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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

RACHEL CONDRY, JANCE HOY, CHRISTINE ENDICOTT, LAURA BISHOP, FELICITY BARBER, and RACHEL CARROLL on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

UnitedHealth Group Inc.; UnitedHealthcare, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Services, Inc.; and UMR, Inc.,

Defendants.

Case No.: 3:17-cv-00183-VC

PLAINTIFFS' MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF PLAINTIFFS' NOTICE OF CROSS-MOTION AND CROSS-MOTION FOR PARTIAL SUMMARY JUDGMENT

Date: February 8, 2018
Time: 10:00 am
Place: Courtroom 4

Honorable Vince G. Chhabria

PLEASE TAKE NOTICE that on February 8, 2018 at 10:00 am in Courtroom 4 of the above-captioned court, located at 450 Golden Gate Avenue, San Francisco, CA 94102, Plaintiffs Rachel Condry, Jance Hoy, Christine Endicott, Laura Hipple (nee Bishop), Felicity Barber, and Rachel Carroll (collectively, the "Plaintiffs"):

(1) hereby oppose Defendants' Motion for Summary Judgment and Memorandum in Support Thereof ("Memo", Dkt. 100), and the Declarations submitted in Support Thereof, namely, Declaration of Abraham J. Souza (Dkt. 103, "Souza Decl."), Declaration of Abby Seay Regarding Plaintiff Jance Hoy (Dkt. 101-1, "Seay/Hoy Dec"), Declaration of Abby Seay Regarding Plaintiff Laura Bishop (Dkt. 101, "Seay/Bishop Decl"), Declaration of Abby Seay Regarding Plaintiff Rachel Carroll (Dkt. 101-9, "Seay/Carroll Decl."), Declaration of Abby Seay Regarding Plaintiff Christine Endicott (Dkt. 102, "Seay/Endicott Decl."), Declaration of Abby Seay Regarding Plaintiff Felicity Barber (Dkt. 102-12, "Seay/Barber Decl."), Declaration of Abby Seay Regarding Plaintiff Rachel Condry (Dkt. 102-21, "Seay/Condry Decl."), Declaration of Janice Huckaby (Dkt. 105, "Huckaby Decl."), Declaration of Michele Nielsen (Dkt. 105-6, "Nielsen Decl."), Declaration of Anthony Fusco (Dkt. 105-7, "Fusco Decl."), Affidavit of Christopher Butler (Dkt. 107, "Butler Aff."), and move the Court for an Order **DENYING** Defendants' Motion; and,

(2) hereby cross move for an Order **GRANTING** Plaintiffs Motion for Partial Summary Judgment, granting final judgment in Plaintiffs' favor on Counts I through III and V-VI, based on findings that, from August 1, 2012 through the date of the Order,

(a) Defendants' coverage for comprehensive lactation support and counseling ("CLS") violated the Patient Protection and Affordable Care Act ("ACA");

(b) Defendants did not establish a provider network that included trained providers of CLS;

(c) Defendants did not provide access to in-network trained providers of CLS;

(d) Defendants were not permitted under the ACA to deny, or apply cost-sharing to, claims submitted for CLS; and

(e) Defendants did not timely and/or properly process the Plaintiffs' claims for CLS;

and ordering:

(a) that Defendants re-process the claims of the Plaintiffs as an in-network, no-cost

benefit;

(b) that Defendants reimburse Plaintiffs for their out-of-pocket expenses, in full, for all costs incurred, without application of any allowable amount, due to the bad faith, conduct and policy with respect to CLS;

(c) that Defendants are permanently enjoined from (i) denying and (ii) applying cost-sharing to all claims submitted for CLS; and,

(d) other equitable relief and damages that the Court deems proper and appropriate arising from Defendants' wrongful conduct.

This Opposition and Cross Motion rely upon this Notice of Motion, the attached Plaintiffs' Memorandum of Points and Authorities, the Declaration of Kimberly Donaldson Smith and exhibits thereto ("Pl. Ex. __"), and the arguments of counsel at the hearing on the Parties' Motions.

Dated: December 18, 2017 **CHIMICLES & TIKELLIS LLP**

By: */s/ Kimberly Donaldson Smith*

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I. INTRODUCTION

UHC's[1] Motion is based on hubris, not law or fact. It is reminiscent of the same "absurd" arguments from UHC's Motion to Dismiss, and improperly recasts this suit as one which asks the Court to "set[] the standard of care for lactation counseling and other healthcare services." Memo at 2:12-14. On the contrary, as the evidence Plaintiffs adduced through these proceedings[2] reveals, this case is about a policy knowingly employed by UHC that constitutes a systemic failure to meet the preventive coverage mandate for comprehensive lactation support and counseling ("CLS") plainly mandated by the ACA. No amount of revisionist history absolves UHC's conduct and its failures. Therefore, Plaintiffs request that the Court deny Defendants' Motion and grant Plaintiffs summary judgment on Counts I-III and V-VI.

"Comprehensive lactation support and counseling" is not limited in scope, duration and frequency. The ACA and HRSA guidelines are clear: CLS is comprehensive and for the duration of breastfeeding. UHC nonetheless seeks to limit coverage to perfunctory education, and labels as "diagnostic" the most critical aspects of CLS. However, CLS must be provided over the period of time following birth, when the mother initiates breastfeeding, to ensure that she is adequately supported in breastfeeding and to avoid the premature cessation of breastfeeding if and when difficulties arise.

Equally fundamentally flawed is UHC's position that pediatricians and obstetricians (OB/GYNs) are all trained to provide CLS, despite the recognition and discussion within UHC that such position was baseless. By taking that stance, UHC refused to establish any infrastructure for covering the benefit as mandated, and used its unsupported stance as the basis to deny, or apply cost-sharing to, Plaintiffs' and members' claims. UHC thereby eviscerated the very purpose of the benefit, which is to provide women preventive care coverage for CLS from trained providers without cost-sharing to ensure the successful initiation and maintenance of breastfeeding. In fact, it is admitted and undisputed that UHC's policy is to merely have in-network pediatricians and OB/GYNs while taking no further steps with respect to identifying (internally or to members) in-network trained providers of CLS. UHC's internal documents

[1] Defendants are comprised of UnitedHealth Group Inc., UnitedHealthcare, Inc., UnitedHealthcare Insurance Company, UnitedHealthcare Services, Inc. and UMR, Inc. (collectively, "UHC" or "Defendants").

[2] UHC's Motion is being considered before full discovery or class certification motion practice are completed. UHC produced 145,365 pages of documents in November, deposed the Plaintiffs and deposed Plaintiffs' four experts, whose reports were delivered in October.

and Plaintiffs' experts irrefutably demonstrate that those providers are not all trained to deliver CLS. Indeed, as recently as January 2016, [redacted] (Pl. Ex. 1, UHC_028002). Despite that and repeated acknowledgments about UHC's lack of a network of trained lactation consultants, UHC shifted the burden and cost to Plaintiffs. UHC's policy conclusively establishes its liability to Plaintiffs.

Compounding UHC's coverage failure was its conscious lack of transparency about CLS coverage and the virtual absence of any in-network trained CLS providers. UHC has admitted that: [redacted] (Pl. Ex. 2, UHC_008061). Indeed, despite being well-aware that neither its call center nor provider directory were useful to insureds seeking to access in-network trained providers of CLS, UHC persistently failed to address or resolve the members' dilemma and coverage failure. UHC's lactation team knew that if the provider directory was to be accurate and useful with respect to CLS, it would need to identify network providers as lactation consultants or specialists. However, making a callous [redacted] (Pl. Ex. 3, UHC 007982). These incontrovertible facts lead invariably to the conclusion that UHC violated the ACA.

The record evidence, which includes UHC's documents, Plaintiffs' documents and testimony, and expert opinion and testimony, refutes the meager, self-serving and ambiguous assertions made by UHC. Simply put, instead of complying with the ACA, UHC chose money over people, and chose not to comply with its obligations under the ACA. This Court should deny Defendants' Motion and grant summary judgment in favor of Plaintiffs on Counts I-III and V-VI.

II. PERTINENT LAW AND FACTS

A. The ACA's Coverage Mandate

UHC continues to ignore the ACA and misstate the applicable law and guidelines concerning the scope of coverage, the nature of a trained provider, and cost-sharing. *See* Memo at 1:1-13, 2:5-21; 2:28-4:4. Ms. Kristi Martin, who served at the Department of Health and Human Services (HHS) during the implementation of the ACA, and coordinated the update of the Women's Preventive Services for the Office of the Secretary at HHS during 2015 and 2016, rebutted the conclusory opinions of UHC's

proffered experts. *See* Pl. Ex. 4. Ms. Martin opined that UHC failed to comply with the ACA, the applicable regulations and guidelines, and its experts fundamentally ignored the meaning of the word "comprehensive." Pl. Ex. 4 at 4-9; Martin Tr. at 78:6-14, 82:19-89:2, 97:3-22).

The ACA added Section 2713 to the PHS Act, requiring that: "(a) [plans and insurers] shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current [USPSTF] recommendations; [and] (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by [HRSA]."

The Departments of HHS, Labor, and the Treasury (the "Tri Departments") were charged with issuing regulations in several phases implementing the ACA, including PHS Act Section 2713. (*See* 7/19/10, 75 FR 41726 at 41728, Pl. Ex. 5). As the 7/19/10 Regulations note that the ACA expanded coverage for preventive services (i) so that "***access and utilization of these services [would] increase***", (*id.* at 41730, Table 1); and (ii) to address "underutilization of preventive services" due to "market failures" identified as "***plans' lack of incentive to invest*** in these services" and "***eliminate cost-sharing requirements, thereby removing a barrier that could otherwise lead an individual to not obtain such services.***" (*Id.* at 41731). UHC's policy conflicts with the mandate to "increase access and utilization." (*Id.* at 41733); (*See* Pl. Ex. 26, Martin Tr. at 77:6-24, 29:6-15, 132:10-16; Pl. Ex. 4, Martin Report at 15).

On August 1, 2011, HRSA adopted and released guidelines for women's preventive services based on recommendations of the independent Institute of Medicine ("IOM", now known as The National Academy of Medicine), which had conducted a review of scientific and medical evidence with respect to effective preventive services to ensure women's health and well-being. The review was reported in "*Clinical Preventive Services for Women: Closing the Gaps.*" (Pl. Ex. 8, "IOM Report"). Notably, the IOM Report defined Preventive Health Services as "***measures—including medications, procedures, devices, tests, education and counseling—shown to improve well-being, and/or decrease the likelihood or delay the onset of a targeted disease or condition.***" (*id.*, page 3, emphasis added). In addition, the IOM Report made the following pertinent points regarding CLS:

- "The challenge is to ensure that the majority of mothers initiate breastfeeding and exclusively breastfeed their children...." *Id.* at page 110.

- "Contrary to popular conception, breastfeeding appears to be a learned skill and the mother ***must be supported to be successful. Nevertheless, a large gap exists in the area of providers discussing breastfeeding with patients prenatally and assisting with breastfeeding issues postnatally***." *Id.* at pages 110-111 (emphasis added).

Grounded on the foregoing, HRSA's 2011 Guidelines mandated CLS coverage as follows:

> The [ACA]...***helps make prevention affordable and accessible***...by requiring health plans ***to cover preventive services*** and by eliminating cost sharing for those services...Non-grandfathered plans ...generally ***are required to provide coverage*** without cost sharing consistent with these guidelines in the first plan year (in the individual market, policy year) that begins on or after August 1, 2012. ...**Breastfeeding support, supplies, and counseling. *Comprehensive lactation support and counseling,*** by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment in conjunction with each birth.

(Pl. Ex. 10, emphasis added).[3] On December 20, 2016, HRSA confirmed the Guidelines for CLS, again recommending comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and the postpartum period to ensure the successful initiation and maintenance of breastfeeding. (Pl. Ex. 11.)[4]

Based on the Congressional mandate, the "[Tri] Departments [ ] released FAQs ...to provide guidance related to the scope of coverage required under the recommendations and guidelines, including coverage of ....breastfeeding and lactation counseling...If additional questions arise regarding the application of the preventive services coverage requirements, the Departments may issue additional subregulatory guidance." (Pl. Ex. 12, July 14, 2015 Final Regulation at 41320; *see Eternal Word TV Network, Inc. v. Sec'y of the U.S.HHS*, 818 F.3d 1122, 1179 (11th Cir. 2016) ("When Congress enacted

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[3] *See also*, the HHS Blueprint for Action, Pl. Ex. 9, at p. 3-4, 9, which "introduces a comprehensive framework" to increase breastfeeding rates, specifying that "all breastfeeding mothers must have access to lactation management support provided by *trained* physicians, nurses, lactation specialists, peer counselors and other *trained* health care providers...", identifying that "***various levels of skill and training may be called for from lactation consultants or specialists to peer counselors***" and recommends that "breastfeeding women have access to comprehensive, up-to-date and culturally tailored lactation services provided by trained physicians, nurses, lactation consultants and nutritionists/dieticians." *Id.* at 14, 16, 19 (emphasis added).

[4] Also instructive is the 2008 USPSTF recommendation on breastfeeding (Pl. Ex. 6), which stated that breastfeeding support includes "interventions...after birth to promote and support breastfeeding" and "Professional support" which "can include providing information about the benefits of breastfeeding, psychological support [ ] and direct support during breastfeeding observations (helping with the positioning of the infant and observing latching). Professional support may be delivered during pregnancy, the hospital stay, the postpartum period, or at multiple stages. It may be conducted in an office setting, in the hospital, through home visits, through telephone support, or any combination of these. Sessions generally last from 15 to 45 minutes, although some programs have used shorter or longer sessions. Most successful interventions include multiple sessions and are delivered at more than 1 point in time." On October 25, 2016 USPSTF updated its 2008 recommendation and stated that "[t]he scope of the review and type of interventions recommended did not change [from 2008]." (Pl. Ex. 7).

the ACA it ceded broad authority to [the Tri-Departments, the] three Executive-branch administrative agencies to promulgate rules governing the availability of women's preventive health services in employer-sponsored health plans.")). The 2/20/2015 FAQs, Part XII (Pl. Ex. 13) confirm the benefit scope as established in 2011 as "Comprehensive" and as based on the 2011 HRSA guidelines.

> **Q18: The [2008] USPSTF already recommends breastfeeding counseling. Why is this part of the HRSA Guidelines?** Under the topic of "Breastfeeding Counseling" the USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding. ***The HRSA Guidelines specifically incorporate comprehensive prenatal and postnatal lactation support, counseling***, and equipment rental. (*Id.*, emphasis added.)

The 10/23/2015 FAQs, Part XXIX (Pl. Ex. 14) also supports Plaintiffs' position that insurers must identify the network CLS providers: "Q1: Are plans and issuers required to provide a list of the lactation counseling providers within the network? Yes." (Pl. Ex. 26, Martin Tr. at 160:26-163:5).

Finally, the Tri-Department's February 20, 2013 FAQ Part XII, Q3 (Pl. Ex. 13), which discusses cost-sharing under Section 2713, is also supportive of Plaintiffs' position. It states that "if a plan or issuer does not have in its network a provider who can provide the particular service, then the plan or issuer must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service." The 10/23/2015 FAQ Part XXIX, Q2 (Pl. Ex.14), specifically restates FAQ Q3 and confirms that *imposing cost-sharing* on insureds is "***premised on enrollees being able to access the required preventive services from in-network providers.***" (*See* Pl. Ex. 4, Martin Report at 10-11; Pl. Ex. 29, Martin Tr. at 133:20-136-14).

Accordingly, Plaintiffs' positions are grounded in the ACA. The positions do not, as UHC contends (Memo at 2:9-21), go beyond the ACA's plain language or to matters beyond the Court's purview. In contrast, UHC's policy on CLS coverage is fundamentally at odds with the foregoing.[5]

B. **UHC Established and Followed a Policy to Avoid The Mandated Coverage**

Beginning in 2011 and continuing through 2017, UHC repeatedly refused to establish the infrastructure and policies required to administer and provide insureds with CLS coverage as mandated.

[5] Contrary to UHC's posturing (Memo at 2:5-21), Plaintiffs' claims do not evoke improper judicial tampering. Plaintiffs have asserted that the ACA coverage mandate is clear and UHC violated it. Federal Courts, including the United States Supreme Court, have had numerous occasions to and have interpreted the ACA and ACA compliance. *See e.g., King v. Burwell*, 135 S. Ct. 2480, 2495-96, 192 L. Ed. 2d 483 (2015) (adopting a reading of the ACA in line with Congress's aim to "improve health insurance markets, not to destroy them").

UHC recognized [redacted] (Pl. Ex. 15, UHC_020548-49). Yet, UHC [redacted] UHC's Memo confirms that wrong-headed strawman approach to coverage, summarized as: UHC has in-network pediatricians and OB/GYNs, ergo it can deny benefits or apply cost-sharing. (Memo at 1-2, 4-6, 18-19). [redacted] Pl. Ex.16, UHC_015995-96, emphasis added).

Despite being on notice that its coverage policy was non-compliant, UHC chose to play hide the ball, not just with insureds but with the plan sponsors. [redacted] (Pl. Ex. 17, UHC_019041, 019053, 019064). [redacted] (*Id.*)

In early 2013, [redacted] (Pl. Ex. 19, UHC_059263). UHC [redacted] (*Id.* at UHC_059262).[6] Evidencing its further failure of coverage for CLS, [redacted]

[6] This position is particularly vexing given (i) UHC's [redacted] CLS (Pl. Ex. 1, UHC_028002), (ii) the long-standing body of research supporting the unavailability and inadequacy of CLS care by pediatricians and OB/GYNs (*see* Section III.A), and (iii) UHC's recognition that [redacted]

[redacted] (*Id.* at UHC_056775). Admitting a component of Plaintiffs' claims, [redacted] (*Id.* at UHC_056774, emphasis added).

The ensuing emails [redacted] (*Id.* at UHC_056772); *see also* (Pl. Ex. 27, UHC_108356) [redacted] (Pl. Ex. 29, UHC_108512) [redacted] (Pl. Ex. 30, UHC_109546) [redacted] (Pl. Ex. 33, UHC_112157) [redacted] Among the other questions raised were:

- [redacted]
- [redacted]

(Pl. Ex. 22, UHC_056772, 56774, emphasis added).

Lactation consultants were the subject of [redacted]. It is rather [redacted] (Pl. Ex. 31, UHC_101627; *see also*, Pl. Ex. 32, UHC_114402). Instead of taking the steps to ensure that it had such providers in-network, UHC [redacted] (*Id.* at UHC_114400). *See also*, Pl. Ex. 20, UHC_135199, email stating: [redacted] and, Pl. Ex. 21, UHC_050802, [redacted]

shocking that two years after CLS coverage was to have begun, [redacted] (Pl. Ex. 23, UHC_011660-62, and Pl. Ex. 24, UHC_008061). Such key items were discussed as follows:

- [redacted]
- [redacted]

(*Id.*, emphasis added)). Following up on the question about [redacted] (Pl. Ex. 25, UHC_007992, emphasis added).

Notes from [redacted] (Pl. Ex. 34, UHC_110054-56). Yet, UHC recommended: [redacted] (*Id.*)

In [redacted] (Pl. Ex. 25,UHC_007985). [redacted] (Pl. Ex. 24, UHC_008059; Pl. Ex. 3, UHC_007980-81, emphasis added). On that same day, [redacted]

[redacted] (Pl. Ex. 35, UHC_008004, emphasis added).

However, [redacted] (Pl. Ex. 25, UHC_007982). In other words, [redacted] UHC's policy [redacted] non-compliant with the ACA. Not only was UHC [redacted].[7] UHC [redacted] (*Id.*, emphasis added). Despite the [redacted] (Pl. Ex. 36, UHC_008085).

The paradox of [redacted] in-network pediatricians and OB/GYNs for CLS coverage, coupled with providing insureds no ability to identify lactation specialists through the Call Center or the provider directory, [redacted] (Pl. Ex. 32, UHC_114402-06). [redacted]

[7] This condition left both primary care physicians and their patients in a state of ignorance, [redacted] (Pl. Ex. 24, UHC_008061).

[redacted]

Pl. Ex. 30, UHC_109546 (emphasis added).[8] [redacted] the Catch 22 inherent with UHC's policy. [redacted] impact on members: the continued lack of CLS coverage, the lack of access to coverage, and lack of relevant, needed information. [redacted] the fallacy of UHC's policy, and the non-existent infrastructure to administer ACA-compliant coverage for CLS.

Evidencing the lack of resolution on this issue, the problems and discussions continued in 2015 and 2016. [redacted]

[redacted] (Pl. Ex. 37, UHC_042394, emphasis added). In an exchange of emails that followed, [redacted]

[redacted]

(Pl. Ex. 40, UHC_052645, emphasis in original). [redacted]

[redacted] (*Id.*) One

[8] UHC's production included [redacted] (Pl. Ex. 39, UHC_0028176).

[redacted] (*Id.*)[9] [redacted] (*Id.*) [redacted] *Id.* at UHC_052646. [redacted] (*Id.*) Thus, in sum, after [redacted].

In [redacted] (Pl. Ex. 41, UHC 128044), UHC still failed to do what was necessary to get the pertinent descriptive information (*i.e.*, whether a network provider was CLS trained) and [redacted] (*Id.*) Ultimately, [redacted] adding a general statement or category about lactation consulting was illusory absent knowledge of who were trained CLS providers, determined by, for example, conducting a survey or contracting. [redacted] Pl. Ex. 43, UHC_055518, emphasis added.)

The policy [redacted] (Pl. Ex. 44, UHC_146784).

The foregoing [redacted] UHC was required to provide CLS to the Plaintiffs and its members, [redacted] it was failing to do so and, yet, continued with its course of action. These facts eviscerate each of UHC's arguments that it complied with the ACA, and [redacted] UHC was not compliant.

[9] During a [redacted] (Pl. Ex. 42, UHC_028140).

III. ARGUMENT

A. UHC's CLS Coverage Did Not Comply With the ACA

UHC's Motion does not demonstrate an entitlement to summary judgment on Counts II -VI, which are premised on the ACA. (Memo at 17:22-21). Rather, UHC's documents (discussed *supra*) and Plaintiffs' evidence demonstrate Plaintiffs' entitlement to summary judgment on Counts I-III and V-VI because UHC's CLS coverage did not comply with the ACA.

1. UHC's Policy On CLS Providers and Identification of the Providers Is Not ACA Compliant

UHC contends that "all of the Plaintiffs had access to UHC's networks, which include tens of thousands of pediatricians, OB/GYNs, and other providers who have received training in the ACA-mandated preventive service" (Memo at 7:7-25), and, therefore, it complied with the ACA because its network includes pediatricians and obstetricians (Memo at 1:16-22, 6-7, 19:4-20).

That argument contradicts the ACA's regulatory framework and requirements, discussed *supra*, mandating that CLS coverage is to be: available to women at every phase of the breastfeeding continuum (from the prenatal period to the end of breastfeeding); inclusive as to the scope of lactation services; and received from a trained lactation provider. That contention also is belied by the evidence. It is contradicted by UHC's [redacted] (Section II.B., *supra*). UHC's contention also is contradicted by the Plaintiffs' experiences with their physicians, which experiences demonstrate that CLS was not available from such providers.[10]

[10] Neither [redacted]. (Pl. Ex. 45, at 64:24-67:10) [redacted] *id.* at 39:21- 44:6 [redacted] (Pl. Ex. 46, at 72:5-18; 76:3-81:3; 83:16-85:7, emphasis added). [redacted] (Pl. Ex. 47, at 85:5-25, 99:8-101:4). [redacted] (Pl. Ex. 48, 57:10-59:2). [redacted] (Souza Decl., Group Ex. G-14 at PL_RC000290-94; *see also* Pl. Ex. 49, at 120:3-15), [redacted] (*id.* at 117:17-118:5). [redacted]

Furthermore, UHC's contentions are based on factually unsupported and refuted expert testimony. (Memo at 1, 6:25-7:25, 19:5-20). Drs. Lee, Cooper and Miller all generally opine that [redacted] *See* Souza Decl., Ex. G-9 (Cooper), Ex. G-10 (Lee), Ex. G-8 (Miller). Those opinions are directly at odds with UHC's statements, including UHC's medical officer's statement, that pediatricians and OB/GYNs are not necessarily trained providers of CLS. (Section II.B., *supra.*) Further, Plaintiffs' experts have authoritatively refuted the opinions. Dr. Morton, a pediatrician, Clinical Professor of Pediatrics, Emerita, Stanford Medical Center; former Director of the Breastfeeding Medicine Program at Stanford University; an executive board member of the American Academy of Pediatrics' ("AAP") Section on Breastfeeding; a Fellow of the Academy of Breastfeeding Medicine ("ABM"); and a designer and implementer of breastfeeding systems, policies and educational curriculums, opines that:

- Drs. Cooper, Lee and Miller fundamentally misunderstand the scope of care necessary to provide CLS; it requires education and clinical training more advanced than the limited exposure to lactation that is provided through medical or nursing school curriculums and residency programs.
- Although some pediatricians or OB/GYNs may provide CLS, it is by no means the norm, the availability of CLS from OB/GYNs or pediatricians is inconsistent and sporadic at best, it is impractical and unrealistic to expect mothers to be able to determine which OB/GYNs, pediatricians or other primary care providers in their health plan's network are providing CLS as a covered benefit, and such policy ignores many practical aspects of a physicians practice, including, among other things, that care is limited to established patients, and availability of appointments for new patients typically require lengthy wait times.

(Souza Decl., Ex. G-12, Morton Report at 11-20; Pl. Ex. 58, Tr. at 63:11-17, 83:21-84:21). Dr. Chetwynd, a PhD., MPH, BSN, RN, and IBCLC, a medical researcher specializing in human lactation and integration of lactation services into the healthcare system, and a former director of Maternal and Child Health, opines that specific training in lactation is essential for adequate provision of care as a trained provider of CLS. (Pl. Ex. 51, Chetwynd Report at 7-20; Pl. Ex. 52, Tr. at 104:25-107:9, 107:23-109:14). Furthermore, Dr. Meek, an MD, MS, RD, FAAP, FABM, IBCLC pediatrician, educator and researcher with clinical interests that include infant and pediatric nutrition, lactation and breastfeeding

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[redacted] (Pl. Ex. 50, Endicott Tr. at 64:5-65:14 [redacted] In fact, UHC even improperly applied cost-sharing co-insurance for these services. (*See* Souza Decl., Group Ex. G-14 at PL_CE000200-01.)

support; a pediatric resident and medical student educator; the current Chair of the AAP's Section on Breastfeeding; Past-Chair of the United States Breastfeeding Committee; Past President of the ABM; a Fellow of the AAP and the ABM; and the ABM Course Director for "What Every Physician Needs to Know about Breastfeeding," opines it is unsupportable to opine that most if not all pediatricians and OB/GYNs can provide CLS. (Souza Decl., Ex. G-13, Meek Report at 13-26; Pl. Ex. 53, Meek Tr. at 58:14-59:12, 59:22-60:11). Frankly, Plaintiffs' experts' opinions should not be a surprise to UHC, as logic and [redacted] confirm Plaintiffs' experts' positions.

In addition, UHC's other "evidence" is similarly unsupported and unpersuasive:

(1) The Nielsen Decl. (¶¶4-20) lists a total of 17 purported hospitals, medical centers, pediatricians and OB/GYNs which provide lactation services. The Nielsen Decl. does not attest to it, but it appears that UHC relies on it as evidence of UHC's purported trained provider network.

(2) The Fusco Decl. only cites to the purported number (in the hundreds and thousands) of pediatricians and OB/GYNs within 30 miles of Plaintiffs' zip codes. Citing to all network pediatricians and OB/GYNs does not equate to identifying network providers for covered CLS.[11]

(3) The Butler Aff. attaches archived webpages of the providers listed in the Nielsen Decl, which webpages purport to show that such providers are lactation consultants.

UHC offers no more than it did in its Motion to Dismiss. In contrast, Plaintiffs offer UHC's [redacted] and Plaintiffs' evidence which conclusively belie UHC's arguments and demonstrate that its policy and conduct were not ACA compliant. The Nielsen, Fusco and Butler submissions do not demonstrate trained network providers of CLS were available to the Plaintiffs. UHC's argument equates to the same futile [redacted] (Pl. Ex. 32, UHC_114402-06; *see* Section II.B.)

Relying on the Nielsen Decl., UHC also claims that four of the Plaintiffs "had at least one in-

[11] UHC's argument is inconsistent with its definition of Network, which provides that: "A provider may enter into an agreement to provide ***only certain Covered Health Services, but not all Covered Health Services***....In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health services and products." Seay/Hoy Decl., Ex. A-1 at UHC_001011; Seay/Bishop Decl., B-1 at UHC_002112; Seay/Endicott Decl., Ex. D-1 at UHC_000790; Seay/Barber Decl., Ex. E-1 at UHC_001934; Seay/Condry Decl., Ex. F-1 at UHC_00220 (emphasis added); Seay/Carroll Decl., C-1 at UHC_002305 ("Knowing which network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services.").

network 'Lactation Specialist' within thirty miles of their zip codes", however, UHC's cited evidence does not support that statement (Memo at 6:25-27.) Nielsen actually declares (¶21) that UHC's online directory listed two (2) "Lactation Specialists" in 2015 and 2016: "Cheryl M. Dronkers, 795 El Camino Real, Palo Alto, CA 94301" and "Maree E. Makins, 4050 Dublin Blvd., Dublin, CA 94568." Even assuming that uncorroborated statement is true, the Nielsen Decl. cites to no other "Lactation Specialist" within 30 miles of Glastonbury, Connecticut (Endicott);[12] Fort Collins, Colorado (Carroll);[13] Leander, Texas (Bishop);[14] and Montgomery County, Pennsylvania (Hoy).[15] Critically, the Nielsen Decl. does not state, and there is no support to suggest, that the address listed for each lactation specialist was their place of service.[16] (*See* fn. 17). Even if it was, Plaintiffs' zip code search indicates that the distances between San Francisco (Barber), Palo Alto and Dublin are 32.7 and 44 miles, respectively, and between Oakland (Condry), Palo Alto and Dublin are 35.4 and 24.3 miles, respectively. (Pl. Ex. 55). Additionally, UHC makes no offer of proof, certainly not meeting its burden, that these two individuals were *available*

[12] UHC has not demonstrated that there was one available trained lactation provider within 30 miles of Endicott. (Memo at 7:5-7.) When Endicott called UHC she was misleadingly told that "There is no coverage for services billed by a lactation specialist...Lactation specialists are generally an exclusion." (Pl. Ex. 54, UHC_002400-2405). Moreover, UHC did not identify *any* in-network lactation specialist during the call (*id.*) and the Nielsen Decl. does not assert that any lactation specialist within 30 miles of Endicott was in-network or listed on the on-line directory.

[13] UHC mischaracterizes Carroll's testimony. Carroll searched UHC's website for providers of CLS, but no such providers were identified within a 100 mile radius of her home. (Pl. Ex. 45 at 89:10-93:5; Souza Decl., Ex. G-16, Rog. Resp. 2(c)). Although she located The Youth Clinic through her independent research, when she contacted the practice she was told that lactation services were only available for established patients. (Pl. Ex. 45 at 89:10-91:12 (switching providers and an initial office visit were prerequisites to getting lactation services)).

[14] Bishop did not identify lactation providers even after thorough "lactation related searches" on UHC's website and contacting UHC. (Pl. Ex. 48 at 54:15-24, 146:8-147:22; Souza Decl., Ex. G-17, Rog. Resp. 2(c)-(d)).

[15] Hoy conducted an exhaustive search of UHC's website for CLS providers and the closest provider was located over 30 miles away in Princeton, NJ. (Pl. Ex. 47 at 124:8-24; Pl. Ex. 59). When Hoy contacted UHC she was told that she was not eligible for coverage because: (1) UHC limited lactation services to hospital-setting following child birth; and (2) Hoy's plan was silent on outpatient lactation services. (Pl. Ex. 47 at 33:4-19). When Hoy called UHC again, she was informed that she would be covered at 60% for out-of-network lactation services. (*Id.* at 161:1-24). This information overtly discouraged Hoy from seeking coverage, and it was wrong.

[16] UHC did not produce any contracts it has with these providers to try to support the contention that they were contracted in-network providers of CLS. Also, one is unable to re-create results from UHC's on-line provider portal search as of 2015 and/or 2016. Plaintiffs' counsel undertook an investigation of these individuals and called the phone contact information for each secured by a recently accessed provider search of UHC's website (Pl. Ex. 60): (a) For Ms. Dronkers, one number was a cardiologist's office in Dublin, the second was not in service, and the third was to a pediatric department that did not work with Ms. Dronkers and could not find her in an internal directory; (b) For Ms. Makins, the numbers connected to a Dublin-based cardiologist, a nutrition and diabetes department (which did not return the phone call), to the Palo Alto Medical Foundation in Sunnyvale where the scheduling assistant did not know nor schedule for Ms. Makins, and to the nutrition department in Palo Alto (which indicated that Ms. Makins was not with that department).

providers, even assuming they were located within 30 miles. UHC makes an important concession: "if in-network providers are unavailable within thirty miles of members' or insureds' urban zip codes, members and insureds may be eligible to receive the in-network level of benefits for out-of-network services, including the ACA-mandated preventive services." (Memo at 4:22-26.) These individuals were not identified contemporaneously by UHC, and based on UHC's policy discussed *supra*, would not have been identified by the UHC Customer Care call center to Plaintiffs in response to inquiries for lactation consultants (*instead,* [redacted]). The Plaintiffs' experiences confirm these facts. (*See e.g.,* fns. 12-16.) Accordingly, UHC does not establish that Plaintiffs had available, trained in-network providers of CLS. In fact, what the evidence demonstrates is that UHC's conduct overtly discouraged mothers from seeking CLS coverage and conflicts with the ACA coverage mandate for CLS.

UHC also argues that the ACA coverage mandate is somehow limited to "financial access" (Memo at 2:22-25, 19-21). That is illogical and not supported by the ACA and HRSA mandates (*supra* Section II.A), which do not state that coverage is limited to only what is necessary to "remove financial barriers." Also, what UHC misses is that inherent in an insurer's financial responsibility with respect to preventive care coverage, is the insured's ability to access the insurance coverage for such preventive care. In other words, assuming *arguendo* that UHC can interject the term "financial access" as the supposed "law", the determination of whether UHC gave insureds so-called "financial access" to coverage for CLS evokes the same result. The rendering of "health insurance coverage" cannot be accomplished if, for example, a patient cannot find the network provider or is subjected to cost-sharing for preventive care when there is no trained network provider identified. UHC's conduct has directly impaired Plaintiffs' and UHC members' financial access to CLS.

Tellingly, UHC fought mightily in its Motion to Dismiss to discredit the "List" FAQ that confirms the importance of a health insurer providing a readily available list and identification of network CLS providers.[17] Discovery, discussed *supra*, has now indisputably revealed that UHC's attack on that

[17] UHC persists in its dismissive treatment of FAQ 29, the "List" FAQ. (Memo at 21). Plaintiffs' expert Ms. Martin (formerly with HHS, of the Tri-Departments) opined that FAQ 29, Q1, confirms the issuer requirement to provide a list of lactation counseling providers to insureds, and responds to the FAQ with an unequivocal "Yes."

FAQ was a litigation strategy aimed at avoiding the Court being informed that, in as early as [redacted] (Pl. Ex. 15, UHC_020548-49), and that beginning in [redacted].

UHC's assertion that the Plaintiffs could have coordinated the care to access a non-Network provider with their physician or secured some type of exception (or "gap" exception), is fantasy in light of its non-disclosure policy. (*See* Memo at 4-5, 6:4-9.) The plan provision cited by UHC states: "if [UHC] ***confirm[s] that care is not available from a Network*** provider, we will work with you..." As discussed *supra*, UHC explicitly took the position that care is available from any pediatrician and OB/GYN, thereby rendering UHC's suggestion of coordination or the application of a gap exception futile. The baselessness of UHC's coordination point is confirmed by this [redacted]"[18] Pl. Ex. 22, UHC_056770, 056772, 056774 (emphasis added.) Furthermore, and importantly, even when a Plaintiff tried to coordinate coverage from an out of network provider, cost sharing was applied; therefore, UHC was not, even under coordination, covering CLS as in-network, no cost preventive service.[19]

(Pl. Ex. 26, Tr. at 160:22-163:5.) In any event, in light of UHC's [redacted] (*supra* Section II.B), UHC's litigation position is unpersuasive and does not entitle it to summary judgment.

When Hoy contacted UHC to inquire about CLS she was told that "she would not be able to get a GAP [sic]" and she was instructed "to speak with the pediatrician, her doctor or hospital to see who they suggest and bill under their INN tax ID#." (Pl. Ex.56, UHC_000888). In a subsequent call to UHC about the denied claims Hoy was informed that she should have requested a gap exception. (Souza Decl., Ex. G-7 at 5:3-8:11).

[19] In an attempt to coordinate in-network benefits for CLS, Bishop contacted UHC and was instructed to fax a referral request. (Pl. Ex. 57, UHC_002044). In advance of the lactation consultation, Bishop's [redacted] (Souza Decl., Group Ex. G-14 at PL_LB000080-81, 85); (Pl. Ex. 48 at 124:23-125:10; 192:10-194:20). There is no evidence that UHC issued a response to either [redacted]. UHC's now proffered excuses are

Plus, UHC's policy must be viewed in the context of a lactating mother and the time constraints associated with the continuation of breastfeeding. In a universe of the hundreds and thousands of potential providers proffered by UHC, it could take weeks to potentially identify any trained provider of CLS from UHC's network, and by then, breastfeeding would have been thwarted. As a practical matter, trying to apply UHC's policy that insureds must hunt down who from the hundreds of pediatricians and OB/GYNs are the purported trained CLS providers demonstrates the absurdity of the policy.[20]

Ultimately, UHC denied claims and applied cost-sharing based on this illusory coverage. That action is not ACA compliant. (*See* FAQ Q2, "while nothing in the preventive services requirements ...requires a...issuer that has a network of providers to provide benefits for preventive services provided out-of-network, ***these requirements are premised on enrollees being able to access the required preventive services from in-network providers***.") It is undisputed that (1) UHC's pediatricians and OB/GYNs were not identifiable as lactation specialists (or as providers of CLS by any nomenclature) by members (or even by UHC itself), (2) that UHC's customer call center gave insureds wrong, inconsistent and incomplete information, [redacted] (*see* Section II,B *supra*), (3) UHC had no public list of trained CLS network providers and (4) UHC's online provider "list" purportedly showed only 2 Lactation Specialists, per the Nielsen Decl. at ¶21.

The Plaintiffs' plans were required to include CLS coverage as set forth in the ACA and HRSA's guidelines. Although told to access in-network provider information through UHC's website and customer care center[21] to secure such coverage, the fate of each Plaintiff's search, coverage and claims

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irrelevant and UHC's conduct of denying the claim (Seay/Bishop Decl., Ex. B-4) demonstrate the futility of the coordination process that UHC now says the Plaintiffs could have used. (Memo at 14:11-22.)

[20] For example: unless a patient gave birth in one of the identified hospitals or facilities, insureds would have to: (a) obtain a list of network hospitals, (b) search through websites and/or call all hospitals in network to attempt to identify those that offered outpatient lactation services, (c) know if the program is tied with or requires a referral from a physician and thus direct the search / call accordingly, (d) ask each hospital if the *lactation facility* and each individual consultant is in-network with UHC *to provide* CLS, then (e) confirm the network status with UHC. For Pediatricians OB/GYNs, the laborious process would be similar.

[21] *See e.g.*, Seay/Hoy Decl., Ex. A-1 at UHC_000908 ("...www.myuhc.com, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use www.myuhc.com to search for Physicians available in your Plan. . .To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto www.myuhc.com."). Substantially similar references appear in each Plaintiff's Benefit Booklet, "You can verify the provider's status by calling Customer Care. A directory of providers is available online at www.myuhc.com or

adjudication was in the hands of UHC's policy. In short, UHC's approach to coverage for CLS amounted to no coverage at all. The Court, therefore, must deny UHC's Motion in full, and grant summary judgment in Plaintiffs' favor on Counts I-III, and V-VI.

2. UHC's Argument About The Narrow Scope of CLS is Unpersuasive

UHC now contends that the scope of CLS is narrow and attempts to distinguish between preventive and diagnostic treatments for CLS. (Memo at 5-6, 18:6-19:3.) UHC's argument is not supported by the ACA and HRSA guidelines (*supra*, Section II.A), UHC's own stated guidance to providers in its Coverage Determination Guidelines ("CDG") or the Plaintiffs' experiences. UHC's current position also directly conflicts with its position in [redacted] (Pl. Ex. 54, UHC_002400-2405, emphasis added).

UHC asserts that the CDG supports its position because the CDG is instructive to the "public" "about what codes need to be billed to obtain reimbursement for preventive services, including the ACA-mandated" CLS. (Memo at 5:10 – 6:9; Huckaby Decl, ¶5 and Exs. H-1-H-5.) The CDG sets forth the procedure and diagnosis codes for CLS and provides that only one of two diagnosis codes, V24.1 or Z39.1, is required for the following procedure codes - 99241-99245, 99341-99345, 99347-99350 – and that no diagnosis code is required for procedure code S9443 *(see e.g., id.* at UHC_149674.) This section of the CDG also cross-references to the "Wellness Examination section", which lists the following procedure codes for which no diagnosis code is required: G0402, G0438, G0439, G0445, S0610, S0612, S0613, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99461. (*Id.* at 149646.) Comparing these codes to the codes submitted on behalf of the Plaintiffs reveals:

(1) Bishop, Condry, Endicott and Hoy's claims were submitted with the procedure code [redacted]; a second claim by Endicott was submitted with the procedure code [redacted].[22] The CDG provides for both these procedure codes: "[d]oes not have diagnosis code requirements for preventive benefits to apply." (*Id.*)

(2) Barber's claim was submitted with procedure code [redacted],[23] a procedure code for which no

by calling Customer Care at the telephone number on your ID card to request a copy." *See* Seay/Condry Decl., Ex. F-1 at UHC_000144; Seay/Endicott Decl., Ex. D-1 at UHC_000694; Seay/Barber Decl., Ex. E-1 at UHC_001854; Seay/Carroll Decl., Ex. C-1 at UHC_002305; Seay/Bishop Decl., Ex. B-1 at UHC_002149.

[22] Seay/Bishop Decl. Ex. B-2; Seay/Condry Decl. Ex. F-2, Seay/Endicott Decl. Ex. D-2; Seay/Hoy Decl. Ex. A-2.

[23] *See* Seay/Barber Decl., Exs. E-2, E-3.

diagnosis code is required for preventive benefits to apply. (*Id.* at 149674.)

(3) Carroll's procedure codes, [redacted][24], do not appear on the CDG, but, her claims [redacted] related to breastfeeding specified in the CDG. Further, the procedure codes are specified in the AMA Guide *Supporting Breastfeeding and Lactation Primary Care – Pediatrician's Guide to Getting Paid.* (Pl. Ex. 62).

The claims with codes [redacted] (Bishop, Condry, Endicott, Hoy) were denied with the explanation – "This is not a reimbursable service. There may be a more appropriate code that describes the service …" (*See* fn. 24). Barber's claims with the procedure code [redacted] were denied with the explanation – "The plan does not cover non-medical service or personal items." (*See* fn. 25). Carroll's claims were processed, one, as an out-of-network claim, and the other was denied because the service was excluded from her health plan. (*See* fn. 26). Notably, the claims for Barber, Carroll, Endicott and Hoy include the [redacted]. Therefore, the CDG does not support UHC's argument as to its treatment of the Plaintiffs' claims. In reality, UHC did not deny the claims and apply cost-sharing due to the diagnosis, but as [redacted] (Pl. Ex. 22, UHC_056778). UHC denied and applied cost-sharing to the Plaintiffs' claims as a result of its callous [redacted][25].

Other aspects of the CDG also undermine UHC's argument. For example, the CDG specifies that for "a preventive service done that results in a therapeutic service done at the same encounter and as an integral part of the preventive service, the therapeutic service *would still be considered a preventive service*". (Huckaby Decl., Ex. H-1, UHC_149632). In contrast to a screening that may be limited to a single encounter, CLS is a series of encounters over months with a single goal to initiate and sustain breastfeeding; each encounter is preventive and therapeutic services or risk factor reductions necessary to initiate or sustain breastfeeding are preventive.[26]

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[24] *See* Seay/Carroll Decl., Ex. C-2.

[25] Further, if UHC (albeit wrongly) had actually believed or intended that there would be a narrowing of coverage for CLS, and "comprehensive" lactation support was to be limited to certain diagnosis codes, UHC's CDGs would have done that, as they did for many of the Preventive Care Services. (*See e.g., Id.* at UHC_149651-3) (listing the diagnosis codes for Behavioral Counseling in Primary Care to Promote a Healthy Diet). [redacted]

[26] Similarly, UHC's and its experts' reliance on the CDC is off-base. As Ms. Martin opined, ACA preventive services are defined by HRSA, and the scientific evidence on which the USPSTF recommendations and HRSA

Plaintiffs' experts' opinions also refute UHC's position. Dr. Chetwynd opines that direct support of mothers during breastfeeding includes counseling and interventions to support sustained breastfeeding when hurdles occur, hurdles that UHC's experts have, without support, labeled as "diagnostic." (Pl. Ex. 51, Report at 20-24.) Dr. Morton opines that CLS includes education, support, counseling and interventions to enable a successful outcome of exclusive breastfeeding for a sustained period of time, to address hurdles to sustained breastfeeding, all of which are critical for a successful outcome to breastfeeding. (Souza Decl., Ex. G-12, Report at 5-11.) Ms. Martin opines that UHC and its experts ignore the word comprehensive, and that their preventive screening analogies are not applicable when discussing CLS. (Pl. Ex. 26, Report at 4-11, Pl. Ex. 26, Tr at 79:4-16, 79:20-81:1, 90:16-95:20.) Dr. Meek opines that "interventions" specifically include addressing conditions that may impede successful breastfeeding, including poor latch, maternal decreased milk production, severe maternal engorgement, maternal nipple abrasion due to trauma from poor latch, and maternal nipple bleeding. (Souza Decl., Ex. G-13, Report at 5-13; Pl. Ex. 53, Meek Tr. 28:10-25).

UHC also wrongly contends that the "ACA and HRSA do not elaborate as to what constitutes '[c]omprehensive lactation support and counseling' or specify the level of instruction that qualifies [ ] a provider as a 'trained provider' of such care", and, therefore, wrongly concludes that it has discretion to rely on "reasonable medical management techniques to determine the frequency, method, treatment, or setting for coverage." (Memo at p. 3:14-23.) This is a red-herring. The ACA and HRSA do state the frequency, method, treatment (*i.e.* comprehensive) and setting for CLS. (*See* Section II.A.)[27] Therefore, UHC cannot hide its business decisions behind an argument that it applied Section 2713(a)(4) medical management techniques. The application of such techniques is only permitted to the extent the treatment

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guidelines rely. (Pl. Ex. 4, Report at 16.) The controlling IOM Report defines "preventive health services" as "measures—including medications, procedures, devices, tests, education, and counseling—shown to improve well-being and/or decrease the likelihood or delay the onset of a targeted disease or condition" (Pl. Ex. 8, page 3), which undercuts UHC's position. Even if the CDC definition applied - "Preventive care includes health services like screenings, check-ups, and patient counseling that are used to prevent illnesses, disease, and other health problems, or to detect illness at an early stage when treatment is likely to work best" - it is consistent with Plaintiffs' position (Souza Decl., Ex. G-9, Cooper Report, Section IV).

[27] (*See* "**Q18: The [2008] USPSTF already recommends breastfeeding counseling. Why is this part of the HRSA Guidelines?** Under the topic of "Breastfeeding Counseling" the USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding. ***The HRSA Guidelines specifically incorporate comprehensive prenatal and postnatal lactation support, counseling***, and equipment rental." (Pl. Ex. 13, page 8)).

is "not specified in the relevant recommendation or guideline," and, even assuming the ACA and HRSA guidelines did not specify the CLS treatment (which they do), Section 2713(a)(4) requires any applied medical management to be based on ***"relevant clinical evidence" and on "established ...techniques"***. Plainly, UHC's after-the-fact attempt to argue that CLS is limited in scope to try to justify its treatment of Plaintiffs is belied by the evidence. The Court, therefore, must deny UHC's Motion in full, and grant summary judgment in Plaintiffs' favor on Counts I-III, and V-VI.

B. Plaintiffs Did Not Receive A Full And Fair Review

UHC's arguments do support summary judgment on Count I. Memo at 21:27-25. Rather, the facts (taken from UHC's documents discussed *supra* (standing alone), in addition to Plaintiffs' evidence, demonstrate Plaintiffs Condry, Hoy, Bishop, Endicott and Barber are entitled to summary judgment on the issue that UHC's conduct breached its "full and fair review" obligation under ERISA Section 503, and its duty to "administer plan benefits in strict accordance with the terms of the underlying plan documents." (Memo at 21-24.) Plaintiffs' breach of fiduciary duty claim, based on UHC's failure to "administer plan benefits in strict accordance with the terms of the underlying plan documents" brought under ERISA Section 502(a)(3), also cannot be dismissed as a matter of law. *Id.* at 21-22, 25.

1. UHC Did Not Provide Plaintiffs With A Full And Fair Review

Aside from a general duty to disclose "where the interests of the beneficiaries so require," *Acosta v. Pac. Enterprises*, 950 F.2d 611, 618 (9th Cir. 1991), ERISA Section 503 specifically requires that participants and beneficiaries be informed in writing of the precise reasons for their claim denials and a reasonable opportunity for a "full and fair review" of those denials. The regulation promulgated under ERISA Section 503 provides that "notification of adverse benefit determinations" must, *inter alia*, "set forth, in a manner calculated to be understood by the claimant—(i) The specific reason or reasons for the adverse determination; (ii) Reference to the specific plan provisions on which the determination is based; and (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary." 29 C.F.R. § 2560.503-1(g)(1), codified as 29 C.F.R. § 2560-503-1(f)(1) until 1/2001; (*see* 65 FR 70246-01 (11/21/2000)).[28] In

[28] As the Ninth Circuit held 20 years ago:

sum, an "administrator does not do its duty under [ERISA] by saying merely 'we are not persuaded' or 'your evidence is insufficient[,]' [n]or does it do its duty by elaborating upon its negative answer with meaningless medical mumbo jumbo.'" *Salomaa v. Honda Long Term Disabilit. Plan*, 642 F.3d 666, 680 (9th Cir. 2011).

First, UHC's contention (Memo at 9) that it is not required to provide "full and fair review of claims that are never submitted," citing to service received by Condry on March 19 and April 14, 2015, is a red-herring. UHC does not dispute the fact that Condry did submit a claim for the services she received on March 4, 2015, which is the claim at issue that was denied.[29] UHC's contention, then, does not warrant dismissal of any Plaintiff's claims with respect to its failure to conduct a "full and fair review."

Second, UHC asserts that its notices of adverse benefit determinations "permitted a sufficiently clear understanding of the administrator's position to permit effective review." (*Id.* at 23-24.) With respect to Condry, Hoy, and Bishop, UHC asserts that the notices' terse explanations that "[t]here may be a more appropriate CPT or HCPCS code that describes this service" or that "[t]he service code is not separately reimbursable in this setting" satisfy the requirements of 29 C.F.R. § 2560.503-1(g)(1) and UHC's obligation to create a "meaningful dialogue", as set forth in *Booton* and its progeny. They do not.

These "explanations" do not provide a "specific reason or reasons for the adverse determination" in "a manner calculated to be understood" by Condry, Hoy, or Bishop. It is plainly unreasonable for UHC to expect that its cryptic references to "service codes" and "CPT or HCPCS codes" could be understood by laypersons like Condry, Hoy, and Bishop. *See Salomaa*, 642 F.3d at 680 ("fooling someone unfamiliar with the medical terms with irrelevant medical mumbo jumbo violates the statutory duty to write a denial 'in a manner calculated to be understood by the claimant'").[30] Also, that assertion contradicts UHC's

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> In simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries. If benefits are denied in whole or in part, the reason for the denial must be stated in reasonably clear language, with specific reference to the plan provisions that form the basis for the denial; if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it. There is nothing extraordinary about this; it's how civilized people communicate with each other regarding important matters.

Booton v. Lockheed Med. Ben. Plan, 110 F.3d 1461, 1463 (9th Cir. 1997).

[29] Naturally, Condry did not submit claims for the March 19 and April 14, 2015 services because such submission would be futile after UHC denied her claim for the March 4, 2015 services. Seay/Condry Decl.,Ex.F-3.

[30] (*See* Pl. Ex. 48 (Bishop Tr.) at 118:13-119:7 ("I don't really understand what a CPT or HCPCS code is"); Pl. Ex. 47 (Hoy Tr.) at 192:11-193:12 ("I have no familiarity with what these abbreviations are or [] diagnostic codes.

[redacted] (Pl. Ex. 63, UHC_005339) that [redacted]

[redacted]

UHC's "explanations" also do not describe "additional material or information necessary for [Condry, Hoy, and Bishop] to perfect [their] claims and an explanation of why such material or information is necessary." 29 C.F.R. § 2560.503-1(g)(1). Indeed, though UHC appears to imply that Condry, Hoy, and Bishop should have "asked their providers for 'more appropriate' codes," UHC's "explanations" never expressly asked them to do so. Seay/Hoy Decl., Exs. A-8, A-9, A-13; Seay/Bishop Decl., Ex. B-4; Seay/Condry Decl., Ex. F-3; *see Booton*, 110 F.3d at 1463 ("if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it").[31] As such, it is irrelevant whether Hoy received any "warnings" from her provider regarding incorrect codes;[32] the burden is on UHC to request additional information, not for Hoy and/or her provider to read Defendants' minds. (Pl. Ex. 64, PL_JH000213-216). In sum, these "explanations" that Condry, Hoy, and Bishop's claims were denied on the basis of "service codes" and "CPT or HCPCS codes" fall far short of UHC's obligation to engage in a "meaningful dialogue".

The same is true for Barber and Endicott. In Barber's instance, the "explanation" that the lactation services she received are "non-medical service[s] or personal item[s]" is self-evidently ludicrous, provides no clarification as to how UHC reached that conclusion, and does not even offer any suggestions as to other information that may support Barber's claim.[33] (Seay/Barber Decl., Ex. E-6). Similarly, UHC's basis for initially denying Endicott's claims was that it "asked the member for more information and didn't receive it in time," (Seay/Endicott Decl., Ex. D-7), which directly conflicted with

. . [t]hat's language that is largely unintelligible to me as a layperson"); Pl. Ex. 49 (Condry Tr.) at 82:3-83:18).

[31] In contrast, a counselor for the trustees in *Brogan v. Holland*, 105 F.3d 158, 166 (4th Cir. 1997), which UHC cites, "explained to [the claimant] that he was required to prove his stroke occurred during the course of his employment" and "needed to submit additional documentary evidence" to support his claim.

[32] Indeed, the so-called "warnings" to Hoy consisted of a general explanation in the middle of a form, "Instructions for Filing for Insurance Reimbursement", that "[o]ften times claims are denied because of incorrect diagnosis or procedure codes." Pl. Ex. 65, PL_JH000032-33. UHC's assertion that Hoy is supposed to distill that general warning to her specific situation is absurd.

[33] *See Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 870 (9th Cir. 2008) (finding benefits termination letter failed to establish a "meaningful dialogue" with claimant where it "notes merely that '[t]he medical information provided no longer provides evidence of disability that would prevent you from performing your job or occupation,' but does not explain why that is the case").

UHC's letter previously sent to Endicott regarding her claims and instructing her that she did "not need to respond or take any action at this time." (Seay/Endicott Decl., Ex. D-7) (stated in bold, "**For your information only – no action required**"). *See Salomaa*, 642 F.3d at 680 (an "administrator does not do its duty under [ERISA] by saying merely 'we are not persuaded' or 'your evidence is insufficient'").

Moreover, absent the receipt of "more information" pursuant to its claim determination, UHC reprocessed Endicott's claims, albeit incorrectly, *only* in response to the Connecticut Insurance Department's inquiry. (Seay/Endicott Decl., Exs. D-8, D-9). *See Saffon*, 522 F.3d at 871 (citing contradictory explanations for denying claim as an inadequacy).[34]

Third, UHC contends that there is no genuine factual dispute that it responded to Plaintiffs' claims and appeals in a timely manner with the exception of Hoy, and in Hoy's instance, any error from UHC's failure to respond to her appeals was harmless. As a preliminary matter, though UHC represents that only Endicott, Bishop, and Hoy submitted appeals, Barber also appealed her benefit denial. (Pl. Ex. 46 at 116:19-117:2, Pl Ex. 66, PL_FB000001-2; Seay/Barber Decl., Ex. E-7). In any event, UHC's contention that any delay in Hoy's situation was "harmless" because the outcome would have been the same is both untrue and irrelevant. Had UHC deigned to provide Hoy a substantive response that she should obtain the "appropriate" codes from her provider to cure her claims—supposing that it was not a mere pretext for UHC's denying her claims—then Hoy could have done so. Instead, Hoy was left ignorant of any recourse on her part and her claims were unpaid. Moreover, UHC's failure to timely respond, as required by ERISA, serves as a separate ground for relief: that the Court grant injunctive relief requiring UHC to comply with ERISA and to timely and substantively respond to appeals. *See Wit*

[34] UHC also cites authorities that "substantial compliance" is sufficient to satisfy their notice requirements. (Memo at 23.) But those authorities only illustrate the inadequacies of UHC's notices and their failure to cure those inadequacies. As noted above, in *Brogan*, the initial denial letter was inadequate, but the defendants cured those inadequacies when a counselor explained to the claimant the precise reasons for the denial and the steps necessary to perfect his claim. *See Brogan*, 105 F.3d at 166. Likewise, in *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 382 (7th Cir. 1994), the defects with the initial notice were cured when the insurer subsequently provided its internal review reports to the claimant, which did have the necessary information. Here, UHC offers no evidence, because there is none, that it subsequently cured the inadequacies of its initial notices. In *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1032 (9th Cir. 2006), the Ninth Circuit found that even though "substantial compliance with the[] requirements [under 29 C.F.R. § 2560.503-1(f)] . . . [but] HP came nowhere close to complying" because it only "communicate[d] the specific reason for the denial," and did not "meet the [p]lan's other obligations." UHC does not even satisfy the first requirement to communicate the "specific reason for the denial" in a "manner calculated to be understood by the claimant."

v. United Behavioral Health, 317 F.R.D. 106, 134 (N.D. Cal. 2016) (injunctive relief to change policies applied to defendant's administered plans).[35]

2. Plaintiffs' Claims Are Proper Under Both ERISA Section 502(a)(1)(B) and 501(a)(3)

UHC is not entitled to judgment on Count I with respect to ERISA section 502(a)(3) (Memo at 25:1-19). First, Plaintiffs' claims encompass "both that they had been improperly denied benefits and that [UHC] [is] using an improper methodology in adjudicating claims." *Wit*, 2014 WL 6626894, at *10 (citing *Hill v. Blue Cross & Blue Shield of Mich.*, 409 F.3d 710, 718 (6th Cir. 2005)). The "latter remedy may (or may not) exceed the scope of what is available under § 502(a)(1)(B)." *Id.* at *11.[36]

Second, UHC relies on *Varity Corp. v. Howe*, 516 U.S. (1996), *Forsyth v. Humana, Inc.*, 114 F.3d 1467 (9th Cir. 1997) and *Harrow v. Prudential Ins. Co. of Am.*, 279 F.3d 244 (3d Cir. 2002), which predate *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011), which "changed the legal landscape by clearly spelling out the possibility of an equitable remedy under ERISA for breaches of fiduciary obligations by plan administrators." *Silva v. Metro. Life Ins. Co.*, 762 F.3d 711, 722 (8th Cir. 2014). "While *Amara* did not explicitly state that litigants may seek equitable remedies under § 1132(a)(3) if § 1132(a)(1)(B) provides adequate relief, *Amara*'s holding in effect does precisely that." *Moyle v. Liberty Mut. Ret. Ben. Plan*, 823 F.3d 948, 960 (9th Cir. 2016). "Additionally, *Amara* makes it very clear that remedies such as reformation, surcharge, estoppel, and restitution are traditionally equitable remedies, and the fact that they take a monetary form does not alter this classification." *Id.* (reversing summary judgment). So even if ERISA Section 502(a)(1)(B) does provide an adequate remedy, it does not foreclose Plaintiffs' ability to assert breach of fiduciary claims under ERISA Section 502(a)(1)(B).

[35] In contrast, the plaintiffs in *Ellenburg v. Brockway, Inc.*, 763 F.2d 1091, 1093 (9th Cir. 1985) and *Hancock v. Montgomery Ward Long Term Disability Tr.*, 787 F.2d 1302, 1303 (9th Cir. 1986) sought only to obtain individual benefits under their respective plans, rather than alter the fiduciaries' planwide policies.

[36] For example, in *Hill*, the Sixth Circuit found that "an award of benefits to a particular Program participant based on an improperly denied claim for emergency-medical-treatment expenses will not change the fact that BCBSM is using an allegedly improper methodology for handling all of the Program's emergency-medical-treatment claims," and "[o]nly injunctive relief of the type available under § 1132(a)(3) will provide the complete relief sought by [p]laintiffs by requiring BCBSM to alter the manner in which it administers all the Program's claims for emergency-medical-treatment expenses. Likewise here, Plaintiffs' individual recovery for their improperly denied CLS claims "will not change the fact that [UHC] [uses] an allegedly improper methodology for handling all of the [plans'] [CLS] claims", which is precisely what the evidence demonstrates.

3. The Evidence Refutes UHC's Arguments on ERISA Co-Fiduciary and Non Fiduciary

Repeating the rejected legal arguments and grounds made in its motion to dismiss, UHC seeks judgment on Count III, asserting claims of co-fiduciary liability *(i.e.*, that there are no facts establishing any two UHC entities as co-fiduciaries of the same plan) and non-fiduciary liability (*i.e.* it is inapplicable here). *Compare* Memo at 25-26 with ECF No. 48 at 16-18. This Court already rejected these arguments:

> [T]his claim "is not confined to formal co-fiduciary liability under 29 U.S.C. § 1105(a) . . . It encompasses the range of situations in which the co-fiduciary or non-fiduciary of a plan may be liable for a breach of fiduciary duty – in this case, for failing to provide lactation counseling without cost sharing. . . This is consistent with the broad scope of potential ERISA liability.

See Harris Trust & Sav. Bank v. Solomon Smith Barney, Inc., 530 U.S. 238, 239 (2000).

Now, UHC's bald legal position is also contradicted by the evidence. First, all UHC's non-grandfathered plans were to operate under the same ACA mandate. Second, UHC's policy with respect to CLS coverage was discussed, established and addressed [redacted] (*see supra* Section II.B). Accordingly, all Defendants were complicit in the fiduciary breaches of all the plans they administered. *See Perez v. City Nat'l Corp.*, 176 F. Supp. 3d 945, 949 (C.D. Cal. 2016) ("the City National defendants are all jointly and severally liable by virtue of their relationship with one another, and that each Defendant enabled the others to commit their fiduciary breaches"). In contrast, UHC presents absolutely no evidence to support its argument. UHC relies solely on legal arguments that the Court previously rejected.[37] Thus, UHC's motion as to Count III should be denied.[38]

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[37] *Compare* Memo, at 26 (citing *Landwehr v. DuPree*, 72 F.3d 726 (9th Cir. 1995); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993); *Renfro v. Unisys Corp.*, 671 F.3d 314 (3d Cir. 2011); *Harris Trust*, 530 U.S. 238) *with* UHC Reply [ECF No. 61] (citing same authorities). As Plaintiffs previously explained, "to the extent that Ninth Circuit case law previously limited the universe of § 502(a)(3) or § 502(a)(5) defendants to fiduciaries and parties in interest (the Court is unconvinced it did so), the case law has been superseded by *Harris Trust*." Opp. to UHC's Motion to Dismiss [ECF No. 59, at 17-18) (quoting *Solis v. Couturier*, No. 2:08CV02732-RRB-GGH, 2009 WL 1748724, at *4 *E.D. Cal. June 19, 2009)).

[38] *See generally United States v. Alexander*, 106 F.3d 874, 876 (9th Cir. 1997) ("[u]nder the 'law of the case' doctrine, 'a court is generally precluded from reconsidering an issue that has already been decided by the same court, or a higher court in the identical case," unless "1) the first decision was clearly erroneous; 2) an intervening

UHC's approach to CLS coverage has been to utterly frustrate the insureds' coverage for CLS. This issue did not just come to UHC's attention for the first time with the filing of the Action. [redacted] Yet, UHC [redacted], shifted the burden and cost to Plaintiffs and members. As fiduciaries and contracting parties, UHC failed in its obligations as to coverage and to convey complete, accurate and timely information material to the insureds' circumstances. The approach that UHC chose, coupled with the wrongful shifting of costs, is contrary to the ACA mandates and Defendants' ERISA duties, and constituted a failure of good faith and fair dealing. Accordingly, and for the reasons set forth *supra,* the ERISA Plaintiffs seek summary judgment on Counts I - III.

C. **Carroll Is Not Required to Exhaust Any UHC Internal Claims Procedure**

UHC's arguments do not demonstrate any entitlement to summary judgment on Counts IV, V and VI with respect to Carroll. (Memo at 27.)[39] Due to UHC's policy on CLS coverage, Carroll was unsuccessful in finding an available network provider (*see* fn. 14) using UHC's provider finder tools, and ultimately received CLS from a trained lactation consultant. (Pl. Ex. 45 at 89:10-93:5; Souza Decl., Ex. G-16, Rog. Resp. 2(c)). Carroll submitted her four CLS claims for reimbursement: the first one was processed at the out-of-network level of benefits (Seay/Carroll Decl., Ex. C-4), and the three subsequent claims were denied on the basis that the "service is excluded by [her] health plan". (Seay/Carroll Decl., Ex. C-5; Pl. Ex. 61, PL_RAC000001). That information was false. When Carroll contacted UHC to

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change in the law has occurred; 3) the evidence on remand is substantially different; 4) other changed circumstances exist; or 5) a manifest injustice would otherwise result").

[39] Regarding Count VI, UHC requests dismissal on the basis that the unjust enrichment claim has no basis other than the alleged breach of contract. (Memo at 30.) "[A] claim for unjust enrichment may be pled in the alternative [and]… may be maintained despite the existence of an express contract where there is evidence of fraud, bad faith, or illegality." *Sherwin-Williams Co. v. JB Collision Servs.*, 2015 U.S. Dist. LEXIS 86033, 13-14 (S.D. Cal. June 29, 2015)(citations omitted). Courts recognize unjust enrichment claims as equitable alternatives to breach of contract claims. *See McKinnon v. Dollar Thrifty Auto. Group*, 2013 U.S. Dist. LEXIS 29095 (N.D. Cal. Mar. 4, 2013). Here, based on the evidence adduced, UHC acted in bad faith, and Carroll is therefore entitled to restitution under an unjust enrichment theory as an appropriate remedy.

request information on submitting an appeal (Pl. Ex. 18, UHC_003677) the representative instructed her to locate the form online, but she could not find it. (Pl. Ex. 45 at 160:16-161:2). The futility of any attempt by Carroll to go through UHC's internal appeals procedure is conclusive. As noted in the case relied on by UHC, *Pepp-Zotter v. Liberty Life Assurance Co.*, 2006 U.S. Dist. LEXIS 66445, at *8 (N.D. Cal. Sep. 5, 2006), "[e]xhaustion...is not an absolute requirement. For example, it can be dispensed with when such an attempt would be futile." Here, Carroll's proceeding with an appeal through UHC's internal claims procedures would have been futile because UHC's policy with respect to CLS was not going to be changed by Carroll's appeal, the challenged policy (as evidenced by this proceeding) evokes issues with respect to federal law and compliance with federal law, and UHC's internal, undisclosed policy, all of which Carroll would not have been able to address pursuant to an appeal. Importantly, the efforts of the other Plaintiffs who sought appeals, illustrate the futility of imposing an exhaustion requirement on Carroll.[40] Thus, UHC's motion should be denied.

D. **UHC Is Not Entitled To Judgment on Plaintiffs' Discrimination Claim**

Repeating the previously rejected legal arguments made in its motion to dismiss, UHC contends that Count IV, asserting a violation of Section 1557 of the ACA, should be dismissed. *See* Memo at 27-29 compared to ECF. No. 48, at 18-19; *see* the Complaint, Dkt. at ¶¶148-175, 221-239, setting forth the legal bases for the Section 1557 claim. Without offering or addressing their own evidence, UHC baldly contends that Plaintiffs have not defined UHC's "supposed policy" and its disparate impact. Memo at 30. UHC's arguments are wrong and UHC provides no grounds entitling it to summary judgment.

Through UHC's policy (see *supra*), Plaintiffs and all breastfeeding women have been uniquely, specifically and knowingly excluded by UHC from participation in an-ACA mandated preventive health benefit.[41] UHC deemed (and apparently still does) it sufficient to direct breastfeeding women to hundreds

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[40] *See e.g., Roche v. Aetna, Inc.*, 681 F. Appx 117, 125 (3d Cir. 2017) (futility of an appeal can be demonstrated by the "existence of a fixed policy denying benefits"); *Tex. Gen. Hosp., LP v. United HealthCare Servs.*, Civil Action No. 3:15-CV-02096-M, 2016 U.S. Dist. LEXIS 84082, at *18 (N.D. Tex. June 28, 2016) (With respect to an ERISA claim, the Court held that exhaustion was futile "based on, either or both [of]: United's failure to provide meaningful access to administrative remedies and the futility of further efforts by Plaintiffs.")

[41] Section 1557(a) provides: [A]n individual shall not, on the ground prohibited under . . . title IX. . . ***be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity...***" The Final Rule implementing Section 1557 states that "OCR interprets Section 1557 as authorizing a private right of action for claims of disparate impact discrimination on the basis of any of the criteria

and thousands of pediatricians and OB/GYNs (without any clinical or informational support for such position), while knowingly keeping from them the identity of any network lactation consultants. That conduct has the specific and significant impact of denying all breastfeeding women members covered benefits and subjecting them to discrimination, as unique to other members seeking the identity of in-network providers in order to secure no-cost preventive care from network providers. UHC's practice is unlawful and discriminatory, and can be so irrespective of motivation or intent. *See Raytheon Co. v. Hernandez*, 540 U.S. 44, 52-53 (2003); *see also Ricci v. DeStefano*, 557 U.S. 557, 578 (2009). However, though, the evidence reveals that UHC's policy was intentionally crafted, with the knowing monetary, mental and physical impact and burden that it put on breastfeeding women, to the financial gain of UHC.

Each Plaintiff sought out covered benefits through UHC, yet, in an attempt to hide its discriminatory practice, UHC has advanced a series of arguments that attempts to impose responsibilities on the Plaintiffs far beyond the responsibilities of any individual covered by UHC health plans. UHC accuses these women of "not trying hard enough" to identify an in-network provider when UHC knowingly concealed the lack of, and its failure to identify, network trained providers, in order to cost-shift to Plaintiffs and even deter members from seeking coverage for CLS. UHC's conduct has caused a significant disparate impact on breastfeeding women, a protected class. *See Lewis v. Aerospace Cmty. Credit Union*, 114 F.3d 745, 750 (8th Cir. 1997); *Gomez v. Quicken Loans, Inc.*, 629 Fed. Appx 799, 802 (9th Cir. 2015) (same). UHC is not entitled to summary judgment on Count IV.

IV. CONCLUSION

Plaintiffs respectfully request that the Court deny UHC's Motion in its entirety and grant summary judgment for Plaintiffs on Counts I -III and V-VI. Plaintiffs request that the Court award other equitable relief and damages that the Court deems proper and appropriate arising from UHC's conduct.

Dated: December 18, 2017 **CHIMICLES & TIKELLIS LLP**

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enumerated in the legislation," (45 CFR 92; 81 FR 31375), and Title IX prohibits discrimination on the basis of sex, which "includes, but is not limited to, discrimination on the basis of pregnancy, false pregnancy, [ ] or recovery therefrom, childbirth or related medical conditions...." 42 U.S.C. § 18116(a) (incorporating Title IX by reference). Lactation is a medical condition related to pregnancy and childbirth. (*See* SAC ¶157.)

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