NO. 20-16823, NO. 20-16857

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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

Plaintiffs-Appellees / Cross-Appellants,

v.

UNITEDHEALTH GROUP, INC.; UNITEDHEALTHCARE, INC.; UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTHCARE SERVICES, INC.; UMR, INC.,

Defendants-Appellants / Cross-Appellees.

Appeal from the United States District Court for the Northern District of California, No. 3:17-cv-00183-VC (Hon. Vince Chhabria)

THIRD BRIEF ON CROSS APPEAL FOR DEFENDANTS-APPELLANTS

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STATEMENT OF JURISDICTION

As explained in United's First Brief, this Court has jurisdiction over United's appeal from a final judgment. United agrees with Plaintiffs that this Court also has jurisdiction over Plaintiffs' cross appeal from a final judgment.

REPLY IN SUPPORT OF UNITED'S APPEAL

I. INTRODUCTION

ERISA Section 503 requires a court to assess a full and fair review claim by analyzing the course of communications between each plan member and the health plan.

United demonstrated in its opening brief that there is no genuine factual dispute that United substantially, if not fully, complied with Section 503's requirements with respect to each Plaintiff's full and fair review claim. With respect to all of the ERISA Plaintiffs,[1] United provided notices that explained the reason for its denial of the claim for benefits that "permitted a sufficiently clear understanding of the administrator's position to permit effective review." *Koblentz v. UPS Flexible Emp. Benefit Plan*, No. 12-CV-0107-LAB, 2013 U.S. Dist. LEXIS 121389, at *11 (S.D. Cal. Aug. 23, 2013) (citing *Brogan v. Holland*, 105 F.3d 158, 165 (4th Cir. 1997)).

In their response, Plaintiffs offer only meritless diversions. For example, failing to point to any law in support, Plaintiffs urge that the one-way intervention rule bars United's appeal because United moved for summary judgment before the class certification stage. This is a misstatement of the one-way intervention rule, which presents no barrier to United's appeal.

Further, Plaintiffs parrot the same reversible error of law that the district court made in its summary judgment and class certification rulings with respect to the remark

[1] United utilizes the same definitions contained in its opening brief.

code/full and fair review issue. Specifically, like the district court, Plaintiffs ignore the controlling standard that required the court to determine if each class member received a "meaningful dialogue" with United regarding the reasons for the claims denial. *Silver v. Exec. Car Leasing Long-Term Disability Plan*, 466 F.3d 727, 731 n.1 (9th Cir. 2006). The court was required to determine "under the circumstances of [each member's] case" whether the denial reasons United provided permitted a sufficiently clear understanding of the administrator's position to permit effective review." *Brogan*, 105 F.3d at 165; *see also Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1032 (9th Cir. 2006) ("substantial compliance" is what Section 503 requires); *Gravelle v. Health Net Life Ins. Co.*, No. C 08-04653 MHP, 2009 U.S. Dist. LEXIS 4929, at *23 (N.D. Cal. Jan. 23, 2009) (noting the appropriate question is whether the beneficiary was provided reasons for the denial that "under the circumstances of the case," permitted an effective review); *Koblentz*, 2013 U.S. Dist. LEXIS 121389, at *11 (citing *Brogan*, 105 F.3d at 165) (same); *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 382 (7th Cir. 1994) (same).

The evidence in the district court—which Plaintiffs do not rebut—was that the ERISA Plaintiffs understood what their denial codes meant. App. Dkt. 9 (United's Opening Appellate Br.) at 35–40.

Because the district court focused only on the content of the remark codes themselves and otherwise failed to examine the course of communications with the ERISA Plaintiffs or the class members, the court's summary judgment ruling cannot survive *de novo* review and it abused its discretion in certifying the Denial Letter Class.

II. ARGUMENT

A. The One-way Intervention Rule does not Preclude United's Appeal of the Portion of The Summary Judgment Order that Relates to the Remark Codes or Certification of and Injunctive Relief Directed to the Denial Letter Class.

As a threshold matter, Plaintiffs claim, without citation, that United cannot seek review of the district court's decisions relating to the remark Codes and Denial Letter Class because of the one-way intervention rule. App. Dkt. 18 (Pls.' Opening Appellee Br.) at 57 (United "has already waived the very challenge it seeks to improperly raise now."). This is misdirection—that rule has nothing to do with the claims that may be raised in this appeal.

The one-way intervention rule provides that a party who suffers a summary judgment before a class certification decision is bound from contesting the applicability of the summary judgment ruling to all class members if the district court later certifies a class. *Gessele v. Jack in the Box, Inc.*, No. 3:10-CV-960-ST, 2012 U.S. Dist. LEXIS 120377, at *7 (D. Or. Aug. 24, 2012) ("by filing a motion for summary judgment prior to class certification, the defendant accepts the potential unfairness of one-way intervention.").

The rule thus does not preclude a party from challenging on appeal the summary judgment ruling, and arguing that if the summary judgment is reversed, reversal of a class certification ruling that rested on the earlier summary judgment ruling also is required. Indeed, the statute that limits appellate review until there is a final order contemplates that an interlocutory order will be reviewed only later, after the final

order. 28 U.S.C. § 1291. This necessarily means that an error occurring at the summary judgment motion stage, even if that error is thereafter applied at the class certification motion stage under the one way intervention rule, will be reviewable only after the final order.

Here, United appeals both the summary judgment ruling and the class certification order. Thus, it challenges the erroneous ruling establishing the premise of liability that the district court then applied through the one-way intervention rule into the class certification ruling. United does not dispute that the summary judgment ruling must be applied to and is binding upon the class certification decision. But if the summary judgment ruling is reversed on appeal—as United has now demonstrated—then a fundamental premise of the class certification ruling must be reversed as well. The one-way intervention rule simply has no bearing on United's ability to pursue its appeal.

B. The District Court Failed to Consider Whether Each ERISA Plaintiff Or Class Member Received a Meaningful Dialogue under ERISA.

With respect to the merits of the full and fair review claim, Plaintiffs cite the ERISA regulations that apply and selectively cite from the controlling law of this Circuit interpreting those regulations. *See, e.g.*, App. Dkt. 18 at 57–58 (citing ERISA Section 1133(1) and *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1163 (9th Cir. 1997)). But Plaintiffs omit the dispositive and controlling standard for full and fair review: did

the administrator have a "meaningful dialogue" with the member? *Booton*, 110 F.3d at 1463 ("meaningful dialogue" is a "common sense standard").

Thus, the appropriate question is whether the administrator substantially complied with ERISA by providing the beneficiary with reasons for the denial that "under the circumstances of the case" permitted an effective review. *Gravelle*, 2009 U.S. Dist. LEXIS 4929, at *23. Plaintiffs fail to explain why this standard does not apply or how the district court's order can be reconciled with this standard. Instead, Plaintiffs argue that ERISA's command that a claim denial be "written in a manner calculated to be understood" eliminates the need to examine the course of communications with each claimant. But Plaintiffs notably cite no law for that erroneous assertion, and the case law United has cited—but which Plaintiffs fail to address—shows that the legal standard the district court applied was reversible error.

The district court failed to determine if each individual plaintiff received a meaningful dialogue. Because the evidence demonstrates each one did, moreover, the district court's decisions on summary judgment and class certification with respect to the remark codes must be reversed. *See, e.g.*, App. Dkt. 9 at 35–40 (demonstrating that each Plaintiff understood the remark code they received). Plaintiffs' claim that the remark codes were incomprehensible also stands in stark contradiction to their failure to identify better language in the Letter the district court required the parties to draft.

1. The District Court Applied an Incorrect Legal Rule in its Summary Judgment Ruling on the Full and Fair Review Claims, Then Made the Same Error of Law Again in Certifying The Denial Letter Class.

Courts in this circuit routinely examine the course of communications at issue in a particular case to determine whether a "meaningful dialogue" occurred and whether there was substantial compliance with ERISA's regulations. *Coleman v. Am. Int'l Grp., Inc.*, 87 F. Supp. 3d 1250, 1260–62 (N.D. Cal. 2015) (deficiencies in denial letter mitigated by subsequent communications); *Palmer v. Unum Life Ins. Co. of Am.*, No. C04-2735 MJJ, 2005 WL 1562800, at *4–5 (N.D. Cal. June 24, 2005) (examining entire appeals process in analyzing meaningful dialogue).

Even the cases Plaintiffs cite illustrate the need for an individualized analysis of a particular claim with respect to determining whether a "meaningful dialogue" took place. In *Saffon*, for example, the court went into detail about the various communications between the administrator and the member and determined that the administrator's communications to the member and her providers were not sufficient based on the facts of that case. *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 869–71 (9th Cir. 2008); *see also Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 676–80 (9th Cir. 2011) (same).

Plaintiffs do not dispute that the district court only discussed the content of the remark codes themselves and did not mention any of the other evidence in the summary judgment record regarding the ERISA Plaintiffs and their communications.

Thus, it is indisputable that the district court's summary judgment ruling did not analyze the entire course of communications between each named Plaintiff and United, and that its class certification analysis likewise presumed that an erroneously truncated inquiry into the single remark code writing alone sufficed to assess each class member's claim. Given the controlling law requiring consideration of the entire course of communications and the record evidence showing that the plan engaged in a meaningful dialogue with each named plaintiff, the summary judgment ruling cannot withstand *de novo* review.[2]

The same error of law establishes that the district court abused its discretion in certifying the full and fair review class. "A class certification order is an abuse of discretion if the district court applied an incorrect legal rule or if its application of

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2 Plaintiffs claim that their "contemporaneous experiences with the EOBs and communicating with [United] about their [lactation services] claims [] show [] that the Remark Codes are both impossible to understand and useless." App. Dkt. 18 at 59–60. In support, Plaintiffs point to "Section E" of their brief, yet Section E offers no such evidence. *See, e.g.*, App. Dkt. 18 at 24–25 (referring to Hoy's experience and, with respect to remark codes, merely reciting the remark code itself and providing no information about why the remark code was not understandable to her); *see also id.* at 26–27 (same regarding Condry); *id.* at 27 (same regarding Barber); *id.* at 25 (claiming that Endicott received a remark code indicating that her claim was denied because United had "asked the member for more information and didn't receive it on time" and that that information "directly conflicted" with a previous communication that told her she need not take any action at that earlier point in time; what Plaintiffs leave out is that Endicott's provider had contemporaneous communication asking the provider to provide more information about the coding the provider had included on Endicott's claim form and that the provider ignored the request.) *See* App. Dkt. 9 at 12–13. That is because there is none. As catalogued in United's opening brief, each code was comprehensible. *Id.* at 35–40.

the correct legal rule was based on a factual finding that was illogical, implausible, or without support in inferences that may be drawn from the facts in the record." (internal citation omitted.) *Sandoval v. Cnty. of Sonoma*, 912 F.3d 509, 515 (9th Cir. 2018). The district court applied an incorrect legal rule in assuming that the claims of each and every absent class member, including those whose claims decisions were amended, could be decided based on assessment of the remark codes alone and without examining the course of communications between United and each class member. The district court thus abused its discretion, so this Court should reverse the order certifying the Denial Letter class.

Plaintiffs assert that the cases United cites in its appeal do not support United's decision because they do not "address remark codes and the adequacy of claim denials . . . ." App. Dkt. 18 at 58. Plaintiffs fail to point to some other standard that would apply to remark codes. That is because there is no other standard. Substantial compliance with the "meaningful dialogue" standard is the controlling legal principle that applies here and in all full and fair review claims, including those involving remark codes. *Silver*, 466 F.3d at 731 n.1; *Gravelle*, 2009 U.S. Dist. LEXIS 4929, at *23 (noting the appropriate question is whether the beneficiary was provided the reasons for the denial that "under the circumstances of the case," permitted an effective review); *see also Chuck*, 455 F.3d at 1032 ("substantial compliance" under the circumstances of the case is required).

2. Plaintiffs Fail To Identify How the Remark Codes Could have Been More Comprehensible.

As United showed in its first brief, in addition to erroneously limiting the analysis of the full and fair review claims, the district court independently erred in ruling that United's remark codes were incomprehensible on their face. In their second brief on cross-appeal, Plaintiffs themselves demonstrate that the remark codes were understandable on their face by failing to show that the information contained in the remark codes is materially different than the information that Plaintiffs themselves proposed be contained in the Letter the district court ordered the parties to draft as injunctive relief for the Denial Letter Class. *See* 2-ER-44–48 (containing version of the Letter that contains both parties' proposed language and the language the parties had agreed to). In their responsive brief, Plaintiffs only address one of the codes in this regard—the KM code. Plaintiffs therefore concede that they were unable to identify any additional information with respect to the other three original remark codes that would make those statements more understandable to the plan's members. *See* App. Dkt. 18 at 61–62 (only referring to the description of the KM code in the Letter).

And as for the KM code, Plaintiffs only point to the fact that they had proposed language for the Letter that would tell members that their out-of-network claim was denied because their "provider was not eligible to bill the medical procedure code" and that they should resubmit the claim with a corrected code. *Id.*

at 62. But in their proposed Letter, Plaintiffs did not address their complaint with the original KM remark code. Their proposed Letter does not go into any detail about what a medical code is (because the provider will know) and it does not—because it cannot—identify the code that the member must supply on a corrected claim (because only the provider knows that information).[3] *See* 2-ER-44–48 (containing no explanation of what a medical code is). United cannot tell the provider how to bill the claim and, therefore, even with Plaintiffs proposed Letter, the member still has to ask the provider for information, leaving each class member in the exact same position each was in when each one received the original remark code itself.[4]

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[3] Plaintiffs assert that United's expert, Palma D'Apuzzo, acknowledged that KM code did not explain what a CPT or HCPCS code is or which particular CPT or HCPCS code was being referenced—but neither does the proposed Letter. App. Dkt. 18 at 31. Had this been a genuine issue for Plaintiffs, they would have certainly addressed it in the proposed Letter. But they did not. *See* 2-ER-44–48 (containing version of the Letter that contains both parties' proposed language and the language the parties had agreed to and failing to define CPT or HCPCS code).

[4] Plaintiffs assert that United made a "candid, material admission" in noting that the proposed Letter risks confusing class members by inviting them to resubmit claims despite there being no reason to believe their resubmitted claims will yield a different outcome." App. Dkt. 18 at 37–38. Plaintiffs claim United's statement is admitting that all out-of-network claims are denied based on United's lactation services policy. *Id.* at 38. That is baseless. None of the remark codes discussed in the proposed Letter indicate that the claims at issue were denied because the member had not utilized a network provider for lactation services. In other words, none of those claims were denied based on the failure of the member to utilize a network provider. The relevant remark codes discuss that the providers used the wrong coding, that the plan did not cover the nonmedical service (which in Barber's case was because what was being denied as a parenting class—not lactation services), and that the provider had not responded to United's request for more information about the coding the provider had included on the claim form. App. Dkt. 9 at 11–17. Plaintiffs' assertion that United

Plaintiffs further ignore that the general purpose of—and industry use of—remark codes is to provide brief explanations of why the claim processed in a certain way. 2-ER-301; 3-ER-517 ¶ 7; 3-ER-518 ¶ 9. For reasons of efficiency and functionality, the remark code is designed to provide enough information to the member or provider to understand the basis for the benefit determination. 3-ER-517–518 ¶¶ 7–9. United's concise remark codes are mapped to industry-standard codes, which are able to be used in United's automated systems. *Id.* at ¶ 14.[5] Here, it is notable that the longer explanations in the Letter do not provide more meaningful detail than the remark codes at issue already offer.

In short, Plaintiffs' inability to differentiate their proposed Letter from the original denial letters containing the remark codes themselves demonstrates that United met its obligation under ERISA with the original denial letters. Those original letters met those obligations because they told each member what additional information was necessary to perfect their claim.[6]

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was admitting that it denies all out-of-network lactation services claims based on its statement in its opening brief is belied by Plaintiffs' own data that indicates that United fully paid 12% of those claims. 1-ER-12–22 (Dec. 23, 2019 Order) at 5 and n.4 (1-ER-16). Plaintiffs' attempt here to grasp at straws to support their arguments should be rejected.

[5] Referring to http://www.wpc-edi.com/Codes.

[6] Plaintiffs claim that it is "plainly unreasonable for [United] to expect that its cryptic references to 'service codes' and 'CPT or HCPCS codes' could be viewed as an explanation 'calculated to be understood' by a claimant," App. Dkt. 18 at 61, but they agreed to the proposed Letter that referred to the exact same codes with no further

3. Plaintiffs' Other Arguments are Similarly Meritless.

Plaintiffs also argue that if United had "intended for Class members to then go ask their providers for more appropriate codes or information, then [United] should have said that." App. Dkt. 18 at 61. This argument fails because the unrebutted expert testimony in this case demonstrates that that is exactly what members do when provided with remark codes such as those in this case that raise medical issues, such as medical coding. Indeed, even testimony from Plaintiffs' own expert, Dr. Lauren Hanley, demonstrates that members seek out their provider for more information in these circumstances. App. Dkt. 9 at 40. Thus, "under the circumstances" where medical coding is the heart of the remark code, and where the provider is necessarily going to need to get involved to resolve the problem with the claim because the provider has the coding expertise, the remark codes were sufficient to communicate what the member needed to do to perfect her claim. *See Gravelle*, 2009 U.S. Dist. LEXIS 4929, at *23 (citing *Schneider v. Sentry Grp. Long Term Disability Plan*, 422 F.3d 621, 628 (7th Cir. 2005) (noting the appropriate question is whether a beneficiary was provided reasons for the denial that "under the circumstances of the case," permitted an effective review)).

Plaintiffs defend the district court's assumption that "[a]lthough subsequent communications may have resolved disputes about benefits, it does not change the

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explanation of what those are or what they mean. This sort of disingenuous argument should be disregarded.

fact that [United's] denial letters to these class members violated ERISA in the same way as to each participant." App. Dkt. 18 at 63. However, the unrebutted evidence that other members who received the same remark codes as the ERISA Plaintiffs contacted United to communicate with United about their claims denied with those codes demonstrates that dialogue was taking place as a result of the codes and supports reversal of the district court's decisions. App. Dkt. 9 at 11–12, 41–42. Barber, for example, plainly understood that United was telling her the service was not a medical one because she filed an appeal that recognized and understood the reason given for the claims denial and she challenged that reason. Barber admitted in deposition testimony that she understood United's explanation that her plan does not cover "non-medical service[s] or personal item[s]" to say that United was not covering the service because it was a parenting class. 4-ER-835 (Excerpts of F. Barber Dep. 219:7–24); 5-ER-931 (Apr. 29, 2016 EOB). Her understanding of the reason for the denial demonstrates that Barber received an explanation that meets the ERISA regulation standards. *See Brogan*, 105 F.3d at 166 (noting that the member's subsequent actions demonstrated that he received a "sufficient explanation" of the defect and that the explanation, therefore, "substantially complie[d]" with the [ERISA] regulation's requirements"). Courts have found substantial compliance with the "meaningful dialogue" standard where subsequent communications took place regarding the remark code. *Coleman*, 87 F. Supp. 3d at 1260–62 (deficiencies in denial letter mitigated by subsequent communications).

In sum, the district court was required to evaluate the entire course of communication between each plan member and United to determine whether a full and fair review occurred. The court's failure to evaluate the entire course of communications between each plan member and United infected the court's summary judgment ruling in favor of Plaintiffs, its decision to certify the Denial Letter Class, and its decision to award injunctive relief to that class. The substantive law does not provide that a plan violates ERISA if a remark code, viewed in isolation, is deemed inadequate. Rather, the substantive law holds that an ERISA violation occurs only if the parties' entire course of communications fails to meet the "meaningful dialogue" or "substantial compliance" standards. *Silver*, 466 F.3d at 731 n.1; *Chuck*, 455 F.3d at 1032; *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 972–73 (9th Cir. 2006); *Coleman*, 87 F. Supp. 3d at 1260–62 (deficiencies in denial letter mitigated by subsequent communications). United's remark codes sufficed to initiate meaningful dialogue making the district court's rulings reversible error.

If the district court's error is allowed to stand, ERISA participants and beneficiaries will have license to flood the courts with litigation any time any isolated portion of the course of communications is not perfectly clear—even though the complete record demonstrates that each member received a meaningful dialogue and hence that none suffered any harm. To avoid this absurd result and corresponding end run on Article III injury-in-fact requirements, this Court should reverse the

district court's summary judgment and class certification rulings with respect to the Denial Letter Class and full and fair review issues.

RESPONSE IN OPPOSITION TO PLAINTIFFS' CROSS-APPEAL

I. INTRODUCTION PERTAINING TO PLAINTIFFS' CROSS-APPEAL

Plaintiffs' cross appeal rests on the fundamental misinterpretation of the Affordable Care Act (the "ACA") that has plagued their claims from day one. To achieve its sweeping twin goals of expanding health care coverage while controlling the cost, the ACA drew upon the established managed care system in which negotiated contracts with networks of providers establish cost effective rates for health services, and health plan members are directed to obtain services from within the network of contracted providers. With regard to lactation support services, the ACA provides that health plans must cover such services without cost-shares (*i.e.*, deductibles, copayments, coinsurance) when a plan member obtains them from an in-network provider. Plans may, however, impose cost-shares on, or deny coverage for, out-of-network services so long as the member had a network provider available.

From the inception of this case, Plaintiffs have ignored the key distinction between in-network and out-of-network services and have maintained the legally erroneous position that any denial of coverage for out-of-network lactation services is a violation of law—regardless of whether the member had in-network services available. The district court, however, applied the correct interpretation of the ACA to individually examine at the summary judgment stage whether each named plaintiff

had available to that plaintiff in-network lactation support services. That individualized analysis yielded a summary judgment against named plaintiffs Rachel Condry ("Condry") and Felicity Barber ("Barber"), summary judgment in favor of two other named plaintiffs, and a finding of a triable issue of fact for two other named plaintiffs. That individualized analysis, along with the different outcomes it yielded, highlighted that Plaintiffs' class claims cannot be adjudicated on a common, non-individualized, basis.

As a result, the district court properly exercised its discretion to deny class certification—twice—of Plaintiffs' proposed nationwide, multi-year classes of present and former UnitedHealthcare ("United") members who allegedly did not obtain full coverage for lactation services under the ACA (the "ACA classes"). The evidence relating to each of Plaintiffs' two class certification motions below showed that the vast majority of women who submitted claims for lactation services received the services in-network, and that members were able to obtain in-network coverage for out-of-network services when appropriate. The wide availability of network providers, and of in-network coverage for out-of-network care, undermined Plaintiffs' assertion that the court could simply presume, without conducting the required individual inquiry, that all women who obtained out-of-network services and did not obtain coverage had suffered a violation of the ACA.

Because the applicable law and known facts required an individualized inquiry into why each putative class member sought services out-of-network and why

coverage was denied, the district court did not abuse its broad discretion in denying class certification.

Plaintiffs' cross appeal is tone deaf to the law and facts that supported the district court's exercise of discretion. For example, Plaintiffs falsely claim that this case involves a uniform policy to deny out-of-network lactation claims. The district court repeatedly noted how the evidence showed this was not the case, repeatedly queried how Plaintiffs' class certification theory could be squared with that evidence and gave Plaintiffs a second chance to retool their class certification theory to frame a viable one that did not flaunt the record evidence. Plaintiffs never addressed this problem, did not adjust their theory, and instead have simply lobbed the same flawed theory over to this Court.

United's approach to coverage for lactation services complies with the ACA and has provided full coverage to the vast majority of those who sought it. The minority of instances in which claims were denied or cost-shares imposed occurred for a variety of individual reasons. Equally unavailing are Plaintiffs' efforts to portray the district court's ruling as inconsistent with Ninth Circuit law and to undercut the court's rock-solid Article III standing analysis. Plaintiffs rely on misstatements of the facts and law, rather than any sound basis in Rule 23 for the portion of the order that they challenge. As discussed more fully in the argument section below, the Court should uphold the district court's denial of class certification with respect to the

ACA Classes and the district court's denial of summary judgment to Condry and Barber.

Plaintiffs also challenge the district court's denial of their motion late in the case for Teresa Harris ("Harris") to intervene as a plaintiff. Plaintiffs proposed Harris's intervention in a belated attempt to avoid the fact that no Plaintiff had standing to bring a claim for prospective relief. But Plaintiffs' motion for intervention was untimely and, in the words of the district court—"unfairly prejudicial" to United. On the merits, the court also noted that Harris's claim would not survive a motion to dismiss because she had not alleged that she had standing to bring the claim. Further, the court noted Harris could bring a suit in her own right, so she would not be prejudiced by not being allowed to intervene at the eleventh hour here.

To establish an abuse of discretion, Plaintiffs were required to demonstrate on appeal that all of the district court's stated grounds exceed the bounds of reason. Yet, Plaintiff have failed to demonstrate that any ground did so. The district court did not abuse its discretion, so this Court should affirm the portion of the lower court's rulings that Plaintiffs have challenged.

II. STATEMENT OF THE CASE REGARDING PLAINTIFFS' CROSS APPEAL

A. The ACA's Requirements.

The ACA requires health plans to cover without cost-sharing certain preventive services, including "comprehensive lactation support services," such as "counseling" and "education" during the antenatal, perinatal, and postpartum period. 42 U.S.C. § 300gg-13(a)(4); HRSA Guidelines.[7]

The ACA and HRSA do not elaborate as to what constitutes "comprehensive lactation support services" beyond "counseling" and "education."

Health plans have discretion to adopt billing codes that pay at no cost-share for lactation services and to use "reasonable medical management techniques to determine the frequency, method, treatment, or setting" for coverage. 29 C.F.R. § 2590.715-2713(a)(4). Plans also may deny coverage for, or impose cost-shares on, services rendered by out-of-network providers, so long as those health plans have in-network providers who offer the services. 29 C.F.R. § 2590.715-2713(a)(3)(i)-(ii). Only when a plan does not have in-network providers must the plan cover out-of-network care without cost-shares.[8] *Id.*

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[7] https://www.hrsa.gov/womens-guidelines-2019.

[8] Plaintiffs mischaracterize the ACA's requirements with respect to out-of-network claims asserting erroneously that out-of-network claims must be covered without cost-shares in every instance. App. Dkt. 18 at 43. But the ACA's regulations plainly allow for payors such as United to impose cost-shares on out-of-network claims when the payor has network providers in its networks. § 2590.715-2713(a)(3)(i)-(ii).

B. United's Coverage of Lactation Services Comports with the ACA.

In accordance with the ACA, United follows the rule that in-network services are presumptively covered, but out-of-network services are not necessarily so. *See* 29 C.F.R. § 2590.715-2713(a)(3)(i)-(ii). United provides coverage without cost-shares for lactation services when rendered by an in-network provider. 2-SER-149–192 (Oct. 1, 2018 Preventive Care Services Coverage Determination Guideline ("CDG")). United has thousands of in-network providers of lactation services, with OB/GYNs, pediatricians, and lactation specialists making up the majority of these providers. FER-50–82 (Dec. 11, 2018 Expert Report of Joao dos Santos) ¶ 31 (FER-60); *see also* 3-ER-535–541 (May 23, 2019 Order on Original Class Motion) at 4 (3-ER-538) (district court acknowledging that pediatricians and OB/GYNs provide lactation services). Thus, the vast majority of plan members who sought lactation services received them in-network and obtained coverage for them without cost-shares. FER-50–82 (Dec. 11, 2018 Expert Report of Joao dos Santos) ¶ 19(a) (FER-56).

The number and location of network providers vis-à-vis United's members varies by geographic region and depends, in part, on federal and state-specific network adequacy laws, which identify the number of providers with whom health plans must contract to maintain sufficient networks.[9] Similarly, federal and state-law

[9] *See, e.g.*, 10 CCR § 2240.1 (listing California's requirements for "adequacy and accessibility of provider services"); 28 Tex. Admin. Code § 11.1607 (similar for Texas for HMOs). Such laws may distinguish between different geographic regions within

rules differ with respect to member notification requirements, such as provider directories, and the particular requirements may vary by plan type.[10]

Women receive lactation services from various provider types—including OB/GYNs, pediatricians, and lactations specialists—throughout their pregnancy, during the hospitalization associated with delivery, and during expected postpartum visits. FER-37–49 (Dec. 11, 2018 Henry Lee Expert Report) at 8 (FER-47); *see also* 2-ER-227–293 (L. Hanley Dep. Tr.) at 102:25–103:13 (2-ER-254). And, to facilitate in-network care, United directs members to network providers, including through United's provider directory, which is available online and in print. FER-140–144 (Mar. 18, 2019 Dietz Decl.) ¶¶ 4–21 (FER-141–43). Further, United's customer service representatives encourage members to work with their primary care providers to obtain the services they need. FER-158–164 (Member Services Breast Pump Benefit SOP) at UHC_003920 (FER-163). If in-network providers are unavailable within a certain distance of members' zip codes, depending on their plan, members may be eligible to receive the in-network level of benefits for out-of-network services—including ACA-mandated services—through United's "gap exception"

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states, requiring, for example, a higher concentration of providers in urban, as opposed to rural, areas. *See, e.g.*, 28 Pa. Code § 9.679(d)-(e) (identifying different adequacy requirements for counties designated as metropolitan statistical areas and other counties).

10 *See, e.g.*, Cal. Code Regs. tit. 10, § 2240.6 (identifying provider directory requirements for network providers); Cal. Health & Safety Code § 1367.27 (similar); 28 Pa. Code § 9.681 (similar); 29 C.F.R. § 2520.102-3 (listing requirements applicable to summary plan descriptions for ERISA plans).

process. FER-131–136 (Mar. 20, 2019 Cappiello Decl.) ¶¶ 4, 17, 24, 26 (FER-132, 134–136). Members may also appeal claim denials. FER-137–139 (Mar. 19, 2019 Seay Decl.) ¶ 8 (FER-138).

United's claims data confirms that tens of thousands of members found and received lactation services in-network during the class period. FER-50–82 (Dec. 11, 2018 Expert Report of Joao dos Santos), ¶ 19(a) (FER-56). In fact, the overwhelming majority of women who submitted claims using United's coding guidance between 2012 and mid-2018 received the services in-network from various provider types and obtained coverage without cost-shares, both over time and across markets.[11] *Id.*

Because lactation services can be very personal, they are the type of services that might prompt many patients to choose a personally selected, but only partially covered, out-of-network provider instead of an available and fully covered in-network provider. Regardless, even including those who may have personally chosen to go out-of-network despite having fully covered services available to them, approximately 73% of adjudicated lactation claims during this time period involved services by network providers, with approximately 83% of those claims being

[11] Plaintiffs assert that United's coding guidance was too narrow, but the ACA does not dictate coding for lactation services and Plaintiffs have not disputed that the codes their own purported expert recommended could be utilized under United's coding guidance. FER-4–16 (Defs' Reply in Support of Daubert Motion Concerning the Expert Testimony and Opinions of Dr. Lauren Hanley in Connection With Plaintiffs' and Intervenor Plaintiff's Renewed Motion for Class Certification) at 4 (FER-10).

covered without cost-shares. *Id.* ¶¶ 19(a), 32–33 (FER-56, 61). OB/GYNS, pediatricians, and lactation specialists were responsible for 63% of total claims. *Id.* ¶ 31 (FER-60). Additional members likely received lactation services through global billing and post-partum wellness visits, which do not appear in Defendants' claims data in a manner that can be identified as lactation services. *Id.* at 16 n.17 (FER-66); *see also* 2-ER-227–293 (L. Hanley Dep. Tr.) at 172:24–173:14 (2-ER-271); FER-145–157 (D'Apuzzo Am. Expert Report) ¶ 27 (FER-152). Further, some members unable to locate a network provider obtained gap exceptions, and others have successfully appealed claim denials. FER-131–136 (Cappiello Decl.) ¶¶ 17, 24, 26 (FER-134–136); FER-137–139 (Mar. 19, 2019 Seay Decl.) ¶ 8 (FER-138).

C. Plaintiffs Sue; After Analyzing Evidence Individual to Each Plaintiff, The District Court Grants Summary Judgment to Two Plaintiffs, Grants Summary Judgment Against Two, And Finds A Triable Issue For Two.

Plaintiffs Condry, Hoy, Endicott, Bishop, Barber, and Carroll (collectively, "Plaintiffs") are current or former members or beneficiaries of health plans administered by United who filed this action, contending United violated the ACA when it denied them coverage for, or imposed cost-shares on, out-of-network lactation services. *See, e.g.*, 6-ER-1214–1290 (Sept. 5, 2017 2d Am. Compl., ¶ 212 (6-ER-1281)).

After the district court dismissed some claims at the pleading stage and the parties completed discovery, the court ruled on the parties' cross-motions for

summary judgment. It assessed the circumstances of each named Plaintiff, analyzing factors such as whether each Plaintiff attempted to locate in-network providers, whether "nearby" providers were available, and the nature and extent of each named Plaintiff's contacts with customer service. 1-ER-23–31 (Summ. J. Order) at 3–5 (1-ER-25–27). Based on this individualized analysis, the court granted summary judgment in Hoy's and Bishop's favor; granted summary judgment in favor of United with respect to Condry and Barber; and denied summary judgment with respect to Endicott and Carroll.[12] *Id.*

The district court found that there was unrebutted evidence that both Condry and Barber had a network lactation specialist located near them but that neither had sought out services from those providers. *Id.* at 4. Thus, they chose to seek out-of-network providers and were not forced to do so because they could not find a network provider.

D. The First Class Certification Ruling.

Plaintiffs subsequently moved for class certification. 4-ER-701–735 (Original Cert Mot.). The district court denied that motion without prejudice on May 23, 2019. 3-ER-535–541 (May 23, 2019 Original Class Order).

As the court explained, the classes consisted of "all people denied lactation

[12] The only other federal court to consider similar ACA claims at summary judgment employed a similarly individualized analysis and granted summary judgment, and the Eighth Circuit affirmed. *See York v. Wellmark, Inc.*, No. 4:16-cv-00627, 2019 WL 1493715, at *4–6 (S.D. Iowa, Feb. 28, 2019), *aff'd, York v. Wellmark, Inc.*, 965 F.3d 633, 636 (8th Cir. 2020).

coverage … whether in-network or out-of-network." *Id.* at 2 (3-ER-536). This was problematic, because "[n]o evidence was presented … to suggest that the claim of a person … for out-of-network services is similar to the claim of a person who was denied coverage in-network." *Id.* at 3 (3-ER-537). Even limiting the classes to out-of-network claimants, there was no "evidence that [United] uniformly applied an unlawful policy to out-of-network claims." *Id.* at 3–4 (3-ER-537–38). The court also observed that the Plaintiffs with active ACA claims lacked Article III standing to seek prospective relief "because they [were] no longer … plan participants." *Id.* at 4 (3-ER-538). Nevertheless, the court exercised "its discretion to grant the plaintiffs leave to take another shot at class certification." *Id.* at 1, 6 (3-ER-535, 540). Plaintiffs had the opportunity to conduct additional discovery. *Id.* at 6 n.2 (3-ER-540); *see also* FER-34–36 (June 26, 2019 Order Regarding Discovery Dispute).

E. The Rulings on the Motion to Intervene and Renewed Motion for Class Certification.

1. The Intervention Ruling.

On September 9, 2019, Plaintiffs moved to intervene, seeking to add Harris—a current United beneficiary—as a named Plaintiff in an effort to cure their standing deficiency. 3-SER-429–449 (Pls.' Mot. to Grant Request for Intervention). The district court had warned Plaintiffs about this deficiency a year-and-a-half prior to the intervention motion, at the pre-class certification summary judgment hearing. FER-165–172 (April 26, 2018 Hr'g Tr.) at 17:1 (FER-171). In denying Plaintiffs' first class

certification motion, the court further warned Plaintiffs that "[i]t does not appear that the named plaintiffs have standing to seek prospective relief because they are no longer [United] plan participants. 3-ER-535–541 (May 23, 2019 Order) at 4 (3-ER-538). Despite these warnings, Plaintiffs waited to have Harris move to intervene until six months after discovery had closed in the case. FER-173–177 (Oct. 9, 2018 Stipulation and Order to Extend Scheduling Order Deadlines) (discovery closed March 29, 2019) (FER-175).

On December 19, 2019, the district court denied Plaintiffs' motion, explaining that Plaintiffs had failed to add a named Plaintiff qualified to seek prospective relief, notwithstanding repeated warnings from the court regarding that issue. 1-SER-2–3 (Order Denying Mot. Intervene). The court added that "the proposed complaint-in-intervention d[id] not allege facts that would give Harris standing to seek prospective relief," because "[a]lthough she allege[d] that she was improperly denied coverage for out-of-network services and that she continues to be a … plan participant, she include[d] no allegations about the likelihood that she will need lactation services in the future." *Id.* at 2 (1-SER-3). The court further found that the intervention motion was untimely and would be "unfairly prejudicial" to United because of the posture of the case and the fact that more discovery would be needed, but discovery had closed. *Id.*

2. The Renewed Class Certification Ruling.

Simultaneous with their motion to intervene, Plaintiffs renewed their motion

for class certification limiting their proposed classes to out-of-network claimants. 3-ER-478–514 (Sept. 9, 2019 Renewed Cert. Mot.) at 14–15 (3-ER-500–501). Their primary theory was that United applied a "blanket policy" to out-of-network claims. *Id.* at 1 (3-ER-487).

In response, United submitted claims data and other evidence demonstrating that thousands of members found and received lactation services from in-network providers and obtained coverage for those services without cost-shares, across markets and over time. 2-ER-196–226 (United's Opp'n to Renewed Cert. Br.) at 8–9 (2-ER-208–09); FER-17–32 (Oct. 21, 2019 Decl. of Joao dos Santos) ¶ 9(b)-(d) (FER-19). Other members unable to locate a network provider obtained in-network coverage for out-of-network services through United's "gap exception" or appeals processes. 2-ER-196–226 (United's Opp'n to Renewed Cert. Br.) at 9 (2-ER-209). Thus, most members were aware of and able to obtain in-network lactation services without cost-shares or, at a minimum, in-network coverage for out-of-network services. *Id.* at 15–16 (2-ER-215–216). The evidence showed that each denial of, or cost-share imposed on, out-of-network claims resulted from a variety of individualized reasons, so individual inquiries were required to assess the claims of ACA violations. *Id.*

In its order denying Plaintiffs' renewed motion, the district court began by observing that "none of the named plaintiffs … has standing to seek prospective injunctive relief," leaving Plaintiffs "to seek certification of … a class consisting of all

people denied coverage for out-of-network lactation services for the purpose of ordering … United … [to] reprocess their claims." 1-ER-12–22 (Dec. 23, 2019 Order) at 3 (1-ER-14). With respect to this reprocessing theory, however, Plaintiffs sought to include not only those "who received out-of-network … services, [and] submitted claims," but also those who "never submitted claims at all." *Id.* at 4 (1-ER-15). It made "no sense to include the second group … when the asserted purpose … is to obtain reprocessing of those clams." *Id.*

Even considering only those putative class members who submitted out-of-network claims, Plaintiffs had "not met their burden of demonstrating that United … applied a uniform standard or practice." *Id.* United "hotly contested" Plaintiffs' analysis of United's claims data (which was performed solely by Plaintiffs' counsel and unsupported by expert testimony), but even that analysis indicated that United fully paid 12% of out-of-network claims. *Id.* at 5 & n.4 (1-ER-16). The district court questioned how United could have applied a uniform policy to out-of-network claims when it fully paid some of them and observed that Plaintiffs had "not presented evidence that would allow the Court to reach a conclusion, or even to make an estimate." *Id.* at 5, 8 (1-ER-16, 19). The court discussed potential explanations for the 12% figure and concluded that "the data and evidence … doesn't come close to proving that United … failed to comply with the ACA in a uniform way." *Id.* at 11 (1-ER-22). This was especially true given that Plaintiffs sought to certify a nationwide class, as "the experiences of proposed class members may have varied by plan, or by

region, or both." *Id.* at 8 (1-ER-19).

III. SUMMARY OF ARGUMENT IN OPPOSITION TO PLAINTIFFS' CROSS-APPEAL

The district court correctly granted summary judgment against Condry and Barber because they had not even tried to avail themselves of any in-network services. The individualized summary judgment analysis that the court applied to these plaintiffs' claims, and those of the other named plaintiffs, also demonstrated the kind of individualized analysis that would be required to adjudicate the claims of the putative ACA Classes in this case. Given the individualized analysis required, the district court did not abuse its discretion in denying class certification.

The court also correctly found that—based on longstanding precedent—none of the Plaintiffs with active ACA Claims following summary judgment had standing to seek prospective relief. The court did not abuse its discretion in rejecting Plaintiffs' effort to remedy this lack of standing through a belated intervention motion. That motion was untimely. Moreover, the claims of the putative intervenor, Harris, would have been dismissed because she too lacked standing to seek prospective relief because she had not demonstrated that she would be injured in the future by United's purported policies relating to ACA.

IV. ARGUMENT IN OPPOSITION TO PLAINTIFFS' CROSS APPEAL

A. Standard of Review

The district court's rulings denying the motion for class certification and the renewed motion for class certification are reviewed for abuse of discretion, as is the court's ruling denying Plaintiffs' motion for Harris to intervene. *See Lozano v. AT&T Wireless Servs. Inc.*, 504 F.3d 718, 725 (9th Cir. 2007) (citing *Valentino v. Carter-Wallace, Inc.*, 97 F.3d 1227, 1234 (9th Cir. 1996)). "A class certification order is an abuse of discretion if the district court applied an incorrect legal rule or if its application of the correct legal rule was based on a factual finding that was illogical, implausible, or without support in inferences that may be drawn from the facts in the record. . . . ." *Sandoval*, 912 F.3d at 515.

The district court's summary judgment and Article III standing rulings are reviewed *de novo*. *See Regula v. Delta Family-Care Disability Survivorship Plan*, 226 F.3d 1130, 1138 (9th Cir. 2001) (citing *Moran v. Washington*, 147 F.3d 839, 844 (9th Cir. 1998)); *Lozano*, 504 F.3d at 725. This Court must determine whether the evidence, when viewed in a light most favorable to the non-moving party, raises any genuine issues of material fact and whether the district court correctly applied the substantive law. *See Regula*, 226 F.3d at 1138 (*citing Berry v. Valence Tech., Inc.*, 175 F.3d 699, 703 (9th Cir. 1999)).

B. United Met its Obligations to Condry and Barber Under ACA Because They Had Access to Network Providers.

The grant of summary judgment against Condry and Barber should be upheld because they failed to demonstrate any wrongdoing on United's part that caused a denial to an ACA-protected benefit. As noted above, ACA's implementing regulations allow plans and insurers to deny coverage for, or impose cost-shares on, the ACA-mandated preventive services if members or insureds receive them out-of-network, so long as those plans and insurers have in-network providers who offer the services. 29 C.F.R. § 2590.715-2713(a)(3)(i)-(ii) (a plan or insurer may deny coverage or impose cost-shares when it has "in its network a provider who can provide an item or service").

As the district court highlighted in its summary judgment ruling, both Condry and Barber chose to go to an out-of-network provider and never attempted to look for an in-network option, even though the unrebutted evidence demonstrated they had in-network options available to them. 1-ER-23–31 (Summ. J. Order) at 4 (1-ER-26). Based on this undisputed evidence, the district court concluded that United "had no obligation to cover out-of-network care" for either Condry or Barber. *Id.* The decision is correct, in accord with ACA, and thus should be upheld.

Plaintiffs incorrectly argue on appeal that the district court erroneously "determined that [United's] policies and conduct were not at issue" and that the court "did not make any findings or determinations as to whether [United's purported

policy] complied with the ACA." App. Dkt. 18 at 54. The district court plainly adjudged each Plaintiff's ability to access network providers and whether United could impose cost shares as a result of their failure to do so against the ACA's requirements, as noted in the opinion. 1-ER-23–31 (Summ. J. Order) at 2 (2-ER-24) (citing ACA's provisions and regulations).

With respect to Plaintiffs Hoy and Bishop, for example, the district court determined that both had tried to utilize network providers, but were unable to locate such services thereby entitling them to summary judgment on their ACA claims against United. 1-ER-23–31 (Summ. J. Order) at 4 (1-ER-26). Plaintiffs have accepted the district court's ruling in favor of Hoy and Bishop, but challenge the exact same analysis that the district court applied to Condry and Barber, simply because the court's analysis in the latter instances yielded an outcome not to Plaintiffs' liking. It is disingenuous for Plaintiffs to accept the application of this analysis to Hoy and Bishop, but not to Condry and Barber.

This Court should affirm the summary judgment with respect to Condry and Barber.

C. The District Court did not Abuse its Discretion in its Class Certification Rulings.

As the summary judgment ruling shows, determining United's liability as to each putative class member requires a granular, fact-bound analysis that precludes class certification of a class. 1-ER-23–31 (Summ. J. Order) at 3–5 (1-ER-25–27).

Given the individualized nature of the analysis, the district court did not abuse its discretion in finding that Plaintiffs failed to meet their burden to justify class certification.

1. The Evidence Permitted the District Court to Find that Plaintiffs Failed to Meet Their Burden to Establish A Uniform Policy That Injured The Class.

Plaintiffs fail to demonstrate an abuse of discretion by the district court with respect to either of its denials of class certification.

Plaintiffs bore the burden to demonstrate a common injury among class members. *See Thomasson v. GC Servs. Ltd. P'ship*, 539 F. App'x 809, 810 (9th Cir. 2013) (plaintiffs must submit "significant proof that the … class suffered a common injury"). The record evidence here, however, easily permitted the district court to find that Plaintiffs did not meet this burden. As discussed, the vast majority of women who submitted claims billed in accordance with United's coding guidance received lactation services in-network and obtained coverage without cost-shares. 2-ER-196–226 (United's Opp'n to Renewed Cert. Br.) at 8–9 (2-ER-208–209). The court thus could not assume every denial of, or cost-share imposed on, out-of-network claims resulted from conduct that violated the ACA. *Id.*

Rather, individualized inquiries would be required to determine whether any putative class members had been injured, and if so, which ones. *Id.*; 1-ER-12–22 (Dec. 23, 2019 Order) at 7–8 n.7 (1-ER-18–19). Plaintiffs did not identify any common method for establishing injury. As the district court noted, "the evidence [Plaintiffs]

submitted . . . in connection with both rounds of class certification briefing as well as the cross-motions for summary judgment as to the named plaintiffs . . . does not demonstrate a uniform standard or practice. If anything, the evidence undermines the plaintiffs' assertion that a uniform standard or approach existed with respect to coverage for out-of-network lactation services." 1-ER-12–22 (Dec. 23, 2019 Order) at 4 (1-ER-15).

Barber and Condry further illustrate this failure of proof. It is undisputed that, not only did they not attempt to locate network providers, but there were network providers available to them. 1-ER-23–31 (Summ. J. Order) at 4 (1-ER-26). Thus, these named Plaintiffs fell within the class definition, but as the district court found on summary judgment when examining their individual circumstances, they were *not* injured. *Id.* (noting that United had no obligation to provide coverage for out-of-network care under the ACA). Plaintiffs did not demonstrate any reliable classwide method for identifying who else within the putative class was not injured. 1-ER-12–22 (Dec. 23, 2019 Order) at 4 (1-ER-15). The only method that appeared from the record would be to conduct the individualized analysis that the court deployed in adjudicating the cross-motions for summary judgment. 1-ER-23–31 (Summ. J. Order) at 4–5 (1-ER-26–27). Again, no abuse of discretion appears.

Plaintiffs argue the district court abused its discretion because United supposedly applied a uniform policy "irrespective of whether [a claim] was an in- or out-of-network [lactation services] claim." App. Dkt. 18 at 43. Plaintiffs claim the

"class certification inquiry should have ended there, as required under Rule 23(b)(1) and/or (2)." *Id.*

This is an inaccurate statement of the relevant facts and law. As a threshold matter, Plaintiffs misstate the ACA and its requirements. Plaintiffs wrongly assert that "the ACA required [United] to provide all of its insures in non-grandfathered, non-federal health benefit plans with cost-share-free coverage" of lactation services. *Id.* But as shown, the ACA only requires cost-share-free coverage if a member sees a network provider or if a network provider was unavailable to the member causing them to have to utilize an out-of-network provider. § 2590.715-2713(a)(3)(i)-(ii).

Based on their faulty reading of the ACA and its regulations, Plaintiffs misstate United's policy. At oral argument, the district court correctly observed that United's approach tracks "the default rule under the Affordable Care Act." 2-ER-49–172 (Nov. 21, 2019 Hr'g Tr.) at 6:14–17 (2-ER-54). This means, as noted above, that in accordance with the ACA, United follows the rule that in-network services are presumptively covered, but out-of-network services are not necessarily so. *See* 29 C.F.R. § 2590.715-2713(a)(3)(i)-(ii). United thus expects its members to seek services through one of the many fully covered in-network options available, and it also has two processes (gap exceptions and appeals) through which members who are unable to find services in-network can obtain coverage for out-of-network services. 2-ER-196–226 (United's Opp'n to Renewed Cert. Br.) at 9, 15–16 (2-ER-209, 215–216). It is only when a member goes out-of-network and does not follow the processes for

obtaining coverage for such services that some members have suffered coverage denials.

In the limited category of cases where a member obtains services out-of-network, even Plaintiffs' own incompetent, inadmissible and erroneous analysis of the data conceded that United fully paid at least 12% of out-of-network lactation claims.[13] 1-ER-12–22 (Dec. 23, 2019 Order) at 5 (1-ER-16). While they quibble with the district court's correct refusal to deem United's practices a "blanket policy" (App. Dkt. 18 at 44), Plaintiffs do not and cannot explain how United could apply a "uniform policy" to out-of-network claims yet fully pay some of those claims. 1-ER-12–22 (Dec. 23, 2019 Order) at 4 (1-ER-15); *see Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 355 (2011) (explaining that "[t]he only corporate policy" was the lack "of a uniform … practice"). Plaintiffs cannot explain this because United did not apply a uniform policy. Rather, as the district court observed, United correctly applied the "default rule" under the ACA in presumptively covering in-network claims, but covering out-of-network claims only when the member could not obtain the services in-network.

In short, relying on their misguided interpretation of the ACA and its regulations, Plaintiffs did not meet "their burden of demonstrating that United …

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[13] The district court noted that Plaintiffs' data was "hotly contested" and that there were "reasons to suspect" that it was not admissible. 1-ER-12–22 (Dec. 23, 2019 Order) at FN4. The district court assumed the data's admissibility for the sake of argument and for purposes of its ruling only. *Id.*

applied a uniform standard or practice." 1-ER-12–22 (Dec. 23, 2019 Order) at 4 (1-ER-15).

Plaintiffs also argue the district court "erroneously ruled on the merits of [United's] policy." App. Dkt. 18 at 44. This is also incorrect. In observing that United's approach tracks "the default rule under the Affordable Care Act" 2-ER-49–172 (Nov. 21, 2019 Hr'g Tr.) at 6:14–17 (2-ER-54), the court's point simply was that United's approach did not eliminate the need for individualized inquiry in cases involving out-of-network services. *See id.* at 88:3–6 (2-ER-136) ("where the rubber hits the road is what happened to these claims").[14]

In finding that United's policy tracked the "default rule" under the ACA, the district court did not "disregard or misunderstand[] the language [of the policy]" as Plaintiffs contend. App. Dkt. 18 at 39. Instead, the court was acknowledging something that the evidence bore out—that United would cover network providers without cost shares and that it would impose cost shares on out-of-network claims when the ACA allowed it to do so. 2-ER-49–172 (Nov. 21, 2019 Hr'g Tr.) at 6:14–17

[14] Plaintiffs erroneously claim that "the evidence" in the case was that United "did not have available network providers who provided [lactation services.]" App. Dkt. 18 at 39. Plaintiffs have no basis whatsoever for this claim. *See supra* at 22–25 (noting the breadth of United's network as demonstrated by the claims data). Plaintiffs also claim that the tools United provided members to locate in-network providers who provided lactation services were "useless" (App. Dkt. 18 at 2), but that is belied by the undisputed fact that the tool identified network providers for both Condry and Barber, who had not bothered to utilize any tools to find a network service. 1-ER-23–31 (Summ. J. Order) at 4 (1-ER-26) (noting that neither looked for an in-network provider).

(2-ER-54). The court's findings in this regard were not "implausible" or based on "unsupported inferences." App. Dkt. 18 at 40. In fact, the evidence supported them in their entirety.

Equally unpersuasive is Plaintiffs' argument that the district court erred in its statement that "the experiences of proposed class members may have varied by plan, or by region, or both." 1-ER-12–22 (Dec. 23, 2019 Order) at 8 (1-ER-19); App. Dkt. 18 at 45. Plaintiffs misconstrue the district court's concern. While the ACA's requirements apply to all class members, the court's point was "that different approaches to ACA compliance" may have been "taken for different plans or in different regions." 1-ER-12–22 (Dec. 23, 2019 Order) at 9 (1-ER-20). The court was right to question whether these potentially differing approaches preclude certification of a nationwide class. *See Dukes*, 564 U.S. at 350 ("Dissimilarities within proposed classes … have the potential to impede … common answers.").

2. The District Court Faithfully Applied This Circuit's Law.

The district court broke no new legal ground in rejecting Plaintiffs' class certification theories. Yet, Plaintiffs claim that the district court's order ran afoul of *Wolin v. Jaguar Land Rover North America, LLC*, 617 F.3d 1168 (9th Cir. 2010) and *Parsons v. Ryan*, 754 F.3d 657 (9th Cir. 2014). App. Dkt. 18 at 45–48. This is another misstatement of the law.

In *Wolin*, this Court determined that class certification was appropriate in a manufacturing defect case where the defect had not manifested in a majority of the

class members' vehicles. *See Wolin*, 617 F.3d at 1173. This Court explained that, under the warranty laws at issue, the existence of a defect would uniformly injure all class members, regardless of whether it ultimately manifested. *See id.* Similarly, in *Parsons*, this Court determined class certification was appropriate in a case challenging policies and practices that allegedly "expose[d] all inmates … to a substantial risk of serious harm." *See Parsons*, 754 F.3d at 676. This Court explained that, if proven on the merits, the alleged risk of harm would violate the Eighth Amendment as to all class members, regardless of individual circumstances. *See id.*

Unlike the laws at issue in *Wolin* and *Parsons*, the ACA does not permit a classwide assessment of injury, irrespective of individual circumstances. Under the ACA provisions at issue here, it is those individualized circumstances that determine whether any given class member has suffered any injury in the first place. Thus, the impact of an alleged policy on any member in terms of liability, remedies, and available defenses would vary depending on each class member's circumstances and preclude a finding of class-wide injury.[15] *See Thomasson*, 539 F. App'x at 810 (claim

[15] Two other Ninth Circuit cases cited by Plaintiffs do not counsel a different result here. For example, in *Abdullah v. U.S. Security Assoc., Inc.*, this Court determined that the legality of the employer's meal break practice was a common issue that was "apt to drive the resolution of the litigation." 731 F.3d 952, 962 (9th Cir. 2013). Similarly, in *Jimenez v. Allstate Insurance Co.*, 765 F.3d 1161, 1165–66 (9th Cir. 2014), this Court found that the employer's practice of requiring unpaid off-the-clock overtime presented a common issue. Here, Plaintiffs miscast the facts, claiming there was a uniform policy to fail to pay cost shares that applied to all putative class members, when it is evident that the majority of women who received lactation services had their claims reimbursed in full and thus were not harmed at all. *See supra* at 22–25.

"would require an individualized inquiry" into each class member's circumstances).

3. Non-Binding, Dissimilar District Court Cases Do Not Warrant Overturning The Class Certification Rulings.

Similarly deficient is Plaintiffs' argument that the certification ruling is inconsistent with purportedly analogous district court decisions. *See* App. Dkt. 18 at 49–51. Each of Plaintiffs' cited cases involved challenges to uniform policies that, under the applicable substantive law, subjected class members to the same injury. *See, e.g.*, *Trujillo v. UnitedHealth Group, Inc.*, No. ED CV 17-2547-JFW (KKx), 2019 WL 493821, at *1, 4–7 (C.D. Cal. Feb. 4, 2019) (denials of coverage for prosthetics breached the terms of the plans); *Des Roches v. Cal. Physicians' Serv.*, 320 F.R.D. 486, 497–504 (N.D. Cal. 2017) (guidelines allegedly did not "comport with general accepted standards" and uniformly injured class members as a result); *Escalante v. Cal. Physicians' Serv.*, 309 F.R.D. 612, 618 (C.D. Cal. 2015) (same for lumbar artificial disc replacement surgery exclusion that applied to the entire class); *Keegan v. Am. Honda Corp.*, 284 F.R.D. 504, 521–22 (C.D. Cal. 2012) (entire class had purchased vehicles with faulty rear suspension); *In re Conseco Life Ins. Co. LifeTrend Ins. Sales & Mktg. Litig.*, 270 F.R.D. 521, 529–30 (N.D. Cal. 2010) (entire class was subject to the same allegedly harmful contract language). These common attributes allowed the district courts to certify classes on the theory the uniform policies were facially unlawful.

Even when the district court focused only on out-of-network claims, the court could not discern a uniform policy because Plaintiffs' analysis of the data revealed that 12% of those claims were paid in full. *See supra* at 30.

Wit illustrates why these cases do not apply here. In *Wit*, the court noted the "harm alleged by Plaintiffs . . . is common to all of the putative class members." *Wit v. United Behavioral Health*, 317 F.R.D. 106, 127–29 (N.D. Cal. 2016). As Plaintiffs themselves point out, in *Wit*, the district court opined that the "injury that [was] the basis of Plaintiffs' claims was the adoption and use of the flawed Guidelines in deciding whether Plaintiffs were entitled to coverage." *Wit v. United Behavioral Health*, No. 14-cv-02346-JCS, 2020 U.S. Dist. LEXIS 205426, at *24 (N.D. Cal. Nov. 3, 2020), *appeal pending, Wit v. United Behavioral Health*, No. 21-15193 (9th Cir.).

Whatever one might conclude of the correctness of the rationale of these other non-binding lower court rulings, here the district court did not abuse its discretion in declining to adopt such a rationale. The record evidence does not demonstrate a uniform policy that the district court found to be unlawful on its face and hence was found to inflict a common injury immediately upon application. 1-ER-12–22 (Dec. 23, 2019 Order) at 4 (1-ER-15) (distinguishing *Wit* and *Des Roches*). United's policies and practices produced an ACA-compliant outcome in the overwhelming majority of instances and the rare occasions on which a plan member may have suffered a violation was a product not of the policy, but of the factual particulars of each case. These circumstances preclude certification of a putative class. *See, e.g.*, *Crosby v. Cal. Physicians' Serv.*, No. SACV 17-01970-CJC (JDEx), 2020 Dist. LEXIS 210654, at *21 (C.D. Cal. Nov. 2, 2020) (denying class certification because not every child was treated the same under the challenged guidelines); *Dennis F. v. Aetna Life Ins.*, No. 12-

cv-02819, 2013 WL 5377144, at *4 (N.D. Cal. Sept. 25, 2013) (defendants' liability to class did not turn on the challenged policy alone); *Graddy v. BlueCross BlueShield of Tenn., Inc.*, No. 4:09-cv-84, 2010 WL 670081, at *9 (E.D. Tenn. Feb. 19, 2010) (uniform policies did "not eliminate the need for an individualized assessment as to the ultimate propriety of the benefits decisions"); *DWFII Corp. v. State Farm Mut. Auto. Ins. Co.*, 469 F. App'x 762, 764–65 (11th Cir. 2012) (similar); *Kartman v. State Farm Mut. Auto. Ins. Co.*, 634 F.3d 883, 893–95 (7th Cir. 2011) (system reform of policies or practices would not establish liability or remedies class-wide). Plaintiffs did not satisfy commonality and, therefore, the district court's denial of certification of the ACA Classes should be upheld.

D. The District Court's Standing Analysis Was Sound.

To establish Article III standing to obtain prospective relief, a plaintiff must demonstrate that she is "realistically threatened by a *repetition* of the violation." *Gest v. Bradbury*, 443 F.3d 1177, 1181 (9th Cir. 2006) (emphasis in original); *see also O'Shea v. Littleton*, 414 U.S. 488, 495–96 (1974). Here, the named Plaintiffs who had survived summary judgment on their ACA claims (Bishop, Hoy, Endicott, and Carroll) were no longer United plan members and, regardless, they presented no evidence on the extent to which they would seek coverage for lactation services in the future. On this basis, and relying on Supreme Court and other precedent, the district court correctly found that these plaintiffs lacked standing to seek prospective relief regarding lactation services because they had not indicated they would be pregnant again or

otherwise access lactation services. 1-ER-12–22 (Order on Renewed Class Cert.) at 3 (1-ER-14); 1-SER-2–3 (Order Denying Mot. to Intervene) at 1–2 (citing *Los Angeles v. Lyons*, 461 U.S. 95, 105 (1983) ("Lyons' standing to seek the injunction requested depended on whether he was likely to suffer future injury . . . .")); *see also* FER-165–172 (Summ. J. Tr.) at 16–17 (FER-170–171).

Plaintiffs argue that the district court should have disregarded the precedent and instead should have followed a non-binding district court case, *Johnson v. Hartford Casualty Insurance Co.*, No. 15-cv-04138, 2017 WL 2224828, at *11 (N.D. Cal. May 22, 2017), in which the court found standing to seek prospective relief based on the possibility that the plaintiff would purchase insurance from the defendant in the future. *See* App. Dkt. 18 at 52–53. As the district court recognized here, that case is irreconcilable with longstanding precedent and, as such, provides no basis to overturn the district court's decision denying class certification. *See* 3-ER-535–541 (May 23, 2019 Original Cert. Order) at 5 (3-ER-539).

E. The District Court Did not Abuse Its Discretion In Denying Plaintiffs' Motion for Harris' Intervention.

The district court also acted within its broad discretion in determining that Plaintiffs' dilatory tactics warranted denial of Plaintiffs' motion for Harris' intervention. *See Lindblom v. Santander Consumer USA, Inc.*, 771 F. App'x 454, 455 (9th Cir. 2019) ("broad discretion" to deny intervention motions); *Donnelly v. Glickman*, 159 F.3d 405, 409 (9th Cir. 1998) ("We review a district court's denial of a motion for

intervention as of right *de novo*, except that we review questions of timeliness for abuse of discretion.").

Timeliness is the threshold requirement for both permissive intervention and intervention as a matter of right. Fed. R. Civ. P. 24(a)-(b). To determine whether intervention is timely, courts in the Ninth Circuit consider three factors: "(1) the stage of the proceeding at which an applicant seeks to intervene; (2) the prejudice to other parties; and (3) the reason for and length of the delay." *Lee v. Pep Boys-Manny Moe & Jack of Cal.*, No. 12-cv-05064, 2016 WL 324015, at *5 (N.D. Cal. Jan. 27, 2016).

"Timeliness is a flexible concept; its determination is left to the district court's discretion." *Id.* (citation omitted). If a court finds that a motion to intervene is untimely, there is no need to evaluate the remaining elements of Rule 24, and a court should deny the motion for this reason alone. *United States v. Washington*, 86 F.3d 1499, 1503, 1505 (9th Cir. 1996); *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Cont'l Ill. Corp.*, 110 F.R.D. 608, 609 (N.D. Ill. 1986) ("[I]ntervention is a game in which *one* strike is out." (emphasis in original)). As applied here, each of the timeliness factors supports the district court's exercise of discretion.

1. Plaintiffs' Motion for Harris' Intervention Was Untimely And Plaintiffs Provided No Reason for the Delay.

"A party must intervene when he 'knows or has reason to know that his interests might be adversely affected by the outcome of the litigation.'" *United States v. Alisal Water Corp.*, 370 F.3d 915, 923 (9th Cir. 2004) (quoting *United States v. Oregon*,

913 F.2d 576, 589 (9th Cir. 1990) (affirming district court's denial of intervention)). The Ninth Circuit has held that courts should focus on the date the person attempting to intervene should have been aware her interests would no longer be protected adequately by the parties or adversely affected by the outcome of the litigation, rather than the date the person learned of the litigation. *SEC v. Small Bus. Capital Corp.*, No. 5:12-cv-03237, 2014 WL 3749900, at *4 (N.D. Cal July 29, 2014) (citing *Officers for Justice v. Civil Serv. Comm'n of San Francisco*, 934 F.2d 1092, 1095 (9th Cir. 1991)). "Even a lengthy delay, however, 'is not as damaging as a failure to adequately explain the reason for the delay.'" *Pep Boys*, 2016 WL 324015, at *7 (citations omitted).

A critical factor in any timeliness analysis is "whether there have been actual proceedings of substance on the merits in the underlying action." *Munoz v. PHH Corp.*, No. 1:08-cv-0759, 2013 WL 3935054, at *7 (E.D. Cal. July 29, 2013). Here, Plaintiffs' request for intervention came at an advanced stage of the litigation. The parties had already litigated a motion to dismiss, cross motions for summary judgment on the named Plaintiffs' claims, and Plaintiffs' original motion for class certification. The parties were in the midst of briefing Plaintiffs' renewed motion for class certification when the intervention motion was filed. FER-33 (July 22, 2019 Order Setting Br. Schedule) (scheduling briefing and argument on Plaintiffs' renewed motion). Moreover, Plaintiffs had already amended their Complaint twice, and fact and expert discovery on both class and merits issues had been closed for nearly six months. FER-173–177 (Oct. 2, 2018 Order Extending Discovery Deadlines)

(discovery closed March 29, 2019) (FER-175). As a result, this case "ha[d] reached too advanced a stage to permit a finding of timeliness." *Pep Boys*, 2016 WL 324015, at *5.

In their appeal, Plaintiffs assert that Harris "sought to intervene when the need arose" (App. Dkt. 18 at 64), but that is a misdirection. In denying Plaintiffs' motion for Harris to intervene, the district court catalogued the numerous points in the case where the court had pointed out that Plaintiffs likely did not have standing to seek prospective relief including as early as argument at the pre-class certification summary judgment stage, which took place a year-and-a-half prior to the intervention motion, as well as in denying the plaintiffs' first attempt at class certification approximately four months prior to the motion. 1-SER-2–3 (Order Denying Mtn. to Intervene) at 1-2; 3-ER-535–541 (May 23, 2019 Original Class Order).

Thus, Plaintiffs' contention that Harris "sought to intervene when the need arose – at class certification" is false. App. Dkt. 18 at 64.[16] Plaintiffs knew they had a standing problem with respect to prospective relief over a year-and-a-half prior to the time Harris moved to intervene.

Courts in the Ninth Circuit repeatedly deny untimely motions for intervention when, as here, the litigation has advanced substantially. *See, e.g.*, *Lindblom v. Santander Consumer USA, Inc.*, No. 1:15-cv-00990, 2018 WL 3219381, at *4 (E.D. Cal. June 29, 2018) (motion to intervene untimely when "[s]everal motions to dismiss had been

[16] Notably, Plaintiffs and Harris share the same counsel.

decided, as well as a motion for judgment on the pleadings, a motion for summary judgment, and a motion for class certification, all of which were extensively briefed by the parties"); *Hanni v. Am. Airlines, Inc.*, No. C 08-00732, 2010 WL 289297, at *5–6 (N.D. Cal. Jan. 15, 2010) (same when the court, in its order, was also ruling on the parties' motions for summary judgment and class certification). The advanced stage of these proceedings warranted denial of Plaintiffs' motion. The district court did not abuse its discretion.

2. Intervention would have been Prejudicial to United.

The district court found that intervention at that stage would be "unfairly prejudicial" to United because of the undue delay that would result from additional discovery. 1-SER-2–3 at 2 (1-SER-3); *see also Pep Boys*, 2016 WL 324015 at *5–7 (further discovery and motion practice required by intervenor's complaint made the intervention prejudicial); *Lindblom*, 2018 WL 3219381, at *4 (similar); *League of United Latin Am. Citizens v. Wilson*, 131 F.3d 1297, 1304 (9th Cir. 1997) ("[E]ven if [intervenor] does in fact limit itself, as it has promised, to filing motions and conducting discovery regarding future issues, its admission as a party will have the inevitable effect of prolonging the litigation to some degree"); *Valley View Health Care, Inc. v. Chapman*, No. 1:13-cv-0036, 2013 WL 4541602, at *4 (E.D. Cal. Aug. 27, 2013) (finding prejudice where intervention would inevitably lead to additional discovery and motion practice); *UMG Recordings, Inc. v. Bertelsmann AG*, 222 F.R.D. 408, 414 (N.D. Cal. 2004) (same because intervention would "necessitate the consideration of

extraneous legal and factual issues that [the original] lawsuit would not otherwise invoke").

This is an independent ground that suffices to affirm.

3. Intervention Was Improper For Additional Reasons.

The district court also found two independent reasons to deny the motion, and each ground alone independently establishes the court did not abuse its discretion. First, even though Harris was a current United member, Harris still could not seek prospective relief because she had not established that she would utilize the ACA benefit in the future. Specifically, Harris did not include "any allegations about the likelihood that she will need lactation services in the future," and thus would not have standing here. 1-SER-2–3 at 2 (1-SER-3) (citing *Lyons*, 461 U.S. at 105). Just as with Plaintiffs' claims for prospective relief, Plaintiffs argue that the district court should have followed *Johnson*, but their argument fails as noted above. *See supra* at 45.

Second, the district court noted that Harris could file her own suit to remedy her claim. 1-SER-2–3 at 2 (1-SER-3); *see also Harris v. Vector Mktg. Corp.*, No. C-08-5198, 2010 WL 3743532, at *6 (N.D. Cal. Sept. 17, 2020) ("the proposed intervenors admitted that they would still be able to file an independent class action"); *Pep Boys*, 2016 WL 324015, at *3 (noting that an argument that filing a new suit would be inefficient is not satisfactory on its own to allow intervention; "to hold as much would require courts to find impairment every time a motion to intervene is filed"). This too was not an abuse of discretion and provides a standalone basis to affirm.

CONCLUSION

This Court should affirm the district court's grant of summary judgment in United's favor with respect to Condry's and Barber's ACA claims, as well as the district court's two denials of class certification of the ACA Classes. This Court should reverse the district court's grant of summary judgment in favor of the ERISA Plaintiffs on the remark code issue, the certification of the Denial Letter Class, and the injunctive relief granted to that certified class.

Dated: March 29, 2021

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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9th Cir. Case Number(s) No. 20-16823, No. 20-16857

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