information about why these twenty-six defendants are liable under any of the SAC's theories of relief. The SAC does not even rise to the level of "an unadorned, the defendant-unlawfully-harmed-me accusation" in violation of Rule 8. *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). These twenty-six welfare plans are left with nothing more than being named as defendants in a lawsuit that seeks no relief from them, contrary to Rule 8(a)'s requirements, and they should be dismissed from the action with prejudice.

B. Plaintiffs Fail To Adequately Plead With Particularity Their Second Claim Under ERISA And Third Claim For Alleged Violations Of Business And Professions Code § 17200.

Plaintiffs' Second Claim under ERISA is predicated on the allegation that "agents of Defendants led Sovereign to believe assignments of claims were permitted" and "Sovereign should accordingly be directly paid for the services rendered." [SAC ¶¶ 285, 288(f).] Based on this allegation, Plaintiffs contend that Defendants should be precluded from enforcing the AAPs in the underlying plan documents "[u]nder the equitable theory of reformation" or, in the alternative, "the equitable theory of estoppel." [*Id*. at ¶¶ 287-88.] Similarly, Plaintiffs' Third Claim for alleged violations of Business and Professions Code § 17200 is singularly based on the assertion that, "during the verification of benefits process, the Blue Cross Defendants *routinely* told Plaintiffs that claims were assignable when in fact they were not." [*Id*. at ¶ 296 (emphasis in original).] In support of both claims, Plaintiffs incorporate their "Appendix concerning the Patients," which purportedly "details the specifics of the misrepresentation for each Patient." [*Id*. at ¶¶ 284, 292.]

Where, as here, a party alleges fraud or mistake, that party "must state with

particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b); *see also* [Dkt. 1063 (Order Granting In Part Omnibus Motion to Dismiss (the "Order") at 4 (citing *Concha v. London*, 62 F.3d 1493, 1503 (9th Cir. 1995))]. The strictures of Rule 9(b) require that fraud be pled "with a high degree of meticulousness." *Chan Tang v. Bank of Am., N.A.*, No. SACV 11–2048 DOC (DTBx), 2012 WL 960373, at *13 (C.D. Cal. Mar. 19, 2012) (quoting *Desaigoudar v. Meyercord*, 223 F.3d 1020, 1022 (9th Cir. 2000)). Rule 9(b) ensures that averments of fraud are "specific enough to give defendants notice of the particular misconduct which is alleged to constitute the fraud charged so that they can defend against the charge and not just deny that they have done anything wrong." *Semegen v. Weidner*, 780 F.2d 727, 731 (9th Cir. 1985). Accordingly, "where a complaint includes allegations of fraud, Federal Rule of Civil Procedure 9(b) requires more specificity including an account of the 'time, place, and specific content of the false representations as well as the identities of the parties to the misrepresentations.'" *Swartz v. KPMG LLP*, 476 F.3d 756, 764 (9th Cir. 2007) (citation omitted). The plaintiff must also state the "who, what, when, where, and how" of the alleged fraud. [Order at 4 (citing *Vess v. Ciba-Geigy Corp. USA*, 317 F.3d 1097, 1106 (9th Cir. 2003); *Neubronner v. Milken*, 6 F.3d 666, 672 (9th Cir. 1993)).] Further, when a plaintiff alleges a claim sounding in fraud against a corporation, the plaintiff must "allege the names of the persons who made the allegedly fraudulent representations, their authority to speak, to whom they spoke, what they said or wrote, and when it was said or written." *Macris v. Bank of Am., N.A.*, No. CV F 11-1986 LJO SKO, 2012 WL 273120, *11 (E.D. Cal. Jan. 30, 2012) (quoting *Tarmann v. State Farm Mut. Auto. Ins. Co.*, 2 Cal.App.4th 153, 157 (1991)).

As this Court previously observed, Rule 9(b)'s heightened pleading standard applies to Plaintiffs' claim for equitable estoppel. [Order at 17.] Similarly, as to Plaintiffs' claim for reformation, this Court noted that, "[s]hould Plaintiffs amend their complaint to include a claim for reformation, they must plead with particularity the facts that show that because of mistake or fraud, the plan terms do not reflect those the sponsor

assented to or intended to impose." [*Id*. at 19, fn. 9 (citing *Gabriel v. Alaska Elec. Pension Fund*, 773 F.3d 945, 955 (9th Cir. 2014); Fed. R. Civ. P. 9(b)).][6] In spite of the Court's express instruction to Plaintiffs, the SAC does not plead any representation by any of the Defendants in the case with particularity. Instead, Plaintiffs' Second and Third Claims are again "pleaded on information and belief and in the vaguest of terms" and should be dismissed with prejudice. [*See* Order at 18.]

Specifically, Plaintiffs' Second and Third Claims are fatally deficient under Rule 9(b) on several independent grounds:

- Plaintiffs fail to allege any representation – at all – by any Defendant. The SAC merely alleges Plaintiffs' (or their agents') subjective understanding based on the alleged communication. [*See* SAC Patient Appendix (alleging that Plaintiffs "requested details" about their patients' coverage and "**learned**" that the patients' "benefits were assignable" for each of the patient claims at issue in the Second and Third Counts) (emphasis added).]
- Plaintiffs fail to allege which Plaintiff entity allegedly communicated with Defendants. [*See id*.] Instead, Plaintiffs allege that "Sovereign," which is defined in the SAC to refer to all of the Plaintiff entities "individually" or "collectively," communicated with Defendants in some instances. [*Id*., ¶ 16 ("[f]or purposes of this Complaint, Dual Diagnosis, Satya, Adeona, Sovereign Phoenix, and SAM, are collectively referred or individually referred to as 'Sovereign…'").]
- Plaintiffs fail to allege whether Plaintiffs communicated with Defendants or if one of their "agents" communicated with Defendants. [SAC Patient Appendix (alleging that "Sovereign **or its agents** contacted…" for each of the patient claims at issue in the Second and Third Counts) (emphasis added).]
- If one of Plaintiffs' "agents" communicated with Defendants, the SAC does not identify the agent that allegedly communicated with Defendants. [*Id*.]

[6] The heightened pleading standard of Rule 9(b) also applies to state unfair competition claims grounded in fraud. *Alvarado v. Aurora Loan Servs., LLC*, No. SACV 12-0524-DOC-(JPRx), 2012 WL 4475330, at *7 (C.D. Cal. Sept. 20, 2012).

- For the vast majority of patient claims at issue, Plaintiffs fail to allege the Defendant entity with whom the Plaintiffs or Plaintiffs' agents allegedly communicated. [*Id*. (alleging that Plaintiffs or one of their agents allegedly communicated with Defendant A "and/or" Defendant B for 104 of the 132 patient claims and Defendant A, Defendant B "and/or" Defendant C for 7 of the 132 patient claims).]
- Plaintiffs fail to identify the names of the individuals from Defendants who made the alleged misrepresentations or their authority to speak on behalf of any Defendant. [*Id*.]
- Plaintiffs fail to allege how Plaintiffs "contacted" Defendants (*e.g.*, by telephone, email, written correspondence, etc.). [*Id*. (alleging that Plaintiffs "contacted" Defendants but failing to specify how).]
- Plaintiffs fail to allege how the alleged misrepresentations were communicated to Plaintiffs (*i.e.*, by telephone, email, written correspondence, etc.). [*Id*.]

This Court has dismissed claims sounding in fraud under Rule 9(b) where, as here, the complaint fails to allege "specific representations that were false or misleading" and "identify the speaker of such misrepresentations." *Chan Tang*, 2012 WL 960373, at *13. Compounding the vagueness of the SAC's allegations, all of Plaintiffs' patient-specific factual allegations are based "on information and belief," which is insufficient to satisfy the requirements of Rule 9(b). *Tatung Co., Ltd. v. Shu Tze Hsu*, 43 F. Supp. 3d 1036, 1062 (C.D. Cal. 2014) (citing *Neubronner*, 6 F.3d at 672) (holding that allegations of fraud are insufficient if they are conclusory and based on "information and belief" without providing "the factual basis for the belief."). Further, the Patient Appendix alleges nearly identical facts for each Defendant, which stretches the bounds of credulity. *See Iqbal*, 556 U.S. at 679 ("[O]nly a complaint that states a plausible claim for relief survives a motion to dismiss."). A plaintiff may not "merely lump multiple defendants together" when suing for fraud, but instead must "differentiate [its] allegations when suing more than one defendant and inform each defendant separately of the allegations surrounding his alleged participation in the fraud." *Tatung*, 43 F. Supp. 3d at 1061-62 (quoting *Swartz*, 476 F.3d at 764-65). Rather than satisfying this standard, the SAC treats

Defendants as an undifferentiated mass of entities, which is insufficient to state a claim for relief sounding in fraud under Rule 9(b). Accordingly, Plaintiffs' Second and Third Claims plainly do not satisfy the pleading requirements of Rule 9(b) on several independent grounds and should be dismissed from the SAC with prejudice.

C. Even Assuming Compliance With Rule 9(b), Plaintiffs' Second Claim Under ERISA Fails As A Matter Of Law.

Plaintiffs' Second Claim seeks the recovery of benefits under ERISA plans that contain AAPs – the vast majority of which this Court previously determined was valid and enforceable. In an attempt at circumventing the express terms of the plan documents, Plaintiffs ask the Court to rewrite the benefit plans under "the equitable theory of reformation" or, in the alternative, to preclude Defendants from enforcing the AAPs under "the equitable theory of estoppel." [SAC ¶¶ 287-88.] For the reasons discussed below, Plaintiffs' request for equitable relief fails, the AAPs should be enforced, and Claim Two should be dismissed with prejudice.

1. Plaintiffs' Claims For Reformation And Equitable Estoppel Fail Because They Are Not Remedies Available Under An ERISA Claim To Recover Benefits.

"ERISA does permit a party to ask for equitable estoppel as a form of equitable relief under 29 U.S.C. § 1132(a)(3)." [Order at 17 (citing *CIGNA Corp. v. Amara*, 563 U.S. 421, 443 (2011)).] Similarly, the remedy of reformation is a claim for "other appropriate equitable relief" under § 1132(a)(3)(B). [*Id*. at 19 (citing *Amara*, 563 U.S. at 443).] However, the SAC does not assert a claim for equitable relief under § 502(a)(3). Instead, Plaintiffs' Second Claim is styled as a "Claim to Recover ERISA Benefits" under § 502(a)(1)(B). [SAC p. 61:2.] As the Supreme Court has explained, the statutory language of § 502(a)(1)(B) "speaks of '*enforc[ing]*' the 'terms of the plan,' not of *changing* them." *Amara*, 563 U.S. at 435-36 (emphasis in original). In contrast, the equitable relief requested by Plaintiffs, if accepted, would necessarily change the literal terms of the ERISA plan documents at issue here because they would either excise valid AAPs or preclude their enforcement entirely. While reformation "is available as a

remedy under 502(a)(3)," it "is *not* available as a remedy pursuant to 502(a)(1)(B)." *Bush v. Liberty Life Assurance Co.*, 77 F. Supp. 3d 900, 908 (N.D. Cal. 2015) (citing *Amara*, 563 U.S. 421). Similarly, equitable estoppel is not available under § 502(a)(1)(B). *See Amara*, 563 U.S. at 436 (analyzing the text of § 502(a)(1)(B) and concluding that "nothing … authorizes a court to alter [the terms of the plan…] where that change, akin to the reform of a contract, seems less like the simple enforcement of a contract as written and ***more like an equitable remedy***.") (emphasis added). In short, the SAC does not bring a claim for equitable relief under § 502(a)(3), nor does it advance any legal or factual basis for the imposition of equitable relief. Plaintiffs therefore should not be permitted to shoehorn equitable remedies reserved under § 502(a)(3) into a § 502(a)(1)(B) claim to recover ERISA plan benefits.

2. Form A Does Not Assign Equitable Claims To Plaintiffs.

Reformation and estoppel are equitable remedies. [Order at 17-18 (citing *Amara*, 563 at 443).] To seek the equitable remedies of reformation and estoppel under ERISA, Plaintiffs must allege that they obtained an assignment of the right to seek equitable relief from their patients. "[I]t is essential to an assignment of a right that the [assignor] manifest an intention to transfer the right to another person." *See Britton v. Co-op Banking Grp.*, 4 F.3d 742, 746 (9th Cir. 1993) (quoting Restatement (Second) of Contracts § 324 (1981)). Here, Form A provides as follows:

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

[Order at 8.][7] By its terms, Form A does not mention – let alone manifest any intent by Plaintiffs' patients to assign – equitable claims under ERISA. While the Court previously held "that Form A manifests an intent to assign a claim for benefits and the right to sue for them under ERISA" [Order at 8.], this Court was clear that Form A does not transfer the right to seek equitable relief under ERISA. Specifically, this Court previously held

[7] The patient claims predicated on Form A are listed at Dkt. 637-7.

that Form A "**is limited on its face to the amount due for treatment and services rendered by Dual Diagnosis**." [Order at 8 (emphasis added).] Thus, by its terms, Form A does not assign the right to seek equitable relief from the Court. *Sanctuary Surgical Ctr., Inc. v. Aetna, Inc.*, 546 F. App'x 846, 851-52 (11th Cir. 2013) (holding that "the scope of an assignment cannot exceed the terms of the assignment agreement itself" and 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 for equitable relief).

3. Plaintiffs' Claim For Reformation Fails As A Matter Of Law.

Reformation is limited to the event of mistake or fraud. [Order at 19, fn. 9]; *Gabriel*, 773 F.3d at 955; *Skinner v. Northrop Grumman Ret. Plan B*, 673 F.3d 1162, 1165 (9th Cir. 2012). Reformation based on fraud requires that (1) the plan document itself "was procured by wrongful conduct, such as undue influence, duress or fraud" or (2) the party's assent to the contract "was induced by the other party's misrepresentations as to the terms or effect of the contract" and it was "justified in relying on the other party's misrepresentations." *Gabriel*, 773 F.3d at 962 (quoting *Skinner*, 673 F.3d at 1166).[8] Reformation is not available if the "[p]lan itself does not contain an error." *See Gabriel*, 773 F.3d at 961. Consistent with these principles, the Ninth Circuit has held that the equitable remedy of reformation based on fraud contemplates, as a necessary condition, the existence of either (1) a trust that was wrongfully procured or (2) a contract induced by the other party's misrepresentation. *See id.* at 962; *Skinner*, 673 F.3d at 1166. In *Gabriel*, the Ninth Circuit rejected a reformation claim premised on fraud where the plaintiff failed to allege that the ***plan document itself*** was "procured by wrongful conduct." *Gabriel*, 773 F.3d at 962. Rather, the *Gabriel* plaintiff attempted to reform the Plan based on conduct subsequent to the creation of the plan: alleged misinformation given by a plan representative in a letter. *Id*.

Here, Plaintiffs do not plead that the actual plan document itself was wrongfully

[8] Plaintiffs do not allege mistake in the SAC, since their theory of reformation turns on allegedly "inequitable conduct" that misled Plaintiffs. [SAC ¶ 287.]

procured by fraud. Like the *Gabriel* plaintiff, who unsuccessfully relied on an after-the-fact statement to attempt to reform the plan document, Plaintiffs plead a theory of reformation that hinges on purported misrepresentations that occurred ***after the plan documents were already in place***. [*See* SAC ¶ 287.] The existence of a plan document necessarily preceded any alleged misrepresentation about the non-assignability of benefits. Thus, as a matter of law, the plan document was not "wrongfully procured" or "induced by misrepresentation." Plaintiffs may not therefore pursue a reformation claim under ERISA that "would result in a payment of benefits that would be inconsistent with the written plan." *Gabriel*, 773 F.3d at 962.[9]

Further, reformation based on fraud in the ERISA context requires a "plausible inference of fraud." *See Parsons v. Bd. of Trs. of Nev. Resort Ass'n-I.A.T.S.E. Local 702 Ret. Plan*, No. 2:12-cv-00299-LDG (VCF), 2012 WL 3319742, at *5 (D. Nev. Aug. 13, 2012) (citing *Peralta v. Hispanic Bus., Inc.*, 419 F.3d 1064 (9th Cir. 2005)). Alleging that the employee of an administrator provided an inaccurate statement regarding plan documents is insufficient for pleading reformation based on fraud. *Id*. In *Parsons*, the plaintiff was a participant in a retirement plan administered by Zenith. *Id*. at *1. The plaintiff alleged that he asked an employee of Zenith for guidance about the terms of a retirement plan, and based on that representation, applied for early retirement. *Id*. After his retirement, he learned that the Zenith employee misstated his retirement benefits and thus sued for breach of fiduciary duty under ERISA. *Id*. The *Parsons* court dismissed the plaintiff's ERISA claim for reformation under Rule 12(b)(6). *Id*. at *5. As it explained, a mere misstatement of the terms of the plan documents is insufficient to warrant the equitable remedy of reformation. *Id*. The complaint was bereft of "trickery, hiding facts, active concealment, or active misrepresentation" in presenting the plan to the participant. *Id*. And simply identifying a discrepancy between the plan document and later representations "do[es] not constitute evidence of fraudulent inducement" for

[9] The doctrine of reformation also contemplates a legal relationship between two parties based on either trust or contract law. *Gabriel*, 773 F.3d at 955; *Skinner*, 673 F.3d at 1166. No such relationship is alleged between Defendants and Plaintiffs.

pleading reformation. *Id.*; *see also Skinner*, 673 F.3d at 1166-67 ("The inconsistency between the 2003 [Summary Plan Description] and the plan master document is not evidence of fraudulent inducement."). So too here: Plaintiffs' SAC does not allege the requisite "fraudulent inducement" in presenting the plans to the patients/participants that would entitle them to reformation of a plan document (to which they are not even a party). Rather, the SAC only alleges that their "agents or employees were informed that claims against plans associated with these Patients were assignable." [SAC ¶ 287.] This does not plausibly allege "fraudulent inducement." It only avers an inconsistency between the literal terms of the AAPs and what someone purportedly informed Plaintiffs' representatives, which both the Ninth Circuit and the *Parsons* court held to be insufficient for reformation.

4. Plaintiffs' Claim For Equitable Estoppel Fails As A Matter Of Law.

To plead equitable estoppel under ERISA, a plaintiff must allege facts supporting each of the following elements: (1) the party to be estopped must know the fact; (2) the party must intend that its conduct shall be acted on or must so act that the party asserting estoppel has a right to believe it is so intended; (3) the party asserting estoppel must be ignorant of the true facts; (4) the party reasonably relied on such conduct to its injury; (5) the plan provision at issue is ambiguous such that reasonable people could disagree about its meaning or effect; (6) the party asserting estoppel must demonstrate "extraordinary circumstances" that warrant application of equitable estoppel; and (7) the representations were interpretations of the plan, not an amendment or modification of the plan. [Order at 17-18.]; *see Gabriel*, 773 F.3d at 955-57. Plaintiffs' claim for equitable estoppel fails as a matter of law on several independent grounds.

a. <u>Estoppel Would Improperly Enlarge Plaintiffs' Rights Beyond The Literal Terms Of The Plan Documents.</u>

Under ERISA, a plaintiff may not use estoppel to enlarge his rights beyond the terms of the plan documents. *Gabriel*, 773 F.3d at 956 (holding that a plaintiff "cannot maintain a federal equitable estoppel claim in the ERISA context when recovery on the

claim would contradict written plan provisions."). Further, the Ninth Circuit has held that "erroneous information" provided by a representative of the plan does not, as a matter of law, serve as a basis for estoppel. *Id*. at 959. In *Gabriel*, the plaintiff relied on a letter from a pension plan representative that incorrectly stated his entitlement to certain retirement benefits—ones that were not promised pursuant to a plan. *Id*. at 958-59. Based on this letter, the *Gabriel* plaintiff argued that the pension plan was equitably estopped from relying on the actual terms of the plan documents. *Id*. The Ninth Circuit rejected this argument, concluding that the letter did not "provide an interpretation of the Plan, but merely provide[d] the erroneous information that [plaintiff] [was] entitled to benefits . . . ." *Id*. at 959. This error, then, was "just the sort of mistake that [the Ninth Circuit] repeatedly [has] held cannot provide a basis for equitable estoppel." *Id*.

Here, Plaintiffs advance the same argument as that of the *Gabriel* plaintiff. The SAC attempts to seize on an alleged mistaken statement by the plans' purported "agents" that are contrary to the AAPs in the plan documents. [*See* SAC ¶ 288.] But as the Ninth Circuit has held, estoppel cannot be used to redraft the literal terms of the underlying plan documents, as Plaintiffs try to do so here. *See Gabriel*, 773 F.3d at 959 (holding that plaintiff may not avail himself of estoppel to "enlarge his rights against the plan beyond what he could recover under the unambiguous language of the plan itself") (citing *Greany v. W. Farm Bureau Life Ins. Co.*, 973 F.2d 812, 822 (9th Cir. 1992) (rejecting ERISA estoppel claim because it "would result in a payment of benefits that would be inconsistent with the written plan and where an ***oral amendment or modification*** would be the practical result of a successful estoppel claim," which would "contradict the writing and amendment requirements of 29 U.S.C. §§ 1102(a)(1) and (b)(3).") (emphasis added); *see also Renfro v. Funky Door Long Term Disability Plan*, 686 F.3d 1044, 1054 (9th Cir. 2012) (holding that "a beneficiary cannot obtain recovery on the basis of estoppel 'in the face of contrary, written plan provision.'").

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b. Estoppel Does Not Apply Because Plaintiffs' Own Allegations Demonstrate That Their Reliance Was Unreasonable.

A party asserting equitable estoppel must also establish that its reliance was reasonable. *Renfro*, 686 F.3d at 1054. A plaintiff's reliance must be "reasonable in light of all the circumstances giving consideration to the plaintiff's intelligence and experience." *Amaco Enters. v. Smolen*, 61 F.3d 909 (9th Cir. 1995). The SAC alleges that Plaintiffs or their agents called on each of their patient's behalf to determine if benefits were assignable and subsequently obtained a "valid assignment of benefits." [*See* SAC ¶¶ 225-226, 233.] Plaintiffs purportedly had "extensive dealings" with Defendants in submitting their claims for payment on each Former Patient's behalf, but allegedly never received ***any*** payments from Defendants for ***hundreds*** of patient claims over ***numerous consecutive years***. [SAC ¶¶ 251-52.] Under these alleged facts, Plaintiffs' reliance here is patently unreasonable. Indeed, the only logical inference from the facts alleged in the SAC is that Plaintiffs would not be paid directly for their services. This is especially true in light of Plaintiffs' commercial sophistication as an allegedly national healthcare provider: they are a "leading provider of comprehensive addiction and mental health treatment programs to individuals in California and other states." [SAC ¶ 206.]. Thus, estoppel does not apply here because of Plaintiffs' unreasonable reliance.

c. Plaintiffs' Allegations Do Not Rise To The Level Of "Extraordinary Circumstances."

Finally, Plaintiffs' failure to sufficiently plead the requisite element of "extraordinary circumstances" is fatal to their equitable estoppel claim. *Advanced Orthopedics and Sports Med. v. Blue Cross Blue Shield of Mass.*, No. 14-7280 (FLW)(LHG), 2015 WL 4430488, *9-10 (D. N.J. July 20, 2015). Courts have required establishing "extraordinary circumstances" to "lessen the danger that commonplace communications from employer to employee will routinely be claimed to give rise to employees' rights beyond those contained in formal benefit plans." *Aramony v. United Way Replacement Benefit Plan*, 191 F.3d 140, 151 (2d Cir. 1999). The Ninth Circuit has

not defined "extraordinary circumstances" when recovering benefits under ERISA, but has referred to the case law of other circuits. *Gabriel*, 773 F.3d at 957 (citing Second and Third Circuit case law). Generally, "'extraordinary circumstances' . . . involve acts of bad faith." *See Burstein v. Ret. Account Plan For Emps. of Allegheny Health Educ. and Research Found.*, 334 F.3d 365, 383 (3d Cir. 2003).

Plaintiffs do not allege any facts that qualify as "extraordinary." The crux of Plaintiffs' claim is that Defendants should be estopped from enforcing the AAPs because Defendants purportedly misled Plaintiffs about assignability "repeatedly, and over a long period of time." [*See* SAC ¶ 288(e).] This is insufficient. As this Court observed, Plaintiffs may be hard pressed to show the requisite "extraordinary circumstances" because "each Blue Cross Defendant is independent" and "may only have a single patient in this case." [Order at 18-19.] Plaintiffs, in other words, do not allege any repeated pattern of conduct over time by the vast majority of Defendants. Rather, for all but a few Defendants, the SAC claims that a Blue Cross entity made a single incorrect representation as to the assignability of benefits with respect to a single patient claim on ***one*** particular date—a far cry from the "extraordinary circumstances" seen in other cases. [*See* SAC ¶ 283; *see, e.g.*, SAC ¶ 317 (alleging, upon information and belief, one misrepresentation on one date as to Patient 1's plan).].

The SAC does not aver any facts that would support a finding of "extraordinary circumstances," despite the Court's providing ample time for Plaintiffs to amend their Complaint. In *Advanced Orthopedics*, the district court dismissed the plaintiff healthcare provider's ERISA claim with prejudice on anti-assignment grounds, even though the provider asserted a claim of equitable estoppel. The *Advanced Orthopedics* court held that because the provider did not allege that the defendant (1) "acted in bad faith"; (2) "attempted to actively conceal information; or (3) "repeated affirmative misrepresentations over time," the provider failed to plead the three factors "required to substantiate estoppel." *Advanced Orthopedics*, 2015 WL 4430488, at *9-10. *Advanced Orthopedics* applies equally here. Plaintiffs do not allege that Defendants acted in bad

faith or actively tried to conceal the AAP. To the extent Plaintiffs allege a misrepresentation about assignability, they are neither "repeated" nor made "over time" for the vast majority of Defendants because Plaintiffs allege a single misrepresentation made at one point in time. [*See, e.g.*, SAC ¶ 317.] Because Plaintiffs do not plead the three necessary factors of "extraordinary circumstances," their estoppel claim should be dismissed with prejudice.

D. Plaintiffs' First And Second Claims Under ERISA Fail Where They Seek Extra-Contractual Damages.

Plaintiffs seek recovery of ERISA benefits under § 502(a)(1)(B) in their First and Second Claims. [SAC ¶¶ 278-289.] Plaintiffs' First Claim incorporates the allegations of their Second Claim. [SAC ¶ 278 ("Plaintiffs re-allege each paragraph of this Complaint as if fully set forth herein.").] Their Second Claim, in turn, alleges that Plaintiffs "incurred significant costs in attempting to collect the money" from Patients. [SAC ¶ 288(d).] Plaintiffs also aver for the first time that they collected ***full*** payment from certain unspecified patients, but allege damages flowing from their collection efforts. [*Id.*] In particular, Plaintiffs claim that they lost "employee time; the time value of money; fees to outside agents, vendors, and attorneys to effect collection; and/or collecting [sic] less than the full balance that was due." [*Id.*] Plaintiffs' ERISA claims, however, fail in two respects: (1) ERISA does not permit recovery of extra-contractual and compensatory damages and (2) the SAC fails to give Defendants sued under the First and Second Claims an opportunity to defend themselves to the extent Plaintiffs' § 502(a)(1)(B) claims rely on impermissible forms of relief.

First, extra-contractual, compensatory, and punitive damages are not available under ERISA. *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1009 (9th Cir. 1998) (citing *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985)). For example, claims that seek "loss of income" are extra-contractual damages not allowed under ERISA. *Sconiers v. First Unum Life Ins. Co.*, No. C 11-01798 WHA, 2011 WL 5192862, at *3 (N.D. Cal. Nov. 1, 2011). Accordingly, courts have dismissed with

prejudice § 502(a)(1)(B) claims to the extent they seek punitive and exemplary damages, as amendment would be futile. *See Cruzeta v. Sony Electronics, Inc.*, No. 12-cv-1430-L-BLM, 2013 WL 12098756, at *7 (S.D. Cal. Dec. 10, 2013). Here, Plaintiffs' ERISA claims impermissibly seek relief for extra-contractual and compensatory damages. Claims for the time value of money, lost employee time, "fees to outside agents" and the like are all outside the scope of ERISA's civil enforcement provision because they are compensatory in nature. *Bast*, 150 F.3d at 1009 ("out of pocket costs" and "loss of income" are not recoverable); [SAC ¶ 288(d).]

Second, Plaintiffs fail to give Defendants fair notice about which Patient claims they collected full payment on, which deprives each Defendant the opportunity to understand the claims against it. [*See* SAC ¶ 283.] For their First and Second Claims, Plaintiffs generally allege the non-payment of benefits against Defendants, but also seek types of damages unavailable under ERISA for those Patient claims on which they did fully recover. [*See* SAC ¶¶ 278 (incorporating all paragraphs of the Complaint); 283, 286, 288(d).] Consequently, each Defendant lacks the opportunity to defend itself against a § 502(a)(1)(B) claim insofar as Plaintiffs seek to collect extra-contractual or compensatory damages. As this Court explained, however, Plaintiffs may not simply lump the Defendants together. Doing so would deny "each Defendant of both the opportunity to understand what it is being accused of doing and the opportunity to defend itself." [Order at 36 (citing *Romero v. Countrywide Bank, N.A.*, 740 F. Supp. 2d 1129, 1136 (N.D. Cal. 2010)).] Under these circumstances, any claim on account of a patient for whom Plaintiffs have been fully paid should be dismissed with prejudice. In addition, Plaintiffs should be directed to disclose those Patients for whom they have been paid in full, so that such dismissals can be effectuated and Defendants can otherwise defend themselves.

E. Even Assuming Compliance With Rule 9(b), Plaintiffs' Third Claim For Alleged Violations Of Business And Professions Code § 17200 Fails To Plead Unlawful, Fraudulent, Or Unfair Conduct.

Plaintiffs' Third Claim for alleged violations of California's Business and

Professions Code § 17200 fails as a matter of law for four reasons. First, it fails to identify a particular statute on which Plaintiffs can base their claim of "unlawful" business practices. Second, it fails to satisfy the pleading standard for a UCL claim grounded in fraud. Third, Plaintiffs are neither consumers of Defendants' services nor competitors of Defendants, and therefore cannot pursue a UCL claim based on "unfair" business practices. Fourth, Plaintiffs' UCL claim is preempted by ERISA § 514.

1. Plaintiffs Fail To Identify A Borrowed Law For Their "Unlawful" Claim.

A UCL claim premised upon "unlawful" conduct requires that the plaintiff show the violation of a "borrowed" law flowing from the defendant's business practice. *Davis v. HSBC Bank*, 691 F.3d 1152, 1168 (9th Cir. 2012). As this Court noted, "[i]n order to state a violation of the unlawful prong, Plaintiffs must identify a particular section of a statutory scheme and describe with reasonable particularity the facts supporting the statutory elements of the alleged violation." [Order at 20:1-3 (citing *Khoury v. Maly's of California, Inc.*, 14 Cal. App. 4th 612, 619 (1993)).]. Plaintiffs' SAC fares no better after amendment since they still cannot identify a freestanding law that Defendants allegedly violated. At most, the SAC only alleges some vague "prohibition against systematically misleading and deceiving an innocent counterparty." [SAC ¶ 305.] Far from identifying a particular statute, the SAC can only conjure up a conclusory statement that "California law independently prohibits" Defendants' business practice. [*See* SAC ¶ 305]; *see People v. McKale*, 25 Cal.3d 626, 635 (1979) ("Without supporting facts demonstrating the illegality of a rule or regulation, an allegation that it is in violation of a specific statute is purely conclusionary [sic] and insufficient to withstand demurrer."). Defendants, as a result, have no notice about what "independent" prohibition they have allegedly violated or the facts supporting that violation. Insofar as Plaintiffs allege some type of fraud as a predicate act for their "unlawful" claim, the SAC has failed to satisfy Rule 9(b)'s particularity requirement. *See* Section IV.B., *supra*.

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2. Plaintiffs Fail To Plead With Particularity For Their "Fraudulent" Claim.

State law causes of action grounded in fraud must satisfy Rule 9(b)'s particularity requirement. *Vess*, 317 F.3d at 1103. As discussed above, the SAC's allegations do not satisfy Rule 9(b)'s pleading requirements and any UCL claim premised on alleged fraudulent conduct necessarily fails as a result. *See* Section IV.B., *supra*.

3. Plaintiffs Do Not Allege That They Are Consumers Or Competitors As Needed For Their "Unfair" Claim.

Plaintiffs' UCL claim, predicated on Defendants' purportedly "unfair" conduct, fails because Plaintiffs are neither competitors of Defendants nor consumers of Defendants' services. As this Court noted, California has adopted three different tests to determine if a practice is unfair. [Order at 20.] Each of these three tests, however, requires as a threshold matter that Plaintiffs be a consumer or competitor. *Almasi v. Equilon Enters.*, No. 5:10-cv-03458 EJD, 2012 WL 3945528, at *9 (N.D. Cal. Sept. 12, 2012) (dismissing UCL claim where plaintiffs were "neither consumers nor competitors" of defendant); *Kasky v. Nike, Inc.*, 27 Cal.4th 939, 949 (2002) ("The UCL's purpose is to protect ***both consumers and competitors*** by promoting fair competition in commercial markets for goods and services.") (emphasis added). If a plaintiff sues in its capacity as a competitor of the defendant's for "unfair" practices, the business conduct at issue must pose some anti-competitive harm. *See Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co.*, 20 Cal. 4th 163, 187 (1999). Alternately, if the plaintiff sues in its capacity as a consumer for "unfair" practices, California appellate courts have announced three different tests. *See Camacho v. Automobile Club of S. Cal.*, 142 Cal. App. 4th 1394, 1403 (2006) (citing three-pronged test that analyzes, among other things, a substantial "consumer injury"); *Davis*, 691 F.3d at 1169 (adopting balancing test that weighs the utility of the defendant's conduct against harm to consumer); *Lozano v. AT&T Wireless Servs., Inc.*, 504 F.3d 718, 735 (9th Cir. 2007) (approving definition of "unfair" as one tethered to a legislatively declared policy in consumer class action). Thus, each test used by California courts necessarily contemplates the existence of a plaintiff

competitor or plaintiff consumer.

Here, the SAC has pled no facts implicating conduct that falls under the "unfair" prong of the UCL. The SAC does not allege that (1) Plaintiffs are competitors of Defendants; (2) Defendants have violated or threaten to violate antitrust laws; or (3) Plaintiffs are consumers of Defendants' services. [*See* SAC ¶¶ 290-305.] Rather, Plaintiffs merely allege that Defendants' "conduct toward out-of-network providers" is unfair. [SAC ¶ 304.] This is inadequate. *See Almasi*, 2012 WL 3945528, at *10 (granting defendant's motion for partial summary judgment that its conduct was not unfair under the UCL because plaintiffs were neither consumers nor competitors of defendant). Further, because Plaintiffs' allegation of "unfairness" fits into none of the tests promulgated by California appellate courts, Defendants still lack adequate notice about what, precisely, is "unfair" about their conduct. Plaintiffs have not identified any legislatively declared policy that Defendants have violated, nor explained the "consumer injury" that they have suffered. *See Lozano*, 504 F.3d at 735; *Camacho*, 142 Cal. App. 4th at 1169. Accordingly, Plaintiffs have failed to even satisfy the more generous pleading standard under Rule 8, which requires showing why they are entitled to relief.

4. Plaintiffs' UCL Claim Is Preempted By ERISA.

Additionally, in spite of Plaintiffs' assertion that they are bringing a UCL claim "in their own right and not as assignees," Plaintiffs' UCL claim challenges the Blue Cross Defendants' administration of ERISA plan benefits and singularly contends that Defendants unlawfully paid ERISA plan benefits to Plaintiffs' patients, rather than Plaintiffs directly. [SAC ¶¶ 5, 256, 263, 295-97.] Thus, Plaintiffs' UCL 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 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., N.A.*, 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. v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1053 (9th Cir. 2000). "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' UCL claim necessarily relates to the ERISA-governed benefit plans at issue because Plaintiffs are challenging the Blue Cross Defendants' administration of ERISA-governed benefit plans and are seeking the direct payment of their patients' plan benefits pursuant to alleged assignments under those ERISA-governed benefit plans. Plaintiffs' UCL claim also ultimately seeks to restructure the relationship between Defendants and their members as it relates to the members' entitlement to receive the payment of benefits directly. As a result, Plaintiffs' UCL claim clearly falls within the preemptive scope of ERISA's express preemption provision and should be dismissed with prejudice on this independent ground.[10]

F. Plaintiffs' Fourth Claim For Relief, Based On Alleged Violations Of State Law, Fails To Give Defendants Fair Notice.

Rule 8 requires that a complaint "give the defendant fair notice of what the . . .

[10] Finally, Defendants note that, for the patient claims that the Court determined are actionable under § 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) ("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"). (internal quotation marks omitted).

claim is and the grounds upon which it rests." *Twombly*, 550 U.S. at 555. Where a complaint "tenders naked assertions devoid of further factual enhancement," it is deficient under Rule 8. *Lincoln v. Silverstein*, No. SACV 09-1072 DOC(Ex), 2011 WL 318318, *2 (C.D. Cal. Jan. 27, 2011) (quoting *Iqbal*, 556 U.S. at 678) (internal quotation marks omitted). Here, the SAC's Fourth Claim lumps together a patchwork of various state law claims, alleging "Misrepresentation, Breach of Contract, and Other State Law." [SAC, p. 67:18.] Plaintiffs also plead equitable estoppel and reformation, and insert a vague catch-all paragraph at the end that seeks "all permissible relief under state law" without identifying the actual claims for relief. [SAC ¶¶ 309, 312-13, 316.] Each state law claim, however, fails to allege sufficient facts that would give fair notice to Defendants about the legal claims at issue. The Fourth Claim should therefore be dismissed with prejudice.

1. Breach Of Contract.

A cause of action for breach of contract requires (1) the existence of a contract between plaintiff and defendant; and (2) defendant's breach of that contract. *Mammoth Lakes Land Acquisition, LLC v. Town of Mammoth Lakes*, 191 Cal. App. 4th 435, 463 (2010). Even if construed liberally, the SAC fails to identify a valid contract between Plaintiffs and Defendants. In fact, the SAC concedes that Plaintiffs lack a written contract with Defendants. [SAC ¶ 231(describing an "out-of-network" provider as "one who ***does not have a contractual relationship with the insurance company***") (emphasis added).] Instead, the SAC alleges the existence of a contract between Defendants and Plaintiffs' ***patients***. [*See* SAC ¶ 308 (noting that "some ***Patients*** are governed by plans or insurance policies that are not covered by ERISA") (emphasis added).] Thus, Plaintiffs' claim for breach of contract should be dismissed with prejudice because the SAC fails to plead any facts regarding a contract between Plaintiffs and Defendants, or the breach of such contract.

2. "Other State Law."

Plaintiffs' Fourth Claim reserves unidentified forms of "permissible relief under

state law." [SAC ¶ 316.] Plaintiffs offer no "factual enhancements" to support their unstated "other state law" claims. *See Silverstein*, 2011 WL 318318 at *2. This is exactly the type of legal label and conclusion in pleadings that *Iqbal* and *Twombly* foreclose. *Iqbal*, 556 U.S. at 678; *Twombly*, 550 U.S. at 555. As a result, Plaintiffs' "other state law" claims should be dismissed with prejudice as they give Defendants no notice about the factual allegations underpinning a coherent theory of liability.

3. Negligent And Intentional Misrepresentation.

For the reasons discussed in Section IV.B., *supra*, Plaintiffs' state law misrepresentation claim fails because they do not satisfy the heightened pleading standard of Rule 9(b). [SAC ¶ 311]; *Forouzesh v. Starbucks Corp.*, No. CV 16-3830 PA (AGRx), 2016 WL 4443203, at *4 (C.D. Cal. Aug. 19, 2016) (applying Rule 9(b) standard to negligent misrepresentation claim). Even if Plaintiffs' negligent misrepresentation claim is subject to the Rule 8 pleading standard, it should be dismissed because Plaintiffs aver no facts supporting the claim. A cause of action for negligent misrepresentation requires (1) a misrepresentation of material fact; (2) without reasonable grounds for believing it to be true; (3) with intent to induce reliance on the misrepresented fact; (4) ignorance of the truth and justifiable reliance thereon by the claimant; and (5) damages. *Fox v. Pollack*, 181 Cal. App. 3d 954, 962 (1986). The SAC does not allege sufficient facts to support Plaintiffs' negligent misrepresentation claim as to two elements. [*See* SAC ¶ 311.] First, Plaintiffs assert in conclusory fashion that Defendants lacked "grounds to believe their representations were true" without reference to any underlying facts (such as what allegedly made it unreasonable for Defendants to misrepresent the existence of an AAP). [*See* SAC ¶ 311.] Second, Plaintiffs fail to plead "justifiable reliance" on the purported misrepresentation. [*See* SAC ¶ 311.] As noted above, Plaintiffs' reliance was unreasonable given the alleged pattern of non-payment spanning years. *See* Section IV.C.4.b., *supra*. Thus, the negligent misrepresentation claim as pled is nothing more than a label and conclusion that "will not do" under Rule 8. *Iqbal*, 556 U.S. at 678.

4. Equitable Estoppel And Reformation.

Finally, Plaintiffs assert the state-law claims of equitable estoppel and reformation. [SAC ¶¶ 309, 312-13.] Plaintiffs attempt to use equitable estoppel to preclude the enforcement of the AAPs based on alleged misrepresentations by Defendants that benefits were "freely assignable." [SAC ¶ 312.] Similarly, Plaintiffs refer to these alleged misrepresentations as a basis for reforming a purported contract between Plaintiffs and Defendants to remove the AAP. [SAC ¶ 313.] First, Plaintiffs' state-law claim for equitable estoppel fails as a matter of law because it is not an independent cause of action. *Moncada v. West Coast Quartz Corp*., 221 Cal. App. 4th 768, 782 (2013); *see also Humetrix, Inc., v. Gemplus S.C.A.*, 268 F.3d 910, 918 (9th Cir. 2001) ("[E]quitable estoppel is a shield," not a sword). Second, Plaintiffs' state-law claim for reformation of contract, based on either fraud or mistake, fails to satisfy the pleading standard of Rule 9(b). *See* Section IV.B., *supra*. Third, Plaintiffs' reformation claim also fails on the merits for the same reasons discussed in Section IV.C., *supra*.

G. Plaintiffs' Claims Fail Where Defendants' Supplemental Declarations And/Or Addenda Establish The Enforceability Of Anti-Assignment Provisions In The Underlying Benefit Plans.

For a significant number of patient claims at issue, this Court has already held that AAPs in the underlying plan documents are valid and enforceable. [Order at 31-35.] As to certain patient claims for which the Court declined to enforce the AAPs in connection with the first Omnibus Motion to Dismiss, or for which the Court is presented with AAPs for the first time, Defendants are renewing their request that the Court enforce the AAPs where Defendants have a good faith basis for believing that the supplemental declarations and/or addenda submitted herewith address the Court's concerns during the prior round of briefing and would operate to further narrow the universe of patient claims at issue. Accordingly, where Defendants' supplemental declarations and/or addenda establish the enforceability of the AAPs in the underlying ERISA plan documents, the associated patient claims should be dismissed with prejudice.

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IV. CONCLUSION

For the reasons set forth above, the Defendants respectfully request that the Court grant Defendants' Omnibus Motion to Dismiss Plaintiffs' SAC in its entirety with prejudice.

DATED: March 1, 2017

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MARKETS LLC EMPLOYEE WELFARE BENEFIT PLAN, FRESENIUS MEDICAL CARE NORTH AMERICA MEDICAL PLAN, erroneously sued as NATIONAL MEDICAL CARE, INC. GROUP MEDICAL, DENTAL, LIFE AND AD&D PLAN, GKN EMPLOYEE WELFARE BENEFIT PLAN, GENERAL NUTRITION GROUP INSURANCE PLAN, GLOBYS, INC. GROUP HEALTH PLAN, HIGHMARK BCBSD, INC., HIGHMARK BLUE CROSS BLUE SHIELD, HIGHMARK BLUE SHIELD, HIGHMARK, INC. d/b/a HIGHMARK BLUE SHIELD, HORIZON HEALTHCARE SERVICES, INC. d/b/a HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY, INLANDBOATMENS UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT TRUST, INTERRAIL SIGNALS, INC. WELFARE BENEFIT PLAN, JENNINGS AMERICAN LEGION HOSPITAL EMPLOYEE BENEFIT PLAN, LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY BLUE CROSS AND BLUE SHIELD OF LOUISIANA, MACHINISTS HEALTH & WELFARE TRUST FUND, MARTIN MARIETTA MEDICAL PLAN, NATURES PATH FOODS, INC. WELFARE BENEFIT PLAN, NORTHERN CALIFORNIA SHEET METAL WORKERS, NOVARTIS CORPORATION WELFARE BENEFIT PLAN, OGLETREE, DEAKINS, NASH, SMOAK & STEWART, P.C. GROUP MEDICAL PLAN, ORASURE TECHNOLOGIES INC. HEALTH AND WELFARE PLAN, PEAK 10, INC. EMPLOYEE BENEFIT PLAN, PREMERA BLUE CROSS, PREMERA BLUE CROSS BLUE SHIELD OF ALASKA, PROFIT INSIGHT HOLDINGS LLC GROUP HEALTH PLAN, PUBLIX SUPER MARKETS, INC. GROUP HEALTH BENEFIT PLAN, PUGET SOUND PILOTS GROUP HEALTH PLAN, RAYONIER, INC. WELFARE PLANS, REGENCE BLUECROSS BLUESHIELD OF OREGON, erroneously sued herein as REGENCE INSURANCE HOLDING CORPORATION; REGENCE BLUECROSS BLUESHIELD OF UTAH, erroneously sued herein as REGENCE INSURANCE HOLDING CORPORATION; REGENCE BLUESHIELD erroneously sued herein as

REGENCE INSURANCE HOLDING CORPORATION; SAS INSTITUTE INC. WELFARE BENEFITS PLAN, SCANA CORPORATION HEALTH & WELFARE PLAN, SEABRIGHT INSURANCE COMPANY GROUP HEALTH PLAN, SPOKANE TEACHERS CREDIT UNION EMPLOYEE MEDICAL & DENTAL PLAN, TUV AMERICA, INC. INSURANCE BENEFITS PLAN, THE MASTER BUILDERS ASSOCIATION HEALTH INSURANCE TRUST, TRINET EMPLOYEE BENEFIT INSURANCE PLAN, UNITED STATES STEEL PLAN FOR ACTIVE EMPLOYEE INSURANCE BENEFITS, U.S. RENAL CARE, INC., WELLMARK OF SOUTH DAKOTA, INC. and WELLMARK, INC.

DATED: March 1, 2017

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J.R. SIMPLOT COMPANY GROUP HEALTH & WELFARE PLAN, ALBERTSON'S LLC HEALTH & WELFARE BENEFIT PLAN, LAYNE CHRISTENSEN COMPANY HEALTH AND WELFARE PLAN, MDU RESOURCES GROUP, INC. HEALTH AND WELFARE BENEFITS PROGRAM, MEDTRONIC, INC. GROUP INSURANCE PLAN, METAL-MATIC, INC. WELFARE BENEFIT PLAN, ST. LUKES LUTHERAN CARE CENTER EMPLOYEE HEALTH CARE PLAN, TRANSPORT CORPORATION OF AMERICA, INC. EMPLOYEE HEALTH AND WELFARE BENEFIT PLAN, TWIN CITIES BAKERY DRIVERS HEALTH & WELFARE FUND and UNIVERSITY OF NEBRASKA FOUNDATION

DATED: March 1, 2017

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LEGAL RESERVE COMPANY d/b/a BLUECROSS BLUESHIELD OF ILLINOIS, BLUECROSS BLUESHIELD OF MONTANA, BLUECROSS BLUESHIELD OF NEW MEXICO, BLUECROSS BLUESHIELD OF OKLAHOMA, and/or BLUECROSS BLUESHIELD OF TEXAS, IESI CORPORATION EMPLOYEE WELFARE BENEFITS PLAN, ION GEOPHYSICAL CORPORATION GROUP HEALTH PLAN, PIONEER ENERGY SERVICES CORP. GROUP HEALTH PLAN, RANDALL S. FUDGE P.C. EMPLOYEE BENEFITS PLAN, SOUTHWEST SHIPYARD, L.P. CAFETERIA PLAN, TENET EMPLOYEE BENEFIT PLAN, THE GROUP LIFE AND HEALTH BENEFITS PLAN FOR EMPLOYEES OF PARTICIPATING AMR CORPORATION SUBSIDIARIES, UNITED SURGICAL PARTNERS, INTL WELFARE BENEFIT PLAN and XEROX BUSINESS SERVICES, LLC FUNDED WELFARE BENEFIT PLAN

DATED: March 1, 2017

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DATED: March 1, 2017

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DATED: March 1, 2017

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DATED: March 1, 2017

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DATED: March 1, 2017

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DATED: March 1, 2017

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DATED: March 1, 2017

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DATED: March 1, 2017

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Filer's Attestation: Pursuant to Local Rule 5-4.3.4(a)(2)(1), Eileen R. Ridley hereby attests that concurrence in the filing of this document and its contents was obtained from all signatories listed.