IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

LAURA BRISCOE, KRISTIN MAGIERSKI, and EMILY ADAMS on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

HEALTH CARE SERVICE CORPORATION and BLUE CROSS AND BLUE SHIELD OF ILLINOIS,

Defendants.

No. 1:16-cv-10294
Honorable John Robert Blakey

PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

TABLE OF CONTENTS

I. INTRODUCTION 1

II. FACTUAL BACKGROUND 2

A. The Parties 2

B. The ACA's Preventive Coverage Mandate for CLS 4

C. HCSC Failed to Provide ACA-Mandated CLS Coverage 6

1. HCSC Bases Its No-Cost ACA Coverage on a Limited Number of Codes Billed by Network Providers 6

2. HCSC's Claims Data and its Adjudication of Submitted Claims Undermine Its Position and Demonstrate That HCSC Improperly Imposed Costs for CLS 9

D. HCSC Created Administrative Barriers That Rendered Illusory its Delivery of ACA-Complaint CLS Coverage 11

1. HCSC's In-Network Trained, CLS Providers are Illusory 11

2. HCSC's Provider Finder Tool and Customer Service Further Evidence the Failure to Provide ACA-Compliant Coverage 13

III. ARGUMENT 14

A. The ERISA and Non-ERISA Classes 14

B. The Proposed Classes Meet the Requirements of Rule 23(a) 16

1. The Numerosity Requirement is Satisfied 17

2. The Case Presents Common Questions of Fact and Law 17

3. The Named Plaintiffs' Claims are Typical of the Claims of the Classes 19

4. Plaintiffs and Counsel Are Adequate Representatives 20

C. The Proposed Classes Meet the Requirements of Rule 23(b) 21

1. Rule 23(b)(1)(A) 22

2. Rule 23(b)(2)....................23

D. In The Alternative, The Court May Certify A Rule 23(c)(4) Issue Class......25

IV. CONCLUSION....................25

TABLE OF AUTHORITIES

PAGE(S)

CASES

A.F. v. Providence Health Plan,
300 F.R.D. 474 (D. Or. 2013) 18

Beaton v. SpeedyPC Software,
2017 U.S. Dist. LEXIS 173631 (N.D. Ill. Oct. 19, 2017)..15

Beley v. City of Chicago,
2015 U.S. Dist. LEXIS 163919 (N.D. Ill. Dec. 7, 2015) 17

Breedlove v. Tele-Trip Co.,
1993 U.S. Dist. LEXIS 10278 (N.D. Ill. July 26, 1993)..24

Condry v. Unitedhealth Grp., Inc.,
2018 U.S. Dist. LEXIS 111233 (N.D. Cal. June 27, 2018) 15

Condry v. Unitedhealth Grp., Inc.,
2019 U.S. Dist. LEXIS 106254 (N.D. Cal. May 23, 2019). 15

Eternal Word TV Network, Inc. v. Sec'y of the U.S.HHS,
818 F.3d 1122 (11th Cir. 2016) 6

Flanagan v. Allstate Ins. Co.,
242 F.R.D. 421 (N.D. Ill. 2007)..18

Gaspar v. Linvatec Corp.,
167 F.R.D. 51 (N.D. Ill. 1996)..19

Healy v. IBEW, Local Union No. 134,
296 F.R.D. 587 (N.D. Ill. 2013)..18

Holmes v. Godinez,
311 F.R.D. 177 (N.D. Ill. 2015)...18, 24

Johnson v. Meriter Health Servs. Emple. Ret. Plan,
702 F.3d 364 (7th Cir. 2012) 24

Kazarov v. Achim,
2003 U.S. Dist. LEXIS 22407, at * (N.D. Ill. Dec. 12, 2003) 23

Magpayo v. Advocate Health & Hosps. Corp.,
2018 U.S. Dist. LEXIS 26282 (N.D. Ill. Feb. 20, 2018) (Blakey, J.)....................16, 19, 20, 21

McReynolds v. Merrill Lynch, Pierce, Fenner & Smith, Inc.,
672 F.3d 482 (7th Cir. 2012) 25

Messner v. Northshore Univ. HealthSystem,
669 F.3d 802 (7th Cir. 2012) 16

Mezyk v. U.S. Bank Pension Plan,
2011 U.S. Dist. LEXIS 13857 (S.D. Ill. Feb. 11, 2011) 22, 23

Mullins v. Direct Digital, LLC,
795 F.3d 654 (7th Cir. 2015) 17

N.B. v. Hamos,
26 F. Supp. 3d 756 (N.D. Ill. 2014) 24

Neil v. Zell,
275 F.R.D. 256 (N.D. Ill. 2011)....................22, 23, 24

Ormond v. Anthem, Inc.,
2009 U.S. Dist. LEXIS 90837 (S.D. Ind. Sept. 29, 2009) 20

Phipps v. Sheriff of Cook County,
249 F.R.D. 298 (N.D. Ill. 2008)....................17

Practice Mgmt. Support Servs. v. Cirque Du Soleil, Inc.,
301 F. Supp. 3d 840 (N.D. Ill. 2018) 17

Ries v. Humana Health Plan,
1997 U.S. Dist. LEXIS 4035 (N.D. Ill. Mar. 31, 1997)....................19

Robertson v. National Basketball Ass'n,
556 F.2d 682 (2d Cir. 1977)....................23

Rodriguez v. Vill. of Montgomery,
2009 U.S. Dist. LEXIS 9166 (N.D. Ill. Feb. 9, 2009) 24

Rosario v. Livaditis,
963 F.2d 1013 (7th Cir. 1992) 19

Smith v. Aon Corp.,
238 F.R.D. 609 (N.D. Ill. 2006)....................24

Stafford v. Carter,
2018 U.S. Dist. LEXIS 34266 (S.D. Ind. Mar. 2, 2018)....................19

Vill of Bedford Park v. Expedia, Inc. (WA),
2015 U.S. Dist. LEXIS 1012 (N.D. Ill. Jan. 6, 2015) 22

Wal-Mart Stores, Inc. v. Dukes,
564 U.S. 338 (2011)....................17, 18

Walker v. Bankers Life & Cas. Co.,
2007 U.S. Dist. LEXIS 73502 (N.D. Ill. Oct. 1, 2007)....................20

York v. Wellmark, Inc.,
2017 U.S. Dist. LEXIS 199888 (S.D. Iowa Sep. 6, 2017)....................15

Zielinski v. Pabst Brewing Co.,
2005 U.S. Dist. LEXIS 36819 (E.D. Wis. Nov. 30, 2005)....................22

Statutes / Other

42 U.S.C. § 300gg-13....................1, 5

29 C.F.R. § 2590.715-2713(a)(3)(i)-(ii)....................1, 4

29 CFR 2590.715-2713....................4

75 FR 41726....................1, 6

Fed. R. Civ. P. 23....................15-17, 21, 24-25

Rule 23(g)....................21

1 William Rubenstein et al., *Newberg on Class Actions* § 3:58 at 341-42 (5th ed.
2011)....................20

I. INTRODUCTION

The Affordable Care Act ("ACA") was touted as an achievement in women's health. One such achievement was the requirement of no-cost coverage for evidence-based preventive care services, which include comprehensive breastfeeding and lactation support services ("CLS"). Yet, in the seven years since CLS preventive care coverage was to have begun, Defendant Health Care Service Corporation ("HCSC") has flouted the ACA CLS coverage mandate. HCSC insureds who receive CLS so as to achieve and support successful breastfeeding have been subjected to HCSC's non-compliant coverage and incurred improper costs for CLS.

The coverage policy at issue here derives from a single source – the ACA – and it applies uniformly to all HCSC non-grandfathered, non-federal health benefit plans. The ACA expressly requires "coverage" of CLS: plans "must provide coverage for all of the following items and services, *and* may not impose any cost sharing requirements…" (42 U.S.C. § 300gg-13, emphasis added). The ACA's preventive services coverage mandate was expressly identified as necessary to increase "access and utilization" of these services, address "underutilization of preventive services" and to "eliminate cost-sharing requirements, thereby removing a barrier that could otherwise lead an individual to not obtain such services." Ex. 1 at 75 FR 41726 at 41730-31, and Table 1.[1] Also, to further its directives and aims, the ACA includes a commonsensical directive to insurers: do not circumvent the ACA's mandate by not having in-network providers for the enumerated preventive services. *See* 29 C.F.R. § 2590.715-2713(a)(3)(i)-(ii).

HCSC violated the ACA mandate in two fundamental respects: first, HCSC diminished CLS with the policy that only CLS claims submitted with a limited set of procedure codes would

[1] All Exhibits referenced herein are attached to the Declaration of Kimberly Donaldson-Smith, which is filed concurrently herewith.

be covered at n-cost, which is not comporting with the scope of the ACA-mandate. Second, HCSC insisted no-cost CLS would be "covered…***if you go to a trained, network provider***" which "***could*** be a provider such as an Obstetrician-Gynecologist, Pediatrician, Certified Nurse Midwife, Certified Nurse Practitioner or Certified Nurse Specialist," but failed to identify such network providers who actually do provide CLS. HCSC's policy resulted either in improper cost-sharing or the shifting of the entire cost of CLS to HCSC's insureds in violation of the ACA.

HCSC had the option to be ACA-complaint by providing CLS with no cost-sharing, irrespective of the provider's network status. HCSC internally recognized this [REDACTED] *See* Ex. 2, HCSC_0097206-7 [REDACTED] The consequence of that corporate decision was to thrust CLS costs on HCSC insureds.

Plaintiffs Laura Briscoe, Kristin Magierski, and Emily Adams (the "Plaintiffs") seek certification of two Classes, an ERISA Plan Class and a Non-ERISA Plan Class, each comprised of thousands of persons, like Plaintiffs, who were all insured under and subjected to HCSC's ACA-violative plans, and incurred ACA-prohibited costs for their CLS claims. This Action is ideally suited for class certification as the common legal and factual issues presented are grounded in the ACA and HCSC's conduct.

II. FACTUAL BACKGROUND

A. The Parties

HCSC administers health care plans through its unincorporated divisions, the Blue

Cross/Blue Shields of Illinois, Texas, Montana, Oklahoma, and New Mexico (collectively, "HCSC Divisions"), that HCSC admits "are subject to the ACA preventive services requirements, including those pertaining to the ACA-mandated breastfeeding support and counseling services." HCSC Answer, Dkt. 57, at ¶1, fn.*, ¶¶21-22, 72. HCSC made no distinction with respect to its CLS coverage policies between and among its Divisions. As Stephanie Janulis (an HCSC 30b6 designee) testified, "We don't make the decisions based on each state. We make a decision about the services that are covered for HCSC, and that decision is then equally administered or applied to the state plans." Ex. 3, Janulis Dep Tr. at 23:14-18.

Shortly after giving birth,[2] each Plaintiff experienced difficulties breastfeeding.[3] None of the Plaintiffs' primary care providers offered CLS; therefore, before receiving services, each Plaintiff made considerable efforts to locate in-network providers of CLS by conducting searches on HCSC's Provider Finder Tool and calling HCSC customer service. *See* Exs. 7-9, Interrogatory No. 2 Response. All three Plaintiffs tried to conduct searches using HCSC's Provider Finder Tool; however, no CLS providers were identified.[4] When each Plaintiff called HCSC's customer service, they were all informed that HCSC had no in-network providers of

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[2] Briscoe gave birth at home in Chicago, IL in November 2014; Magierski gave birth in April 2016 at Northwest Community Hospital; and Adams gave birth in May 2016 at West Suburban Medical Center.

[3] Briscoe Dep. (Ex. 4) 61:20-62:16 ("I was experiencing such a degree of pain breast feeding" that "it was clear…that I needed to get help if [] I was going to continue breastfeeding); Magierski Dep. (Ex. 5) at 221:19-222:21 (Experiencing issues with latch, engorgement, and cracked and bleeding nipples); Adams Dep. (Ex. 6) at 126:4-22 (Experiencing breastfeeding difficulties and was anxious about her child's "inability to nurse").

[4] *See* Briscoe Dep. (Ex. 4) at 57:4-58:1 ("there was no way to find lactation consultants through the provider finder website…I tried multiple search terms and was never able to find anything."); Magierski Dep. (Ex. 5) at 73:20-74:7 (Magierski could not "find anyone" when searching for lactation consultants, whereas a search using OB/GYN resulted in "a list of hundreds of people… and it wasn't clear [] who was focusing on lactation consulting versus just OB/GYN."); Adams Dep. (Ex. 6) 55:17-56:11; 96:7-24 (Adams was "not able to locate any lactation consultants" because there were "zero results or no results found.")

CLS. *Id*.[5]

Since HCSC did not have identified in-network providers of CLS, each Plaintiff sought and paid out-of-pocket for one-on-one CLS from trained out-of-network providers. *See* Exs. 7-9, Interrogatory No. 11 Response. Plaintiffs submitted their CLS claims to HCSC, and ultimately each claim had cost-sharing imposed by HCSC: HCSC admits that Plaintiffs Briscoe, Magierski and Adams were, at all relevant times, insured by non-grandfathered BCBSIL plans, and that each was "held responsible" for $40, $245.20, and $125.36, respectively. HCSC Answer, Dkt. 57, at ¶¶ 16-18.[6]

B. <u>The ACA's Preventive Coverage Mandate for CLS</u>

This Court has aptly stated that "[a]t summary judgment, the parties can address the precise legal contours of the ACA's coverage requirements." (12/4/17 Order, Dkt. 50, at 13). Plaintiffs believe that in the context of this Motion, it is appropriate to address how profoundly and uniformly HCSC's "scope of coverage" fell markedly short of being ACA-compliant.

The ACA added Section 2713 to the Public Health Service Act (29 CFR 2590.715-2713) stating "[Non-grandfathered health plans] must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements...:

> (i) Evidenced-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force [USPSTF] with respect to the individual involved . . .;
> * * *

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[5] *See* Briscoe Dep. (Ex. 4) at 91:15-93:5 ("I was specifically asking for in-network lactation consultants and was told that there were none in-network."); Magierski Dep. (Ex. 5) at 70:4-73:17 (customer service representative "said it doesn't appear that there is anyone in the network."); Adams Dep. (Ex. 6) at 55:27-56:11 ("I asked if they had anybody in Illinois that they were contracted with, and they replied no.").

[6] All three Plaintiffs appealed, contesting HCSC's coverage determinations. In response to Plaintiff Briscoe's appeal of her initially denied claim, HCSC reprocessed her claim by reflecting that $200 was "covered", but then applied $40 to coinsurance. Meanwhile, HCSC upheld the initial determinations as to Plaintiff Magierski's and Adam's claims leaving them with out-of-pocket expenditures of $245.20 and $125.36, respectively. HCSC Answer, Dkt. 57, at ¶¶ 103, 110, 116-119.

> (iv) With respect to women...evidence-informed preventive care and screening provided for in comprehensive guidelines supported by the Health Resources and Services Administration [HRSA]. . . ."

See 42 U.S.C. § 300gg-13(a)(1), (a)(4). HCSC admits that the ACA requires coverage without cost-shares for preventive care as provided for by HRSA. *See* HCSC Answer, Dkt. 57, at ¶ 4.

On August 1, 2011 and December 20, 2016, pursuant to (a)(4), HRSA adopted and released its guidelines (the "HRSA Guidelines") for "[b]reastfeeding support, supplies, and counseling" which HRSA described as:

- "[c]omprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment" (in 2011, Ex. 10), and
- "[c]omprehensive 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" (in 2016, Ex. 11).[7]

HCSC admits that the HRSA Guidelines are as stated above and included "[b]reastfeeding support, supplies, and counseling," (*see* HCSC Answer, Dkt. 57, at ¶5). The 2011 HRSA Guidelines were based on studies and recommendations of the independent Institute of Medicine ("IOM") (now known as the National Academy of Medicine) as set forth in its report, *Clinical Preventive Services for Women: Closing the Gaps.* (IOM Report excerpts, Ex. 12). The 2016 HRSA Guidelines were based on the Women's Preventive Services Initiative 2016 Final Report ("WPSI Report" excerpts, Ex. 13). As the WPSI Report at 41 confirms, "The gap in services provided under the [ACA provisions] previously identified by [IOM] was that comprehensive prenatal and postnatal lactation support, counseling, and supplies were not included…The IOM recommendation includes an explicit description of a ***more comprehensive set of services***…"

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[7] As this Court concluded in its Opinion and Order, dated Dec. 4, 2017 (Dkt. 50), the "relevant [HRSA] provisions remain substantively the same in the [2016] version." (12/4/17 Order at p. 2 fn. 1).

(emphasis added). *See also*, Ex. 12, IOM Report at 116.

Further, per the Tri-Departments[8], the ACA expanded preventive services coverage was to address "access and utilization of these services", "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." Ex. 1, 75 FR 41726 at 41730, Table 1, and at 41731.

C. HCSC Failed to Provide ACA-Mandated CLS Coverage

Notwithstanding its acknowledgment that the ACA applies to HCSC's plans, HCSC has rendered illusory CLS coverage, putting its insureds in the position of improperly incurring costs for CLS. Understanding how HCSC's CLS coverage has been illusory begins with examination of (a) HCSC's CLS coverage policy that was grounded on a set of restrictive billing codes, and (b) the claims HCSC produced in discovery.

1. HCSC Bases Its No-Cost ACA Coverage on a Limited Number of Codes Billed by Network Providers

HCSC[9]

See Ex. 14, Janulis 30b6 Doc. at pg. 2, response to 4(b). Instead, HCSC "defined the scope of the CLS benefit" by "identifying [procedure] codes associated with the ACA-mandated service that pay at no cost-share ***when billed by a network provider***..." Ex. 17, HCSC Interrogatory No. 1

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[8] "When Congress enacted the ACA it ceded broad authority to [the Departments of HHS, Labor, and the Treasury (the "Tri-Departments")] to promulgate rules governing…women's preventive health services in employer-sponsored health plans." *Eternal Word TV Network, Inc. v. Sec'y of the U.S.HHS*, 818 F.3d 1122, 1179 (11th Cir. 2016).

[9] In response to Plaintiffs' Fed. R. Civ. P. 30(b)(6) Notice, HCSC designated the following witnesses, each of whom came to their depositions with printed notes setting out responses to each of their 30(b)(6) designated Subject Matters: Stephanie Janulis, who, as of approximately April 2019, was HCSC's Director of Clinical Regulatory Oversight for HCSC, and prior to that, from approximately April 2015, HCSC Manager of Care Integration; Marla Ludacka, who has been HCSC's VP of Network Operations since 2016; and Teresa Benner, who as of 2017, was HCSC's Director, Group Member Services, and was prior a HCSC Senior Manager/Manager since 2007. The documents are: "Janulis 30b6 Doc.", Ex. 14; "Ludaka 30b6 Doc.", Ex. 15; and "Benner 30b6 Doc.", Ex. 16.

Answer, at pg. 6 (emphasis added).[10] HCSC's CLS coverage policy was set forth:

(1) From August 1, 2012 - July 14, 2017, in HCSC's Medical Policy for Preventive Care Services (ADM1001.030), which stated that [redacted] *See* Ex. 19 (Example of ADM1001.030, at pgs. 1-2 (Janulis Dep. Ex. 7)).

(2) From July 14, 2017 onward, in the Enterprise Clinical Payment and Coding Policy for Preventive Services (CPCP006), which stated that [redacted] *See* Exhibit 20 (Example of the CPCP006, at pages 1 and 17 (Janulis Dep. Ex. 16)).

The [redacted] the ADM1001.030 and then the CPCP006 constituted HCSC's policy for CLS claims eligible for "cost-share-free-coverage" by HCSC, and therefore [redacted] *See* Ex. 14, Janulis 30b6 Doc. at pgs. 1-2 (emphasis added); and, Ex. 16, Benner 30b6 Doc. at pgs. 4-6. Ms. Janulis was not aware of any other document that she would identify as an HCSC policy with respect to CLS coverage that was in effect from August 1, 2012 through the present. *See* Ex. 3, Janulis Dep. Tr. at 174:4-10.

Grounded in the HRSA Guidelines (discussed *supra,* Section II.B), CLS means comprehensive lactation support, counseling and education services provided during the antenatal, perinatal, and the postpartum period. HCSC wholly ignored this coverage scope through its use of a limited set of procedure codes. Plaintiffs' expert, Nicole Peluso, IBCLC: (a) describes the type of training undertaken and CLS provided by trained lactation providers such as International Board Certified Lactation Consultants ("IBCLCs"); and (b) identifies procedure

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[10] Procedure codes are discussed in Ex. 18, Report of Plaintiffs' Expert Nicole Peluso, Dated May 3, 2019, at pgs. 9, 18-20.

codes that reflect the provision of CLS that appropriately allows physician or non-physician providers to identify the actual CLS rendered by trained CLS providers. *See* Ex. 18, Report of Plaintiffs' Expert Nicole Peluso, at pgs. 3-4, 8-9, 12-16, 18-19, Ex. B thereto. Among other things, Ms. Peluso determined that HCSC's CPT codes are extremely limiting and that a greater universe of procedure codes must be covered without cost-sharing in order to provide flexibility to the healthcare professional rendering lactation consultations. *Id.* at pgs. 18-19.[11]

In addition, Plaintiffs' expert, Dr. Lauren Hanley (an MD and IBCLC) identified diagnosis codes that may be reasonably used by providers to indicate that their encounter with a patient was for CLS. *See* Ex. 21, Report of Plaintiffs' Expert Dr. Hanley, Dated May 2, 2019, at pgs. 12-20. As Dr. Hanley explained, "diagnosis codes" (or "ICD Codes") are used by providers, both physician and non-physician healthcare professionals, in their patients' records to indicate the diagnosis of the conditions being evaluated and/or discussed with the patient during the visit. *Id.* at 13. According to Dr. Hanley, it is a provider's professional responsibility to include a procedure code and diagnosis code(s) on the patient records and for billing purposes that accurately describe the service provided and the conditions that are contributory to the clinical condition(s) addressed. *Id.* Dr. Hanley identifies, from a clinical perspective, diagnosis codes individually or in combination that can indicate the rendering of CLS. *Id.* at 13-20.

Absent utilization of the appropriate CPT codes coupled with appropriate diagnosis codes, HCSC failed to capture, and thus cover, the ACA-mandated scope of CLS. An ACA-

[11] For example, Ms. Peluso points out that limiting CLS coverage to procedure codes that refer to preventive counseling (99401-4, 99411, 99412) does not adequately cover the clinical exam that normally takes place at a lactation appointment. *Id.* at 19. Similarly unreflective of the scope and reality of CLS are HCSC's codes that refer only to certain home visits for established patients (99347-99350), which wrongly presumes an existing relationship between the provider and patient, when that circumstance does not exist for lactation consultations. *Id.* Further, as Ms. Peluso opines, CLS coverage policies that do not include codes to reflect the occurrence of a clinical exam (*e.g.* an office visit 99201-5, 99211-5, or home visit 99341-5, or hospital visit 99221-3, 99231-3), ignore the actual scope of lactation services being rendered and exclude coverage for CLS claims. *Id.*

compliant policy requires the use of appropriate, and a necessarily broader set of, procedure and diagnosis codes.

2. *HCSC's Claims Data and its Adjudication of Submitted Claims Undermine Its Position and Demonstrate that HCSC Improperly Imposed Costs for CLS*

In discovery, without agreeing that such claims constituted CLS, HCSC produced claims data for the HCSC Divisions based on an agreed-to set of procedure and diagnosis codes identified by Plaintiffs. In total, the production contained approximately [REDACTED] lines of data, collectively, the "Claims Data".[12] The Claims Data included claim lines [REDACTED] To account for that, for purposes of the below analysis, Plaintiffs identified a subset of approximately [REDACTED] claim lines that included certain CLS codes.[13]

First, HCSC [REDACTED] Instead, of the [REDACTED].[14] HCSC did not get it right, even under its own policy.

Second, contrary to HCSC's position about the sufficiency of its CLS policy, there were [REDACTED]

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[12] The spreadsheets and number of data fields comprising the Claims Data (HCSC_0178796 – 8 ([REDACTED], HCSC_0178799 ([REDACTED]), HCSC_0178800 ([REDACTED]), HCSC_0178801 ([REDACTED]) and HCSC_0178802 ([REDACTED])) are voluminous and can only be viewed electronically. Therefore, Plaintiffs do not attach them to their Motion, but can make them available to the Court electronically, under seal, upon request.

[13] The [REDACTED] claim lines have dates of service from 8-1-2012 through 12-30-2018, and are comprised of: (1) claim lines with the S9443 code ("lactation classes"), irrespective of the diagnosis code; and, (2) claim lines with at least (a) one of the procedure codes listed in Ms. Peluso's Report (Ex. 18, at Exhibit B, which includes HCSC's Policy procedure codes discussed *supra*) and (b) one of the diagnosis codes identified in Table 1 in Dr. Hanley's Report (Ex. 21).

[14] The claim lines included: [REDACTED] when appearing on a claim line with diagnosis codes [REDACTED]. *See* Ex. 23, hereto, at footnotes 1 and 2 (on pgs. 8-9) of the June 6, 2019 Expert Report of Palma D'Apuzzo Rebuttal to Expert Report Dr. Hanley.

.[15]

There are approximately that fall into that category. Of those, approximately . This is further proof of the constricted scope and thus non-compliance of HCSC's CLS policy, and the harm to members of the Class who had their claims illegally adjudicated.

Third, HCSC deposed and submitted declarations from certain providers (primarily hospitals) to attempt an after-the-fact identification of the purported in-network providers who render CLS and were accessible to its insureds. According to HCSC's expert, *See* Ex. 24, Expert Report of Dr. Henry Lee at pg. 10. The claims provide a different picture. For example, of the claim lines, Plaintiffs identified: (1) (2) (3) (4) (5) (6) ; and (7) . Furthermore, .

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[15] *See* Ex. 23, hereto, at footnotes 1 and 2 (on pgs. 8-9) Report of Palma D'Apuzzo. ee Ex. 21, at Table 1.

The foregoing demonstrates the illusory CLS coverage being peddled by HCSC.

D. HCSC Created Administrative Barriers That Rendered Illusory its Delivery of ACA-Compliant CLS Coverage[16]

1. HCSC's In-Network Trained, CLS Providers are Illusory

Plaintiffs requested from HCSC the identity of every provider in HCSC's network since August 1, 2012 who HCSC contends offered(s) network CLS. *See* Ex. 17, HCSC Interrogatory No. 5 Answer, at pg. 12. After stating boilerplate objections, HCSC did not identify such providers. Instead it cited to its claims data production. *See id*. Plaintiffs have already addressed HCSC's claims data production in Section II.C.2, *supra*.

Separately and *not* referenced as responsive to Interrogatory No. 5, [REDACTED] (HCSC_0177965, HCSC_0177966, HCSC_0177967, and HCSC_0178008) [REDACTED][17] [REDACTED] HCSC's proffer demonstrates the absurdity and futility of HCSC's position that, from a list of thousands of providers, insureds were to hunt for network providers who render CLS.

Plaintiffs' expert Dr. Lauren Hanley points out the impossibility of HCSC's position from a clinical and practice standpoint. *See* Ex. 21, Dr. Hanley Report at pgs. 1-3.[18] Dr. Hanley

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[16] This Court has already addressed the fact that the ACA can be violated "by imposing administrative barriers that render full coverage for preventive breastfeeding services illusory." (12/4/17 Order, at 10). As demonstrated herein, discovery has uncovered the pervasive and uniform nature of these HCSC barriers to securing no-cost CLS coverage.

[17] [REDACTED]

[18] Dr. Hanley is a practicing physician and IBCLC with a specialty in obstetrics, gynecology and breastfeeding medicine with an appointment with the Massachusetts General Hospital, an Assistant Professor at the Harvard Medical School, a Fellow of The American College of Obstetricians and Gynecologists (FACOG), and a Fellow of the Academy of Breastfeeding Medicine (ABM).

opines, among other things, about the level of training in CLS received by health care professionals who identify as rendering CLS. *Id.* In sum, Dr. Hanley opines that absent specific CLS training, physicians and their staff are not providing CLS, and, in addition, physician shortages combined with short time availability during office visits make it nearly impossible for a physician to provide CLS, including observed feedings, to mother and child. *Id.* at pg. 10.

The circularity and futility of HCSC's stance – by its reference to its general network of providers without knowledge of whether any such providers were able and willing CLS providers – was not lost on HCSC members and clients, as well as HCSC employees. For example,

(Emphasis added).

Ex. 25, HCSC_0097081-87 at HCSC_0097086. Similarly,

See Ex. 26, HCSC_0097040-47 at HCSC_0097043.[20]

[19] This Court anticipated "needle in a haystack" metaphor. 12/4/17 Order at 12 ("the fact that some members *might* find the needle in the haystack…". What the Court (and Plaintiffs) may not have anticipated is

[20]

2. *HCSC's Provider Finder Tool and Customer Service Further Evidence the Failure to Provide ACA-Compliant Coverage*

Beginning in 2016, HCSC's websites conveyed the same confounding message as its Policies. *See* Ex. 14, Janulis 30b6 Doc. at 3; Ex. 15, Ludaka 30b6 Doc. at 1 (emphasis added).

HCSC admitted insureds were on their own in locating CLS providers: Ex. 16, Benner 30b6 Doc. at 1, part (b). And, effectively directing insureds not to bother submitting claims for out-of-network CLS,

Moreover, in stark contrast to its litigation stance in seeking dismissal of the Action,

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October 23, 2015 FAQs, Part XXIX (Ex. 34)[21]. FAQ No. 1 stated: "Are plans and issuers required to provide a list of the lactation counseling providers within the network? Yes." *See* Ex. 35, HCSC_0095287-97, at HCSC_0095416,

Ultimately, in the Fall of 2017, *See* Ex. 14, Janulis 30b6 Doc. at pgs. 3-4, Subject Matter 13.3.ii. Notwithstanding – HCSC did not change its CLS coverage policy.[22]

III. ARGUMENT

A. The ERISA and Non-ERISA Classes

In addition to Plaintiffs, thousands of HCSC insureds were denied ACA-compliant

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[21] In its 12/4/17 Order (Dkt. 50), the Court did not address the FAQs, instead finding that "[e]ven if this Court accords no deference to the FAQs, however, Plaintiffs state a plausible ACA violation based upon the alleged failures of PF [provider finder] and Defendant['s] representatives to identify an in-network lactation consultation providers." *Id.* at 13, n. 3.

[22] Instead, HCSC added a "filter" option to its provider finder tools, available only since December 2017 for its BLUE ACCESS for Members ("BAM"), a member-only access site, and since August 2018 for its Provider Finder public website. *See* Ex. 17, HCSC Interrogatory No. 5 Answer, at pg. 13; Ex. 16, Benner 30b6 Doc. at pg. 2. But the "filter" option is only as useful and reliable as the inputs; *See* Ex. 22 (listing duplicate entries for providers and providers with specialties such as optometry, urology, radiology, and, anesthesiology.

coverage for their CLS.[23] Accordingly, Plaintiffs seek certification under Federal Rules of Civil Procedure 23(b)(1) and (b)(2) of two Classes, or, in the alternative, Rule 23(c)(4), an ERISA Class and a Non-ERISA Class, defined as follows:

> **The ERISA Plan Class (Lactation Services Class):** All individuals who on or after August 1, 2012 (i) were or are participants in or beneficiaries of any non-grandfathered[24], ERISA employee welfare benefit plan sold, underwritten or administered by HCSC in the United States in its capacity as insurer or administrator; (ii) received Comprehensive Lactation Services ("CLS"); and (iii) incurred costs for a CLS claim unreimbursed by HCSC.
>
> **The Non-ERISA Plan Class (ACA Class):** All individuals who on or after August 1, 2012 (i) were or are participants in or beneficiaries of any non-grandfathered, non-federal health benefit plan sold, underwritten or administered by HCSC in the United States in its capacity as insurer or administrator, and (ii) received CLS for which HCSC did not provide coverage without cost-sharing; and (iii) incurred costs for a CLS claim unreimbursed by HCSC.[25]

Excluded from the Classes are Defendant, its subsidiaries or affiliate companies, its legal representatives, assigns, successors and employees. Grounded in the ACA and HRSA

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[23] As this Court is aware, other cases are pending challenging insurance companies' compliance with the ACA's CLS coverage mandate. Since the Court's 12/4/2017 Order, the court in *Condry v. UnitedHealth Grp., Inc.,* granted in part plaintiffs' cross motion for summary judgment (asserted pre-class certification at United's option). In its decision, the *Condry* Court set out some "general points" that applied to the plaintiffs' claims, including that "the ACA's requirement that health insurers provide coverage for [CLS] is a requirement that women have meaningful access to those services. Illusory or de minimis access is not sufficient, and a woman does not have access to lactation support if she cannot practically find those services." *Condry v. Unitedhealth Grp., Inc.*, No. 17-cv-00183-VC, 2018 U.S. Dist. LEXIS 111233, at *4 (N.D. Cal. June 27, 2018), *citing* this Court's 12/4/2017 Order, and *York v. Wellmark, Inc.*, No. 4:16-cv-06627, 2017 U.S. Dist. LEXIS 199888, at *15-16, *26-29 (S.D. Iowa Sep. 6, 2017). The *York* decision is currently on appeal to the Eighth Circuit Court of Appeals. Earlier this year, the *Condry* Court denied, without prejudice, plaintiffs' motion for class certification, with leave to file a renewed motion. *Condry*, No. 17-cv-00183-VC, 2019 U.S. Dist. LEXIS 106254, at *3 (N.D. Cal. May 23, 2019). Plaintiffs in the *Condry* action will file a renewed motion for class certification that addresses the concerns Judge Chhabria raised in the *Condry* class certification order.

[24] A non-grandfathered plan means any health insurance policy created or purchased (i) after March 23, 2010, and (ii) before March 23, 2010, that subsequently lost its grandfathered status.

[25] Each definition is equivalent to or narrower than the Class definitions set forth in the Complaint. Specifically, the Classes encompass claims and issues that were raised in the Action from the outset, and were the subject of discovery; there is no prejudice to HCSC and such argument is baseless. *See Beaton v. SpeedyPC Software,* No. 13-cv-08389, 2017 U.S. Dist. LEXIS 173631, at *9 (N.D. Ill. Oct. 19, 2017) ("nothing prevents this Court from considering a revised definition or, indeed, *sua sponte* revising the definition of a proposed class") (citing *Green v. Serv. Master on Location Servs. Corp.,* No. 07-cv-4705, 2009 U.S. Dist. LEXIS 53297 (N.D. Ill. June 22, 2009) (same).

Guidelines, for each Class, CLS means comprehensive lactation support, counseling and education services provided during the antenatal, perinatal, and the postpartum period, and not as improperly restricted substantively and procedurally by HCSC.

Plaintiffs propose that Plaintiff Briscoe serve as the Class Representative for the ERISA Plan Class. The Court upheld Plaintiff Briscoe's claim under § 404 of ERISA (12/4/2017 Order at 16), alleging ACA violations constituting breaches of fiduciary duties, the improper denial claims for services that should be covered, and a failure to act with the requisite care, skill, prudence, and diligence. Plaintiffs propose that Plaintiffs Magierski and Adams (both of whom were not participants in ERISA-governed plans) serve as the Class Representatives for the Non-ERISA Plan Class. The Court upheld Plaintiff Magierski's claim for breach of contract (to which claim Plaintiff Adams was later added, Complaint, Dkt. 56, Count II) by HCSC through its conduct in refusing to cover CLS. *See* 12/4/2017 Order at 24.

B. The Proposed Classes Meet the Requirements of Rule 23(a)

The threshold questions under Rule 23 are whether "(1) the class is so numerous that joinder of all members is impracticable; (2) there are questions of law or fact common to each class; (3) the claims or defenses of the representative parties are typical of the claims or defenses of each class; and (4) the representative parties will fairly and adequately protect the interests of each class." Fed. R. Civ. P. 23(a).[26]

[26] In conducting the Rule 23 analysis, "the court should not turn the class certification proceedings into a dress rehearsal for the trial on the merits." *Messner v. Northshore Univ. HealthSystem*, 669 F.3d 802, 811 (7th Cir. 2012); *Magpayo v. Advocate Health & Hosps. Corp.*, No. 16-cv-01176, 2018 U.S. Dist. LEXIS 26282, at *7 (N.D. Ill. Feb. 20, 2018) (Blakey, J.)(citing *Messner*). While Plaintiffs must show that a proposed class satisfies the Rule 23 requirements, the showing need not be made to a degree of absolute certainty; rather, it is sufficient if each disputed requirement has been proven by a preponderance of evidence. *See id.*

1. The Numerosity Requirement is Satisfied

Plaintiffs need not identify each and every potential class member or specify the exact number of potential members to demonstrate numerosity; a sensible estimate suffices. *Phipps v. Sheriff of Cook County*, 249 F.R.D. 298, 300 (N.D. Ill. 2008) ("Plaintiffs are not required to allege the exact number or identity of the class members and [the court is] permitted to make common sense assumptions in order to find support for numerosity."). First, class members are identifiable from HSCS's Claims Data which contain thousands of CLS claims at issue, representing thousands of unique individuals who wrongly incurred costs for a CLS claim. Second, there are additional HCSC insureds who did not submit a CLS claim to HCSC, but based on their and HCSC's records will demonstrate the receipt of CLS and costs incurred for CLS to which they were entitled to coverage without cost-sharing.[27] The members of the Classes are sufficiently numerous.

2. The Case Presents Common Questions of Fact and Law

To meet Fed. R. Civ. P. 23(a)(2)'s commonality requirement, even a single common question or a "common contention" of law or fact will do. *Beley v. City of Chicago*, No. 12-c-9714, 2015 U.S. Dist. LEXIS 163919, at *10 (N.D. Ill. Dec. 7, 2015) (citing *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338 (2011)); *see also Wal-Mart,* 564 U.S. at 350.[28] The commonality

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[27] Such class members will be identified through the receipt of the notice of the pendency of the Class Action published in HCSC's service areas as well as direct notice sent based on objective information in HCSC's records as to HCSC insureds who had submitted a claim for a breast pump to HCSC since August 1, 2012, as the acquisition of a breast pump is directly correlated with insureds who initiate breastfeeding. *See, e.g., Practice Mgmt. Support Servs. v. Cirque Du Soleil, Inc.*, 301 F. Supp. 3d 840, 858 (N.D. Ill. 2018) (applying *Mullins v. Direct Digital, LLC*, 795 F.3d 654 (7th Cir. 2015) and finding that affidavits could be submitted to establish class membership where there was "a starting point for identifying potential class members" based on defendants' records).

[28] "While the Rule is phrased in terms of questions, what matters for class certification is the capacity of a classwide proceeding to generate common *answers* apt to drive the resolution of the litigation." *Beley*, 2015 U.S. Dist. LEXIS 163919, at *10 (citations omitted). It need not resolve every issue in the case (*Phillips* ., 828 F.3d at 551), but the "common contention" will "be of such a nature that it is capable of

inquiry here is straightforward: did HCSC's coverage of CLS comply with the ACA? The answer to that is central to both the validity of each class member's claim, is capable of class-wide resolution, and the resolution of the issue will result in the same standard applying to all. *See A.F. v. Providence Health Plan*, 300 F.R.D. 474, 477, 481 (D. Or. 2013) (certifying a class of persons who were denied treatment based on a plan exclusion of a particular treatment for autism because, among other reasons, "all class members have in common the issue of whether the [exclusion] violates state or federal law").

Where a plaintiff presents evidence that a defendant has engaged in standardized conduct with respect to putative class members, the legality of which is an "outcome determinative issue," commonality is satisfied. *Healy v. IBEW, Local Union No. 134*, 296 F.R.D. 587, 592 (N.D. Ill. 2013).[29] Any argument by HCSC that factual variations in class members' situations would defeat commonality would be misplaced. *See e.g. Holmes v. Godinez*, 311 F.R.D. 177, 220 (N.D. Ill. 2015) ("Despite factual variations in putative class members' situations, Plaintiffs' allegations regarding [Illinois Department of Corrections'] system-wide failures [of failing to provide hearing accommodations to inmates] are the 'glue' that ties their [ADA] claims together."). Indeed, the Seventh Circuit has upheld commonality findings in analogous circumstances. *See e.g.*, *id.* (rejecting defendant's argument that plaintiffs' claims challenged hundreds of individual decisions regarding inmate hearing accommodations, finding that "[Plaintiffs'] complaint principally attacks IDOC's system-wide policies… [and] common issues bind the Plaintiffs' claims together if IDOC's high level policies and practices do not conform to

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classwide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Wal-Mart*, 564 U.S. at 350.

[29] *See Flanagan v. Allstate Ins. Co.*, 242 F.R.D. 421, 428 (N.D. Ill. 2007) (finding, in ERISA and breach of fiduciary duty action, "our courts have often found a common nucleus of operative facts when the defendants are, as here, alleged to have directed standardized conduct toward the [class]").

the law").

Further, as the Court's MTD Order held, insurance plans that provide "illusory coverage" violate public policy, and "this Court sees no reason why health plans could offer illusory coverage without running afoul of the ACA." (Dkt. 50 at 11). The presence and resolution of that issue meets the commonality requirement.[30]

3. The Named Plaintiffs' Claims are Typical of the Claims of the Classes

"The question of typicality in Rule 23(a)(3) is closely related to the preceding question of commonality." *Rosario v. Livaditis*, 963 F.2d 1013, 1018 (7th Cir. 1992). Named Plaintiffs' claims here are "typical" because they (i) arise "from the same event or practice or course of conduct that gives rise the claims of the other class members" and/or (ii) are "based on the same legal theory." *Id.* "Typical does not mean identical." *Gaspar v. Linvatec Corp.*, 167 F.R.D. 51, 57 (N.D. Ill. 1996). "Factual distinctions can exist between the named Plaintiffs' claims and other class members' claims, but the claims must share the same essential characteristics." *Magpayo*, 2018 U.S. Dist. LEXIS 26282, at *32 (quotation omitted). Plaintiffs satisfy both alternative constructs of typicality. First, Plaintiffs' claims arise from the same practice and course of conduct that gives rise to the claims of other class members: they were insured under HCSC plans that did not comply with the ACA-mandate for CLS coverage. Second, the Plaintiffs' claims arise under the same legal theory: the violation of the ACA.[31]

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[30] *See Stafford v. Carter*, 2018 U.S. Dist. LEXIS 34266, at *13-17 (S.D. Ind. Mar. 2, 2018) (rejecting defendants' arguments that "whether a particular individual is receiving a standard of care treatment for their medical conditions is an individualized inquiry," instead finding that common questions arise out of defendants' standard of care, whether plaintiffs had been denied certain treatments, and whether such denial caused injury).

[31] No "individualized issue" that HCSC is certain to conjure up, such as any "need" for individual medical record review, or varying payment amounts incurred by class members, even if accurate, precludes certification. *See e.g. Ries v. Humana Health Plan*, 1997 U.S. Dist. LEXIS 4035, (N.D. Ill. Mar. 31, 1997) (rejecting defendants' arguments that individual issues of the various plaintiffs would

4. Plaintiffs and Counsel Are Adequate Representatives

To satisfy Rule 23(a)(4)'s adequacy requirement, Plaintiffs must show that they "will fairly and adequately protect the class's interests." *Id.* at *33-34. The "adequacy" requirement is satisfied so long as Plaintiffs have (a) no antagonistic or conflicting claims with other members of the class, (b) an interest in the outcome of the case to ensure vigorous advocacy, and (c) qualified and competent counsel. *See id.* at *34.[32]

All class members, including the Plaintiffs, share an interest in establishing that HCSC's CLS policy violated the ACA, and in obtaining appropriate relief, including an injunction requiring HCSC to process and reprocess CLS claims under an ACA-compliant policy.[33] Plaintiffs' interests are aligned with those of the members of their respectively proposed Classes.

Also, each Plaintiff has been actively involved in each phase of this litigation and will continue to vigorously represent the interests of the class members going forward. Plaintiffs Adams, Briscoe and Magierski each:

- responded to 33 document and produced hundreds of pages of documents, including their and their children's medical records;
- responded to 17 interrogatories; and,

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overshadow common questions where "[t]he overwhelmingly predominant issue in this case [was] whether defendants' [ ] procedures … violate ERISA"); *Ormond v. Anthem, Inc.*, 2009 U.S. Dist. LEXIS 90837, at *40-41 (S.D. Ind. Sept. 29, 2009) (rejecting defendants' contention that plaintiffs' class would require a "plan-by-plan evaluation" because defendants acted "across the board, not on a plan-by-plan basis" and the plaintiffs' claims were based on defendants' documents and state law, not "on the health insurance coverage under specific policies," certifying subclass of participants in ERISA benefit plans).

[32] *See also* 1 William Rubenstein et al., *Newberg on Class Actions* § 3:58 at 341-42 (5th ed. 2011) (explaining that only "fundamental" conflicts that "go to the heart of the litigation" render a class representative inadequate).

[33] Factual differences between named plaintiffs and class members do not defeat adequacy. *See Walker v. Bankers Life & Cas. Co.*, No. 06-cv-6906, 2007 U.S. Dist. LEXIS 73502, at *16 (N.D. Ill. Oct. 1, 2007) (regardless of whether the particulars of plaintiff's situation differed from those of other class members, the court found her adequate to represent the interests of the class) (citing *Duffin v. Exelon Corp.*, No. 06-cv-1382, 2007 U.S. Dist. LEXIS 19683 (N.D. Ill. Mar. 19, 2007) (Conlon, J.) (citations omitted) (finding adequacy even though factual differences existed)).

- took two days to prepare for and provide deposition testimony.[34]

Further, Plaintiffs propose Chimicles Schwartz Kriner & Donaldson-Smith LLP be appointed as Class Counsel pursuant to Rules 23(a)(4) and 23(g).[35] Proposed Class Counsel is experienced in prosecuting complex litigations and class actions in federal courts nationwide, are amply qualified to litigate this case, have successfully prosecuted numbers nationwide class actions, and will continue to commit the necessary resources to representing the Classes. *See* Ex. 36, Firm Resume.

C. The Proposed Classes Meet the Requirements of Rule 23(b)

Plaintiffs must also establish one of the requirements of Rule 23(b). *Magpayo*, 2018 U.S. Dist. LEXIS 26282, at *7. Here, Plaintiffs seek certification under subsections (b)(1)(A) and (b)(2). Plaintiffs challenge HCSC's unitary course of conduct in administering non-ACA compliant coverage for CLS that shifts costs to its insureds. Because HCSC's illegal policy and its imposition of cost for CLS applied to all members of the Classes, and the members of the Classes seek injunctive and declaratory relief, the Court should certify the Classes under Rules 23(b)(1)(A) and (b)(2).

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[34] *See, e.g.*, Briscoe Dep. (Ex. 4) at 95:8-19 (testifying that as a named plaintiff she seeks "to receive restitution for the money that was paid out that should have been paid in full and, more importantly, seeking a future in which providers who can provide lactation support are easily identified and also that their services are paid in full in accordance with the Affordable Care Act."); Adams Dep. (Ex. 6) at 59:18-60:2 ("I'm asking to be reimbursed for the amounts that were not covered under my insurance company. I'm asking for the insurance company to go back and process any claims [] they may have denied or not fully reimbursed pursuant to the Affordable Care Act. And I'm also asking the insurance companies to change their practices going forward to provide a network of lactation consultants going forward."); Magierski Dep. (Ex. 5) at 26:12-17 ("I would hope that the claim would be reprocessed and paid for in full, and I am also hoping that Blue Cross/Blue Shield establishes a network of providers in the Chicago area to not only help women, but, [] to help [] the breastfeeding babies as well.").

[35] Under Rule 23(g), courts consider: (1) the work counsel has performed in identifying the potential class claims; (2) class counsel's experience in handling complex litigation and class actions; (3) counsel's knowledge of the applicable law; and (4) the resources that class counsel will commit to representing the class.

1. Rule 23(b)(1)(A)

Rule 23(b)(1)(A) authorizes certification where "prosecuting separate actions by or against individual class members would create a risk of…inconsistent or varying adjudications with respect to individual class members that would establish incompatible standards of conduct for the party opposing the class." *See, Neil v. Zell*, 275 F.R.D. 256, 267 (N.D. Ill. 2011).[36]

HCSC insists that its CLS coverage complies with the ACA. HCSC argued previously that "the ACA allowed them to impose cost sharing for out-of-network services because their network has lactation counseling providers." 12/4/17 Order at 6. Discovery has affirmed HCSC's commitment to its unlawful position. If each person to whom HCSC denied coverage or imposed cost-sharing based on its CLS coverage policy were to litigate an individual action, and if some courts were to find that HCSC's conduct violated the ACA, and others were to find no violation, such "varying adjudications would establish incompatible standards of conduct" for HCSC. *See Vill of Bedford Park v. Expedia, Inc. (WA)*, 2015 U.S. Dist. LEXIS 1012 (N.D. Ill. Jan. 6, 2015) ("Rule 23(b)(1)(A) takes in cases where the party is obliged by law to treat the members of the class alike…").

Further, the prospect of inconsistent declaratory and/or injunctive relief satisfies Rule 23(b)(1)(A). *See Mezyk v. U.S. Bank Pension Plan,* No. 09-cv-384, 2011 U.S. Dist. LEXIS 13857, at *28 (S.D. Ill. Feb. 11, 2011). Here, Plaintiffs and the members of the Classes are seeking declaratory and injunctive relief that would require HCSC to fundamentally reform its treatment of CLS coverage to comply with the ACA, and then process and reprocess all claims

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[36] "Rule 23(b)(1)(A) is applicable whenever 'actions by or against a class provide a ready and fair means of achieving unitary adjudication.'" *Zielinski v. Pabst Brewing Co.*, No. 04-C-0385, 2005 U.S. Dist. LEXIS 36819, at *11 (E.D. Wis. Nov. 30, 2005) (citing Fed. R. Civ. P. 23 advisory committee's note).

for CLS since August 1, 2012 under an ACA-compliant policy.[37] Plainly, pursuit of similar claims for systemic reform through multiple individual lawsuits would be inefficient, and create a very real risk that different courts might order divergent or even conflicting relief. Accordingly, to avoid such a result, the Classes should be certified pursuant to Rule 23(b)(1)(A). *See Robertson v. National Basketball Ass'n*, 556 F.2d 682, 685 (2d Cir. 1977) (Rule 23(b)(1) certification is proper where plaintiffs sought rule changes that would impact future members).

2. Rule 23(b)(2)

Certification of the Classes is also proper under Rule 23(b)(2) because HCSC has "acted or refused to act on grounds that apply generally to the [Classes], so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." Fed. R. Civ. P. 23(b)(2); *Mezyk v. U.S. Bank Pension Plan*, No. 3:09-cv-384-JPG, 2011 U.S. Dist. LEXIS 13857, at *28-29 (S.D. Ill. Feb. 11, 2011). Rule 23(b)(2) "does not require that all members of the class be aggrieved by the challenged conduct," but plaintiffs "must be able to demonstrate that the conduct or lack of it which is subject to challenge be premised on a ground that is applicable to the entire class, and that the entry of declaratory or injunctive relief would remove a barrier or impediment common to the class." *Kazarov v. Achim,* No. 02-cv-5097, 2003 U.S. Dist. LEXIS 22407, 2003, at * (N.D. Ill. Dec. 12, 2003) (citation omitted). Further, certification under Rule 23(b)(2) is particularly appropriate to vindicate alleged violations of statutory rights

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[37] "ERISA class actions are commonly certified under either or both subsections of 23(b)(1) because recovery for a breach of the fiduciary duty owed to an ERISA plan, as is the predominant claim here, will inure to the plan as a whole, and because defendant-fiduciaries are entitled to consistent rulings regarding operation of the plan." *Neil*, 275 F.R.D. at 267. Essentially, in an ERISA action in which relief is being sought on behalf of the plan as a whole (as it is here), a plaintiff's victory would necessarily settle the issue for all other prospective plaintiffs. *Id.* Courts have held that breach of fiduciary duty claims brought under ERISA, like the ERISA Plan Class claims, are paradigmatic examples of claims appropriate for certification as a Rule 23(b)(1) class. *Id.* (citations omitted). Similarly, with respect to the Non-ERISA Plan Class claims, the breach of contract claim here is grounded in the health plans' requirements to provide ACA mandated CLS coverage.

based on a uniform practice applied numerous individuals. *See Rodriguez v. Vill. of Montgomery,* No. 08 C 1826, 2009 U.S. Dist. LEXIS 9166, at *13 (N.D. Ill. Feb. 9, 2009).[38]

Plaintiffs and the members of the Classes are seeking declaratory and injunctive relief for all, namely, a declaration that HCSC's conduct violated the ACA, an injunction requiring that HCSC process and reprocess class members' claims under an ACA-compliant policy, and any other relief the Court may find appropriate. "A single declaration that the policies and practices alleged violate federal law would be final and would provide relief to each class member equally." *Holmes v. Godinez*, 311 F.R.D. 177, 223 (N.D. Ill. 2015).[39] Accordingly, the relief requested is sufficient to certify the class under Rule 23(b)(2). *See id.; see also, Johnson v. Meriter Health Servs. Emple. Ret. Plan*, 702 F.3d 364, 372 (7th Cir. 2012) (Seventh Circuit affirmed class certification under Rule 23(b)(2) where the relief sought included monetary damages to correct a past error in ERISA benefits, as well as an injunction to resolve the issue going forward).[40]

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[38] *See also N.B. v. Hamos,* 26 F. Supp. 3d 756, 774 (N.D. Ill. 2014) (where success on plaintiffs' claims would require policy modifications and such policy changes were generally applicable, and therefore would benefit all class members, certification under 23(b)(2) was appropriate).

[39] Further, like Rule 23(b)(1), Rule 23(b)(2) has been a frequent vehicle for certification of classes in ERISA actions, including actions involving allegations of breach of fiduciary duty, because injunctive and declaratory relief are appropriate where defendants act or fail to act on grounds that affect the plan as a whole. *See, e.g. Neil,* 275 F.R.D. at 269 (finding certification of a 23(b)(2) class appropriate in ERISA action because of the equitable relief sought and because the incidental damages sought could be calculated mechanically); *Smith v. Aon Corp.*, 238 F.R.D. 609, 618 (N.D. Ill. 2006) (plaintiffs satisfied the requirements of Rule 23(b)(2) where "[t]he alleged breaches of fiduciary duty [ ] have affected all of the Plan's participants and beneficiaries").

[40] "Several cases hold that certification of an ERISA claim is proper under Rule 23(b)(2) where monetary relief, in conjunction with injunctive relief, is sought." *Breedlove v. Tele-Trip Co.*, No. 91 C 5702, 1993 U.S. Dist. LEXIS 10278, at *25-26 (N.D. Ill. July 26, 1993) (citing *Morgan v. Laborers Pension Trust Fund,* 81 F.R.D. 669, 681 (N.D. Cal. 1979) ("Courts are not precluded from certifying a class under Rule 23(b) merely because plaintiffs have included a request for monetary damages in their complaint. Rather, 'where the monetary relief sought is integrally related to and would directly flow from the injunctive or declaratory relief sought, 23(b)(2) status is appropriate.'"); *Jansen v. Greyhound Corp.,* 692 F. Supp. 1022, 1028 (N.D. Iowa 1986) (ERISA monetary relief for retroactive payment of welfare benefits will flow directly from declaratory and injunctive relief, and is secondary to the declaratory/injunctive relief requested)).

D. In The Alternative, The Court May Certify A Rule 23(c)(4) Issue Class.

Plaintiffs plainly satisfy Rules 23(a), (b)(1)(A) and (b)(2), and the Court should certify the Classes under those rules. There are no individualized issues that would defeat certification. In the unlikely event, however, that the Court were to conclude that the requirements of Rule 23(b) have not been satisfied, which they have been, the Court should nevertheless certify a Class under subsection (c)(4), which provides that, "[w]hen appropriate, an action may be brought or maintained as a class action with respect to particular issues." Fed. R. Civ. P. 23(c)(4). *See McReynolds v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 672 F.3d 482, 483, 491 (7th Cir. 2012) (reversing denial of certification of (c)(4) class on the issue of "whether the defendant has engaged and is engaging in practices that have a disparate impact"). This case presents a common issue to which class treatment is clearly appropriate: whether HCSC's coverage for CLS violated the ACA.

IV. CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court certify the classes as defined above under Federal Rules of Civil Procedure 23(b)(1) and (b)(2), or, in the alternative, Rule 23(c)(4).

DATED: August 23, 2019

CHIMICLES SCHWARTZ KRINER & DONALDSON-SMITH LLP

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CERTIFICATE OF SERVICE

I, Kimberly M. Donaldson Smith, an attorney, hereby certify that on August 23, 2019, I electronically filed a true and correct copy of the foregoing document with the Clerk of the Court using the CM/ECF system. Participants in the case who are registered CM/ECF users will be served by the CM/ECF system.

/s/ Kimberly M. Donaldson- Smith
Kimberly M. Donaldson-Smith