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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

JOHN DOE ONE, et al.,
Plaintiffs,
v.
CVS PHARMACY, INC., et al.,
Defendants.

Case No. [18-cv-01031-EMC](#)

**ORDER GRANTING DEFENDANTS’
MOTIONS TO DISMISS**

Docket Nos. 87, 89, 97, 113

United States District Court
Northern District of California

Plaintiffs bring this putative class action alleging that they have been discriminatorily denied benefits under their employer-offered prescription drug benefit plans. The complaint names two sets of defendants: CVS Pharmacy, Inc., Caremark, LLC., and Caremark California Specialty Pharmacy, LLC (collectively “CVS”), and Amtrak, Lowe’s Companies, and Time Warner, Inc. (collectively “Employer Defendants”). CVS contracted with Employer Defendants to provide prescription drug benefits to Plaintiffs. Plaintiffs allege that their benefit plans allow them to obtain their HIV/AIDS medications at favorable “in-network” prices only via mail or from a CVS pharmacy. Compared to the non-CVS “community pharmacies” from which Plaintiffs were previously able to obtain their medications, the mail order and CVS Pharmacy pickup options do not offer the same level of privacy, convenience, reliability, and service.

Plaintiffs bring eight causes of action: (1) violation of the anti-discrimination provision of the Affordable Care Act (“ACA”); (2) violation of Title III of the Americans with Disabilities Act (“ADA”); (3) violation of the California Unruh Civil Rights Act; (4) violation of the California Unfair Competition Law (“UCL”); (5) claim for benefits due under plans governed by the Employee Retirement Income Security Act (“ERISA”); (6) claim for breach of fiduciary duties under ERISA; (7) failure to provide full and fair review under ERISA; and (8) declaratory relief.

1 Counts 1–4 are against CVS only. Counts 5–8 are against all Defendants. CVS and each of the
2 Employer Defendants have moved to dismiss the complaint.

3 For the reasons discussed below, the Court **GRANTS** CVS and Employer Defendants’
4 motions to dismiss. Plaintiffs’ ACA and ADA claims fail because the benefit plan restrictions
5 they challenge do not discriminate on the basis of HIV/AIDS status or disability generally; the
6 restrictions apply to medications that treat disabilities as well as those that do not. Plaintiffs’
7 Unruh Act claim fails because they cannot show intentional discrimination on the part of CVS.
8 They have not stated a claim under the UCL because the benefit restrictions are neither “unlawful”
9 nor “unfair.” Plaintiffs’ ERISA claims against CVS fail because their benefit plans do not entitle
10 them to the benefit they seek, and because CVS is not an ERISA fiduciary with respect to the
11 benefit plans. Plaintiffs’ ERISA claims against Employer Defendants fail for similar reasons.

12 **I. FACTUAL AND PROCEDURAL BACKGROUND**

13 The First Amended Complaint alleges the following. Plaintiffs¹ are individuals living with
14 HIV/AIDS who are enrolled in employer-sponsored health plans. Docket No. 75 (“FAC”) ¶ 1.
15 CVS Defendants “act as agents of one another and operate as a single entity for purposes of
16 administering pharmacy benefits and providing prescription drugs to health plans and health plan
17 members.” *Id.* ¶ 14. One of the CVS Defendants, CVS Caremark, administers the prescription
18 drug benefits under Plaintiffs’ plans. *Id.* ¶ 1. In order to qualify for lower “in-network” drug
19 prices under their plans, Plaintiffs are required by CVS Caremark to obtain their HIV/AIDS
20 medications from Caremark California Specialty Pharmacy, which delivers medications in one of
21 two ways: by mailing the medications to Plaintiffs directly, or by mailing them to a CVS
22 Pharmacy for pickup. *Id.* Otherwise, Plaintiffs “must either pay more out-of-pocket or pay full-
23 price” to procure their HIV/AIDS medication from an “out-of-network” community pharmacy. *Id.*
24 Plaintiffs refer to this CVS-mandated scheme for obtaining medications as “the Program.” *Id.* All
25 drugs designated in the benefit plans as “specialty medications” are subject to the Program’s
26 restrictions, not just drugs that treat HIV/AIDS. However, Plaintiffs allege that HIV/AIDS

27 _____
28 ¹ Plaintiffs are proceeding under pseudonyms due to the sensitive nature of this action. FAC at 1
n.3.

1 patients are “disproportionately impacted by the Program” due to the “complex nature of their
2 disease and medications.” *Id.* ¶¶ 92, 94. CVS Caremark offers “financial inducements” to health
3 plan sponsors—Plaintiffs’ employers—to enroll Plaintiffs in benefit plans subject to the Program.
4 *Id.* ¶ 2.

5 Before their employers enrolled Plaintiffs in the Program, each of the Named Plaintiffs
6 was able to purchase their HIV/AIDS medications through their benefit plan from any in-network
7 pharmacy, including non-CVS pharmacies, with full insurance benefits. *See id.* ¶¶ 9–13. Many of
8 them had long obtained their medications from their local “community pharmacies” and had
9 developed relationships with their pharmacists. *Id.* These in-person appointments with expert
10 pharmacists who were familiar with Plaintiffs and their medical histories serve a critical function
11 because the pharmacists can “detect potentially life-threatening adverse drug interactions and
12 dangerous side effects, some of which may only be detected visually”; immediately prescribe new
13 drug regimens as Plaintiffs’ conditions progress and evolve; and provide essential counseling to
14 help Plaintiffs and their families navigate the challenges of living with a chronic condition. *Id.* ¶¶
15 70, 80–84, 89.

16 Since being enrolled in the Program, however, Plaintiffs have faced numerous difficulties
17 and indignities in their efforts to obtain their HIV/AIDS medications. Those who opted to have
18 the medication mailed to their homes have experienced delivery problems. *Id.* ¶¶ 37, 46, 51. For
19 example, in some instances the packages containing their medications were left “baking in the
20 afternoon sun,” which could “quickly degrade the potency and stability” of the medication. *Id.*
21 ¶ 24. Out of concerns about parcel theft, some Plaintiffs have had to wait at home on the days
22 their medications are scheduled for delivery, resulting in missed doctor appointments and missed
23 days of work. *Id.* ¶¶ 46, 51. Those who have opted to pick up their prescriptions from CVS
24 Pharmacies have also encountered problems. For some, the closest CVS Pharmacy is many miles
25 away. *Id.* ¶ 34. Some have had to make multiple trips to and from a pharmacy to deal with
26 incorrectly filled prescriptions. *Id.* Others have experienced “CVS personnel shout[ing] the name
27 of their HIV/AIDS Medications across the room in front of other customers, raising severe privacy
28 concerns.” *Id.* ¶ 76. Many Plaintiffs have reached out to CVS in an attempt to resolve their

1 problems, only to encounter bureaucracy and long wait-times. *See id.* ¶¶ 29, 35, 40, 91.

2 Reportedly, CVS representatives also “appear to have no specialized knowledge about HIV/AIDS
3 Medications or the concerns of HIV patients.” *Id.* ¶¶ 39, 48, 85.

4 In short, Plaintiffs allege, the Program forces them into a “potentially life-threatening”
5 decision: to either “forego essential counseling from an expert pharmacist at a community
6 pharmacy and face risks to their privacy that are inherent in the Program,” or “pay hundreds or
7 thousands of dollars out-of-pocket monthly for their medications at their non-CVS community
8 pharmacy.” *Id.* ¶ 69. Thus, the Program “constitutes a material and discriminatory change in
9 [Plaintiffs’] coverage, a significant reduction in or elimination of prescription drug benefits, and a
10 violation of the standards of good health care and clinically appropriate care for HIV/AIDS
11 patients.” *Id.* ¶ 78.

12 Many Plaintiffs have attempted to opt-out of the Program, but their requests were denied.
13 *Id.* Some have made formal, written opt-out requests, appealed the denial of those requests, and
14 ultimately received “final determinations” affirming the denials. *See id.* ¶ 27.

15 Plaintiffs seek to represent the following class:

16 All persons currently or previously enrolled in or covered by a
17 health plan since January 1, 2015 in which the prescription drug
18 benefit is or was administered by CVS Caremark, and who: (i)
19 obtained or may obtain HIV/ADIS Medications; and (ii) have been
or may in the future be required to participate in the Program with
no right to opt-out or notice thereof, but not including individual
claims for personal injury or bodily harm.

20 *Id.* ¶ 131.

21 Plaintiffs filed their original class action complaint on February 16, 2018. *See* Docket No.
22 1. After CVS and Amtrak each filed a motion to dismiss, Plaintiffs filed the operative First
23 Amended Class Action Complaint on June 18, 2018. *See* Docket No. 75. Each Defendant filed a
24 motion to dismiss thereafter. *See* Docket Nos. 87 (“CVS Mot.”), 89 (“Amtrak Mot.”), 97
25 (“Lowe’s Mot.”), 113 (“Time Warner Mot.”).

26 **II. LEGAL STANDARD**

27 To survive a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6), a
28 complaint must contain a “short and plain statement of the claim showing that the pleader is

1 entitled to relief” to give the defendant “fair notice” of what the claims are and the grounds upon
 2 which they rest. *See* Fed. R. Civ. P. 8(a)(2); *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555
 3 (2007). A complaint must contain sufficient factual allegations, accepted as true, “to state a claim
 4 to relief that is plausible on its face.” *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). “A claim has
 5 facial plausibility when the plaintiff pleads factual content that allows the court to draw the
 6 reasonable inference that the defendant is liable for the misconduct alleged.” *Id.* “The plausibility
 7 standard is not akin to a ‘probability requirement,’ but it asks for more than a sheer possibility that
 8 a defendant has acted unlawfully.” *Id.* (quoting *Twombly*, 550 U.S. at 556).

9 If it grants a motion to dismiss, a court is generally required to allow the plaintiff leave to
 10 amend, even if no request to amend the pleading was made, unless amendment would be
 11 futile. *Cook, Perkiss & Liehe, Inc. v. N. Cal. Collection Serv. Inc.*, 911 F.2d 242, 246–47 (9th Cir.
 12 1990). In determining whether amendment would be futile, the court examines whether the
 13 complaint could be amended to cure the defect requiring dismissal “without contradicting any of
 14 the allegations of [the] original complaint.” *Reddy v. Litton Indus., Inc.*, 912 F.2d 291, 296 (9th
 15 Cir. 1990).

16 **III. CVS’S MOTION TO DISMISS**

17 **A. Group Pleading Against CVS Defendants**

18 Plaintiffs have named CVS Pharmacy, Inc., Caremark, LLC., and Caremark California
 19 Specialty Pharmacy, LLC as defendants in this action and collectively termed them “CVS
 20 Caremark.” FAC at 1. The complaint asserts that the “various CVS/Caremark Defendants act as
 21 agents of one another and operate as a single entity for purposes of administering pharmacy
 22 benefits and providing prescription drugs to health plans and health plan members,” *id.* ¶ 14, and
 23 for the most part makes its allegations against “CVS Caremark” generally. CVS contends that the
 24 complaint engages in undifferentiated pleading that fails to make clear what claims are being
 25 alleged against each defendant. CVS Mot. at 7.

26 As an initial matter, Plaintiffs are incorrect to state that “the prohibition against group
 27 pleading only applies in cases of fraud.” Docket No. 115 (“Opp.”) at 3. While Federal Rule of
 28 Civil Procedure 9(b) sets forth a heightened pleading requirement in fraud cases, the general

1 pleading standard articulated in Rule 8(a) requires a complaint to “provide sufficient notice to all
 2 of the Defendants as to the nature of the claims being asserted against them.” *Adobe Sys. Inc. v.*
 3 *Blue Source Grp., Inc.*, 125 F. Supp. 3d 945, 964 (N.D. Cal. 2015); *see Gauvin v. Trombatore*, 682
 4 F. Supp. 1067, 1071 (N.D. Cal. 1988) (finding that a complaint in which “all defendants are
 5 lumped together in a single, broad allegation” failed to satisfy the notice requirement of Rule
 6 8(a)(2)).

7 Plaintiffs have painted their allegations with a broad brush. The majority of their
 8 allegations are made against the collective “CVS Caremark,” without specifying what role each
 9 CVS Defendant played. Their claim that the CVS Defendants “act as agents of one another and
 10 operate as a single entity” is conclusory and unsupported by factual allegations. At no point does
 11 the complaint describe what kind of entities CVS Pharmacy, Inc. and Caremark, LLC are or
 12 generally what type of business they conduct. Nevertheless, the complaint does make clear the
 13 role Caremark California Specialty Pharmacy, LLC plays in filling prescriptions by mail. *See*
 14 FAC ¶ 1. And, construing the pleadings in the light most favorable to Plaintiffs, it is also
 15 sufficiently clear from the complaint that Plaintiffs intend the allegations regarding the “CVS
 16 Caremark” collective to apply to all the CVS defendants. *See Adobe Sys.*, 125 F. Supp. 3d at 965
 17 (finding that defendants were put on sufficient notice where “the gravamen of Adobe’s allegations
 18 . . . are that all the Defendants infringed on Adobe’s trademarks and copyrights”). Finally, the
 19 complaint is specific and detailed as to what unlawful actions “CVS Caremark” has allegedly
 20 engaged in, and therefore put CVS Defendants on notice of “what conduct is at issue.” *Id.*

21 On balance, Plaintiffs have done just enough to meet the pleading requirements of Rule 8.²

22 B. ACA Discrimination Claim

23 Count One of the complaint asserts that CVS’s alleged conduct violates the anti-
 24 discrimination provision at Section 1557 of the ACA. Section 1557 provides that “an individual
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26
 27 ² CVS protests that Plaintiffs’ claims arise out of a pharmacy benefit management service’s
 28 (“PBM”) design of a prescription plan, and that two of the CVS Defendants are not PBMs but
 rather pharmacies. CVS Mot. at 8. However, these disputes over questions of fact are not
 appropriate for resolution on a motion to dismiss.

1 shall not, on the ground prohibited under[, *inter alia*,] section 504 of the Rehabilitation Act of
 2 1973 (29 U.S.C. § 794), be excluded from participation in, be denied the benefits of, or be
 3 subjected to discrimination under, any health program or activity, any part of which is receiving
 4 Federal financial assistance.” 42 U.S.C. § 18116(a). In turn, § 504 of the Rehabilitation Act
 5 provides that “[n]o otherwise qualified individual with a disability in the United States . . . shall,
 6 solely by reason of her or his disability, be excluded from the participation in, be denied the
 7 benefits of, or be subjected to discrimination under any program or activity receiving Federal
 8 financial assistance.” 29 U.S.C. § 794(a).

9 CVS puts forth two primary reasons why Plaintiffs’ ACA claim should be dismissed. Each
 10 is addressed below.

11 1. Offered Benefit

12 First, CVS argues that Plaintiffs are not entitled to the benefit which they claim is being
 13 denied—to be able to purchase specialty medication from non-CVS pharmacies at in-network
 14 prices. *See* CVS Mot. at 11. In fact, Plaintiffs were specifically told that their plans do *not* allow
 15 them to do so. *See, e.g.*, FAC ¶¶ 21–22, 40. CVS reasons that Plaintiffs could not have been
 16 unlawfully denied a benefit to which they were not entitled in the first place. This argument fails,
 17 however, because it is at odds with the text of the ACA and the Rehabilitation Act.

18 Both § 1557 and § 504 use identical, disjunctive language to describe the conduct they
 19 proscribe. *See* 42 U.S.C. § 18116(a) (“be excluded from participation in, be denied the benefits of,
 20 *or* be subjected to discrimination under . . .”) (emphasis added); 29 U.S.C. § 794(a) (“be excluded
 21 from the participation in, be denied the benefits of, *or* be subjected to discrimination under . . .”) (emphasis added). Courts have understood this disjunctive language, as well as substantially
 22 similar language in the ADA, to bar the operation of a program in a discriminatory manner even
 23 when a specific offered benefit is not being denied. *See Crowder v. Kitagawa*, 81 F.3d 1480, 1483
 24 (9th Cir. 1996) (rejecting as “flaw[ed] . . . the assumption that no violation of the ADA occurs
 25 unless a service or benefit of the state is provided in a manner that discriminates against disabled
 26 individuals” given the “insertion of ‘or’ between exclusion from/denial of benefits on the one hand
 27 and discrimination by a public entity on the other” in the statutory text); *Halpern v. Wake Forest*

1 *Univ. Health Scis.*, No. 1:09CV00474, 2010 WL 3057597, at *15 n.23 (M.D.N.C. July 30, 2010)
 2 (“The disjunctive nature of the two prongs of the third element effectively recognizes that Section
 3 504 creates two different types of claims: “a plaintiff must show that she was [1] excluded from
 4 participation in, or denied the benefits of, a program or service offered by a public entity, *or* [2]
 5 subjected to discrimination by that entity.”), *aff’d*, 669 F.3d 454 (4th Cir. 2012); *Brewer v.*
 6 *Wisconsin Bd. of Bar Examiners*, No. 04-C-0694, 2006 WL 3469598, at *5 (E.D. Wis. Nov. 28,
 7 2006) (“Brewer’s claim is not just that she was excluded from, or denied access to, the Board’s
 8 services, but also that she was otherwise discriminated against by the Board. The language of the
 9 [ADA] is disjunctive; it prohibits exclusion from participation, denial of benefits, *or*
 10 discrimination against by reason of disability.”).

11 Accordingly, Plaintiffs’ ACA claim is not doomed just because they have not alleged that
 12 their benefit plan entitles them to obtain HIV/AIDS medication for favorable prices at non-CVS
 13 pharmacies. They may proceed on the theory that the benefit plan operates in a way that
 14 discriminates against them by reason of disability. *See, e.g.*, FAC ¶ 92 (alleging that “HIV/AIDS
 15 patients are particularly hard hit and discriminated against by [the benefit plan] requiring patients
 16 to obtain their specialty medications exclusively under the Program”).

17 2. Disparate Impact/Meaningful Access

18 CVS next contends that Plaintiffs fail to sufficiently allege that the Program discriminates
 19 against Plaintiffs on the basis of their HIV/AIDS status.

20 No consensus has yet emerged as to the standard for assessing ACA anti-discrimination
 21 claims. *See Briscoe v. Health Care Serv. Corp.*, 281 F. Supp. 3d 725, 737 (N.D. Ill. 2017). At
 22 least one court has held that “§ 1557 creates a ‘health-specific’ anti-discrimination claim ‘subject
 23 to a singular standard, regardless of a plaintiff’s protected class status.’” *Id.* (quoting *Rumble v.*
 24 *Fairview Health Servs.*, No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at *11 (D. Minn. Mar.
 25 16, 2015)). Others have concluded that § 1557 imports the standard corresponding to the civil
 26 rights statute on which the plaintiff’s ACA claim is premised. *See id.*; *Se. Pennsylvania Transp.*
 27 *Auth. v. Gilead Scis., Inc.*, 102 F. Supp. 3d 688, 698 (E.D. Pa. 2015). Thus, an ACA claim based
 28 on allegations of § 504 violations would be analyzed under the substantive standard for § 504

1 cases. Both parties here agree that § 504 case law serves as a useful guide for evaluating what
 2 kind of disability-based discrimination violates the ACA, and neither has suggested applying a
 3 standard different from that applicable under Section 504. *See* CVS Mot. at 8; Opp. at 5.
 4 Applying the § 504 standard here also comports with “Health and Human Services Department’s
 5 rules emphasiz[ing] that the [ACA] nondiscrimination provision ‘is not intended to apply lesser
 6 standards for the protection of individuals from discrimination than the standards under . . .
 7 Section 504.’” *In re Express Scripts/Anthem ERISA Litig.*, 285 F. Supp. 3d 655, 687 (S.D.N.Y.
 8 2018) (quoting 81 Fed. Reg. 31381 (2016)).

9 Section 504 protects persons with disabilities from both intentional and disparate-impact
 10 discrimination.³ *Crowder*, 81 F.3d at 1484 (citing *Alexander v. Choate*, 469 U.S. 287, 295
 11 (1985)). CVS points out, and Plaintiffs appear to concede, that they are not alleging an intentional
 12 discrimination claim under § 504.⁴ *See* Opp. at 9 (characterizing CVS’s intentional discrimination
 13 argument as “a *non sequitur*, as Plaintiffs in this action allege a disparate *impact* on HIV/AIDS
 14 patients”) (emphasis in original).

15 As for disparate impact, the Supreme Court has rejected “the boundless notion that all
 16 disparate-impact showings constitute *prima facie* cases under § 504”; an instance of disparate
 17 impact is actionable only where it “effectively denies otherwise qualified handicapped individuals
 18 the meaningful access” to programs or benefits to which they are entitled. *Alexander*, 469 U.S. at
 19 299–301; *see Crowder*, 81 F.3d at 1484 (explaining that *Alexander* “determined it more useful to
 20 assess whether disabled persons were denied ‘meaningful access’” to benefits in order to identify
 21

22
 23 ³ The Office for Civil Rights in the Department of Health and Human Services also promulgated a
 24 rule “interpret[ing] Section 1557 as authorizing a private right of action for claims of disparate
 25 impact discrimination on the basis of any of the criteria enumerated in” that section. 81 Fed. Reg.
 26 31375, 31440 (May 18, 2016).

27 ⁴ Under their Unruh Act claim, however, Plaintiffs contend that they “do allege actual [intentional]
 28 discrimination.” Opp. at 14 (emphasis in original). The allegations they identify, however, would
 be insufficient to support an intentional discrimination claim under § 504 for the same reasons
 they fail under the Unruh Act; the allegations are wholly conclusory and undermined by the
 complaint’s descriptions of accommodations CVS made to assist Plaintiffs in accessing their
 HIV/AIDS medications. *See* Part III.D, *infra*.

1 discrimination cognizable under § 504). Thus, to state a § 504 disparate impact claim, Plaintiffs
 2 must show (1) that the Program’s restrictions had a disparate impact on enrollees with HIV/AIDS,
 3 and (2) that the impact was so significant as to deny those enrollees “meaningful access” to their
 4 benefits. Plaintiffs’ allegations fail in both respects.

5 First, Plaintiffs have not sufficiently alleged that enrollees with HIV/AIDS are disparately
 6 impacted by the Program’s restrictions relative to other enrollees. As CVS points out, Plaintiffs
 7 themselves acknowledge that “*all* specialty medicines must be filled through the Program,” not
 8 just those that treat HIV/AIDS. FAC ¶ 43 (emphasis added). These specialty medicines treat a
 9 wide variety of conditions in addition to HIV/AIDS. See FAC ¶ 94 (listing medicines and
 10 conditions). In a recent decision, the Western District of Tennessee found no disparate impact
 11 under the ACA on allegations essentially the same as those made here—that employer health plans
 12 discriminated against individuals with HIV/AIDS by classifying their HIV/AIDS medication as
 13 “specialty medication” that can only be obtained by mail or at designated in-network pharmacies.
 14 See *Doe v. Bluecross Blueshield of Tennessee, Inc.*, No. 217CV02793TLPCGC, 2018 WL
 15 3625012, at *5–8 (W.D. Tenn. July 30, 2018). The *Bluecross Blueshield* court observed that the
 16 specialty medications “list includes medications for conditions that are not disabilities under the
 17 ADA or the Rehab Act,” so “plan enrollees who are not disabled yet take specialty medications
 18 subject to the Program must endure the same procedural and logistical hurdles that HIV/AIDS
 19 patients face.” *Id.* at *8. Here, as in *Bluecross Blueshield*, this fact is “fatal to Plaintiff[s]’ claim”
 20 because it means they cannot allege that they were treated differently on the basis of their
 21 HIV/AIDS status. *Id.* Other cases are in accord. See *E.S. by & through R.S. v. Regence*
 22 *BlueShield*, No. C17-01609 RAJ, 2018 WL 4566053, at *3 (W.D. Wash. Sept. 24, 2018) (holding
 23 that plaintiffs with hearing impairments failed to show disparate impact based on their health
 24 plan’s exclusion from coverage of hearing loss treatment because the “coverage exclusion is
 25 applied to all insureds, whether disabled or not”); *In re Express Scripts/Anthem ERISA Litig.*, 285
 26 F. Supp. 3d at 686–88 (finding no disparate impact under the ACA where plaintiffs alleged that
 27 their health plan set inflated prices for HIV drugs designated as “specialty medications” but did
 28 not allege that the rates they actually paid for their HIV medication were higher than for other,

1 non-HIV related drugs); *Gilead Scis., Inc.*, 102 F. Supp. 3d at 700 (holding that plaintiffs could
2 not show that a drug manufacturer’s pricing scheme that allegedly overcharged for Hepatitis C
3 drugs had a disparate impact based on disability because there were “no allegations that [the
4 manufacturer] changes the prices of its drugs depending upon whether the potential consumer has
5 Hepatitis C”).⁵ Given the breadth of the drugs subject to the Program’s restrictions, Plaintiffs
6 cannot show that they are discriminated against as HIV/AIDS patients or as patients with
7 disabilities.

8 Plaintiffs respond that, “[d]ue to the complex nature of their disease and medications, . . .
9 patients with HIV and AIDS are disproportionately impacted by the Program . . . even compared
10 to patients prescribed non-HIV/AIDS specialty medications.” FAC ¶ 92. The challenges
11 particular to individuals with HIV/AIDS include “stigma and discrimination,” a “high number of
12 known adverse side effects and adverse drug interactions associated with HIV/AIDS Medications
13 that need to be monitored,” the “psychological and social issues involved” with living with
14 HIV/AIDS, the “continua[l] mutat[ion]” of the HIV/AIDS virus necessitating timely changes in
15 treatment, and the sensitivity of HIV/AIDS medications to “[s]torage at high temperatures.” *Id.* ¶¶
16 24, 74, 80, 86, 89. As a result, Plaintiffs argue that forcing enrollees with HIV/AIDS to obtain
17 their medications either in-person from CVS pharmacists untrained to provide HIV/AIDS-related
18 counseling or via mail impacts them in a way that is “unique.” *Opp.* at 7.

19 The Court does not discount the struggles individuals with HIV/AIDS continue to
20 experience in their daily lives or the difficulties Plaintiffs face in obtaining their medications
21 through the Program. But Plaintiffs have “alleged no statistical evidence sufficient to show that
22 Defendant’s Program has a ‘significantly adverse or disproportionate impact’ on . . . HIV/AIDS
23 patients.” *Bluecross Blueshield*, 2018 WL 3625012, at *8. Nor does the complaint compare the
24 Program’s impact on HIV/AIDS patients with its impact on non-HIV/AIDS patients in any other
25

26 ⁵ Plaintiffs argue that “*Gilead* was decided before the federal regulations authorizing disparate
27 impact claims under the ACA were issue” and thus inapposite. *Opp.* at 9. However, *Gilead*
28 nevertheless applied the disparate impact framework articulated in *Alexander*, which continues to
guide courts in analyzing § 504 disparate impact claims. *See Gilead*, 102 F. Supp. 3d at 699–700
& n.4.

1 way. In fact, Plaintiffs acknowledge that HIV/AIDS is not the only condition that is stigmatized.
 2 See FAC ¶ 93 (“[The Program] is not appropriate for all patients with complex, chronic
 3 conditions, especially *illnesses* subject to social stigma where privacy is a significant concern *like*
 4 *HIV/AIDS*”) (emphases added). For example, Plaintiffs note that drugs for treating opioid
 5 dependency and addiction are also included in the specialty medicine formulary, and the ADA
 6 “aims to protect [individuals recovering from addiction] from the stigma associated with
 7 their addiction.” *Jones v. City of Boston*, 752 F.3d 38, 58 (1st Cir. 2014) (citing 42 U.S.C. §
 8 12114(a), (b)). Thus, the allegations in the complaint are not sufficient to support Plaintiffs’ claim
 9 that the Program’s impact on enrollees with HIV/AIDS is “unique.” *Rodde v. Bonta*, 357 F.3d
 10 988, 998 (9th Cir. 2004) (observing that discrimination is actionable under the “meaningful
 11 access” standard where it “disproportionately burdens the disabled because of their *unique needs*”) (emphasis added). The *Bluecross Blueshield* court rejected a disparate impact theory similarly
 12 based on allegations that “[c]ompared to nondisabled patients who received non-HIV/AIDS
 13 specialty medications,” patients with HIV/AIDS have to endure “the social stigma and
 14 discrimination associated with being HIV/AIDS positive,” “the potentially serious effect of
 15 missing a dose of HIV/AIDS medication, the potential for heat damage to HIV/AIDS medications,
 16 and . . . a heightened need for access to in-person consultations with community pharmacists.”
 17 2018 WL 3625012, at *5, *8.

18
 19 Second, even accepting that the Program does disproportionately impact enrollees with
 20 HIV/AIDS, that impact is not so significant as to constitute a denial of “meaningful access” to
 21 Plaintiffs’ prescription drug benefits. The Supreme Court’s decision in *Alexander*, which
 22 established the “meaningful access” standard, is instructive. *Alexander* was an action brought
 23 under § 504 in response to the Tennessee Medicaid program’s decision, in response to budget
 24 pressures, to reduce from 20 to 14 the number of inpatient hospital days that Tennessee Medicaid
 25 would cover for a Medicaid recipient annually. 469 U.S. at 289. The plaintiffs contended that the
 26 14-day limitation would have a discriminatory effect on disabled individuals because statistical
 27 evidence showed that a higher percentage of Medicaid patients with disabilities required more
 28 than 14 days of inpatient care than non-disabled patients. *Id.* at 290. The Supreme Court denied

1 the claim. It reasoned that because “both classes of users [were] subject to the same durational
2 limitation,” patients with disabilities, just like non-disabled patients, would still “benefit
3 meaningfully from the coverage they will receive under the 14-day rule.” *Id.* at 302.

4 The *Alexander* Court went on to reject as “simply unsound” the plaintiffs’ suggestion that
5 “their greater need for prolonged inpatient care means that, to provide meaningful access to
6 Medicaid services, Tennessee must single out the handicapped for *more* than 14 days of
7 coverage.” *Id.* As the Court explained, “Medicaid programs do not guarantee that each recipient
8 will receive that level of health care precisely tailored to his or her particular needs” but rather
9 provide “a particular package of health care services” with “the general aim of assuring that
10 individuals will receive necessary medical care.” *Id.* at 303. *Alexander* concluded that “Section
11 504 does not require the State to alter this definition of the benefit being offered simply to meet
12 the reality that the handicapped have greater medical needs”; it “seeks to assure evenhanded
13 treatment and the opportunity for handicapped individuals to participate in and benefit from
14 programs receiving federal assistance” rather than to “guarantee the handicapped equal results.”
15 *Id.* at 303–04 (citation omitted).

16 Likewise here, § 504 does not require CVS to alter the terms of their benefit plans to
17 provide the Plaintiffs “meaningful access” to specialty medications at favorable prices outside the
18 Program’s network. Like the 14-day inpatient coverage limitation in *Alexander*, the Program is
19 “neutral on its face”—its restrictions apply on the basis of the type of medication sought and “do[]
20 not distinguish between” enrollees based on disability. *Id.* at 302. And although the Program
21 limits the ways in which enrollees can obtain their specialty medication, it “does not exclude
22 [them] from or deny them the [prescription drug] benefits” provided under their plan. Plaintiffs
23 are able to access their HIV/AIDS drugs at in-network prices as long as they go to a CVS
24 Pharmacy or subscribe to delivery by mail. *Id.* Plaintiffs seek exemption from the Program’s
25 restrictions on the ground that HIV/AIDS patients have a “greater need” for ready access to their
26 medications, but they do not allege that their benefit plans guarantee them the “level of health care
27 precisely tailored to [their] particular needs.” *Id.* at 302–03.

28 At bottom, Plaintiffs are seeking to change the terms of their benefit plan so that they (and

1 not other plan enrollees) can obtain their HIV/AIDS medication from non-CVS pharmacies at in-
 2 network prices. *Alexander* makes clear that “Section 504 does not require the [benefit provider] to
 3 alter this definition of the benefit being offered simply to meet the reality that [Plaintiffs] have
 4 greater medical needs.” *Id.* at 303. Rewriting the benefit plan in this way would be “virtually
 5 unworkable.” *Id.* at 308. “Before taking any across-the-board action affecting [benefit plan
 6 enrollees], an analysis of the effect of the proposed change” on the enrollees would have to be
 7 performed, “broken down by class of handicap” or type of disability, that “balance[s] the harms
 8 and benefits to various groups to determine, on balance, the extent to which the action disparately
 9 impacts the handicapped.” *Id.* The logical extension of Plaintiffs’ discrimination challenge could
 10 threaten the basic structure of Health Maintenance Organizations (“HMOs”) and Preferred
 11 Provider Organization insurance plans (“PPOs”). HMOs and PPOs are able to provide insurance
 12 coverage at favorable rates by requiring enrollees to access care from a defined set of in-network
 13 physicians. *See California v. Sutter Health Sys.*, 84 F. Supp. 2d 1057, 1062 (N.D. Cal.), *aff’d*, 217
 14 F.3d 846 (9th Cir. 2000). If enrollees could avail themselves of out-of-network providers at in-
 15 network rates by contending that in-network care is inferior for any particular disability, then the
 16 basis of the HMO/PPO model would be undermined. “[T]here is nothing in the [ACA] or its
 17 legislative history to suggest that this type of expansion was Congress’ intent when enacting the
 18 [statute].” *Regence BlueShield*, 2018 WL 4566053, at *3 (rejecting plaintiffs’ request under
 19 § 1557 to remove a coverage exclusion for hearing loss treatments under their health plan because
 20 § 504 does not “require insurers to offer coverage for all [medical needs] regardless of the health
 21 condition, injury, or illness”). CVS “need not redefine its [benefits] program to eliminate . . .
 22 limitations on [prescription drug] coverage.” *Alexander*, 469 U.S. at 308–09.

23 Further, the obstacles Plaintiffs have to surmount to obtain their HIV/AIDS medication
 24 under the Program, while understandably a source of frustration and stress, do not rise to a level
 25 that deprives Plaintiffs of “meaningful access” to their benefits. Cases finding a denial of
 26 meaningful access have required significantly more severe deprivations. *See, e.g., Crowder*, 81
 27 F.3d at 1484–85 (Hawaii law requiring all dogs, including guide dogs, entering the state to be
 28 quarantined “*effectively preclude[d]* visually-impaired persons from using a variety of public

1 services”) (emphasis added); *Rodde*, 357 F.3d at 991, 997 (upholding a preliminary injunction
 2 preventing the closure of a hospital that “provide[d] services disproportionately required by the
 3 disabled and available *nowhere else in the County*”) (emphasis added).

4 The Court agrees with the observation in *BlueCross BlueShield*: “Although the Court
 5 understands the inconvenience facing that HIV/AIDS patients like Plaintiff as a result of
 6 Defendant’s policy, interpreting Section 504 of the Rehab Act to reach the claims in the Amended
 7 Complaint would flout the Supreme Court’s cautionary instructions in *Alexander*.” 2018 WL
 8 3625012, at *8. Accordingly, CVS’s motion to dismiss Plaintiffs’ ACA claim is **GRANTED**
 9 **without leave to amend.**⁶

10 C. ADA Discrimination Claim

11 Title III of the ADA provides that “[n]o individual shall be discriminated against on the
 12 basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges,
 13 advantages, or accommodations of any place of public accommodation by any person who owns,
 14 leases (or leases to), or operates a place of public accommodation.” 42 U.S.C. § 12182(a). To
 15 prevail on a discrimination claim under Title III, a plaintiff must show that: (1) he is disabled
 16 within the meaning of the ADA; (2) the defendant is a private entity that owns, leases, or operates
 17 a place of public accommodation; and (3) the plaintiff was denied public accommodations by the
 18 defendant because of his disability. *Molski v. M.J. Cable, Inc.*, 481 F.3d 724, 730 (9th Cir. 2007).
 19 The parties dispute whether Plaintiffs have sufficiently pleaded the second and third elements. A
 20 review of Plaintiffs’ claim shows that they have not.

21 1. “Place of Public Accommodation”

22 CVS argues that the alleged discrimination in this case arises from the administration of
 23 Plaintiffs’ *benefit plan*, which is not a “place of public accommodation” subject to the ADA. CVS
 24 Mot. at 14. Plaintiffs respond that it is the *community pharmacies* to which CVS is denying
 25 access, and the ADA expressly designates pharmacies as places of public accommodation. Opp.

26
 27 ⁶ Because Plaintiffs failed to establish they have been denied meaningful access to their benefits,
 28 the Court need not reach CVS’s separate argument that Plaintiffs have also failed to sufficiently
 plead that CVS “receiv[es] Federal financial assistance,” as required by the ACA. 42 U.S.C.
 § 18116(a).

1 at 11 (citing 42 U.S.C. § 12181(7)(F)). Plaintiffs’ argument is foreclosed by Ninth Circuit law.

2 In *Weyer v. Twentieth Century Fox Film Corp.*, the plaintiff sued the insurance company
 3 administering the disability benefits policy offered by her employer because the policy allegedly
 4 provided more benefits for physical disabilities than for mental disabilities. 198 F.3d 1104, 1107
 5 (9th Cir. 2000). The Ninth Circuit held that the plaintiff failed to establish the “place of public
 6 accommodation” element of a Title III claim. *Id.* at 1114. The court explained that although, in a
 7 literal sense, “an insurance office is a place where the public generally has access,” the case at its
 8 core was a “dispute . . . over the terms of a contract that the insurer markets through an employer,
 9 [which] is not what Congress addressed in the public accommodations provisions.” *Id.* Citing
 10 precedent from the Third and Sixth Circuits, *Weyer* concluded that “[a] benefit plan offered by an
 11 employer is not a good offered by a place of public accommodation.” *Id.* at 1115 (quoting *Ford v.*
 12 *Schering-Plough Corp.*, 145 F.3d 601, 612–13 (3d Cir. 1998); citing *Parker v. Metropolitan Life*
 13 *Ins. Co.*, 121 F.3d 1006, 1010–11 (6th Cir. 1997) (en banc)).

14 Plaintiffs’ claims are unavailing for the same reason. Although Plaintiffs attempt to
 15 reframe the argument to cast community pharmacies as the “places of public accommodation” at
 16 issue, CVS does not “bar Plaintiffs and Class Members’ access to” those pharmacies. Opp. at 13.
 17 Rather, the *terms* of the benefit plan administered by CVS force Plaintiffs to pay higher prices for
 18 specialty medications if they choose to fill their prescriptions at community pharmacies. Thus, it
 19 is of no moment that the Plaintiffs allege CVS “exercise[s] their direct and contractual control
 20 over establishing which pharmacies are available to Plaintiffs,” *id.*, because “Title III does not
 21 address the terms of the policies that [a benefit plan administrator] sells,” *Weyer*, 198 F.3d at
 22 1115. It is the *term* of the insurance plan overall that is at issue here. *See Bluecross Blueshield*,
 23 2018 WL 3625012, at *10 (dismissing Title III claim because it was “based on the terms of
 24 BCBST’s coverage for specialty medications, not the availability of coverage for those
 25 medications—even when the effect of those terms is that Plaintiff may not obtain his HIV/AIDS
 26 medication from a community pharmacy without incurring exorbitant costs”).

27 2. “On the Basis of Disability”

28 The complaint also fails to adequately allege that Plaintiffs were discriminated against on

1 the basis of their disability. The ADA “protect[s] disabled persons not just from intentional
2 discrimination but also from thoughtlessness, indifference, and benign neglect.” *Lentini v.*
3 *California Ctr. for the Arts, Escondido*, 370 F.3d 837, 846 (9th Cir. 2004) (citation and internal
4 quotation marks omitted). Actionable discrimination can therefore take the form of “outright
5 intentional exclusion” as well as “the discriminatory effects of . . . failure to make modifications to
6 existing facilities and practices, exclusionary qualification standards and criteria, segregation, and
7 relegation to lesser services, programs, activities, benefits, jobs, or other opportunities.” *Id.* at
8 846–47 (citing 42 U.S.C. § 12182(b)(2)(A)(ii); 42 U.S.C. § 12101(a)(5)).

9 Plaintiffs have not shown that the Program has a discriminatory *effect* on them that is
10 cognizable under the ADA. The Ninth Circuit in *Weyer* held, in line with seven other circuits, that
11 “there is no discrimination under the [ADA] where disabled individuals are given the same
12 opportunity as everyone else, so insurance distinctions that apply equally to all employees cannot
13 be discriminatory.” *Weyer*, 198 F.3d at 1116. Thus, a plan administrator that does not “vary the
14 terms of its plan depending on whether or not the employee was disabled” does not violate the
15 ADA. *Id.* (quoting *E.E.O.C. v. CNA Ins. Companies*, 96 F.3d 1039, 1044 (7th Cir. 1996)).
16 Because the Program’s restrictions apply equally to all enrollees, whether or not they have
17 HIV/AIDS and whether or not they have a disability within the meaning of the ADA, the same
18 rationale compels dismissal of Plaintiffs’ claims in this case.⁷

19 Plaintiffs counter that there is evidence the Program *intentionally* discriminates on the
20 basis of disability because “the reality is that all but two of the hundreds of medications subject to
21 the Program treat disabilities.” *Opp.* at 14. In other words, only disability medications are subject
22 to the Program’s restrictions. The complaint supports this contention by listing all of the drugs on
23 CVS’s specialty formulary and explaining why the conditions they treat qualify as “disabilities”
24 under the ADA. *See* FAC ¶ 94. But, even assuming these explanations are correct,⁸ Plaintiffs

25 _____
26 ⁷ This ADA analysis is consistent with that for disability-based discrimination under the ACA and
27 § 504. *See* Part III.B, *supra*; *Zukle v. Regents of Univ. of California*, 166 F.3d 1041, 1045 n.11
28 (9th Cir. 1999) (“There is no significant difference in analysis of the rights and obligations created
by the ADA and the Rehabilitation Act.”).

⁸ CVS cites a number of cases in which courts have found that conditions treated by specialty

1 undermine their own argument by conceding that there are at least two drugs on the formulary that
 2 do not treat a disability. *See id.* ¶ 94 n.8. Plaintiffs believe that CVS included the two outlier
 3 drugs as a “fig leaf to avoid an ADA or ACA violation,” an impermissible act of “subterfuge to
 4 evade the purposes of [Title III]” that is proscribed by 42 U.S.C. § 12201(c). *Opp.* at 14. In
 5 making this allegation, however, Plaintiffs offer only a formulaic recitation of the language of
 6 § 12201(c) and the bare assertion that “CVS cannot seriously contend that a disability-based
 7 distinction does not exist with regard to the Program.” *Opp.* at 14. Without more specific factual
 8 allegations supporting the inference that CVS intentionally compiled the specialty formulary to
 9 discriminate against persons with disabilities while evading accountability under the ADA,
 10 Plaintiffs have not made a sufficient showing that the Program discriminates on the basis of
 11 disability. *See Twombly*, 550 U.S. at 555 (a pleading consisting of “labels and conclusions” or “a
 12 formulaic recitation of the elements of a cause of action” cannot survive a motion to dismiss);
 13 *Leonard F. v. Israel Disc. Bank of New York*, 199 F.3d 99, 104 (2d Cir. 1999) (holding that “the
 14 subterfuge clause in [§ 12201(c)] should be construed . . . to require an intent to evade”).

15 Because the terms of Plaintiffs’ benefit plan do not constitute “a place of public
 16 accommodation,” a required element of a Title III claim, granting Plaintiffs leave to amend
 17 “would be futile” even if they can establish through amendment that CVS discriminated against
 18 them on the basis of disability. *Cervantes v. Countrywide Home Loans, Inc.*, 656 F.3d 1034, 1041
 19 (9th Cir. 2011); *see Molski*, 481 F.3d at 730 (listing elements of Title III claim). Accordingly,
 20 CVS’s motion to dismiss Plaintiffs’ ADA claim is **GRANTED without leave to amend.**

21 D. California Unruh Civil Rights Act Claim

22 The California Unruh Civil Rights Act provides that all persons within the State of
 23 California are “entitled to the full and equal accommodations, advantages, facilities, privileges, or
 24 services in all business establishments of every kind whatsoever.” Cal. Civ. Code § 51(b). The
 25 Unruh Act expressly incorporates the ADA by providing that a “violation of the right of any
 26 individual under the federal Americans with Disabilities Act . . . shall also constitute a violation

27 _____
 28 medication subject to the Program are not per se disabilities under the ADA. *See* Docket No. 118
 at 7 n.8.

1 of this section.” *Id.* § 51(f). Otherwise, only facial or intentional discrimination is actionable
 2 under the Unruh Act. The Act generally “does not extend to practices and policies that apply
 3 equally to all persons.” *Greater Los Angeles Agency on Deafness, Inc. v. Cable News Network,*
 4 *Inc.*, 742 F.3d 414, 425 (9th Cir. 2014) (quoting *Turner v. Ass’n of Am. Med. Colls.*, 167 Cal. App.
 5 4th 1401, 1408 (2008)). “Thus, to establish a violation of the Unruh Act independent of a claim
 6 under the [ADA], [a plaintiff] must ‘plead and prove *intentional discrimination* in public
 7 accommodations in violation of the terms of the Act.” *Id.* (emphasis added).

8 As explained above, Plaintiffs have failed to state a claim under the ADA. Therefore, to
 9 state an Unruh Act claim, they must plausibly allege intentional discrimination on the part of CVS,
 10 which in this context means “willful, affirmative misconduct . . . more than the disparate impact of
 11 a facially neutral policy.” *Id.* (citation and internal quotation marks omitted). Plaintiffs have not
 12 met that standard. They can point to only two allegations of intentional discrimination in the
 13 complaint, both of which are conclusory and therefore insufficient to meet the pleading standards
 14 of Rule 8(a). *See* FAC ¶ 114 (“Defendants’ intentionally discriminatory actions have denied
 15 Plaintiffs and members of the Class full and equal enjoyment of . . . prescription drug benefit.”); ¶
 16 153 (“By implementing the Program . . . the CVS Caremark Defendants have specifically and
 17 intentionally targeted individuals on the basis of a particular disability and affirmatively
 18 discriminated against such persons on the basis of their disability.”).

19 What is more, the allegations of intentional discrimination are undermined by references in
 20 the complaint to instances where CVS made accommodations or assisted Plaintiffs in accessing
 21 their prescription drug benefits. For example, a “CVS Caremark gave [Plaintiff John Doe Three] a
 22 one-time exception” from the Program’s restrictions “and allowed his [community] pharmacy to
 23 fill his HIV/AIDS Medications,” FAC ¶ 43, and “CVS Caremark sen[t] a same day courier with
 24 [Plaintiff John Doe Five’s] HIV/AIDS medications” when he did not receive his original order, *id.*
 25 ¶ 60. “That Defendants provided some, but not all, accommodations to Plaintiff tends to negate an
 26 inference that Defendants’ conduct was purposefully discriminatory.” *Wilkins-Jones v. Cty. of*
 27 *Alameda*, 859 F. Supp. 2d 1039, 1052 (N.D. Cal. 2012); *see Greater Los Angeles*, 742 F.3d at 426
 28 (finding assertions that “CNN intentionally excluded deaf and hard of hearing individuals from

1 accessing CNN.com” were “belied by the record” indicating that CNN offered caption-based
 2 services and was prepared to comply with the FCC’s then-pending captioning rules).

3 Because Plaintiffs’ ADA claim is dismissed with prejudice, and Plaintiffs’ conclusory
 4 allegations of intentional discriminations are contradicted by other allegations in their complaint,
 5 CVS’s motion to dismiss Plaintiffs’ Unruh Act claim is **GRANTED without leave to amend**.
 6 *See United States v. Corinthian Colleges*, 655 F.3d 984, 995 (9th Cir. 2011) (leave to amend
 7 would be futile if the deficiencies in a complaint can only be cured by amendments that
 8 “contradict the allegations in the original complaint”).

9 E. California Unfair Competition Law Claim

10 The California UCL prohibits “unlawful, unfair or fraudulent business act[s] or
 11 practice[s].” Cal. Bus. & Prof. Code § 17200. “Each of these three adjectives captures a separate
 12 and distinct theory of liability.” *Rubio v. Capitol One Bank*, 613 F.3d 1195, 1203 (9th Cir. 2010).
 13 Here, Plaintiffs explicitly assert that CVS’s actions violate the “unlawful” prong of the UCL. *See*
 14 FAC ¶ 186. This coverage under this prong is “broad and sweeping, and embraces ‘anything that
 15 can properly be called a business practice and that at the same time is forbidden by
 16 law.’” *Prescott v. Rady Children’s Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1102 (S.D. Cal.
 17 2017) (quoting *Cel-Tech Commc’ns v. L.A. Cellular Tel. Co.*, 20 Cal. 4th 163, 180 (1999)). “By
 18 proscribing ‘any unlawful’ business practice, section 17200 borrows violations of other laws and
 19 treats them as unlawful practices that the unfair competition law makes independently
 20 actionable.” *Cel-Tech Commc’ns*, 20 Cal. 4th at 180 (citation omitted). Because Plaintiffs’
 21 predicate ACA, ADA, and Unruh Act claims all fail, they cannot sustain a claim under the UCL
 22 “unlawful” prong. *See Pantoja v. Countrywide Home Loans, Inc.*, 640 F. Supp. 2d 1177, 1190
 23 (N.D. Cal. 2009) (“[S]ince the Court has dismissed all of Plaintiff’s predicate violations, Plaintiff
 24 cannot state a claim under the unlawful business practices prong of the UCL.”).

25 Plaintiffs assert one other basis for an “unlawful” prong claim. They allege that CVS
 26 violated 45 C.F.R. § 156.122(e)(1), a regulation implementing the ACA, which provides that a
 27 health plan providing “essential health benefits . . . must allow enrollees to access prescription
 28 drug benefits at in-network retail pharmacies, unless (i) The drug is subject to restricted

1 distribution by the U.S. Food and Drug Administration; or (ii) The drug requires special handling,
 2 provider coordination, or patient education that cannot be provided by a retail pharmacy.” There
 3 is no indication that CVS’s alleged conduct violates § 156.122(e)(1). Plaintiffs’ benefit plan *does*
 4 allow them to access their specialty medications at in-network retail pharmacies—CVS
 5 pharmacies. *See* FAC ¶ 1. The regulation does not guarantee Plaintiffs’ access to out-of-network
 6 pharmacies. Plaintiffs therefore have not stated a claim under the UCL “unlawful” prong.

7 In their opposition brief, Plaintiffs also assert that CVS violated the “unfair” prong of the
 8 UCL even though the complaint did not expressly allege an unfairness prong claim. CVS urges
 9 dismissal of the claim because it was “not well pled.” CVS Mot. at 18 n.21. However, the
 10 complaint contains an allegation that echoes the legal standards for assessing UCL unfairness
 11 claims. *Compare* FAC ¶ 189 (“The gravity of the consequences of the CVS Caremark
 12 Defendants’ conduct . . . outweighs any justification, motive or reason therefor, and is immoral,
 13 unethical, and unscrupulous, offends established public policy that is tethered to legislatively
 14 declared policies as set forth in the laws detailed above, or is substantially injurious to Plaintiffs
 15 and other members of the Class.”), *with In re Carrier IQ, Inc.*, 78 F. Supp. 3d 1051, 1115 (N.D.
 16 Cal. 2015) (The analysis under the unfairness prong “asks whether the alleged business practice is
 17 immoral, unethical, oppressive, unscrupulous or substantially injurious to consumers and requires
 18 the court to weigh the utility of the defendant’s conduct against the gravity of the harm to the
 19 alleged victim.”) (citation and internal quotation marks omitted), *and Graham v. Bank of Am.*,
 20 *N.A.*, 226 Cal. App. 4th 594, 613 (2014) (An unfairness claim must be “predicated on public
 21 policy” which is “tethered to specific constitutional, statutory or regulatory provisions.”).
 22 Plaintiffs’ allegation in FAC ¶ 189 is “specific enough to give defendants notice of the particular
 23 misconduct . . . so that they can defend against the charge.” *Sanford v. MemberWorks, Inc.*, 625
 24 F.3d 550, 558 (9th Cir. 2010). Hence, this case is distinguishable from *Moss v. Infinity Ins. Co.*,
 25 197 F. Supp. 3d 1191, 1199 (N.D. Cal. 2016), cited by Defendant.

26 Plaintiffs’ unfairness claim nevertheless fails on the merits. “The standard for determining
 27 what business acts or practices are ‘unfair’ under the UCL for consumer actions remains
 28 unsettled.” *Graham*, 226 Cal. App. 4th at 612. “One line of cases applie[s] a . . . balancing test”

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1 weighing the utility of the defendant’s conduct against the gravity of the harm to the victim. *Id.*
2 Another assesses whether the defendant’s conduct offends a “public policy . . . tethered to specific
3 constitutional, statutory or regulatory provisions.” *Id.* at 613.

4 Plaintiffs have not met the first test. They allege that the Program causes them harm in the
5 form of less convenient access to their prescription medication, and that Defendants’ decision to
6 enroll Plaintiffs in the Program was “ultimately motivated by profit.” FAC ¶ 79. But California
7 courts have generally held that merely entering into a contract or transaction with for profit does
8 not make the contract or transaction “immoral, unethical, oppressive, unscrupulous or
9 substantially injurious to consumers” for the purposes of the UCL. *Smith v. State Farm Mut. Auto.*
10 *Ins. Co.*, 93 Cal. App. 4th 700, 719 (2001); *see, e.g., Wayne v. Staples, Inc.*, 135 Cal. App. 4th
11 466, 483–84 (2006) (finding no UCL violation where plaintiff claimed defendant charged an
12 insurance coverage fee that constituted a 100% markup on its cost of obtaining the coverage);
13 *Searle v. Wyndham International, Inc.*, 102 Cal. App. 4th 1327, 1333 (2002) (not unfair for hotel
14 to assess a mandatory service charge on guests).

15 The second test presents a closer question. Plaintiffs allege that CVS’s conduct “offends
16 established public policy that is tethered to legislatively declared policies as set forth in” the ACA,
17 ADA, 45 C.F.R. 156.122(e), and the Unruh Act. FAC ¶¶ 186, 189. However, Plaintiffs have
18 failed to show that CVS has violated any of the listed substantive statutes or regulations. The
19 complaint elsewhere references the “right to privacy” guaranteed by “Article I, section 1 of the
20 California Constitution,” and alleges that “the Program violates Class Members’ inalienable right
21 to privacy by eliminating their choice to keep their medical condition private, by requiring public
22 delivery of their medications by someone they do not know and from CSP personnel who may not
23 be sensitive to or have extensive knowledge of their condition.” FAC ¶ 116.

24 ///
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28 ///

1 To be sure, the protections afforded by article I, section 1 of the California Constitution
 2 extend to an individual’s medical privacy.⁹ For example, the California Court of Appeal has held
 3 that article I, section 1 protects the confidentiality of medical records. *See Bd. of Med. Quality*
 4 *Assurance v. Gherardini*, 156 Cal. Rptr. 55, 61 (Ct. App. 1979), *disapproved of on other grounds*
 5 *by Williams v. Superior Court*, 398 P.3d 69 (Cal. 2017). And, particularly pertinent to this case,
 6 the court in *Urbaniak v. Newton* affirmed that “disclosure of HIV positive status may under
 7 appropriate circumstances be entitled to protection under article 1, section 1.” 277 Cal. Rptr. 354,
 8 360 (Ct. App. 1991). But not every disclosure of medical information violates a patient’s privacy
 9 right. “The California Constitution and the common law set a high bar for an invasion of privacy
 10 claim,” and “[a]ctionable invasions of privacy must be sufficiently serious in their nature, scope,
 11 and actual or potential impact to constitute an egregious breach of the social norms underlying the
 12 privacy right.” *Low v. LinkedIn Corp.*, 900 F. Supp. 2d 1010, 1025 (N.D. Cal. 2012) (quoting *Hill*
 13 *v. Nat’l Collegiate Athletic Assn.*, 865 P.2d 633, 655 (Cal. 1994)).

14 Only one of Plaintiffs’ allegations makes out a violation of article I, section 1. According
 15 to the complaint, Plaintiffs “have reported that CVS personnel shouted the name of their
 16 HIV/AIDS Medications across the room in front of other customers, raising severe privacy
 17 concerns and making it untenable to pick up their medications at a CVS pharmacy in the future.”
 18 FAC ¶ 76. Such indiscretion on the part of CVS personnel in announcing to anyone within
 19 earshot that Plaintiffs were taking HIV/AIDS drugs could be sufficiently serious to be actionable
 20 under the California Constitution, because “even negligent disclosure of HIV-positive status can
 21 be an egregious violation of social norms if it causes harm—including psychological harm—to the
 22 patient.” *Doe v. Beard*, 63 F. Supp. 3d 1159, 1170 (C.D. Cal. 2014). However, Plaintiffs do not
 23 allege this is a regular or widespread practice, as opposed to an isolated incident, sufficient to
 24 entitle Plaintiffs to equitable and injunctive relief directed against the Program as a whole. There
 25

26
 27 ⁹ The California Supreme Court has made clear that “the Privacy Initiative in article I, section 1 of
 28 the California Constitution creates a right of action against private as well as government entities.”
Hill v. Nat’l Collegiate Athletic Assn., 865 P.2d 633, 644 (Cal. 1994).

1 is no allegation this incident was integrally or inevitably part of the Program.

2 Accordingly, CVS's motion to dismiss Plaintiffs' UCL claim is **GRANTED without**
3 **leave to amend.**

4 F. ERISA Claims

5 1. Denial of Benefits

6 Section 502(a)(1)(B) of ERISA allows for recovery of benefits due "under the terms of [an
7 ERISA] plan." 29 U.S.C. § 1132(a)(1)(B). "In order to state a claim for denial of benefits under
8 ERISA, Plaintiffs must allege plausible facts showing they were owed benefits under the . . . Plan.
9 This requires Plaintiffs to allege (1) the existence of an ERISA plan, and to identify (2) the
10 provisions under the plan that entitle [them] to benefits." *B.R. v. Beacon Health Options*, No. 16-
11 CV-04576-MEJ, 2017 WL 5665667, at *3 (N.D. Cal. Nov. 27, 2017) (citations and internal
12 quotation marks omitted). Here, Plaintiffs have alleged that the benefit plan administered by CVS
13 is an ERISA plan, *see* FAC ¶ 126, but have not identified the provisions of the plan that entitle
14 them to the benefits they seek. Indeed, their challenge is to the overall scope of the plan, not
15 denial of benefits under the plan.

16 Plaintiffs argue in broad terms that they are "entitled to prescription medication benefits
17 under the terms of their plans," and that "Defendants have effectively denied Plaintiffs" these
18 benefits "by, *inter alia*, denying access to a local, knowledgeable pharmacist, by requiring a
19 process that risks missed medications and lost or stolen shipments as well as other obstacles."
20 *Opp.* at 16–17. Accordingly, Plaintiffs "seek the benefit of continued access to community
21 pharmacies as an 'in-network' benefit." FAC ¶ 201. However, they are unable to point to any
22 allegation in the complaint specifying which terms under their plans entitle them to such a benefit.
23 Indeed, the complaint attributes the "designation of the community pharmacy as now being 'out-
24 of-network'" to "Defendants' changes to Class Members' health plans' prescription drug benefit."
25 *Id.* ¶ 197. Hence, their plans do not confer the benefit they seek.

26 "A plaintiff who brings a claim for benefits under ERISA must identify a specific plan
27 term that confers the benefit in question." *Steelman v. Prudential Ins. Co. of Am.*, No. CIV S-06-
28 2746 LKKGGH, 2007 WL 1080656, at *7 (E.D. Cal. Apr. 4, 2007) (quoting *Stewart v. National*

1 *Educ. Ass'n*, 404 F. Supp. 2d 122, 130 (D.D.C. 2005), *aff'd*, 471 F.3d 169 (D.C. Cir. 2006)).
 2 Simply alleging violations of the plan “without reference to the terms of the controlling plans” is
 3 not sufficient. *Forest Ambulatory Surgical Assocs., L.P. v. United HealthCare Ins. Co.*, No. 10-
 4 CV-04911-EJD, 2011 WL 2748724, at *5 (N.D. Cal. July 13, 2011). Thus, the lack of any
 5 specific reference to plan provisions which affords the benefits to which they contend they are
 6 entitled warrants dismissal of Plaintiffs’ denial-of-benefits ERISA claim. *See id.* (finding that
 7 plaintiff’s “conclusory allegations” that “[u]nder the terms of the relevant written ERISA plans
 8 and written Assignment Agreements, [defendant] was obligated to pay [plaintiff] the amount of
 9 the Claims submitted under the ERISA plans for the procedures performed by [plaintiff’s] medical
 10 staff” were insufficient to plead an ERISA claim).

11 Accordingly, Plaintiffs’ denial of benefits claim under ERISA is **DISMISSED with**
 12 **prejudice.**

13 2. Breach of Fiduciary Duty

14 Plaintiffs next argue that CVS breached its fiduciary duties in administering the benefit
 15 plans. There are two types of ERISA fiduciaries: “named” and “functional.” *Santomenno v.*
 16 *Transamerica Life Ins. Co.*, 883 F.3d 833, 837 (9th Cir. 2018). CVS argues it is neither a named
 17 nor a functional fiduciary with respect to Plaintiffs’ benefit plans. CVS seeks to introduce the
 18 prescription benefits services contracts between CaremarkPCS and three of the Employer
 19 Defendants (Amtrak, Time Warner, and Lowe’s). *See* Docket Nos. 88-1, 88-2, 88-4. Plaintiffs
 20 object to CVS’s attempt to introduce the contracts. *See* Docket No. 116. On a motion to dismiss,
 21 “courts may take into account documents whose contents are alleged in a complaint and whose
 22 authenticity no party questions, but which are not physically attached to the plaintiff’s pleading.”
 23 *Davis v. HSBC Bank Nevada, N.A.*, 691 F.3d 1152, 1160 (9th Cir. 2012) (citation, internal
 24 quotations marks, and alterations omitted).

25 As an initial matter, Plaintiffs “question the authenticity of these contracts having not had
 26 an opportunity to confirm whether these are, in fact, the correct and complete contracts between
 27 the parties through discovery.” Docket No. 116 at 2. In response, CVS quotes the Ninth Circuit’s
 28 statement in *Davis* that “[w]hether or not [the plaintiff] had access to and reviewed the proffered

1 documents is a matter unrelated to their authenticity—i.e., whether the documents are ‘what its
2 proponent claims.’” Docket No. 119 at 2 (quoting *Davis*, 691 F.3d at 1161). However, this quote
3 is taken out of context. *Davis* was assessing the claim of a plaintiff who insisted that he had
4 properly challenged the authenticity of documents proffered by the defendant before the district
5 court by simply asserting that he had not been able to review the documents. *See Davis*, 691 F.3d
6 at 1160. It was in response to this argument that the Ninth Circuit explained that objecting to a
7 lack of access to documents is not equivalent to challenging the authenticity of documents. *See id.*
8 at 1161.

9 In contrast to the plaintiff in *Davis*, Plaintiffs in this case have explicitly questioned the
10 authenticity of the contracts, which are between CVS and Plaintiffs’ employers. However,
11 Plaintiffs’ “ongoing and substantial reliance on the [contracts] as a basis for [their] allegations
12 substantially weakens [their] position.” *In re Silicon Graphics Inc. Sec. Litig.*, 183 F.3d 970, 986
13 (9th Cir. 1999), *abrogated on other grounds as recognized in South Ferry LP, No. 2 v. Killinger*,
14 542 F.3d 776, 784 (9th Cir. 2008). Among other things, the complaint alleges that “one of CVS
15 Caremark’s roles as a prescription drug benefit administrator . . . is to establish and contractually
16 control which, if any, non-CVS pharmacies are “in-network,” thereby determining where Class
17 Members may purchase their prescription drugs with full insurance coverage, FAC ¶ 68; that
18 “CVS Caremark is specifically identified in the Summary Plan Descriptions of certain employers’
19 health benefit plans . . . as a fiduciary,” *id.* ¶ 100; that Employer Defendants “have entered into a
20 series of agreements [with CVS] that reduced the health benefits available to their members and
21 resulted in discriminatory conduct against them,” *id.* ¶ 102; that CVS exercises “significant direct
22 and indirect control over their subsidiary CVS pharmacies and Class Members’ access to their
23 preferred community pharmacies . . . through contractual agreements and financial arrangements,”
24 *id.* ¶ 163; and that “AMTRAK, Lowe’s, and Time Warner each knowingly participated in CVS’s
25 breach of its fiduciary duties through its agreement with CVS subjecting members of its health
26 plan to the Program,” *id.* ¶ 209. These allegations belie Plaintiffs’ contention that they “do not
27 reference or rely on the agreements between CVS and Plaintiffs’ employers.” Docket No. 116 at
28 2. Accordingly, the Court will consider the contracts in reviewing Plaintiffs’ breach of fiduciary

1 duty claim. *See Silicon Graphics*, 183 F.3d at 986 (affirming district court’s consideration of SEC
 2 filings under incorporation by reference doctrine despite plaintiff’s challenge to their authenticity
 3 because plaintiff “raised questions about [defendants’] stock sales, based [her] allegations on
 4 [defendants’] SEC filings, and submitted expert declarations that rely on the SEC forms at issue”);
 5 *see also Santomenno*, 883 F.3d at 836 n.2 (incorporating ERISA documents by reference where
 6 the complaint referred to the documents).

7 The contracts show that the CVS Defendants are neither named nor functional fiduciaries
 8 with respect to Plaintiffs’ benefit plans. A “‘named fiduciary’ means a fiduciary who is named in
 9 the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a
 10 fiduciary (A) by a person who is an employer or employee organization with respect to the plan or
 11 (B) by such an employer and such an employee organization acting jointly.” 29 U.S.C.
 12 § 1102(a)(2). The contracts here do not name any of the CVS Defendants in this action as a
 13 fiduciary. They only provide that CaremarkPCS—a non-party—shall be a “fiduciary solely for
 14 the purposes of initial claim adjudication and appeals relating to the coverage of prescription drug
 15 benefits” (neither of which is at issue here), but otherwise “shall not be . . . a named fiduciary with
 16 respect to the Plan for purposes of ERISA.” Docket Nos. 88-1 at Pricing Schedule A § 16, 88-2
 17 § 6.2, 88-4 § 6.2. Because none of the CVS Defendants in this case is named in the plan
 18 instrument, none is a named fiduciary.

19 A party not named in an ERISA plan is deemed a functional fiduciary if:

20 (i) he exercises any discretionary authority or discretionary control
 21 respecting management of such plan or exercises any authority or
 control respecting management or disposition of its assets,

22 (ii) he renders investment advice for a fee or other compensation,
 23 direct or indirect, with respect to any moneys or other property of
 such plan, or has any authority or responsibility to do so, or

24 (iii) he has any discretionary authority or discretionary responsibility
 25 in the administration of such plan.

26 29 U.S.C. § 1002(21)(A). The CVS Defendants sued in this action are neither parties to the
 27 contracts with Plaintiffs’ employers nor given any “discretionary authority or discretionary
 28 control” under the terms of the contracts over the management or administration of the benefit

1 plans. The actual party contracting with each employer is “CaremarkPCS Health L.L.C.” Docket
2 Nos. 88-1 at 1, 88-2 at 1, 88-4 at 1. “[B]ecause [the CVS Defendants] [are] not . . . part[ies] to the
3 . . . PBM Agreement,” they are not fiduciaries with respect to Plaintiffs’ plans. *Bickley v.*
4 *Caremark Rx, Inc.*, 361 F. Supp. 2d 1317, 1326 (N.D. Ala. 2004), *aff’d*, 461 F.3d 1325 (11th Cir.
5 2006).

6 But, even assuming CaremarkPCS had been named as a defendant here, the terms of the
7 contract undermine any argument that CaremarkPCS “exercises significant if not sole
8 discretionary authority” over management of the benefit plans. FAC ¶ 205. The CaremarkPCS-
9 Amtrak contract makes clear that Amtrak “retain[s] the sole and absolute authority to design,
10 amend, terminate, or modify . . . the Plan,” as well as “complete discretionary, binding and final
11 authority to construe the terms of the Plan . . . [and] to make factual determinations regarding the
12 payment of Claims or provisions of benefits.”¹⁰ Docket No. 88-1 at Pricing Schedule A § 16. The
13 contract expressly disclaims any discretionary authority in CaremarkPCS; it states that
14 CaremarkPCS “shall not be . . . the administrator of the Plan for any purpose,” “delegated
15 discretionary authority . . . with respect to the Plan or its administration,” or “deemed a fiduciary
16 with respect to the Plan for purposes of ERISA.” *Id.* Near-identical provisions appear in the
17 Timer Warner and Lowe’s contracts. *See* Docket Nos 88-2 § 6.2, 88-4 § 6.2. It also appears from
18 the contracts that while CaremarkPCS designates drugs as “specialty medications” subject to the
19 Program’s restrictions, the Employer Defendants retain the ultimate authority to exempt drugs so
20 designated from the restrictions. *See* Docket No. 88-2 § 2.6(a) (providing that Employer can
21 “elect[] to treat” certain drugs “designated as excluded from coverage” as “Covered Drugs.”), 88-4
22 § 2.6(a) (same).

23 Relying on similar express contract terms limiting the discretionary authority of the PBM,
24

25 ¹⁰ CaremarkPCS is designated as a fiduciary “solely for the purposes of initial claim adjudication
26 and appeals relating to the coverage of prescription drug benefits.” Docket Nos. 88-1 at Pricing
27 Schedule A § 16, 88-2 § 6.2, 88-4 § 6.2. But the Plaintiffs do not allege that CVS breached its
28 fiduciary duty with respect to those two functions. *See Del Prete v. Magellan Behavioral Health,*
Inc., 112 F. Supp. 3d 942, 946 (N.D. Cal. 2015) (“[A]n entity may be a fiduciary under ERISA for
some purposes and not for others . . .”) (citing *Pegram v. Herdrich*, 530 U.S. 211, 225 (2000)).
CaremarkPCS is not afforded discretionary authority over the *design* of the plan.

1 Courts have consistently determined that the PBM is not a functional fiduciary.¹¹ In *Moeckel v.*
 2 *Caremark, Inc.*, as in this case, the plaintiff alleged that the benefit plan administrator served as an
 3 ERISA fiduciary by exercising discretion in determining what drugs to include on the formulary.
 4 622 F. Supp. 2d 663, 686 (M.D. Tenn. 2007). But because the agreement between the
 5 administrator and the employer offering the plan expressly provided that the employer “retained
 6 exclusive control and authority over the . . . Plan and its administration, including with respect to
 7 its formulary(ies) and associated programs,” the court concluded that the administrator’s
 8 “formulary design and management activities with respect to its proprietary formularies are not
 9 fiduciary in nature.” *Id.* at 687. See also *Chicago Dist. Council of Carpenters Welfare Fund v.*
 10 *Caremark, Inc.*, 474 F.3d 463, 474–77 (7th Cir. 2007) (holding that plan administrator was not a
 11 fiduciary for the purposes of managing the formulary, negotiating prices with drug retailers, and
 12 managing rebates where “[t]he express language of the contracts contradicts th[e] characterization
 13 of [the administrator’s] authority over these programs”); *Bickley*, 361 F. Supp. 2d at 1333–34
 14 (finding that PBM was not acting as fiduciary in negotiating “rebates, discounts, and other pricing
 15 advantages”); *Bd. of Trustees of W. Lake Superior Piping Indus. Pension Fund v. Am. Benefit Plan*
 16 *Adm’rs, Inc.*, 925 F. Supp. 1424, 1429 (D. Minn. 1996) (concluding that corporation which
 17 performed administrative services on behalf of a benefit plan was not a fiduciary based on “the
 18 express terms of the Agreement” providing that “the functions it performed, in administering the
 19 Fund, were ‘purely ministerial’”).

20 The cases cited by Plaintiffs do not change the analysis. *Glanton ex rel. ALCOA*
 21 *Prescription Drug Plan v. AdvancePCS Inc.* found that a PBM managing a drug benefit program
 22 was a functional fiduciary “[i]n choosing whether to fill a prescription or shift a participant to a
 23 different drug,” because “it exercise[d] discretion over the plans’ assets.” 465 F.3d 1123, 1124

24
 25 ¹¹ Plaintiffs make the argument that the Court “cannot find that a PBM [like CaremarkPCS] is
 26 [not] a fiduciary” based on “adjudicated facts set forth in other courts’ opinions,” because in ruling
 27 on a motion to dismiss, a court may not take judicial notice of another court’s opinion “for the
 28 truth of the facts recited therein.” *Opp.* at 19 n.3. The rule Plaintiffs cite has no application here,
 because these opinions conclude, in light of the terms of the governing contracts, that plan
 administrators are not fiduciaries as a matter of law; this Court is not taking judicial notice of
 facts, but of the persuasiveness of the construction of similar contracts.

1 (9th Cir. 2006). But there was no indication that the contract at issue expressly limited the PBM’s
 2 discretionary authority over those functions. In *In re Express Scripts, Inc., PBM Litig.*, the court
 3 recited the general proposition that “once the PBM contracts were formed, [the PBM] was a
 4 fiduciary to the extent (if any) it exercised discretion over the management of a plan or disposition
 5 of plan assets.” No. 4:05-MD-01672 SNL, 2008 WL 2952787, 10* (E.D. Mo. July 30, 2008).
 6 Immediately following that sentence, however, the court observed that “[u]nder the [relevant]
 7 Contract(s), [the PBM] had no discretion over” drug prices, and accordingly ruled that it was not a
 8 fiduciary for drug pricing purposes. *Id.* Because the contracts here similarly divest CaremarkPCS
 9 of discretion with respect to its challenged functions under the plan, *Express Scripts* supports
 10 CVS’s contention that it is not a fiduciary.

11 Plaintiffs’ contention that the CaremarkPCS contracts should be ignored because “a
 12 contract exonerating an ERISA fiduciary from fiduciary responsibilities is void as a matter of law”
 13 is likewise inapposite. Opp. at 21 (quoting *IT Corp. v. Gen. Am. Life Ins. Co.*, 107 F.3d 1415,
 14 1418 (9th Cir. 1997)); see 29 U.S.C. § 1110(a). While the rule cited by Plaintiffs is valid, it does
 15 not apply until *after* a court has resolved the “‘threshold question’ of whether a party ‘was
 16 performing a fiduciary function when taking the action subject to complaint.’” *Santomenno*, 883
 17 F.3d at 840–41 (quoting *Pegram*, 530 U.S. at 226). It is only “[i]f [CVS] is a fiduciary . . . [that]
 18 any interpretation of the Plan which prevents [CVS] acting in a fiduciary capacity from being
 19 found liable as a fiduciary is void.” *IT Corp.*, 107 F.3d at 1418 (citation, internal quotation marks,
 20 and alterations omitted). Plaintiffs’ argument ignores the threshold question that begs to be
 21 answered. For the reasons stated above, neither the named CVS Defendants nor CaremarkPCS
 22 was performing a fiduciary function with respect to the alleged wrongdoing here, so the rule
 23 Plaintiffs cite does not come into play.

24 Finally, Plaintiffs raise for the first time in their opposition brief the claim that CVS also
 25 violated Section 510 of ERISA, which prohibits an employer from taking any adverse
 26 employment action against an employee “for exercising any right to which he is entitled under the
 27 provisions of an employee benefit plan,” or “for the purpose of interfering with the attainment of
 28 any right to which such participant may become entitled under the plan.” 29 U.S.C. § 1140.

1 Section 510 is designed to “prevent persons and entities from taking actions which might cut off
2 or interfere with a participant’s ability to collect present or future benefits or which punish a
3 participant for exercising his or her rights under an employee benefit plan.” *Lessard v. Applied*
4 *Risk Mgmt.*, 307 F.3d 1020, 1024 (9th Cir. 2002) (quoting *Tolle v. Carroll Touch, Inc.*, 977 F.2d
5 1129, 1134 (7th Cir. 1992)). “Where a plaintiff alleges discriminatory interference under section
6 510, a showing of the defendant’s ‘specific intent’ to interfere with ERISA rights is . . . required.”
7 *Schuman v. Microchip Tech. Inc.*, 302 F. Supp. 3d 1101, 1122–23 (N.D. Cal. 2018). This requires
8 evidence that the exercise of the plaintiff’s ERISA rights was “the motivating force” for the
9 adverse actions he suffered. *See Kimbro v. Atl. Richfield Co.*, 889 F.2d 869, 881 (9th Cir. 1989).
10 No action lies where the alleged loss of rights “is a mere consequence, as opposed to a motivating
11 factor behind the [adverse employment action].” *Dytrt v. Mountain States Tel. & Tel. Co.*, 921
12 F.2d 889, 896 (9th Cir. 1990).

13 Here, Plaintiffs claim that CVS violated Section 510 “by intentionally discriminating
14 against Plaintiffs because of their health conditions.” Opp. at 19. But they have alleged no facts
15 that give rise to an inference that CVS implemented the Program’s restrictions with the specific
16 intent of denying Plaintiffs their prescription drug benefits. Instead, the complaint throughout
17 emphasizes that Defendants’ “decision to force Class Members to accept CSP as their exclusive
18 provider under the Program” were “ultimately motivated by profit.” FAC ¶ 79; *see also id.* ¶ 78
19 (“By implementing [the Program], CVS Caremark effectively reduces the quality of prescription
20 drug care provided to Class Members, . . . allowing CVS Caremark to profit . . .”), ¶128
21 (“Defendants have put their own interests above their subscribers through their conduct of
22 discrimination and self-dealing by mandating the use of CSP . . . all the time profiting as a result
23 thereof.”), ¶ 210 (“CVS Caremark has decreased or eliminated plan benefits in order to increase
24 their own profits by requiring enrollees to only use CSP . . .”). These allegations do not state a
25 Section 510 claim. *See Powers v. AT&T*, No. 15-CV-01024-JSC, 2015 WL 5188714, at *7 (N.D.
26 Cal. Sept. 4, 2015) (dismissing Section 510 claim where allegations in complaint “give rise to an
27 inference that the [plaintiff’s] constructive discharge occurred due to age discrimination, but not
28 that Plaintiff’s supervisor or [employer] more generally had some plan to force Plaintiff into

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1 retirement to deprive him of otherwise available benefits”).

2 Accordingly, CVS’s motion to dismiss Plaintiffs’ breach of fiduciary duty claim under
3 ERISA is **GRANTED without leave to amend.**

4 3. Co-Fiduciary Liability

5 Plaintiffs additionally contend that CVS and Employer Defendants are co-fiduciaries, and
6 thus liable for each other’s fiduciary breaches under ERISA. Opp. at 20. Co-fiduciary liability
7 under ERISA is codified at 29 U.S.C. § 1105(a), which provides:

8 [A] fiduciary with respect to a plan shall be liable for a breach of
9 fiduciary responsibility of another fiduciary with respect to the same
10 plan in the following circumstances:

11 (1) if he participates knowingly in, or knowingly undertakes to
12 conceal, an act or omission of such other fiduciary, knowing such
13 act or omission is a breach;

14 (2) if, by his failure to comply with section 1104(a)(1) of this title in
15 the administration of his specific responsibilities which give rise to
16 his status as a fiduciary, he has enabled such other fiduciary to
17 commit a breach; or

18 (3) if he has knowledge of a breach by such other fiduciary, unless
19 he makes reasonable efforts under the circumstances to remedy the
20 breach.

21 However, as explained below, the Employer Defendants were not acting as fiduciaries with
22 respect to their alleged conduct in this case, and therefore co-fiduciary liability cannot attach to
23 CVS. See Part IV.B.2, *infra*. Accordingly, CVS’s motion to dismiss Plaintiffs’ co-fiduciary
24 liability claim under ERISA is **GRANTED without leave to amend.**

25 4. Full and Fair Review

26 ERISA requires an employee benefit plan to “afford a reasonable opportunity to any
27 participant whose claim for benefits has been denied . . . a full and fair review by the appropriate
28 named fiduciary of the decision denying the claim.” 29 U.S.C. § 1133(2). Regulations set forth
the minimum requirements that employee benefit plans must include to ensure a full and fair
review. See 29 C.F.R. § 2560.503-1(a)–(o).

Plaintiffs allege they were denied a full and fair review by CVS’s “fail[ure] to provide a
reasonable procedure for opting-out of the Program.” FAC ¶ 224. Put another way, the “benefit”

1 as to which their claim is being denied is the option to obtain HIV/AIDS medication from a non-
 2 CVS pharmacy at in-network prices. *See id.* ¶ 228 (“Plaintiffs seek the aforementioned benefit of
 3 continued access to community pharmacies as an ‘in-network’ benefit . . .”). But Plaintiffs’
 4 complaint reveals that they are not entitled to such a benefit under the Program, since they allege
 5 that their employers entered into contracts with CVS with a “‘non-opt-out’ plan option that
 6 subjects members to the Program” with “no right to request exemption from the Program.” FAC
 7 ¶ 102. Plaintiffs cannot be denied a full and fair review of a claim for a benefit they do not have.
 8 *See* 29 C.F.R. § 2560.503-1(e) (defining “a claim for benefits” as “a request for a *plan benefit or*
 9 *benefits* made by a claimant in accordance with a plan’s reasonable procedure for filing benefit
 10 claims”) (emphasis added).

11 In any event, Plaintiffs have not identified any procedural defects in the opt-out process.
 12 They allege that each of the named Plaintiffs followed the prescribed opt-out procedures and each
 13 was ultimately denied. *See id.* ¶ 220. On this basis, they argue that “the review process was
 14 neither meaningful nor performed in good faith,” without alleging any particular procedural
 15 deficiencies or bad faith on the part of CVS. *Opp.* at 24. Their assertion that “the outcome
 16 denying Plaintiffs’ claims was foreordained,” *id.*, demonstrates that their complaint is directed to
 17 the result of the review, not the process.

18 Accordingly, CVS’s motion to dismiss Plaintiffs’ full and fair review claim under ERISA
 19 is **GRANTED without leave to amend.**

20 G. Declaratory Relief

21 Plaintiffs’ claim for declaratory relief “rises or falls with [their] other claims.” *Surf &*
 22 *Sand, LLC. v. City of Capitola*, No. C 07-05043 RS, 2008 WL 2225684, at *2 n.5 (N.D. Cal. May
 23 28, 2008). Because Plaintiffs’ other claims fail, their claim for declaratory relief is **DISMISSED.**

24 **IV. EMPLOYER DEFENDANTS’ MOTIONS TO DISMISS**

25 A. Rule 8(a) Pleading Standard

26 Employer Defendants argue that the complaint fails to meet the pleading requirements of
 27 Federal Rule of Civil Procedure 8(a) because it makes general allegations against undifferentiated
 28 defendants, and does not identify which named Plaintiff is employed by which Defendant. *See*

1 Amtrak Mot. at 6–7; Lowe’s Mot. at 9–10; Time Warner Mot. at 9–10.

2 The complaint is not a model of clarity. But it does make clear that Counts 1 through 4 are
3 only brought “brought against the CVS Caremark Defendants.” *See* FAC ¶¶ 140, 151, 170, 184.
4 No such express statement accompanies Counts 5 through 8, but it is fair to understand them as
5 being against all Defendants, since in contrast to the references to only “CVS Caremark” or
6 “Employer Defendants” elsewhere in the complaint, those Counts largely use the general term
7 “Defendants.” *See, e.g., id.* ¶¶ 196–97, 208, 232. Within these Counts, the complaint also
8 continues to use “CVS Caremark” to make allegations against CVS specifically, *see, e.g., id.* ¶¶
9 198, 205, 220–26, and to use “Employer Defendant” or the names of individual employers when
10 making allegations against them specifically, *see, e.g., id.* ¶¶ 196, 206, 209. Thus, for example,
11 Plaintiffs’ denial of benefits claim under ERISA against CVS is based on the allegation that it
12 “caused a reduction in or elimination of Plaintiffs’ and Class Members’ benefits by exclusively
13 requiring their use of CSP to acquire these specialty medications,” *id.* ¶ 198, whereas the same
14 claim against Employer Defendants is based on their “entering into agreements with CVS that did
15 not provide an ability to opt-out of the Program, . . . as well as the failure to provide clear notice
16 thereof,” *id.* ¶ 196. The complaint is sufficient to give Employer Defendants “fair notice of the
17 claim[s] [against them] and the grounds upon which [they] rest[.]” *Erickson v. Pardus*, 551 U.S.
18 89, 93 (2007) (citing *Twombly*, 550 U.S. at 555).

19 The complaint’s failure to indicate which Named Plaintiff corresponds to which Employer
20 Defendant is more problematic. To be sure, the Named Plaintiffs make the same legal claims
21 based on similar underlying facts: each of them, prior to enrolling in the Program, obtained his
22 HIV/AIDS medications from a non-CVS pharmacy but is now subject to the requirements of the
23 program, *see* FAC ¶ 20, 29, 32, 43, 50, 58; has experienced problems with prescription deliveries
24 under the Program, *see id.* ¶¶ 24, 34, 46, 51, 59; has not experienced satisfactory consultation or
25 counseling services at CVS Pharmacies under the Program or with CVS service representatives,
26 *see id.* ¶ 25, 39, 48, 55, 63; (with the exception of John Doe Four) has requested to opt-out of the
27 Program without success, *see id.* ¶¶ 23, 41, 45, 67; and has suffered significant stress as a result of
28 having to navigate the Program, *see id.* ¶¶ 30, 42, 49, 57, 66. But without knowing which specific

1 Named Plaintiff is enrolled in its benefit plan, an Employer Defendant cannot verify allegations
 2 about that Plaintiff, such as when and how they requested to opt-out, and what difficulties they
 3 experienced in obtaining their medications. *See Corazon v. Aurora Loan Servs., LLC*, No. 11-
 4 00542 SC, 2011 WL 1740099, at *4 (N.D. Cal. May 5, 2011) (a “complaint fails to state a claim
 5 [where] plaintiffs do not indicate which individual defendant or defendants were responsible for
 6 which alleged wrongful act,” because a defendant “should not be required to guess which
 7 allegations pertain to it”). The complaint therefore does not give Employer Defendants “fair
 8 notice” of the claims against them, as required by Rule 8(a). *See In re Sagent Tech., Inc.,*
 9 *Derivative Litig.*, 278 F. Supp. 2d 1079, 1094 (N.D. Cal. 2003).

10 Ordinarily, pleading defects like this can be cured by amendment with more specific
 11 allegations. Here, however, the Court declines to grant Plaintiffs leave to amend the complaint,
 12 because their claims against Employer Defendants also fail on the merits, as explained below.

13 B. ERISA Claims

14 1. Denial of Benefits

15 Plaintiffs’ claim for denial of benefits under Section 502(a)(1)(B) of ERISA against
 16 Employer Defendants fails for the same reason as against CVS. According to Plaintiffs, they have
 17 “allege[d] that they are entitled to prescription medication benefits from the in-network pharmacist
 18 of their choice under the terms of their employer sponsored plans.” *See* Docket No. 121 at 6.
 19 However, they have not “identif[ied] a specific term that confers the benefit[s] in question,” as is
 20 required for such a Section 502(a)(1)(B) claim. *Steelman*, 2007 WL 1080656, at *7; *see* Part
 21 III.F.1, *supra*. The paragraphs from the complaint cited by Plaintiffs merely allege that the Named
 22 Plaintiffs were able to obtain their HIV/AIDS medications from community pharmacies “*prior to*
 23 the implementation of the Program.” FAC ¶ 32 (emphasis added); *see also id.* ¶¶ 43, 50 (Plaintiffs
 24 “had *previously* been able to obtain” medications from community pharmacies) (emphasis added).
 25 They do not allege that under the Program, they are *still* entitled to the same benefit.

26 Plaintiffs’ citation to *Central Laborers’ Pension Fund v. Heinz* for the proposition that “an
 27 amendment placing materially greater restrictions on the receipt of the benefit ‘reduces’ the
 28 benefit” does not change the analysis. 541 U.S. 739, 744 (2004). *Heinz* reviewed the effect of a

1 plan amendment on accrued benefits in a pension plan, which, once vested, “may not be decreased
2 by an amendment of the plan” under what is known as the “anti-cutback rule.” *Id.* at 744 (quoting
3 29 U.S.C. § 1054(g)(1)). The anti-cutback rule “does not apply to ‘employee welfare benefit
4 plans.’” *Anderson v. Suburban Teamsters of N. Illinois Pension Fund Bd. of Trustees*, 588 F.3d
5 641, 650 (9th Cir. 2009) (quoting 29 U.S.C. § 1051(1)). Plaintiffs have not alleged that they have
6 any vested pension benefits reduced by the Program.

7 2. Breach of Fiduciary Duty

8 Plaintiffs’ claim against Employer Defendants for breach of fiduciary duty under ERISA
9 fails because Employer Defendants did not act in a fiduciary capacity with respect to the
10 challenged conduct.

11 ERISA deems an entity a fiduciary only “to the extent” that it acts in a fiduciary capacity
12 in relation to an ERISA plan. 29 U.S.C. § 1002(21)(A). “In every case charging breach of ERISA
13 fiduciary duty, then, the threshold question is . . . whether that person was acting as a fiduciary
14 (that is, was performing a fiduciary function) when taking the action subject to complaint.”
15 *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000). The Supreme Court has emphasized that
16 “[n]othing in ERISA requires employers to establish employee benefits plans. Nor does ERISA
17 mandate what kind of benefits employers must provide if they choose to have such a plan.”
18 *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) (citation omitted). Therefore, “[e]mployers or
19 other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify,
20 or terminate welfare plans.” *Id.* at 890 (quoting *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S.
21 73, 78 (1995)). “When employers undertake those actions, they do not act as fiduciaries” *Id.*
22 (citations omitted).

23 Here, most of the allegations against Employer Defendants relate to non-fiduciary plan
24 design functions. Plaintiffs allege that Employer Defendants “decreased or eliminated Plaintiffs’
25 and Class Members’ plan benefits.” FAC ¶ 213. But “without exception, [p]lan sponsors who
26 alter the terms of a plan do not fall into the category of fiduciaries.” *Hughes Aircraft Co. v.*
27 *Jacobson*, 525 U.S. 432, 445 (1999) (quoting *Lockheed Corp.*, 517 U.S. at 890). Plaintiffs next
28 allege that Employer Defendants “exercise[d] discretion over whether and which pharmacy

1 benefits manager to select for administering pharmacy benefits for the health plans in which their
2 employees are enrolled.” FAC ¶ 206. But “[Employer Defendants’] decision to enter into the
3 PBM Agreement with [CVS], and to agree to the various terms contained therein, was a plan
4 design decision, exempt from fiduciary review.” *Moeckel*, 622 F. Supp. 2d at 678.

5 The remaining allegations fall into three categories. First, Plaintiffs argue that Employer
6 Defendants engaged in “financial self-dealing” in implementing the Program, FAC ¶ 208,
7 presumably because they accepted “financial incentives” from CVS to choose the Program over
8 other benefit plans, *id.* ¶ 79. But this is just an attempt to challenge the design of the plan in
9 another guise. Plaintiffs’ own language in the complaint demonstrates this allegation concerns the
10 form of the plan and its structuring of benefits: “CVS Caremark provid[ed] financial incentives to
11 self-funded plans and other plan sponsors *to select the Program over a prescription drug benefit*
12 *plan that allows enrollees to use the pharmacy of their choice.*” FAC ¶ 79 (emphasis added).
13 “ERISA’s fiduciary duty requirement simply is not implicated where [an employer] . . . makes a
14 decision regarding the form or structure of the Plan such as who is entitled to receive Plan benefits
15 and in what amounts.” *Hughes Aircraft Co.*, 525 U.S. at 444.

16 The distinction between plan design, which does not implicate a fiduciary duty, and plan
17 administration, which does, is illustrated by the two cases Plaintiffs cite. In *Caplan v. CNA Short*
18 *Term Disability Plan*, an employer created a conflict of interest by outsourcing the review of
19 benefits claims to a third-party that allegedly had a financial incentive to deny claims. 479 F.
20 Supp. 2d 1108, 1109 (N.D. Cal. 2007). Similarly, in *Finkelstein v. Guardian Life Ins. Co. Am.*, the
21 breach of fiduciary duty arose from the issuer of a benefit plan “systematically den[ying]
22 legitimate claims in an attempt to boost profits.” No. C 07-01130 CRB, 2007 WL 4287329, at *4
23 (N.D. Cal. Dec. 5, 2007). Reviewing benefits claims is a prototypical aspect of plan
24 administration. In contrast, deciding to adopt a particular prescription drug benefit plan is an
25 aspect of plan design, and “ERISA does not prohibit an employer from acting in accordance with
26 its interests as employer when not administering the plan.” *Kalda v. Sioux Valley Physician*
27 *Partners, Inc.*, 481 F.3d 639, 646 (8th Cir. 2007).

28 Second, Plaintiffs argue that Employer Defendants “are liable under ERISA for their

1 failure to monitor CVS in adopting this discriminatory Program.” Docket No. 121 at 12. “Failure
2 to monitor” was not expressly alleged as a claim in the complaint, but Plaintiffs now argue that the
3 claim is grounded in the allegation in FAC ¶ 103: “Amtrak, Lowe’s, and Time Warner have each
4 knowingly participated in CVS’s breach of its fiduciary duties through its agreement with CVS
5 subjecting members of its health plan to the Program,” and “having expressly agreed to subject its
6 members to the Program, each knew of CVS’s breach of its fiduciary duties and failed to make
7 reasonable efforts to remedy the breach.” To the contrary, it is clear that FAC ¶ 103 pertains to
8 Plaintiffs’ ERISA co-fiduciary claim, not a failure to monitor claim. The language of the
9 allegation echoes the language of 29 U.S.C. § 1105(a), which imposes co-fiduciary liability where
10 a fiduciary “participates knowingly in . . . an act or omission of such other fiduciary, knowing
11 such act or omission is a breach,” and where “he has knowledge of a breach by such other
12 fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach.”
13 Paragraph 103 is also sandwiched between FAC ¶ 102, which alleges that “[t]he employers . . . act
14 as co-fiduciaries with CVS,” and ¶ 104, which alleges that “CVS is also a co-fiduciary with each
15 of Amtrak, Lowe’s, and Time Warner in that CVS . . . had knowledge of the breach by each of
16 those employers and failed to make reasonable efforts to remedy the breach.”

17 Even if the allegation is construed as a “failure to monitor” claim, it is again a challenge to
18 the plan design packaged in another guise. Plaintiffs make clear that the “breach” at issue is CVS
19 and Employer Defendants’ “agreement” to provide a benefit plan that has terms Plaintiffs feel are
20 unfavorable. The challenge is to the Employer Defendants’ “decision regarding the form or
21 structure of the Plan” offered to employees. *Hughes Aircraft Co.*, 525 U.S. at 444. That decision
22 does not create a fiduciary duty.

23 In any case, “[t]he duty of an ERISA fiduciary to review the performance of its appointees
24 is a limited one. Specifically, a fiduciary must review the performance of its appointees at
25 reasonable intervals in such a manner as may be reasonably expected to ensure compliance with
26 the terms of the plan and statutory standards.” *In re Calpine Corp.*, No. C-03-1685 SBA, 2005
27 WL 1431506, at *6 (N.D. Cal. Mar. 31, 2005) (citing 29 C.F.R. § 2509.75-8, FR-17). Here,
28 Plaintiffs have not alleged any facts to show that Employer Defendants “failed to periodically

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1 review the performance of [CVS].” *Id.*

2 Third, Plaintiffs raise for the first time in their opposition brief, as they did against CVS,
3 the argument that Employer Defendants violated Section 510 of ERISA. That argument fails for
4 the same reasons as against CVS. *See* Part III.F.2, *supra*.

5 3. Co-Fiduciary Liability

6 Plaintiffs’ claim against Employer Defendants for co-fiduciary liability under ERISA fails
7 because CVS did not breach its fiduciary duties. *See* Part III.F.2, *supra*; 29 U.S.C. § 1105(a).

8 4. Full and Fair Review

9 It is not clear whether Plaintiffs are bringing the “full and fair review” claim against only
10 CVS or against all Defendants. There are allegations that three of the named Plaintiffs submitted
11 opt-out requests to both CVS and their employers. *See* FAC ¶ 220. But otherwise the complaint
12 attributes the lack of a full and fair review process solely to CVS. *See id.* ¶¶ 224–26. Plaintiffs
13 argue in their opposition to Lowe’s and Time Warner’s motions to dismiss that they pleaded the
14 “full and fair review” claim against Employer Defendants. *See* Docket No. 121 at 15.

15 Even if this claim was adequately plead against Employer Defendants, it fails for the same
16 reasons it fails against CVS. First, Plaintiffs are not entitled to the benefit of being able to opt out
17 of the Program under their plans, so Plaintiffs cannot be denied a full and fair review of an opt-out
18 request. Second, as noted above, Plaintiffs have not identified any procedural defects in the opt-
19 out process. *See* Part III.F.4, *supra*.

20 Accordingly, Employer Defendants’ motions to dismiss Plaintiffs’ ERISA claims is
21 **GRANTED without leave to amend.**

22 5. Declaratory Relief

23 Because Plaintiffs have not successfully stated claims for relief against Employer
24 Defendants under ERISA, their claim for declaratory relief is **DISMISSED.**

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1 **V. CONCLUSION**

2 For the foregoing reasons, CVS and Employer Defendants' motions to dismiss are
3 **GRANTED**. Plaintiffs' claims are **DISMISSED with prejudice**.

4 The Clerk is instructed to enter judgment and close the file.

5 This order disposes of Docket Nos. 87, 89, 97, and 113.

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7 **IT IS SO ORDERED.**

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9 Dated: December 12, 2018

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13 EDWARD M. CHEN
14 United States District Judge

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