In re Out-of-Network Substance Use Disorder Claims Against UnitedHealthcare
SACV 19-2075 JVS (DFMx)

TENTATIVE Order Regarding Cross-Motions for Summary Judgment on Plaintiff-Providers' Third Amended Complaint and Defendant-United's Counterclaims [149] [144] [156]

Before the Court are three cross-motions for summary judgment. Plaintiff Providers ("Providers")[1] move for summary judgment on their ERISA and Breach of Contract causes of action. (Dkt. No. 149-1.) Defendant United ("United")[2] opposed the motion (Dkt. No. 211) and Providers responded (Dkt. No. 237). Providers also filed a separate motion seeking summary judgment on each of United's counterclaims. (Dkt. No. 144). United opposed the motion (Dkt. No. 207) and Providers responded (Dkt. No. 235).

United moved separately for summary judgment on Providers' ERISA, Breach of Contract, Oral Contract, Promissory Estoppel, and California's Unfair Competition Law causes of action, as well as its own ERISA and breach of contract counterclaims. (Dkt. No. 156 (redacted); Dkt. No. 178 (unredacted).) Providers opposed the motion (Dkt. No. 217) and United responded (Dkt. No. 233).

For the following reasons, the Court **GRANTS** in part and **DENIES** in part the motions.

I. BACKGROUND

A. Factual Background

1. The Parties

[1] "Providers" refers to the Band 1 Plaintiffs, as designated in the Court's Case Management Order. (See Dkt. 38.)

[2] "United" refers collectively to UnitedHealth Group, Inc., United HealthCare Services, Inc., United HealthCare Insurance Company, UCH of California, United HealthCare Services LLC, United Behavioral Health, Inc, United Medical Resources, Inc., OptumInsight, Inc., Optum Services, Inc., Optum, Inc., and UMR, Inc.

Providers are out-of-network ("non-network") substance abuse disorder treatment facilities and clinical laboratories who provided treatment and services to patients seeking substance abuse treatment. (Dkt. No. 211-1 ¶ 1.) Some number of patients treated at Providers' facilities, including the ten exemplar patients identified by the parties pursuant to the Court's Case Management Order, had health insurance plans that were insured and administered by United. (Id., ¶¶ 1-4)

Certain of the United Defendants insure or provide third-party claims administration services for individual and group-health plans sponsored by employers that provide health benefits to covered employees and dependents. (Plaintiffs' Statement of Genuine Disputes ("Pl. SGD"), Dkt. No. 220 ¶ 1.) For "fully insured plans," an employer pays a per-employee premium to United, and United provides health coverage for insured events. (Id. ¶ 2.) The terms governing fully insured plans are contained the Benefit Plans and summarized in a "Certificate of Coverage" issued by United. (Id. ¶ 2.)

United acts as a third party administrator for self-funded employer benefits plans, or Administrative Services Only Plans ("Service Plans"). (Id. ¶ 3.) United provides covered individuals ("members") with access to a network of providers who have contracted to accept established fees in exchange for being part of United's provider network ("in-network" providers). (Id. ¶ 4.) Service Plans include an accompanying "Summary Plan Description" ("Plan Summary"). (Id. ¶ 3.)

2. The Plans

For providers not part of United's network, such as Plaintiff Providers, United does not have a direct, written contractual agreement and does not have a specific agreement with the provider to pay certain rates. (Id. ¶ 5.) Rather, as an insurer or claims administrator, United processes claims according to the terms and limitations set forth in each member's health benefit plan. (Id.) The plans contain various provisions related to eligibility and enrollment. The focus of the present actions is the reimbursement methodology provisions.

For group benefit plans, the plan sponsor determines whether to provide

non-network benefits and which reimbursement methodologies to be used. (Id. ¶ 80.) When non-network benefits are available, the amount the plan will pay for non-network service is established in the plans. (Id. ¶ 81.) The plans allow providers to bill the member for the difference, if any, between the amount allowed for the non-network service and the non-network provider's billed charge. (Id. ¶ 82.) The plans also provide what the member's deductible, copayment, or coinsurance amounts (collectively "Member Responsible Amounts") are for non-network benefits and any out-of-pocket maximum. (Id. ¶ 83.)

If a plan provides for non-network coverage, it will have one of two types of reimbursement methodologies: Reasonable and Customary, and Maximum Non-Network Reimbursement Program ("Maximum Reimbursement"). (Id. ¶ 90.) Although the parties hotly dispute the specifics of what each reimbursement methodology entails and how it should be interpreted, the following baseline facts are undisputed. Reasonable and Customary plans aim to arrive at an Eligible Expenses rate that is "reasonable and customary." (Dkt. No. 211-1 ¶ 5.) United uses one of three data sources to arrive at the Reasonable and Customary rate: FAIR Health, Facility R&C Program offered by Viant/MultiPlan, and the Facility Repricer developed by United Behavioral health. (Id.) Maximum Reimbursement plans calculate Eligible Expenses based on a pre-negotiated rate, a percentage of Medicare rates published by the Centers for Medicare and Medicaid Services ("Medicare Services") for the same or similar services, a gap-methodology, or a percentage of the provider's billed charges. (Id.)

3. Verification of Benefits Calls

Prior to accepting new patients, Providers or their third-party biller often contacted United to conduct a Verification of Benefits Call ("Verification Call"). (Dkt. No. 220 ¶ 151.) The purpose of these calls was to confirm the prospective patients' insurance coverage and out of network benefits. (Id. ¶ 252.) During verification calls, United gave non-network providers with information about the member, including the member's non-network benefits, percentage of Eligible Expenses that the plan will pay for covered services, copayments, coinsurance, and deductible. (Id. ¶¶ 253, 259-60.) At the time of the verification call, Providers and their billers did not know what the eligible expenses would be or how much United would ultimately pay. (Id. ¶ 293.) Additionally, Providers' billers understood the call to be a "verification that the client has the benefits," but

not a "verification that the client meets the medical necessity for the need to use benefits." (Id. ¶ 296.)

4. Pre-Authorization Calls

In addition to verification calls, Providers often call United to confirm that benefits will be authorized for certain types of treatment. (Id. ¶ 373.) The purpose of pre-authorization calls is to obtain United's approval for treatment. During pre-authorization calls, Providers give United information about the patient's diagnosis and contemplated course of treatment so United can determine the medical necessity of the treatment under the member's benefit plan. (Id. ¶373-74.) The amount of payment or reimbursement is not discussed during pre-authorization calls, and United does not make any express promises to pay. (Id. ¶ 375.) Following the pre-authorization calls, United sends a letter to Providers stating "Payment for services described in this letter is subject to the member's eligibility at the time the services are provided, including . . . benefit plan limitations, and availability of remaining coverage." (Id. ¶¶ 376-77.)

5. Member Responsible Amounts

Each of the plans at issue requires the members to pay Member Responsibility Amounts in order to share in the cost of out-of-network services. (See, e.g., Dkt. No. 158-165.) These Member Responsibility Amount provisions identified a percentage of expenses the member must pay until they reach their annual out-of-pocket maximum. (Dkt. No. 220 ¶¶ 81-83.) If a patient does not have any remaining Member Responsibility Amount because they have reached their annual out-of-pocket maximum, the plans do not require Providers to collect any amount from the member. (Id. ¶ 247.) Providers did not collect Member Responsibility Amounts for some patients. (Id.)

B. Procedural Background

Providers filed separate actions in California State Court between September 20, 2019, and October 29, 2019, which Defendants timely removed to federal court. (See Third Amended Complaint ("TAC"), Dkt. No. 80.) On February 6, 2020, the Court entered an order consolidating these actions. (See Dkt. 29.) On February 21, 2020, the Court granted in part and denied in part

MultiPlan and United's first motions to dismiss. (See Motion to Dismiss ("MTD"), Dkt. No. 35.) Additionally, certain defendants United Healthcare Services, Inc., UnitedHealthcare Insurance Company, United Behavioral Health, and UMR, Inc. (collectively, "Counterclaimants") brought counterclaims against DR Recovery Encinitas, LLC, MMR Services, LLC, TML Recovery, LLC, Woman's Recovery Center, LLC, Kool Living, Inc., Pacific Palms Recovery, LLC, Inland Detox, Inc., Southern California Addiction Center, Inc., and Addiction Health Alliance (collectively, "Counter-Defendants"). (See Counterclaim, Dkt. No. 99, at 156–221.)

On March 3, 2020, the Court entered a case management order regarding how the consolidated cases shall proceed. (See Case Management Order, Dkt. 38.) The first nine cases filed were placed into Band 1; related actions filed after October 28, 2019, and prior to July 31, 2020, were placed into Band 2 and stayed; any action filed after July 31, 2020 would be placed into Band 3 and stayed. (Id. at 2–4.) Under that order, discovery would proceed with Plaintiffs choosing 10 patients from each provider, and Defendants choosing ten patients from each provider. (Id. at 4.) Further, for any claims remaining after dispositive motions, the Court will conduct a bellwether trial for Band 1, composed of five patients chosen by United and five patients chosen by each provider out of the discovery sample pool. (Id. at 5–6.) Following the parties' filing of several motions for summary judgment (see Dkt Nos. 142, 144, 149-1, and 156), resulting in an unmanageable number of exemplar patients, the Court ordered the United and Providers to select five patients each to be addressed in dispositive motions. (See Dkt. 256.) After selecting their new subset of exemplar patients, MultiPlan and Viant (collectively "MultiPlan"), Providers, and United submitted supplemental briefing identifying the patients to which each claim applied. (See Dkt. Nos. 268, 270, and 273.)

During discovery, United had only provided the Plan Summaries for the patients at issue in this case. On September 30, 2022, the Court ordered the parties to submit the legally operative Benefit Plans. In response to the Court's request, United filed a Request for Judicial Notice containing excerpts of the Administrative Agreements relating to nine of the ten exemplar patients. (Dkt. No. 277.) On October 17, the Court held a hearing on the tentative order. At the hearing, the Court was informed that the Administrative Services Agreements were not the operative Benefit Plans whose terms decided the majority of the

issues presented on summary judgment. The Court therefore decided it could not proceed further until the parties had produced the legally operative Benefit Plan Documents for each exemplar patient. The Court ordered the parties to obtain the Benefit Plans and submit them to the Court. (Dkt. No. 284, Hearing Tr. 10/17/22 at 22:14-25.)

On October 24, United filed with the Court the additional Plan Documents it received. (Dkt. No. 290.) The Court held a status conference at which United informed the Court it obtained additional plan documents for six of the ten exemplar patients but was unable to reach several Plan Sponsors. (Hearing Tr. 10/24/22 at 3:18-4:2.) The Court ordered United to subpoena the employers that had been non-responsive to obtain the Benefit Plans. (Id. 5:2-14, 9:15-10:24.) The Court further ordered both parties to submit supplemental briefing on the standard of review issue under the Benefit Plans themselves. (Id. 7:8-8:18.)

United submitted supplemental briefing on December 1, 2022 (Dkt. No. 297) and Providers filed supplemental briefing on December 15, 2022 (Dkt. No. 300).

C. Allegations

The TAC brings five causes of action against all defendants for: (1) Claims for plan benefits under ERISA, 29 U.S.C. § 1132(a)(1); (2) Breach of Written Contract for non-ERISA plans; (3) Breach of Implied Covenant of Good Faith and Fair Dealing; (4) Breach of Oral Contract; and (5) Promissory Estoppel. (TAC ¶¶ 197-275.) Additionally, Providers brought a sixth cause of action against the United Defendants for violation of the California Unfair Competition Law ("UCL") (Bus. & Prof. Code §§ 17200 et seq.). (Id. ¶¶ 276–282.) The Court previously dismissed the claim for breach of implied covenant of good faith and fair dealing. (See Order, Dkt. 92 at 9–10.)

United brings a total of eight counterclaims against Providers: (1) Fraud; (2) Negligent Misrepresentation; (3) Conversion; (4) Breach of Contract for claims relating to non-ERISA plans; (5) Intentional Interference with Contractual Relations; (6) Violation of the UCL; (7) Restitution under ERISA § 502(a)(3); (8) Injunctive and Declaratory Relief under ERISA § 502(a)(3). (See Dkt. No. 99 ¶¶ 183-248.)

D. Exemplar Patients

For the sake of clarity, the Court has synthesized the parties' claims as they pertain to individual exemplar patients. The Court will refer to each patient by their first and last initials to maintain anonymity.

1. Patients whose Benefit Plans accord discretion to United: AM; CB; CR; JB; JS; JT; LF; ME; NA; NL. (See Dkt. No. 273 at 1-2.)

2. Patients whose claims are governed by the Maximum Reimbursement methodology: CR; JS; LF; ME;[3] NA; NL. (See id. at 2-4; Dkt. No 270 at 3-4.)

3. Patients whose claims are governed by the Reasonable & Customary reimbursement methodology: AM; JB; JT. (See Dkt. No. 273 at 4-5; Dkt. No. 270 at 2-3.)

4. Patients whose claims are barred by a failure to collect Member Responsible Amounts: CB; JS; NL. (See Dkt. No. 273 at 6-7.)

5. Patients whose claims are barred by their Benefit Plans' time limitations: JB. (See id. at 5.)

6. Patients whose claims are barred by failure to exhaust administrative remedies: JB. (See id. at 5-6.)

II. LEGAL STANDARD

Summary judgment is appropriate where the record, read in the light most favorable to the nonmoving party, indicates "that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); see also Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1986).

[3] Patient ME was originally included as a patient whose claim was governed by the Reasonable and Customary reimbursement methodology. However, United produced the incorrect version of ME's employer's Benefit Plan in discovery. The correct plan showed that Patient ME's claims are governed by the Maximum Reimbursement methodology. (See Dkt. 274; 276.)

Summary adjudication, or partial summary judgment "upon all or any part of [a] claim," is appropriate where there is no genuine dispute as to any material fact regarding that portion of the claim. Fed. R. Civ. P. 56(a); see also Lies v. Farrell Lines, Inc., 641 F.2d 765, 769 n.3 (9th Cir. 1981) ("Rule 56 authorizes a summary adjudication that will often fall short of a final determination, even of a single claim . . . .") (internal quotation marks omitted).

Material facts are those necessary to the proof or defense of a claim, and are determined by referring to substantive law. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). In deciding a motion for summary judgment, "[t]he evidence of the non-movant is to be believed, and all justifiable inferences are to be drawn in his favor." Anderson, 477 U.S. at 255.[4] A trial court may not resolve issues of credibility to determine whether a fact is "genuinely disputed." Id. at 658–59. To do so is to improperly weigh the evidence. Id. A court may discount uncorroborated, self-serving testimony where "it states only conclusions and not facts." Nigro v. Sears, Roebuck & Co., 784 F.3d 495, 497–98 (9th Cir. 2015). However, a court may not discount "self-serving" testimony that includes contrary factual assertions and requires the observation of a witness's demeanor to assess credibility. See Manley v. Rowley, 847 F.3d 705, 711 (9th Cir. 2017).

The moving party has the initial burden of establishing the absence of a material fact for trial. Anderson, 477 U.S. at 256. "If a party fails to properly support an assertion of fact or fails to properly address another party's assertion of fact . . ., the court may . . . consider the fact undisputed." Fed. R. Civ. P. 56(e)(2). Furthermore, "Rule 56[(a)] mandates the entry of summary judgment . . . against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." Celotex Corp., 477 U.S. at 322. Therefore, if the nonmovant does not make a sufficient showing to establish the elements of its claims, the Court must grant the motion.

The Court has only relied on admissible evidence in determining the

[4] "In determining any motion for summary judgment or partial summary judgment, the Court may assume that the material facts as claimed and adequately supported by the moving party are admitted to exist without controversy except to the extent that such material facts are (a) included in the 'Statement of Genuine Disputes' and (b) controverted by declaration or other written evidence filed in opposition to the motion." L.R. 56-3.

outcome of this motion. When the order cites evidence to which the parties have objected, the objection is impliedly overruled. Additionally, the Court declines to rule on objections to evidence upon which it did not rely.

III. DISCUSSION

Because the parties have each moved for summary judgment on certain claims, the Court will address each party's arguments separately. See Fair Hous. Council of Riverside Cnty., Inc. v. Riverside Two, 249 F.3d 1132, 1136 (9th Cir. 2001). The Court will consider each party's evidentiary showing, regardless of which motion the evidence was tendered under. See id. at 1137.

A. United's Request for Judicial Notice

Under Federal Rule of Evidence 201, the Court may take judicial notice of matters of public record if the facts are not "subject to reasonable dispute." Lee v. City of Los Angeles, 250 F.3d 668, 688-89 (9th Cir. 2001); see Fed. R. Evid. 201(b). Upon the Court's request, United submitted various Administrative Services Agreements for the ten exemplar patients. (Dkt. No. 277.) Providers do not dispute the validity of these documents, merely the timing of production. (Dkt. No. 278.) Although the Court recognizes United's delay in producing these documents, the Court finds that Providers have not been unduly prejudiced because the Administrative Services Agreements' language is consistent with the Plan Documents already in the record. The result therefore does not change.

Accordingly, the Court takes judicial notice of Exhibits 1 through 9, containing the Administrative Services Agreements for Patients N.A., J.B., M.E., L.F., N.L., A.M., C.R., J.S., and J.T. United did not produce an Administrative Services Agreement for Patient C.B. However, as United subsequently produced the Benefit Plan for Patient C.B., analysis of this patient's Administrative Services Agreement is unnecessary at this time.

B. United's Motions for Summary Judgment

United seeks partial summary judgment on Counts I and II of the Providers'

Third Amended Complaint and Counts IV, VII, and VII of its counterclaim.[5] (Dkt. No. 178 at 1.) United argues that Providers are not entitled to additional reimbursement on paid claims under their ERISA and breach of contract causes of action because those claims were paid consistent with the policies outlined in members' Benefit Plans.[6] (Id.) United also argues that other members' claims fail due to specific Benefit Plans terms based on timeliness, failure to exhaust administrative remedies, failure to collect coinsurance or deductibles from patients, and because United is not a proper defendant where it is not the insurer or administrator. (Id.) United seeks summary judgment on Providers' claims for breach of oral contract and promissory estoppel claims because they allege that Providers failed to raise a genuine dispute as to the presence of an agreement to reimburse claims based on billed charges. (Id. at 2.) Finally, United seeks summary judgment on Providers' UCL claim based on a number of different theories. (Id.)

1. ERISA & Breach of Contract Claims

Courts "apply contract principles from state law . . . guided by the policies expressed in ERISA and other federal labor laws" to interpret ERISA plans. Gilliam v. Nev. Power Co., 488 F.3d 1189, 1194 (9th Cir. 2007) (internal quotations omitted). Under California law, insurance contracts are "contracts governed by the ordinary rules of contract interpretation." Van Ness v. Blue Cross of Cal., 87 Cal. App. 4th 364, 372 (2001). "The overriding goal of contract interpretation is to give effect to the parties' mutual intentions as of the time of

[5] The introduction to United's Motion for Summary Judgment states it seeks "partial summary judgment on Count I of its Counterclaim." (Dkt. No. 178 at 1.) However, the substance of United's argument indicates that it actually seeks summary judgment on Count IV (Breach of Contract), Count VII (Restitution under ERISA § 502(a)(3)), and Count VIII (Injunctive and Declaratory Relief under ERISA § 502(a)(3)) of its Counterclaim. (See id. at 15-16 (seeking summary judgment for failure to collect Member Responsible Amounts in violation of the contract terms and ERISA provisions); Counterclaim at ¶¶ 227-240 (seeking the imposition of an equitable lien by agreement over the Overpayments, or assets than can be traced from the Overpayments," and "equitable restitution to recover" assets United alleges Providers "unlawfully obtained"); Dkt. No. 233 at 20-21 (responding to Providers' arguments that it had not established an equitable lien by agreement).)

[6] United is not moving for summary judgment on Counts I and II of the TAC as to Benefit Plans that do not explicitly grant United discretion. (See Dkt. No. 178 at 7, n.4.)

contracting." Id. (citing Cal. Civ. Code, § 1636.). "Where contract language is clear and explicit and does not lead to an absurd result, we ascertain this intent from the written provisions and go no further." Id. (citing Cal. Civ. Code §§ 1638, 1639).

The language of the plan must be construed to give effect to every term. Mirpad, LLC v. Cal. Ins. Guarantee Ass'n, 132 Cal. App. 4th 1058, 1072 (2005). Courts "read a contract as a whole in order to 'give effect to every part, if reasonably practicable, each clause helping to interpret the other.'" Van Ness, 87 Cal. App. 4th at 372 (quoting Cal. Civ. Code § 1641). Thus, the Court will "look to the agreement's language in context and construe each provision in a manner consistent with the whole such that none is rendered nugatory. Dupree v. Holman Prof'l Counseling Ctrs., 572 F.3d 1094, 1097 (9th Cir. 2009).

a. Standard of Review

"[D]enial of benefits challenged under [29 U.S.C.] § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Kearney v. Standard Ins. Co., 175 F.3d 1084, 1089 (9th Cir. 1999) (quoting Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). "Where an ERISA Plan grants discretionary authority to determine eligibility for benefits or to construe the terms of the plan, a plan administrator's interpretation of a plan is reviewed for abuse of discretion." O'Rourke v. N. Cal. Elec. Workers Pension Plan, 934 F.3d 993, 998 (9th Cir. 2019) (quoting Lehman v. Nelson, 862 F.3d 1203, 1216 (9th Cir. 2017)). A defendant bears the burden of proving that a plan grants it discretionary authority. Prichard v. Metro. Life Ins. Co., 783 F.3d 1166, 1169 (9th Cir. 2015).

United contends the plans of all ten Exemplar Patients explicitly delegate discretion to United to make benefit determinations. (Dkt. No. 178 at 7.) Specifically, United points to language that the Plans expressly delegate discretion to United to interpret plan terms, make factual determinations, and determine eligibility for benefits. (Id.) Thus, it argues that the Court should apply the arbitrary and capricious standard of review for those claims. (Id.) Providers argue that United has not produced sufficient evidence to demonstrate that there was a conveyance of discretionary authority. (Dkt. No. 217 at 2-3; Dkt. No. 149-1 at 9-

10.) They maintain that "[a]ny discretionary authority must be expressly granted to United in the language of the employer's trust instrument." (Id.)

Until October 24, 2022, the only plan documents in the record were Plan Summaries, which are not themselves the trust instrument or legally operative Benefit Plan. In CIGNA Corporation v. Amara, the Supreme Court held that "summary documents, important as they are, provide communication with beneficiaries about the plan, but that their statements do not themselves constitute the terms of the plan." 563 U.S. 421, 438 (2011). Since Amara, language in a Plan Summary is not sufficient on its own to determine that there was a grant of discretionary authority. Instead, courts look to the specific language of the Plan Summary in relation to the language of the Plan itself. See Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc., 99 F. Supp. 3d 1110, 1161 (C.D. Cal. 2015). Amara makes clear that statements made in Plan Summaries "do not themselves constitute the terms of the plan." 563 U.S. at 438. Thus, even if the Plan Summaries indicate that there was a grant of discretionary authority, if "the official insurance certificate contains no discretion-granting terms, we will not, consistent with Amara, hold that the [Plan Summary's] grant of discretion constitutes an additional term of the Plan." Prichard v. Metro. Life Ins. Co., 783 F.3d 1166, 1171 (9th Cir. 2015).

Nevertheless, Plan Summaries may "constitute a formal plan document, consistent with Amara, so long as the [Plan Summary] neither adds to nor contradicts the terms of existing Plan documents." Prichard, 783 F.3d at 1170. For example, the Tenth Circuit held:

> "We interpret Amara as presenting either of two fairly simple propositions, given the factual context of that case: (1) the terms of the [Plan Summary] are not enforceable when they conflict with governing plan documents, or (2) the [Plan Summary] cannot create terms that are not also authorized by, or reflected in, governing plan documents."

Eugene S. v. Horizon Blue Cross Blue Shield of N.J., 663 F.3d 1124, 1131 (10th Cir. 2011); see also Prichard, 783 F.3d at 1171 (holding the district court erred in finding that Plan Summary constitutes the Plan document where [Plan Summary] itself declared that "official plan documents . . . remain the final authority" and "shall govern" in the event of conflict with official Plan documents).

However, "Amara addressed only the circumstance where both a governing plan document *and* [a Plan Summary] existed and the plan administrator sought to enforce the [Plan Summary's] terms *over* those of the plan document. It did not address the situation . . . that a plan administrator seeks to enforce the [Plan Summary] as the one and only formal plan document." Mull for Mull v. Motion Picture Industry Health Plan, 865 F.3d 1207, 1210 (9th Cir. 2017) (quoting Prichard, 783 F.3d at 1170).

As noted above, prior to October 24, 2022, the only Plan documents in the record were Plan Summaries. Now before the Court are Plan documents of varying levels of legal implications. Upon the request of the Court, United produced relevant portions of the controlling Plan documents for six of the ten exemplar patients.[7] United attests that it was unable to reach the plan sponsor for Patient A.M. (Fuchsteiner Oct. Decl., Dkt. No. 288-1 ¶ 9.) United further attests that the three remaining exemplar patients' plan sponsors informed United there were no additional plan documents (J.T., N.A., and N.L.). (Fuchsteiner Dec. Decl., Dkt. No. 297-1 ¶¶ 3-5.) Each of the ten exemplar patients have a self-funded plan in which the patient's employer is the Plan Administrator and United acts as the Claims Administrator. (See Pl. SGD ¶ 5.) For clarity, the Court will address the relevant plan language of each patient individually.

I. Patients With Benefit Plans Other Than Plan Summaries

Upon the Court's request, United produced Benefit Plans for six of the ten exemplar patients: C.B., C.R., J.B. (2014), J.S., L.F., and M.E. (Dkt. No. 297 at 2, citing Fuchsteiner Oct. Decl.)

Patient C.B.

Patient C.B.'s Benefit Plan states in relevant part that "the Company, as Plan Administrator, has delegated discretionary authority . . . to the Claims

[7] The Court recognizes that United delayed in producing these documents, doing so only when the Court requested them, not when demanded during fact discovery. (See Dkt. 278.) However, because the Court finds that all Plan documents in the record unambiguously grant United discretion, Providers have not suffered prejudice as a result of United's failure to produce.

Administrator to determine all claims with respect to eligibility for participating in the Plan and any Participating Benefit, subject to the eligibility requirements of any insurance policy or other contract." (Fuchsteiner Oct. Decl., Ex. B. § 6.2.) Patient C.B.'s Benefit Plan further clarifies over which claims the Claims Administrator has discretion:

> Claims Administrator shall have the responsibility for review and payment of claims and recordkeeping related thereto and, to the extent directed by the Company, a selfinsured Participating Benefit's Claims Administrator shall have the full authority to exercise its discretion with respect to the initial determination of benefits under the Participating Benefit and the review of a Covered Person's appeal of any claim denials under such Participating Benefit. Each Claims Administrator under an insured Participating Benefit shall have full discretionary authority to determine initial claims and the appeal of any claim denials under such Participating Benefit, subject to the terms of the insurance policy or contract under which benefits are provided. Benefits shall not be paid under any Participating Benefit unless the Claims Administrator decides in its discretion that the applicant is entitled to them.

(Id. § 2.8.)

On its face, this language unambiguously grants discretionary authority to United to determine initial benefits, review claims, and administer appeals of claim denials.

Providers contend that the Plan Summary United refers to in its Supplemental Briefing on Standard of Review is not the Plan Summary United originally relied upon in its motion for summary judgment. (Dkt. No. 300 at 10.) However, this is contradicted by the record. (See Dkt. No. 273 at 1 ["Patient C.B.: ECF 158-2"]; Dkt. No. 158-2 [Exhibits A-5 – A-9]; Dkt. No. 297 [citing to Exhibits A-8 and A-9 as Patient C.B.'s Plan Summaries].) Providers make the same objections to each Plan Summary and nearly all are similarly without merit, with the exception of Patient M.E. The Court will address this discrepancy when it discusses Patient M.E.'s plan.

Providers further argue that this document contradicts the Plan Summary

United originally cited in its motion for summary judgment. (Dkt. No. 300 at 10.) Again, this is contradicted by the record. The 2018 Plan Summary the parties relied upon in their motions for summary judgment and supplemental briefing explicitly states that United has "the final authority" to "Interpret Benefits and the other terms, limitations and exclusions" of the Plan. (Dkt. No 158-2, Ex A-8 at 461, 508.)[8] The 2019 Plan Summary similarly states that United has the "final authority" to "Interpret Benefits" and "other terms, conditions, limitations, and exclusions" set out in the Policy. (Id., Ex. A-9 at 612, 660.)

Accordingly, the Court finds that Patient C.B.'s Benefit Plan confers upon United discretionary authority to interpret the plan terms. The Court will therefore apply an abuse of discretion standard as to Patient C.B.'s plan.

Patient C.R.

Patient C.R.'s Benefit Plan specifies that C.R.'s employer, as the Plan Administrator, has discretionary authority to interpret the plan benefits and may delegate that discretion. The Plan states in relevant part:

> The Plan Administrator shall have absolute and exclusive discretion to manage the Constituent Medical Arrangement and to determine all issues and questions arising in the administration, interpretation, and application of this Medical Plan with respect to the Constituent Medical Arrangement, including, but not limited to, issues and questions relating to a Participant's eligibility for benefits and to the nature, amount, conditions, and duration of any benefits.

(Dkt. No. 290, Ex. E § 5.3.) The Plan further specifies that the Plan Administrator may delegate "the right to exercise any of its powers or the obligation to carry out any or all of its duties as Plan Administrator." (Id. § 5.4.) The Plan additionally specifies that the Plan Administrator and the designated Claims Administrator, in this case United, have "full power and discretion" to, among other things, interpret the Plan, "determine the rights and benefits" of plan participants, and "determine the rights of the Participant applying for or receiving benefits under the [Plan] and

[8] Citations to patients' plans are to their respective docket numbers and, where necessary, the exhibit numbers. Citations to specific pages refer to the stamped page number within the docket, rather than page numbers within a specific exhibit.

afford any such individual dissatisfied with such findings or determination the right to a hearing or other appeal." (Id. § 7.3.) Appendix A of the agreement lists United Healthcare as the Claims Administrator for the Plan. (See Dkt. No. 290, Ex. F.)

This arrangement is reiterated in the Plan Summary:

> Fortive Corporation has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

(Dkt. No. 160-7, Ex. A-66 at 197.)

Providers contend that there is no indication in the Benefit Plan that United "was designated as the plan administrator with discretionary authority." (Dkt. No. 300 at 6.) While Providers are correct that United did not become the plan administrator for Patient C.R.'s Benefit Plan, the Plan language clearly states that the C.R.'s employer, as the plan administrator, may delegate "the right to exercise any of its powers or the obligation to carry out any or all of its duties as Plan Administrator."[9] (Id. § 5.4.) The plan administrator, Fortive Corporation, in fact delegated the "discretion and authority" to make benefits and eligibility determinations. (Dkt. No. 160-7, Ex. A-66 at 197.) Where there is no conflict between the Plan Summary and the Benefit Plan, the terms of the Plan Summary may be enforceable. See Mull for Mull, 865 F.3d at 1210 (A Plan Summary "may constitute formal plan document, consistent with Amara, so long as the [Plan Summary] neither adds nor contradicts the terms of existing Plan documents.") (quoting Prichard, 783 F.3d at 1170). Because the delegation of discretion by the

[9] Plaintiffs also argue that Patient C.R.'s Administrative Services Agreement was not disclosed in discovery and, in any event, explicitly states that United is the Claims Administrator, not the Plan Administrator. (Dkt. No. 300 at 6.) Because there is a Benefit Plan now in the record for Patient C.R., the Court has not considered the Administrative Services Agreement in determining whether United had discretionary authority to make benefits determinations. Additionally, as the Court previously noted, it is undisputed that United is the Claims Administrator for this and the other exemplar patients' plans. That United "disclaims any responsibility as plan administrator" is therefore inconsequential to the present analysis. (Id.) The Court will not address Plaintiffs' similar arguments for other patients.

Plan Administrator to United is in the Benefit Plan and the Plan Summary's description of such delegation does not contradict the language of the Benefit Plan, the Court finds it to be a valid grant of discretion. See Zavislak v. Netflix, Inc., 2021 WL 3621835, at *5 (N.D. Cal. Aug. 16, 2021) ("Here, Netflix treats its summary plan descriptions as part of the plan itself, and Zavislak has not identified any conflict between any of the summary documents and the 2020 Wrap Plan Document.").

Patient J.B. (2014)

Although the document United has submitted to the Court appears to be merely a Plan Summary, the document states on its face that it is both the Summary and "Plan document, as required" by ERISA. (Dkt. No. 290, Ex. A. at 4.) While Amara did not address the circumstance where *only* a Plan Summary exists, the Ninth Circuit recognized that, in some cases, "particularly in the context of health plans, the [Plan Summary] is sometimes argued to *be* the plan – that is, to serve simultaneously as the governing plan document." Prichard, 783 F.3d at 1170; see also 3 ERISA Practice and Litigation § 12:38 (2022) ("For certain types of plans, notably health plans, plan sponsors frequently take a "consolidated" approach to plan document drafting where the plan document and the [Plan Summary] take the form of a single document"). Lower courts applying this concept have similarly enforced the language of Plan Summaries in the absence of other plan documents. See Grace F. v. Aetna Life Ins. Co., 2017 WL 15493334, at *4 (N.D. Cal. May 1, 2017) (adopting the terms of the Benefits Guides because it was the only plan document); Dual Diagnosis Treatment Ctr., Inc. v. Blue Cross of Cal., 2016 WL 6892140, at *56 (C.D. Cal. Nov. 22, 2016) (noting that if a Plan Summary was the only plan document, then it would be a consolidated plan and the Summary's terms would control). Accordingly, the Court holds that this document constitutes the operative Benefit Plan document.

The Plan explicitly grants United discretion to make benefits determinations under the Plan. It states in relevant part:

> The Plan Administrator has delegated claims and appeals responsibilities to Claims Administrator. The "Claims Administrator" is UnitedHealthcare. The Claims Administrator has discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Claims Administrator determines, in its

discretion and in accordance with the terms of the Plan, that the applicant is entitled to them.

(Id. at 85.)

Providers assert the Plan documents indicate that the plan sponsor "delegated administrative responsibility and authority with respect to the Plan to the Cablevision Investment & Benefits Committee," rather than to United. (Dkt. No. 300 at 11, citing Dkt. No. 159-2, Ex. A-31 at 363.) This argument does not change the unambiguous grant of discretion to United to interpret "grant or deny benefits under the Plan," which is the subject matter of the case now pending before this Court. (Dkt. No. 290, Ex. A. at 85.) Additionally, Providers cite to the incorrect Plan document for this proposition, as the Plan Summary for Patient J.B. (2014) is Exhibit A-29 rather than Exhibit A-31. (See Dkt. No. 273 at 5-6.)

Taken together, the Court finds that Patient J.B.'s 2014 Plan unambiguously granted discretion to United to make benefits determinations and interpret plan provisions.

Patient J.S.

As with Patient J.B. (2014), the document purporting to be the Benefit Plan states on its face that it is the "Summary Plan Description for the TalentWave Wrap Benefit Plan S." (Dkt. No. 290, Ex. H. at 439.) However, unlike the document United provided for Patient J.B. (2014), this document explicitly states that it is a Summary Plan Description that "reflects and summarizes the terms of the Plan," but does not itself constitute the Benefit Plan. (Id. at 441.) The Plan Summary goes on to state that the "terms of each Component Benefit Plan are incorporated into this SPD by reference," but the "Component Benefit Plan will control" should there be a conflict between the two. (Id.)

In the declaration of Ellyn Fuchsteiner submitted with this document, United explains that this was the only document TalentWave provided in response to its request. (Fuchsteiner Oct. Decl., Dkt. No. 288-1.) However, merely accepting this as the operative Benefit Plan when it states on its face it is not is insufficient to comply with the Court's order. On October 24, 2022, the Court ordered United to serve subpoenas on at least one plan sponsor that was unresponsive to United's request for additional plan documents. (Hearing Tr.

10/24/22 at 3:18-5:22.) United has not explained why it did not go to similar lengths to obtain J.S.'s Benefit Plan when the "additional document" TalentWave sent states on its face it is not the legally operative Plan document.

The Court therefore **ORDERS** United to submit a declaration detailing the steps it took to acquire the operative Plan Document rather than a Plan Summary. The Court may require further efforts on United's part to obtain the Benefit Plan for Patient J.S.

Patient L.F.

The Benefit Plan for Patient L.F. states that Southwest Airlines, as the Plan Administrator, has "complete and final discretionary authority to administer, enforce, construe, and interpret the Plan, including interpretation of all Plan documents, decisions relating to all questions of eligibility to participate and determination of the amount, manner and time of payment of any benefits." (Dkt. No. 290, Ex. D § 4.2(a).) The Plan further states that the Plan Administrator "may delegate responsibilities for the operation and administration of the Plan." (Id. § 4.4.)

If the Plan Administrator delegates its responsibilities, the Plan dictates the proper method of such delegations:

> Any such delegation of responsibilities shall be in writing and may be evidenced in such form as is deemed appropriate by the Plan Administrator, including, but not limited to, an executed services agreement with an insurer or other entity. Any such written delegation shall specify the responsibilities, functions and duties of the person to whom such responsibilities are delegated, including, if applicable, whether such person will be acting as a fiduciary under ERISA.

(Id.) In the case of Patient L.F., the Administrative Services Agreement unambiguously delegates this authority to United:

> You [Southwest Airlines] appoint us [UnitedHealthcare] a named, ERISA fiduciary under the Plan . . . As such, you delegate to us the discretionary authority to: [] construe and interpret the terms of the

> Plan; [] to determine the validity of charges submitted to us under the Plan; and [] make final, binding determinations concerning the availability of Plan benefits.

(Dkt. No. 277, Ex. 4 § 12.2.) The Plan Summary for Patient L.F. similarly reflects this delegation:

> The Claim Administrator is the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Claim Administrator shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact.

(Dkt. No. 163-7, Ex. A-141.)

The Court finds this delegation of authority to comply with the Benefit Plan's requirements. The delegation is in writing in an executed services agreement between United and Southwest Airlines, specifies United's responsibilities as the Plan Administrator's delegate, and that United is a fiduciary for adjudicating claims under the Plan. See Placidio v. Prudential Ins. Co. of America, 2010 WL 3118666, at *5 (N.D. Cal. Aug. 5, 2010) ("the plan documents grant discretionary authority to [the Plan Administrator]. The ASA, in turn, unambiguously conferred that authority from [the Plan Administrator] to Prudential. This is sufficient to confirm discretionary authority upon Prudential to make final decisions with respect to the payment of claims.").

Accordingly, the Court holds that United has discretionary authority to interpret and administer benefits under this Plan and will review its decisions with an abuse of discretion standard.

Patient M.E.

Finally, Patient M.E.'s Benefit Plan outlines the rights and duties of M.E.'s employer, as the Plan Administrator:

> the Plan Administrator shall have discretionary authority to determine eligibility for benefits, to construe the terms of the Plan and the

> Component Benefit Programs, to resolve questions of fact, and to decide any and all matters arising under the Plan and the Component Benefit Programs. . . the Plan Administrator shall have the following specific powers and duties with respect to the Plan . . . (d) To designate specified other persons to carry out any of its responsibilities under the Plan and the Component Benefit Programs, provided that any such designation shall be in writing and in accordance with applicable requirements of law. . .
>
> All claims for Component Benefits shall be resolved by the designated claims fiduciary in accordance with the claims filing procedures established by such claims fiduciary and described in the applicable Component Benefit Program.

(Dkt. No. 290, Ex. C. §§ 4.3, 4.5.)

Patient M.E.'s Administrative Services Agreement explicitly delegates this authority to United:

> In applying the provisions of each Plan, We [UnitedHealthcare] will use claim procedures and standards that We develop for benefit claim determination and, to the extent that We standardly communicate these procedures to individuals covered by plans We administer We will first provide these standards to Your [employer] participants. You delegate to Us the discretion and authority to use such procedures and standards. . . We will be responsible for (i) performing initial benefit determinations concerning the availability of Plan benefits, and related payment services and (ii) performing the fair and impartial review of first level appeals. With respect to these functions, You delegate to Us the discretionary authority to (i) construe and interpret the terms of the Plans and (ii) determine the validity of charges submitted to Us under the Plans.

(Dkt. No. 277, Ex. 3 §§ 4.1, 4.2.) This delegation is reflected in the language of Patient M.E.'s Plan Summary:

> The Plan Administrator [employer] or its delegate [United] has the sole and exclusive discretion to interpret, construe, to finally

> determine appeals, and apply all terms and provisions of the Plan. All decisions by the Plan Administrator or its delegates are final and binding on all parties.

(Dkt. No. 276, Ex. C at 127-28.)

Providers argue that the Plan Summary United currently relies upon is not the same Plan Summary initially provided during discovery. (Dkt. No. 300 at 8.) This is, indeed, reflected in the record. United previously attested it "inadvertently identified the incorrect John Deere plan document as relevant to Patient M.E." and substituted the correct plan document at that time. (Dkt. No. 276 at 2.) Providers argue that a failure to produce relevant documents, whether by a good faith mistake or otherwise, is in violation of Federal Rule of Civil Procedure 37 and Local Rule 37 and causes them prejudice. (Dkt. No. 278 at 4-5.) Although this untimely disclosure could be prejudicial to Plaintiffs in some cases, the Court finds that it is not for three reasons. First, United produced M.E.'s Benefit Plan which is now the controlling document for Patient M.E. Second, both plan documents grant United discretionary authority to make benefits determinations. Third, the relevant difference between the two Plan Summaries is the type of reimbursement methodology. In this Order, the Court addresses the validity of United's decision according to each type of reimbursement methodology, not necessarily by patient. Accordingly, the only effect a different reimbursement methodology makes for purposes of this Order is that the Court put Patient M.E. in the Medicare reimbursement group rather than the Reasonable & Customary group.

ii. Patients Where Plan Sponsor Informed United the Plan Summary is the Only Plan Document

United attests that it contacted the Plan Administrators for Patients J.B. (2015), J.T., N.A., and N.L. and was informed that no Plan documents exist beyond the Plan Summaries already in the record. (See Fuchsteiner Dec. Decl. ¶¶ 3-5.) However, merely accepting as true that the Plan Summaries are the only plan documents when they state on their face there are other documents is not sufficient. October 24, 2022, the Court ordered United to serve subpoenas on at least one plan sponsor that was unresponsive to United's request for additional plan documents. (Hearing Tr. 10/24/22 at 3:18-5:22.) United has not explained why it did not go to similar lengths to ensure the Plan Summaries for these

patients are, in fact, the only plan documents in existence. The Court therefore **ORDERS** United to submit a declaration detailing the steps it took to acquire the operative Benefit Plans rather than Plan Summaries. The Court may require further efforts on United's part to obtain the Benefit Plans for Patients J.B. (2015), J.T., N.A., and N.L.

Assuming that the Plan Summaries are the only Plan Documents that exist, the Court must address an issue not settled by the Ninth Circuit: what to do when *only* a Plan Summary exists. The Ninth Circuit noted in dicta that, in some cases, "particularly in the context of health plans, the SPD is sometimes argued to *be* the plan – that is, to serve simultaneously as the governing plan document." Prichard, 783 F.3d at 1170; see also 3 ERISA Practice and Litigation § 12:38 (2022) ("For certain types of plans, notably health plans, plan sponsors frequently take a 'consolidated' approach to plan document drafting where the plan document and the SPD take the form of a single document"). Lower courts applying this concept have similarly enforced the language of Plan Summaries in the absence of other plan documents. See Grace F., 2017 WL 15493334, at *4 (adopting the terms of the Benefits Guides because it was the only plan document); Dual Diagnosis Treatment Ctr., Inc., 2016 WL 6892140, at *56 (noting that if a Plan Summary was the only plan document, then it would be a consolidated plan and the Summary's terms would control). Here, the Plan Summaries are the only Plan documents in the record. Providers, like United, have been unable to acquire any additional Plan documents. The Court therefore finds the Plan Summaries constitute the operative Benefit Plans for Patients J.B. (2015), J.T., N.A., and N.L.

Additionally, Administrative Services Agreements are not themselves Plan Documents. Becker v. Williams, 777 F.3d 1035, 1039-40 (9th Cir. 2015) (holding that only documents "that provide information as to where [the participant] stands with respect to the plan, such as an SPD or trust agreement [] could qualify as governing documents") (internal quotations omitted). However, Administrative Services Agreements can be used to confirm whether an administrator has been granted discretionary authority under a plan. See, e.g., Placido v. Prudential Ins. Co. of Am., 2010 WL 3118666, at *5 (N.D. Cal. Aug. 5, 2010) (accepting an Administrative Services Agreement's conferring of discretionary authority from the plan sponsor to the insurer "as a matter of contractual agreement").

Taking these standards into consideration, the Court finds that each Plan Summary, as confirmed by their respective Administrative Services Agreements,

delegate discretionary authority to make benefits determinations to United. For clarity, the Court will address the language of each patient's Plan.

Patient J.B. (2015)

Patient J.B.'s 2015 Plan Summary unambiguously states that United has discretionary authority:

> Cablevision has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

(Dkt. No. 159-2, Ex. A-30 at 125.) Patient J.B.'s Administrative Services Agreement confirms this grant of discretion:

> You [employer] appoint us [United] a named, ERISA fiduciary . . . [and] delegate to us the discretionary authority to (I) construe and interpret the terms of the Plan, and (ii) determine the validity of charges submitted to us under the Plan.

(Dkt. No. 277, Ex. 2 § 11.2.)

Taken together, the Court finds that United was properly delegated discretionary authority to make benefits determinations with respect to Patient J.B.'s 2015 plan.

Patient J.T.

Similarly, Patient J.T.'s Plan Summary notes that United has discretion to make benefits determinations:

> Parsons Corporation has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan. . . Parsons Corporation and UnitedHealthcare have the sole and exclusive discretion to Interpret Benefits under the Plan, Interpret the terms, conditions, limitations

> and exclusions of the Plan . . [and] make factual determinations related to the Plan and its Benefits.

(Dkt. No. 162-4, Ex. A-114 at 226, 400-01.)

This delegation of authority is confirmed in Patient J.T.'s Administrative Services Agreement:

> You [employer] appoint us [United] a named, ERISA fiduciary under the Plan . . . As such, you delegate to us the discretionary authority to construe and interpret the terms of the Plan, to determine the validity of charges submitted to us under the Plan, and make final, binding determinations concerning the availability of Plan benefits.

(Dkt. No. 277, Ex. 9 § 12.2.)

Taken together, the Court finds that United was properly delegated discretionary authority to make benefits determinations with respect to Patient J.T.'s plan.

Patient N.A.

Patient N.A. has two Plan Summaries: one the 2016 Plan Summary and the 2017 Plan Summary. Both Plans use identical language to grant United discretion to make benefits determinations:

> Dayton-Phoenix Group, Inc. has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan . . . Dayton-Phoenix Group, Inc. and UnitedHealthcare have the sole and exclusive discretion to Interpret Benefits under the Plan, Interpret the terms, conditions, limitations and exclusions of the Plan . . [and] make factual determinations related to the Plan and its Benefits.

(Dkt. No. 159-9, Ex. A-50 at 19, 115; Ex. A-51 at 179, 278.) The Administrative Services Agreement confirms this grant of discretion:

> Customer appoints United a named, ERISA fiduciary . . . Customer delegates to Untied the discretionary authority to (I) construe and interpret the terms of the Plan and (ii) determine the validity of charges submitted to United under the Plan.

(Dkt. No. 277, Ex. 1 § 5.1.)

Taken together, the Court finds that United was properly delegated discretionary authority to make benefits determinations with respect to Patient N.A.'s plan.

Patient N.L.

Lastly, Patient N.L.'s Plan Summary unambiguously grants discretionary authority to United to make benefits determinations:

> We [United] have the final authority to do all of the following: Interpret Benefits under the Policy, Interpret the other terms, conditions, limitations and exclusions set out in the Policy, [and] Make factual determinations related to the Policy and its Benefits.
>
> UnitedHealthcare . . . is your Plan's Claim Fiduciary and has been delegated that responsibility by your Plan Sponsor.

(Dkt. No. 163-4, Ex. A-133 at 95, 161.) In the case of Patient N.L., the parties have not submitted other Plan documents, including an Administrative Services Agreement. In the absence of other Plan documents, the Court finds the grant of discretionary authority to United under the Plan Summary to be valid with respect to Patient N.L.

iii. Patients Where Plan Sponsor Was Unreachable

Finally, United attests that it was unable to reach the Plan Administrator of Patient A.M.'s plan to request additional documentation. (Fuchsteiner Oct. Decl. ¶ 9.) While the Plan Summary alone is typically insufficient to determine whether the Plan grants discretion, A.M.'s Plan Summary appears to follow the consolidated approach. The Plan Summary states on its face that it "serves as both the Plan Document and the SPD." (Dkt. No. 160-5, Ex. A-59 at 302.) This

arrangement is consistent with other healthcare plans where the Plan Administrator adopted a "consolidated" approach and the Plan Summary may actually be the Benefit Plan. See Prichard, 783 F.3d at 1170; see also 3 ERISA Practice and Litigation § 12:38 (2022) ("For certain types of plans, notably health plans, plan sponsors frequently take a "consolidated" approach to plan document drafting where the plan document and the [Plan Summary] take the form of a single document"). Accordingly, the Court finds the Plan Summary to be the legally operative trust document in the case of Patient A.M.

The Plan Summary language for Patient A.M. clearly grants discretion to United to make benefits determinations:

> DST Systems, Inc. has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

(Dkt. No. 160-5, Ex. A-59 at 314.) This grant of discretion is mirrored in Patient A.M.'s Administrative Services Agreement:

> You [DST Systems] grant Us [United] a named, ERISA fiduciary under the Plan . . . As such, You delegate to Us the discretionary authority to (I) construe and interpret the terms oft he Plan, (ii) to determine the validity of charges submitted to Us under the Plan, and (iii) make final, binding determinations concerning the availability of Plan benefits.

(Dkt. No. 277, Ex. 6 § 5.1.)

The Court finds this to be a proper delegation of discretionary authority to United to make benefits determinations under Patient A.M.'s Plan.

Conclusion Regarding Standard of Review

Taken together, the responsibility of performing claim processing and payment, which includes a grant of discretionary authority to "construe and interpret the terms of the Plans" indicates that the "benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for

benefits or to construe the terms of the plan." Kearney, 175 F.3d at 1089. Based on the Court's review of the Plan language for each exemplar patient, the Court finds that the applicable standard of review regarding United's interpretation of the Benefit Plans is abuse of discretion.

iv. Conflicts of Interest

Providers next argue that, should the Court apply an abuse of discretion standard, it should take into account any conflicts of interest on United's part. (Dkt. No. 149-1 at 14-15.) As analyzed above, the Benefit Plans' language for each exemplar patient grants to United the discretion to make benefits determinations, including how much it will pay for each claim under the Plans' terms. If there is a conflict of interest, such a conflict should be "weighed as a factor in determining whether there is an abuse of discretion." Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 115 (2008) (citing Firestone, 489 U.S. at 113). The significance of a conflict of interest varies from case to case and is "informed by the nature, extent, and effect on the decision-making process of any conflict of interest that may appear in the record." Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 965 (9th Cir. 2006) (en banc). Additionally, when issues regarding the nature and impact of a conflict of interest arise, "summary judgment may only be granted if after viewing the evidence in the light most favorable to the non-moving party, there are [no] genuine issues of material fact." Stephan v. Unum Life Ins. Co. of America, 697 F.3d 917, 930 (9th Cir. 2012).

The types of conflicts of interests that may arise differ between self-funded plans (those in which the benefits are paid by the employer and United acts only as an administrator) and fully-funded plans (those in which United both funds the plans and acts as an administrator). The Ninth Circuit has held that fully-funded plans produce an inherent structural conflict. See Abatie, 458 F.3d at 965 (citing Tremain v. Bell Indus., Inc., 196 F.3d 970, 976 (9th Cir. 1999). Accordingly, the Court finds there to be a conflict of interest at play for the fully-funded plans in this case. When such a conflict arises, the Court will weigh it as a factor in determining whether there was abuse of discretion. Stephan, 697 F.3d at 921. However, it is the Court's understanding that all of the ten exemplar patients at issue in this motion have self-funded plans. Therefore, the Court does not have an opportunity to address this type of conflict at this point.

Providers argue the conflict in self-funded plans arises from United's

decision to apply the Maximum Reimbursement Methodology, purportedly increasing its profits at the expense of patients and providers. (Dkt. No. 149 at 7.) In these plans, Providers contend that United's reimbursement policies allow them to generate revenue through "Shared Savings" programs incorporated into the Administrative Services Agreements. (Id. at 8.) The Administrative Services Agreements for self-funded plans provide two methods of funding: (1) a per member, per month fee, or (2) a Shared Savings program. (Paradise Depo., Dkt. No. 152-11 at 26:7-9.) The Court does not understand Providers to be arguing that the per member fee creates a conflict of interest. However, Providers do argue that the structure of the Shared Savings program incentivizes United to reduce the amount they pay to Providers in order to create greater "savings," of which they collect a certain percentage. (Dkt. No. 149 at 8.) Providers further contend that United "abruptly shifted to reimbursing claims with a Medicare-based rate" sometime "in or around 2016" because United determined it "would save them tens of millions of dollars a year." (Id., citing Mao Depo., Dkt. No. 152-10.)

Under ERISA, United has a duty to make claim determinations "solely in the interests of the [plan's] participants and beneficiaries. Stephan, 697 F.3d at 929 (quoting Glenn, 554 U.S. at 106). The Shared Savings method of funding benefits plans gives rise to a certain "degree of skepticism," as it could incentivize United to under-reimburse claims in order to earn a higher percentage of savings. Id. Although this is a contractual term agreed upon by United and the patients' employers, the incentive to under-reimburse claims remains. Furthermore, the evidence before the Court indicates that United expressly contemplated the amount United would save by implementing a Maximum Reimbursement methodology. (Mao Depo. Dkt. No. 152-10 at 28:4–29:25.) Given the way this type of plan funding is structured, the Court finds there to be no genuine dispute of fact that a conflict of interest exists in plans utilizing the Shared Savings program.

However, the Court finds there are no "indicia of bad faith or self-dealing" in the record. Abatie, 458 F.3d at 966 (noting that the presence of "malice, of self-dealing, or of a parsimonious claims-granting history" may lead a court to give the conflict of interest more weight). Providers argue that United "implemented a number of initiatives and strategies that were . . . intended . . . to discourage access and increase the patient's responsibility for the cost of treatment." (Dkt. No. 149 at 7.) However, Providers' proffered evidence in support of this assertion does not, in fact, show such malintent. Providers cite to the deposition of Debra Nussbaum, a United employee who has been with United since 2010. Nussbaum

testified the shift to a Maximum Reimbursement methodology was primarily United's customers' decisions rather than United's choice. United's customers were concerned about rising network costs and believed the Maximum Reimbursement methodology would lower those costs. (Nussbaum Depo., Dkt. No. 152-21 at 40:16-41:11.) Providers also point to the deposition testimony of Chi Mao, another United employee. In that deposition, Mao testified that United executives asked him to prepare a memorandum detailing the financial impact of implementing a Maximum Reimbursement methodology. (Mao Depo. at 28:4–29:25.) Although this memorandum indicated United would save "seven figures" by this change, the evidence viewed in the light most favorable to United does not necessitate a finding that this cost-savings was one of the ultimate, or even one a main, factor in choosing to shift reimbursement methodologies. Nevertheless, even in the absence of bad faith, conflicts of interest should still be weighed in the analysis of whether United abused its discretion. Therefore, when analyzing United's various reimbursement methodologies, the Court will take into account whether these conflicts of interest played a role in choosing to apply a specific reimbursement methodology as well as how that methodology was applied.

b. Claims Paid Pursuant to Maximum Reimbursement Methodology

United argues that it is entitled to summary judgment on claims paid pursuant to the Maximum Reimbursement methodology. (Dkt. No. 178 at 8–10.) This pertains to Patients M.E.,[10] N.A., N.L., J.S., C.R., and L.F. (Dkt. No. 273 at 2.) As previously noted, when interpreting the language of an ERISA plan, courts "apply contract principles derived from state law . . . guided by the policies expressed in ERISA and other federal labor laws." Gilliam, 488 F.3d at 1194 (internal quotations omitted). Accordingly, courts in California interpret ERISA plans by giving "effect to the parties' mutual intentions as of the time of contracting." Van Ness, 87 Cal. App. 4th at 372. Further, the Court will "look to the agreement's language in context and construe each provision in a manner consistent with the whole such that none is rendered nugatory." Dupree, 572 F.3d

[10] United incorrectly identified patient M.E.'s plan as one that was reimbursed based on the Reasonable and Customary methodology. Therefore, the Court consider Patient M.E. under the Maximum Reimbursement Methodology section rather than the Reasonable and Customary methodology section.

at 1097.

The language of the exemplar patients' Plan Summaries is undisputed.[11] (Dkt. No. 220 ¶ 92.) The relevant portion of the Maximum Reimbursement language, as reflected in each exemplar patient's Plan Summary with immaterial variations for purposes of the motions before the Court, is as follows:

> Eligible Expenses are determined based on [x]% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market . . .
>
> • When a rate is not published by CMS for the service, we use an available gap methodology to determine a rate for the service as follows:
>
> o For services other than Pharmaceutical Products, we use a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale….
>
> • When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

(See Dkt. No. 178 at 9; Dkt. No. 220 ¶¶ 91–92; Grant Decl., Dkt. No. 157, Ex. F-0 (emphasis supplied).)

United posits the Maximum Reimbursement clause should be read as a "waterfall," or a hierarchy, only progressing to the next provision if the conditions triggering a previous provision are not met. (Dkt. No. 178 at 10; Dkt. No. 233 at 5-6.) United offers testimony from its witness that this "waterfall" approach is how its employees interpreted and applied the Maximum Reimbursement clause, such that rate determination only proceeds to the next item in the list if the prior item did not apply. (Dkt. No. 233 at 6, citing Collins Decl. Ex 46, 32:13–33:2; Ex. 45, 10:9-12:23.). United also disputes that this language is ambiguous, or that it requires heightened scrutiny. (Dkt. No. 233 at 6-7.) Therefore, United argues, that where there is no negotiated rate, the plan provides that Eligible Expenses are determined based on a percentage of published rates allowed by CMS for the

[11] The Court is unaware of any language in the Benefit Plans submitted to the Court on October 24, 2022 that would alter the analysis of the reimbursement methodology language in the Plan Summaries.

"same or similar" services within a geographic market. (Dkt. No. 178 at 9.) Accordingly, United's use of Medicare rates for Specialized Nursing Facilities as a "similar" service as Substance Use Disorder treatment comports with the Plan's language. (Id. at 9–10.)

Providers contend that United's interpretation is contrary to the Plan's language. (Dkt. No. 217 at 5–8; Dkt. No. 149-1 at 10-11.) They maintain that United's calculating reimbursement rates based on the "same or similar service" language ignores other language that limits the use of a Medicare rate to instances when there is actually a Medicare rate for the same (not similar) service. (Id.) Providers read the Plan language as requiring United to "reimburse [Substance Use Disorder] claims based upon a percentage of the provider's billed charges when there is no Medicare rate for 'the service.'" (Dkt. No. 217 at 6.) They maintain that this is required because contracts must be read in an ordinary sense, and any ambiguities must be construed against the drafter. (Id. at 7–8.) Accordingly, because there is no Medicare rate for Substance Use Disorder Treatment, United's substitution of the Medicare rate for Specialized Nursing Facilities violates the Plan's language. (Id.)

The Court finds that United's interpretation of the Plan's language is in accordance with contract principles. Reading each provision in the order it is written, it is clear that the provisions are not separate "options" from which United chooses, as Providers contend. Rather, they are intended to be read one at a time. If the first provision does not apply, the reader moves on to the next until arriving at the clause that applies to a given claim. Should the Maximum Reimbursement language be read according to Providers' interpretation, it would render the phrase "or similar" irrelevant, as it would never be applicable. See Van Ness, 87 Cal. App. 4th at 372. Furthermore, the Court finds that there is no evidence a conflict of interest impacted United's decision to interpret the Maximum Reimbursement language in this manner.

For these reasons, the Court **GRANTS** United's motion in part and finds as a matter of law that United did not abuse its discretion in interpreting the Benefit Plans' language as permitting it to apply the Medicare rate for a same *or similar* service if there is no pre-negotiated rate. The Court will address Providers' arguments that United's determination that Specialized Nursing Facilities are "similar" to Substance Use Disorder treatment centers below, as Providers have moved for summary judgment on those grounds.

c. Claims Paid Pursuant to Reasonable and Customary Rate Methodology

Next, United argues that it is entitled to summary judgment on claims paid based on the determination of a Reasonable and Customary rate. (Dkt. No. 178 at 10–13; Dkt. No. 273 at 4 (identifying Patients J.B., J.T., and A.M. as exemplar patients in this category).) The claims at issue for these patients were paid pursuant to plans that contain largely identical language, the substance of which is undisputed. The language communicates that eligible expenses from out-of-network providers will be reimbursed based on a "reasonable and customary" rate. (See No. Dkt. 159-2 ("The Plan will pay (out-of-network) benefits based on the (Reasonable & Customary) charge"); Dkt. No. 162-4 at 227-28 and Dkt. No. 160-5 at 315 ("If rates have not been negotiated…Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.").)

United used one of three methodologies for the exemplar patients at issue. (Dkt. No. 178 at 11.) For certain services, United applied the rate recommended by FAIR Health, a not-for-profit company that maintains a database of privately billed health insurance claims. (Id., Dkt. No. 220 ¶ 113.) For other claims, United used a rate recommended by Viant, an independent third-party vendor that uses proprietary software to recommend a rate based on its own database of health insurance claims. (Dkt. No. 178 at 11; Dkt. No. 220 ¶¶ 114-15.) Finally, other claims were priced using a "Facility Repricer" developed by United Behavioral Health that looks at data from all out-of-network providers that submitted substance use disorder treatment claims to United, and then applies a percentile based on geographic area and level of care. (Dkt. No. 178 at 12; Dkt. No. 220 ¶¶ 125–26.) United contends that it is entitled to summary judgment on claims paid pursuant to each of these Reasonable and Customary reimbursement methodologies because its methods were reasonable and the rate determinations were not arbitrary and capricious. (Dkt. No. 178 at 13; Dkt. No. 233 at 11-13.)

Providers do not contest that claims reimbursed based on FAIR Health's database are reasonable; Providers included this reimbursement methodology in their patient sampling "to demonstrate to the Court the arbitrary and capricious disparity in reimbursements." (Dkt. No. 217 at 14.) Rather, Providers argue that the Viant methodology is not Reasonable and Customary because it is "infected with Medicare claims data for services provided by facilities that are neither the same nor similar to Providers." (Id.) Thus, they contend that the use of the Viant

Reasonable and Customary rate is arbitrary and capricious when compared to the "true" rates generated by FAIR Health. (Id. at 14–16.)

United contends that isolated citations to specific patients does not show there was an abuse of discretion. (Dkt. No. 233 at 12-13.) United further asserts that Providers incorrectly state Viant's databases utilized Medicare rates. (United Supp. at 4 n.2.) However, this assertion is contradicted by United's own Statement of Uncontested Facts. (See United SUF ¶¶ 117-122 (explaining how Viant utilizes data from the Center for Medicare and Medicaid Services).) Providers proffer evidence of large disparities between billed charges and amounts reimbursed in support of its claim that United abused its discretion in applying the Reasonable and Customary reimbursement methodology. (See Dkt. No. 217 at 14-15.) United has not presented evidence explaining why reimbursing 7% of the billed charges for one patient and 80% for another was a proper exercise of its discretion. Accordingly, there remains an issue of fact as to whether United abused its discretion in applying the Reasonable and Customary reimbursement rate based on Viant's methodology.

For these reasons, the Court **DENIES** United's motion as to claims paid on a Reasonable and Customary reimbursement rate based on Viant's methodology and **GRANTS** the motion as to claims based on FAIR Health and the Facility Repricer methodology.

d. Claims Barred by Different Plan Provisions

Next, United seeks summary judgment on certain of Providers' ERISA and contract claims based on a number of different plan provisions. (Dkt. No. 178 at 13–17.)

I. Plan Time Limitations Clauses

Many plans at issue contain language requiring lawsuits to be filed within three years after filing the claim or after written proof of loss is required to be submitted. (Dkt. No. 178 at 13.) Heimeshoff v. Hartford Life & Acc. Ins. Co., 571 U.S. 99, 109 ("We must give effect to the Plan's limitations provision unless we determine either that the period is unreasonably short, or that a controlling statute prevents the limitations provision from taking effect.") (internal quotation omitted). United contends that the claims for Patient J.B. under their 2014 and

2015 plans must be dismissed because the limitations periods expired prior to the filing of Providers' complaint in September and October of 2019. (Dkt. No. 178 at 13; Dkt. No. 273 at 5.)

ERISA does not provide its own statute of limitations for suits to recover benefits. Nathaniel W. v. United Behavioral Health, 2018 WL 3585180, at * 4 (N.D. Cal. July 26, 2018). Accordingly, Courts apply the state law statute of limitations for written contracts to ERISA claims. See Wetzel v. Lou Ehlers Cadillac Grp. Long Term Disability Ins. Program, 222 F.3d 643, 646–48 (9th Cir. 2000) Therefore, the default statute of limitations for an ERISA action to recover benefits in California is four years. See Wetzel, 222 F.3d at 646. However,"in the absence of a controlling statute to the contrary, a provision in a contract may validly limit, between the parties, the time for bringing an action on such contract to a period less than that prescribed in the general statute of limitations, provided that the shorter period itself shall be a reasonable period." Heimeshoff, 571 U.S. at 109. Accordingly, that the plans contain limitations clauses shorter than California's default does not render them per se impermissible.

Additionally, ERISA mandates that plan administrators give claimants notice of adverse benefit determination and to include in such notices specific information regarding their appeal rights. Pertinent here is the requirement that plan administrators include "any additional material or information necessary for the claimant to perfect the claim" and a "description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action." 29 C.F.R. § 2560.503-1(g). Taken together, the plans may include a shorter statute of limitations than California's default of four years, providing the shorter period is reasonable. See Heimeshoff, 571 U.S. at 109. Further, United was required to notify its members, and Providers as their assignees, of adverse benefit determination, and a description of the Plan's review procedures, including a statement of the claimant's right to bring a civil action.

Providers do not contest the plans' limitation clauses' reasonableness. Rather, they argue that the Court should apply California's four-year statute of limitations, not the Plans' limitations, for two reasons. First, Providers assert that they did not receive notice of patients' adverse benefit determination as required by ERISA; and second, Providers were entitled to pre-litigation notice of plan provisions regarding advance accrual provisions. (Dkt. No. 217 at 16–17).

Relevant to both of Providers' arguments is the principle that Providers, as assignees of their patients' ERISA claims, stand in the shoes of the patients. See Aerofund Financial, Inc. v. Elliot, 11 Fed. Appx. 792, 793-94 (9th Cir. 2001); Prof'l. Collection Consultants v. Hanada, 52 Cal. App. 4th 1016, 1019 (1997) ("An assignee stands in the shoes of the assignor, acquiring all of its rights and liabilities"). Providers are therefore entitled to all relevant notices to which the patients are entitled, and are bound by the terms of the patients' Benefit Plans and accompanying documents.

The question then becomes: what notice did United give Providers, and did it comply with ERISA's requirements? Although United provided adequate notice to its members, the same cannot be said for Providers. The exemplar patient on this issue, J.B., received notice of their "right to file a civil action under ERISA if all required reviews of your claim have been completed." (Dkt. No. 238, Ex. X-3.) This language meets ERISA's standard that adverse benefit determination of benefits include a "description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action." 29 C.F.R. § 2560.503-1(g).

However, the notice provided to J.B.'s provider, TML, states only that the non-network provider must "follow the process for appeals in the member's benefit plan document." (Dkt. No. 186 at 4, 12.) This language points TML to the patient's benefit plans for additional information. While The Ninth Circuit does not impose an "additional 'duty to inform' on claims administrators" beyond those required in the ERISA plans themselves, see Scharff v. Raytheon Co. Short Term Disability Plan, 581 F.3d 899, 907 (9th Cir. 2009), United did not give Providers either notice in Provider Explanation of Benefits or the patients' plans against which they could cross-check the plan language.

United has not presented evidence that it supplied Providers with its members' Plan documents who assigned their claims to Providers. On the contrary, Providers proffer declarations stating that United "did not provide [Providers] with the health plan documents at issue any time prior to this action, and [Providers] did not see such plan documents prior to this action." (See, e.g., Eisenbrey Decl., Ex. C. ¶ 13 (testimony that TML did not have pre-litigation access to the Benefit Plans of Plan Summaries); Rowe Decl., Ex. U-45, 118:19 - 119:15 (deposition testimony that Addiction Alliance Health requested Plan Summaries from United and did not receive them).) See White v. Jacobs Eng'g

Grp. Long Term Disability Benefit Plan, 896 F.2d 344, 350 (9th Cir. 1989) ("[A]n administrator should not be permitted to deter a claimant from filing a timely appeal by . . . withholding information claimants need to appeal effectively.) (internal quotations omitted).

Because the Provider Explanation of Benefits did not give Providers notice of the members' Benefit Plan time limitations, nor did United give Providers access to the Plan documents themselves, United has not met its burden to show the absence of a genuine dispute of material fact on this claim. For these reasons, the Court **DENIES** United's motion for summary judgment on the grounds that Providers did not comply with the Plans' time limitations.

ii. Failure to Exhaust Administrative Remedies

United's argument that some claims must be dismissed because certain Providers had notice of appeal rights and failed to exhaust their administrative remedies[12] fails for similar reasons. (Dkt. No. 178 at 13–15.) As United has identified J.B. as the exemplar patient for this argument, the same facts regarding Providers' access to the Benefit Plans apply here as well. (Dkt. No. 273. at 5-6.)

"As a general rule, an ERISA claimant must exhaust available administrative remedies before bringing a claim in federal court." Spinedex, 770 F.3d at 1298 (quoting Barboza v. Cal. Ass'n of Prof'l Firefighters, 651 F.3d 1073, 1076 (9th Cir. 2011). "ERISA does not explicitly require a participant or beneficiary to exhaust administrative remedies prior to filing suit, but federal courts have held, based on ERISA's text and legislative history, that 'an ERISA plaintiff claiming a denial of benefits must avail himself or herself of a plan's own internal review procedures before bringing suit in federal court.'" Greiff v. Life Ins. Co. of N. Am., 386 F. Supp. 3d 1111, 1113 (D. Ariz. 2019) (quoting Vaught v. Scottsdale Healthcare Corp. Health Plan, 546 F.3d 620, 626 (9th Cir. 2008)). However, "a claimant need not exhaust when the plan does not require it." Spinedex, 770 F.3d at 1299. Additionally, "an administrator should not be permitted to deter a claimant from filing a timely appeal 'by sending vague and

[12] Providers argue that the "Court already ruled in favor of Plaintiffs on exhaustion." (Dkt. No. 217 at 18.) However, in that order, the Court merely held that Providers' allegations that United failed to instruct Providers that they must appeal adverse decisions were "sufficient to avoid dismissal for failure to exhaust." (Order at 7.)

inadequate appeal notices, withholding information claimants need to appeal effectively.'" White, 896 F.2d at 351 (internal quotations omitted.)

As noted above, United sent an Explanation of Benefits to both J.B. and TML notifying them of J.B.'s adverse determination of benefits. However, the language in each notice was different. The notice provided to J.B. specifically notified the patient of their "right to file a civil action under ERISA if all required reviews of your claim have been completed." (Dkt. 238, Ex. X-3.) That this language communicates to J.B. the need to exhaust administrative remedies is undisputed. (Dkt. No. 220 ¶ 202.) It is similarly undisputed that J.B.'s Plan Summary itself contains language that clearly communicates to J.B. the need to exhaust administrative remedies prior to filing suit. (Id. ¶¶ 204-05.) Finally, it is undisputed that the Explanation of Benefits sent to TML did not contain such language. (Id. ¶ 200.) Rather, the Providers' Explanation of Benefits documents only indicated that an authorized representative *may* request reconsideration or appeal." (Id.)

United argues that the language from J.B.'s Explanation of Benefits and Plan Summary should satisfy its notice requirements to TML as the assignee. (Dkt. No. 233 at 17.) The Court disagrees. As the Court noted in its Order deciding United's Motion to Dismiss, "assignees take the 'rights that belong to the patients at the time of assignment.'" (Order at 7, quoting United MTD at 5.) This includes the right to be notified of any adverse benefit determination, including "any additional material or information necessary for the claimant to perfect the claim" and a "description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action." 29 C.F.R. § 2560.503-1(g). The information in the Explanation of Benefits United gave to TML does not meet this standard. Other courts have held that sending a Provider an Explanation of Benefits that does not adequately communicate the requirement of administrative exhaustion is insufficient under ERISA. See, e.g., Brand Tarzana Surgical Inst. v. Aetna Life Ins. Co., 541 F. Supp. 3d 1031, 1036-37 (C.D. Cal. 2021). Additionally, although the Ninth Circuit has not addressed this particular question, other circuits have held that inadequate notice excuses a party from its obligation to exhaust administrative remedies prior to filing a civil suit. See Bourgeois v. Pension Plan for Emps. of Santa Fe Int'l Corps., 215 F.3d 475, 482 (5th Cir. 2000); Strom v. Siegel Fenchel & Peddy P.C. Profit Sharing Plan, 497 F.3d 234, 246 (2d Cir. 2007); Cromer-Tyler v. Teitel, 294 F. App'x 504, 508 (11th Cir. 2008).

United attempts to distinguish two cases in which courts found that insurance companies' inadequate notices obviated claimants' obligation to exhaust administrative appeals. Laura B v. United Health Grp. Co., 2017 U.S. Dist. LEXIS 137174, at *12-13 (N.D. Cal. Aug. 25, 2017); Greiff, 386 F. Supp. 3d at 1114-16. In those cases, the Plan Summaries did not state that the exhaustion of administrative remedies was a mandatory prerequisite to filing a civil action. See Greiff, 386 F. Supp. 3d at 1114-15; Laura B, U.S. Dist. LEXIS 137174 at *13-15. Here, United argues, the Plan Summaries "provide[] that no legal action can be brought until all appeal procedures have been exhausted." (Dkt. No. 233 at 17.) However, this distinction is immaterial in this case as United never provided the Benefit Plans to Providers. As analyzed above, Providers were entitled to the same notice that United's members were. Therefore, the Providers' Explanation of Benefits are insufficient to meet United's burden on summary judgment.

For these reasons, the Court **DENIES** United's motion on these grounds.

iii. Failure to Collect Member Responsibility Amounts

United next argues that it is entitled to summary judgment on claims where Plaintiffs did not collect member responsibility amounts. (Dkt. No. 178 at 15–17.) United argues that for Patients NL, J.S., and C.B., Providers' claims fail as a matter of law because the applicable plans provide that no benefits are available if a non-network provider, like Providers in this case, fail to collect co-payments, co-insurance, or deductibles (collectively "member responsible amounts") from members.[13] (Id. at 15; Dkt. No. 220 ¶ 246.)

The plan provisions at issue here purport to allow United to withhold benefits for services for which a non-network provider "waives, does not pursue, or fails to collect Copayment, Coinsurance, any deductible or other amount owed for a particular health service." (Dkt. No. 273; Dkt. No. 158-2 at 487-88, 639-40; Dkt. No. 163-4 at 78-79; Dkt. No. 164-3 at 88-90.) As an initial matter, this scheme is permissible. See Kennedy v. Conn. Gen. Life Ins. Co., 924 F.2d 698, 702 (7th Cir. 1991) (upholding summary judgment in favor of insurer because "if

[13] The Court notes that United "is not moving for summary judgment on plans that exclude benefits where a provider 'waives' member responsibility amounts," as opposed to not pursuing or failing to collect those amounts. (Dkt. No. 178 at 16, n.16.)

[the provider] wishes to receive payment under a plan that requires co-payments, then [it] must collect those co-payments–or at least leave the patient legally responsible for them"); Smile care Dental Grp. v. Delta Dental Plan of Cal., Inc., 88 F.3d 780, 783 (9th Cir. 1996) (noting that the Ninth Circuit "adopted the Seventh Circuit's reasoning" in Kennedy, "approving an insurer's prohibition on providers' waiver of patient co-payments because 'waivers annul the benefits of the co-payment system'") (quoting Deviates v. Delta Dental Plan of Cal., 946 F.2d 1476, 1477 n.1 (9th Cir. 1991)).

The parties dispute how the plans' language should be interpreted. The full language of this provision for the exemplar patients' plans state with immaterial variations that "[i]n the event an out-of-Network provider waives, does not pursue, or fails to collect Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived." (Dkt. No. 158-2 at 488; Dkt. No. 163-4 at 79; Dkt. No. 164-3 at 89.)

In United's view, the language's meaning is clear: United may withhold benefits when a non-network provider waives, or does not pursue, or fails to collect co-payments or other member responsible amounts. (Dkt. No. 178 at 15.) Providers argue this language should be interpreted such that benefits are not available only if the Coinsurance and/or deductible are *waived*. (Dkt. No. 217 at 19.) However, the clause initially describes an event where the provider "waives, does not pursue, or fails to collect" the deductible. If the Court were to adopt Providers' view of the word "waived," the remainder of that first clause would be meaningless. See Turlock Irrigation Dist. v. FERC, 903 F.3d 862, 872 (9th Cir. 2018) ("We will not interpret a contract so as to render one of its provisions meaningless."). Thus, United is not required to provide evidence of affirmative waiver in order for this provision to apply.

Next, Providers argue that United waived this argument because it did not provide pre-litigation notice to Providers of these plan provisions. (Dkt. No. 217 at 19–20.) However, unlike with United's claims regarding failure to exhaust or time limitations, ERISA does not require United to provide notice as to a prerequisite of collecting Member Responsible Amounts. See 29 C.F.R. § 2560.503-1(g)(1)(iv) (requiring plan administrators to provide, in part, "[a] description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action

under Section 502(a) of the Act following an adverse benefit determination on review"). Therefore, the Court finds that Providers were not entitled to pre-litigation notice of their responsibility to collect Member Responsible Amounts.

Providers next argue United suggested to them that billing and collection of member responsible amounts was optional. (Dkt. No. 217 at 20.) Providers assert that the language of documents received from United's repricing agent, MultiPlan, communicated that Providers "retain[ed] the right" to collect member responsible amounts. (Id.) However, Providers misunderstand the Plan language. In addition to stating that Providers retained the right to collect member responsible amounts, the Plans also state "Provider shall not waive any such patient responsibility amounts due directly from the patient" and "Payment of benefits, if any, is subject to the terms and conditions of the Patient's plan." (Dkt. No. 233 at 19.) The language Providers cite must be considered in light of the first set of provisions quoted by United that expressly state that waiver is not permitted and the terms and conditions of the Plan must be followed. (Id.)

Finally, Providers argue that United's contentions should only apply to specific claims prior to the out of pocket maximum being reached. (Dkt. No. 217 at 20–21.) However, the mere accumulation of expenses billed is not the determining factor. The pertinent question is whether the patients actually paid any out of pocket expenses for deductibles. (Dkt. No. 233 at 20.) Providers have not presented evidence showing that the exemplar patients actually paid the required out-of-pocket expenses. Therefore, Providers have not presented any evidence that creates a dispute of material fact as to whether that threshold condition is satisfied.

For these reasons, the Court **GRANTS** United's motion as to claims for which Providers did not collect the required member responsible amounts.

2. United's ERISA and Breach of Contract Counterclaims

United also moves for summary judgment on its Breach of Contract and ERISA counterclaims for patient plans that prohibit United from paying benefits

in the event the Provider fails to collect Member Responsibility Amounts.[14] (Dkt. No. 178 at 15-17.) As analyzed above, Providers did not collect Member Responsibility Amounts for many patients. (Dkt. No. 207-1 ¶ 247.) Based on this failure, United contends that it overpaid benefits for each of these patients and argues that it is entitled to equitable restitution in the amount it overpaid.

ERISA provides an avenue for equitable relief where the party seeking such relief can prove "(1) that there is a remediable wrong, *i.e.*, that the plaintiff seeks relief to redress a violation of ERISA or the terms of a plan; and (2) that the relief sought is 'appropriate equitable relief.'" Gabriel v. Alaska Elec. Pension Fund, 773 F.3d 945, 954 (9th Cir. 2014). United seeks restitution through the imposition of an equitable lien by agreement and a constructive trust over the amounts United alleges it overpaid to Providers as a result of Providers' misrepresentations and failure to collect Member Responsible Amounts. (Dkt. No. 207 at 8.)

An equitable lien by agreement requires establishment of three elements: "*First*, there must be a promise by the beneficiary to reimburse the fiduciary for benefits paid under the plan in the event of a recovery from a third party. *Second*, the reimbursement agreement must 'specifically identify] a particular fund, distinct from the [beneficiary's] general assets,' from which the fiduciary will be reimbursed. *Third*, the funds specifically identified by the fiduciary must be 'within the possession and control of the [beneficiary].'" Bilyeu v. Morgan Stanley Long Term Disability Plan, 683 F.3d 1083, 1092-93 (9th Cir. 2012) (quoting Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356, 363-64 (2006) (internal citations omitted).

The undisputed facts show Bilyeu's first prong is met by virtue of Providers' status as assignees of the patients' benefit plans. Although Providers dispute they promised United to reimburse them for any amount, this argument is unavailing. As previously discussed, Providers are their patients' assignees, submitted claims on their behalf, and accepted payments from United. They are therefore subject to the patients' plan terms. United points to specific terms in patients' plans that reserve the right to recover overpayments. (See Dkt. No. 158-7, Ex. A-21; Dkt. No. 162-5, Ex. A-115; Dkt. No. 163-3, Ex. A-130.) The Court

[14] United does not move for summary judgment on plans which prohibit United from paying benefits in the event the Provider *waives* Member Responsibility Amounts.

notes that none of the three plans United points to correspond to the plans of the 10 exemplar patients, and the Court declines to hunt for this language in the thousands of pages of plans. However, to the extent those 10 patients' plans contain similar language granting the right to seek recovery of overpayments, the Court's analysis applies.

As to Bilyeu's second prong, United has presented sufficient evidence to support a finding that the funds sought are "specifically identified." In that case, Bilyeu had a long-term disability plan through her employer which was administered by Unum. Bilyeu, 683 F.3d at 1083. Under the plan terms, Bilyeu agreed to reimburse Unum "any overpayment resulting from my receipt of benefits from other sources." Id. at 1090. After filing for long-term disability, Bilyeu received payments from both Unum and from social security disability benefits, but did not reimburse Unum. Id. at 1091. Unum sought the imposition of an equitable lien under ERISA, alleging that "once Bilyeu received her social security disability benefits, the specifically identified fund – the overpaid long-term disability benefits – came into existence, and Unum was allowed to impose a lien against that fund." Id. at 1093. The Ninth Circuit rejected this argument, finding that the overpayment amount was specific, but as "property or as a fund . . . the overpayment is lacking in specificity because it is an undifferentiated component of a larger fund." Id. Here, conversely, United does not seek an "undifferentiated component of a larger fund," but rather the entirety of benefits it paid for all plans in which Providers waived or did not otherwise collect Member Responsible Amounts. (Dkt. No. 207 at 9.) Therefore, United has met its burden on Bilyeu's second prong.

However, the Court finds that United cannot meet its burden establishing that Providers currently maintain possession over the specific funds United paid them in connection with these patients. Under the third prong of Bilyeu's analysis, United must show that Providers still possess the specific funds it seeks in restitution. Bilyeu, 683 F.3d at 1094. The court in Bilyeu declined to impose an equitable lien where the overpaid benefits were no longer in Bilyeu's possession because she had spent them. Id. In doing so, the court expressly declined to follow other circuits' holdings that a fiduciary could assert an equitable lien even if the beneficiary no longer possessed the specifically identifiable funds. Id. The court held that "Unum's argument that an equitable lien can be enforced against general assets when the specifically identified property has been dissipated finds no support in the traditional doctrine governing equitable liens by agreement." Id.

at 1095 (citing 4 Pomeroy, *A Treatise on Equity* § 1235, p. 696 (5th ed.1941)). Accordingly, "[i]f the property or fund subject to the lien (or proceeds to which the property or fund can be traced) are no longer in the defendant's possession, then there is no *res* against which the equitable lien can be enforced." Id. (citing 53 C.J.S. *Liens* § 46 (2012).

Here, the Court finds that there remains a dispute of fact on this prong. United asserts that its expert, Josiah Lamb, "traced funds paid by United for specific patients into specific bank accounts" of Providers. (Dkt. No. 207 at 10.) However, Lamb's report indicates that, after Providers deposited the funds paid by United into their accounts, they used the money to pay current and former owners of Providers. (Lamb Decl. at 2.) Because no current or former owners are parties to this action, the money used to pay them is no longer in Providers' possession. See Bilyeu, 683 F.3d at 1094 (if the funds are no longer in "the defendant's possession, then there is no *res* against which the equitable lien can be enforced.")

Lamb's report further concludes that money paid by United was "transferred the funds to related-entity bank accounts." (Lamb Decl., 6-9.) Although Lamb's report does not identify these accounts "related-entity" or explain whether or how they are controlled by Providers, the Court finds there to be a triable issue of fact as to whether the funds United paid Providers are still in Providers' possession. However, the opposite is also true – Lamb's assertions are insufficient to show that Providers currently possess the specific funds paid by United such that imposing an equitable lien is appropriate as a matter of law. See Bilyeu, 683 F.3d at 1095 ("that the fiduciary must recover from specifically identified funds in the beneficiary's possession, rather than from general assets"); Cf. Sereboff, 547 U.S. at 363 (imposing an equitable lien on specifically identified funds that were "within the possession and control of the Sereboffs, . . . set aside and preserved in the Sereboffs' investment accounts).

As the requirements for establishing an equitable lien by agreement and a constructive trust are essentially the same for purposes of this motion, the Court holds its analysis applicable to United's request to impose a constructive trust in addition to an equitable lien. See, e.g., Great-West Life & Annuity Ins. Co. v. Knudson, 534 U.S. 204, 213-14 ("Where the property sought to be recovered or its proceeds have dissipated so that no product remains, the plaintiff's claim is only that of a general creditor, and the plaintiff cannot enforce a constructive trust or an equitable lien upon other property of the defendant.")

Accordingly, the Court **DENIES** United's motion for summary judgment on its claims for equitable relief under ERISA.

3. Breach of Oral Contract

United next argues that it is entitled to summary judgment on Providers' claim for Breach of Oral Contract because Providers have not established a genuine issue of material fact as to a "meeting of the minds," the terms of the contracts, or the presence of adequate consideration. (Dkt. No. 178 at 17-20.)

The elements of a breach of contract claim are (1) the existence of a contract, (2) performance or excuse for nonperformance, (3) defendant's breach, and (4) damages. Oasis West Realty, LLC v. Goldman, 51 Cal. 4th 811, 821 (2011). An oral contract requires the same elements as a written contract. Cal. Civ. Code § 1550. "Consent is not mutual, unless the parties all agree upon the same thing in the same sense." Id. at § 1580. Additionally, the terms of a contract "must be definite enough that a court can determine the scope of the duty." See Ladas v. California State Auto. Ass'n., 19 Cal. App. 4th 761, 770 (1993). "Where a contract is so uncertain and indefinite that the intention of the parties in material particulars cannot be ascertained, the contract is void and unenforceable." Id. (internal quotations omitted).

Here, Providers allege the presence of an oral contract based on the verification of benefits and pre-authorization of treatment calls. (See TAC ¶¶ 263-269.) However, the undisputed evidence shows that no oral contract was formed at the time of the Verification of Benefits calls because neither party had sufficient information to constitute a meeting of the minds as to the specific terms of a contract. It is undisputed that, at the time of the verification call, Providers and their billers did not know what the eligible expenses would be or how much United would ultimately pay. (Dkt. No. 220 ¶ 293.) Additionally, Providers' billers understood the call to be a "verification that the client has the benefits," but not a "verification that the client meets the medical necessity for the need to use benefits." (Id. ¶ 296.) See Cedars Sinai Medical Center v. Mid-West Nat. Life Ins. Co., 118 F. Supp. 2d 1002, 1008 (C.D. Cal. 2000) (granting summary judgment where neither party understood conversations about verification of coverage to create a contract). Providers allege that United "orally promised to pay" them for the treatment they provided to United members "equal to a percentage of their covered charges." (TAC at ¶ 264.) However, the evidence

does not support such an allegation. Rather, the undisputed facts show that the amount payable under a member's plan is determined only after receiving the claim, reviewing it, and by applying the plan's terms and limitations to the provider's charge. (Dkt. No. 220 ¶¶ 257, 296.) A verification that a member is insured with United cannot, without more, "be construed as a binding contractual agreement." Tenet Healthsystem Desert, Inc. v. Fortis Ins. Co., Inc., 520 F. Supp. 2d 1184, 1194 (C.D. Cal. 2007) (internal quotations omitted).

United does not argue that there was no oral contract was created at the time of the Pre-Authorization calls. The Court therefore leaves that question of fact for the jury.

For these reasons, the Court **GRANTS in part** and **DENIES in part** United's motion for summary judgment as to Providers' claim for Breach of Contract.

4. Promissory Estoppel

Similarly, United argues that Providers' claim for Promissory Estoppel is not supported by the undisputed facts and it is therefore entitled to summary judgment. Under California law, a promissory estoppel claim requires (1) the existence of a promise with clear and unambiguous terms; (2) reliance on that promise by the promisee; (3) that the reliance was reasonable and foreseeable; and (4) that the promisee was injured by relying on the promise. See Orcilla v. Big Sur, Inc., 244 Cal. App. 4th 982, 1007 (2016).

United asserts that it "does not make promises of future payment" during Verification of Benefit calls. (Dkt. No. 178 at 21.) Rather, United "merely confirms members have coverage and provides information about that coverage." (Id.) The undisputed facts support this argument. During Verification calls, United representatives give Providers information regarding members' out-of-network benefits, but do not make representations about how the claims associated with the proposed treatment will be paid. (Dkt. No. 220 at ¶ 254.) As courts in this district have repeatedly held, "within the medical insurance industry, an insurer's verification is not the same as a promise to pay." ABC Servs. Grp. v. Health Net of Cal., Inc., 2020 U.S. Dist. LEXIS 78397, at *21 (C.D. Cal. May 4, 2020) (quoting TML Recovery, LLC v. Humana Inc., 2019 WL 3208808, at *4 (C.D. Cal. Mar. 4, 2019)). Additionally, the evidence in the record reflects that

Providers' third-party billers, with whom United spoke during Verification calls, did not understand United's verification of benefits to constitute a guarantee of payment. At least two of these billers testified that during Verification calls, the billers did not ask whether Providers would be paid for their services, and United did not represent as much. (See Dkt. No. 220 ¶¶ 294, 297.)

Because there is no genuine dispute as to whether United made a promise of future payment during Verification calls, nor that Providers understood them as such, the Court **GRANTS** United's motion for summary judgment on Plaintiff's claim for promissory estoppel.

5. Unfair Competition Law

Finally, United contends that it is entitled to summary judgment on Providers' Unfair Competition Law claim for five reasons: (1) Providers have not presented evidence that they have suffered an injury; (2) Providers have an adequate remedy at law; (3) Providers impermissibly seek general compensatory damages; (4) ERISA preempts Providers' UCL claim; and (5) Providers have not presented evidence of substantive violation of Federal Parity laws. (Dkt. No. 178 at 23-28.) Because the Court finds no genuine dispute of material fact as to Providers' injury, the Court will not address United's other arguments under this claim.

California's UCL requires "the plaintiff to be the one 'who has suffered injury in fact and has lost money or property as a result of the unfair competition." Amalgamated Transit Union, Local 1756, AFL-CIO v. Superior Ct., 46 Cal.4th 993, 1002 (2009) (quoting Cal. Bus. & Prof. Code § 17204). Consequently, "an injured [party's] assignment of rights cannot confer standing on an uninjured assignee." Id. Therefore, in order to recover under the UCL, Providers themselves must have been directly injured by United's unfair competition.

United argues that Providers have been unable to produce evidence to substantiate their allegations that their injury was in the form of "lost revenue necessary to keep their businesses in operation." (See TAC ¶ 279.) United asserts, and Providers do not contest, that Providers have "disclaimed that damages theory," leaving only the members' injuries whose claims Providers have been assigned. (Dkt. No. 178 at 24 ("In a stipulation by counsel, Plaintiffs deny seeking damages for 'business interruption' and 'lost profits.'").) See also Fed. R.

Civ. P. 56(e)(2) ("If a party fails to properly support an assertion of fact or fails to properly address another party's assertion of fact . . ., the court may . . . consider the fact undisputed.").

Providers' arguments in rebuttal are unpersuasive. First, Providers re-state allegations from their complaint that a "lower reimbursement rate results in a greater balance bill that the [out-of-network] provider must send to the patient in order to be fully reimbursed." (Dkt. No. 217 at 28.) In addition to not being accompanied by a citation to any facts in the record, this assertion merely shows that Providers' UCL claims are premised on harm to their patients, not to Providers directly. Similarly, Providers state in their opposition that "United is creating an economic barrier to accessing [Substance Use Disorder] treatment by driving down reimbursement rates . . . to the point where the providers can no longer stay in business to provide these essential healthcare benefits." (Id.) However, the 35-page expert report to which Providers cite in its entirety without specific page citations does not support the notion that Providers "can no longer stay in business" because of United's reimbursement practices. See In re Wellpoint, Inc. Out-of-Network "UCR" Rates Litig., 903 F. Supp. 2d 880, 898-99 (C.D. Cal. 2012) (finding that Provider Plaintiffs lacked UCL standing to the extent they were "suing as assignees of [the assignor's] claims"). Finally, Providers point the Court to Ryan S. v. UnitedHealth Group for the notion that "the individual patient is not the one suffering harm as a result of United's wrongful reimbursement policies." 2022 WL 883743 (9th Cir. Mar. 24, 2022). However, that case is wholly inapplicable to the facts before the Court because it involved a putative class action and does not allege a UCL claim.

For these reasons, the Court finds that there is no dispute of material fact as to whether Providers have standing to bring a UCL claim and therefore finds it unnecessary to address United's other arguments. Accordingly, the Court **GRANTS** United's motion for summary judgment on Providers' UCL claim.

C. Providers' Motion for Summary Judgment

Providers move for partial summary judgment on their first cause of action for denial of ERISA benefits and the second cause of action for breach of written contract. (See Dkt. No. 149-1 at 1.) Providers additionally move for summary judgment on all eight of United's counterclaims. (Dkt. No. 144 at 6-15.) The Court will address each in turn.

1. Specialized Nursing Facilities

As analyzed above, the Court finds as a matter of law that the Benefit Plans grant United discretion to interpret the terms of the plans, and their determinations are therefore reviewed under an abuse of discretion standard. See Kearney, 175 F.3d at 1089. Further, the Court finds that United did not abuse its discretion in interpreting the plan language as permitting apply a percentage of a Medicare-based rate for the same *or similar* service.

Accordingly, the Court will address Providers' arguments as to whether United's use of a Medicare rate for Specialized Nursing Facilities to reimburse claims for care provided at Substance Use Disorder treatment clinics was an abuse of discretion. First, Providers argue that they are entitled to summary judgment on the issue of whether United abused its discretion in applying the Medicare rate for Specialized Nursing Facilities to claims associated with treatment provided at Substance Use Disorder treatment facilities. (Dkt. No. 149-1 at 5.) It is uncontested that there is no Medicare rate for Substance Use Disorder treatment centers. (See Dkt. No. 220 ¶¶ 923-99.) The parties strongly dispute, however, whether Specialized Nursing Facilities are sufficiently comparable to Substance Use Disorder treatment centers to render them "similar."

Providers contend that United's Skilled Nursing Facilities are not the same as, and alternatively not sufficiently similar to, Substance Use Disorder treatment centers. (Dkt. No. 149-1 at 5.) Providers point to the testimony of Debra Nussbaum in which she differentiates between Substance Use Disorder treatment centers and Skilled Nursing Facilities (Collins Decl., Ex. LL at 65:1-66:25; 76:14-77:18.) Additionally, Providers offer the testimony of their expert, Dr. Barthwell, how the Skilled Nursing Facility rates reflect "no recognition of the work that goes into treating individuals with a substance use disorder and managing their care in the complex environment." (Collins Decl. Ex G.)

In opposition, United asserts that the care provided at Specialized Nursing Facilities is similar to that provided at Substance Use Disorder treatment centers such as Providers' due to the similar "types and intensity of services between treatment received in skilled nursing facilities and substance abuse rehabilitation facilities." (Dkt. No. 211 at 12.) United asserts that its determination to reimburse Substance Use Disorder claims at a Specialized Nursing Facilities rate "was a result of a deliberate, principled reasoning process and is supported by substantial

evidence." (Id.; Dkt. No. 220 ¶¶ 99-101.)

The Court finds that there is a triable issue of fact as to whether United abused its discretion in reimbursing Substance Use Disorder claims at a Specialized Nursing Facilities rate. Although Providers are correct that these two types of care are not the same, as analyzed above, the Plans' language permits United to reimburse a percentage of the Medicare rate for the same service, or a *similar service*. Providers have not met their burden in showing no genuine dispute of fact as to the differences regarding these types of care. Further, while Providers argue that Substance Use Disorder treatment centers and Specialized Nursing Facilities are not sufficiently similar, United has proffered evidence sufficient to create a genuine dispute of fact as to whether they abused their discretion in choosing this reimbursement methodology.

Therefore, the Court **DENIES** Providers' motion for summary judgment as to its ERISA and Breach of Contract Claims on this issue.

2. Providers' Motion for Summary Judgment on United's Use of a Per Diem Rate

Next, Providers argue that they are entitled to summary judgment on their ERISA and Breach of Contract claims based on United's use of a per diem rate for acute inpatient care. (Dkt. No. 149-1 at 15.) Providers argue that United's use of Medicare rates to calculate a per diem rate for acute inpatient claims is impermissible because Providers "have not contracted with [United] for a per diem rate," and the plans do not "authoriz[e] [United] to unilaterally impose a single day per diem rate" resulting in a lower reimbursement rate. (See Dkt. No. 149-1 at 15.) United counters that the Plans do, in fact, "provide notice to members that payment of claims are based on United's various reimbursement policy guidelines." (Dkt. No. 220 ¶ 88; Dkt. No. 211-1 ¶ 3.)

The Court holds that Providers have not met their burden in showing that United abused its discretion in applying a per diem rate to reimburse claims for acute inpatient care. In support of its contention, Providers cite to the entirety of two exhibits with no pincites. See Local Rule 56(c)(1)(A). Although the Court is not required to search through Providers' documents to locate the information they purport it contains, the Court did so in this case, and found that the cited depositions do not support Providers' contentions. Further, as analyzed above, the

Plans permit United to reimburse based on a percentage of Medicare rates for the "same or similar service." United's evidence shows that United used a Medicare rate for Inpatient Psychiatric Facility to reimburse for acute inpatient care claims from Providers. (See Dkt. No. 220 ¶ 98.) As Providers have not presented any evidence that acute inpatient care is not the "same or similar" as Inpatient Psychiatric Facility, the Court **DENIES** Providers' Motion for Summary Judgment as to their ERISA and Breach of Contract claims on this issue.

3. Fraud

Providers additionally seek summary judgment on each of United's counterclaims. Providers first argue that they are entitled to summary judgment on Count I of United's Counterclaim to the extent this claim is based on Providers' waiver of Member Responsible Amounts. To prove fraud, United must establish (1) a misrepresentation (concealment or nondisclosure); (2) knowledge of falsity; (3) intent to defraud; (4) justifiable reliance; and (5) resulting damage. Lazar v. Superior Ct., 12 Cal. 4th 631, 638 (1996). Providers argue that United's claim for fraud fails as a matter of law as to the first prong because United cannot present evidence that Providers waived Member Responsibility Amounts, nor did they make any representations to United regarding waiver, non-waiver, or collection of Member Responsible Amounts. (Dkt. No. 144 at 6.) Providers further argue that they expected United members to pay their Member Responsible Amounts, and the members were advised as such and agreed in writing that they are responsible for these amounts. (See DDR Decl., ¶ 9B; TML Decl., ¶ 9B; WRC Decl., ¶ 9B; Kool Decl., ¶ 9B; PPR Decl., ¶ 9B; Inland Decl., ¶ 9B; SCAC Decl., ¶ 9B; AHA Decl., ¶ 9B.)[15]

United has not presented any direct evidence of waiver in rebuttal. United asserts that at least one provider, SCAC, "admitted in contemporaneous correspondence that it waived Member Responsible Amounts." (Dkt. No. 207 at 6.) However, the evidence to which United cites does not, in fact, support this assertion. Rather, the correspondence concerns potential financial hardship, and does not reference Member Responsible Amounts in any capacity. (See Rowe

[15] United contends that Providers' evidence on this issue constitutes "self-serving declarations" and should not be admitted. (Dkt. No. 207 at 6.) However, it is not for the Court to weigh the evidence or make any findings of credibility at this stage. See Manley v. Rowley, 847 F.3d 705, 711 (9th Cir. 2017).

Decl., Ex. 20.)

United alternatively argues that the "systematic failure to collect" Member Responsible Amounts constitutes circumstantial evidence of waiver. (Dkt. No. 207 at 6.) Specifically, United contends that Providers' undisputed failure to collect Member Responsible Amounts from nearly all patients is evidence that Providers' waived members' individual contributions. (See First Rowe Decl., Exs. N-1 - N-9.) Although the cases United cites in support of this argument are not directly applicable, they do support the notion that a repeated failure to collect Member Responsible Amounts and subsequently not accounting for that failure on claims submitted to the insurance company constitutes a misrepresentation. See, e.g., Aetna Life Ins. Co. v. Bay Area Surgical Mgm't., LLC, 2016 Cal. Super. LEXIS 161, at *7-9 (Feb. 24, 2016) (finding a triable issue of material fact as to whether providers' affirmative representation of the "total amounts charged" on claims forms was accurate when they did not include an accounting for waived Member Responsibility Amounts); United States v. Chang, 2018 U.S. Dist. LEXIS 227830, at *25 (C.D. Cal. June 1, 2018) (finding that the complaint's allegations that providers "routinely waived co-payments" and subsequently certified on the claims submitted to insurance companies that they charged such co-payments and deductibles was sufficient to state a claim for fraud); Nutrishare, Inc. v. Conn. Gen. Life Ins. Co., 2014 U.S. Dist. LEXIS 33904, at *4 (E.D. Cal. Mar. 13, 2014) (noting that insurance company successfully stated a claim where it alleged that a provider "told some participants that they would not be billed at all" for provider's services, and did not inform the insurance company they were "not charging the required co-payments, deductibles, or coinsurance").

Additionally, United proffers a publication from the Office of the Inspector General to support its argument that Providers' failure to collect Member Responsibility Amounts "is functionally identical to the waiver of these amounts." (Dkt. No. 207 at 5.) While United overstates the report's substance, the Court nonetheless finds it useful to the present analysis. The cited line is part of a list titled "Indications of Improper Waiver of Deductibles and Copayment." 59 Fed. Reg. 65372. The non-exhaustive list includes instances such as "[f]ailure to collect copayment or deductibles for a specific group of Medicare patients for reasons unrelated to indigency" may be an indication of improper waiver of deductibles and copayment. Id. Although Providers' practice does not rise to this level, the Court finds that there remains a dispute of fact regarding whether Providers' failure to collect Member Responsible Amounts constituted a waiver.

For these reasons, the Court **DENIES** Providers' motion as to Count I of United's counterclaim to the extent it is based on Providers' waiver of Member Responsible Amounts. As Providers have not requested summary judgment on United's claim for fraud "based on allegations that Providers billed for services not performed or not medically necessary," the Court also leaves this question for the jury

4. Negligent Misrepresentation

Providers next move for summary judgment on United's claim for negligent misrepresentation. To prove a claim for Negligent Misrepresentation, United must show (1) a misrepresentation of a past or existing material fact, (2) without reasonable ground for believing it true, (3) with intent to induce another's reliance on the fact misrepresented, (4) justifiable reliance, and (5) damage. Apollo Capital Fund, LLC v. Roth Capital Partners, LLC, 158 Cal. App. 4th 226, 243 (2007). Providers put forth three arguments in support of its motion on this count. First Providers assert that United cannot prove waiver of Member Responsible Amounts as a basis for the misrepresentation claim. The Court has previously addressed this argument, finding there remains a genuine dispute of fact as to whether Providers waived this obligation.

Second, Providers contend that United's claim is based on an omission, rather than an affirmative misrepresentation. However, United's claim for negligent misrepresentation is based on Providers' "knowing submission of claim forms misstating the total charges of the service." (Dkt. No. 207 at 5.) "Unlike fraud, 'negligent misrepresentation does not require knowledge of falsity.'" UMG Recordings v. Global Eagle Ent., 117 F. Supp. 3d 1092, 1111 (C.D. Cal. 2015) (quoting Apollo Capital Fund, 158 Cal. App. 4th at 243). United proffers evidence of claim forms that do include any indication that Providers failed to collect Member Responsibility Amounts. (Second Rowe Decl. Exs. U-27, U-29 - 36.) Accordingly, because Providers knowingly submitted these forms that contained incorrect information, there remains a dispute of fact on this issue.

Finally, Providers assert that United did not provide them pre-litigation notice as to the plans' "'requirements for coverage' based on 'charged and collected'" Member Responsible Amounts. (Dkt. No. 144 at 7 (quoting Dkt. No. 99, ¶ 194).) However, Providers do not cite to any legal authority requiring such notice. In their reply, Providers point to this Court's orders on the parties'

motions to dismiss, arguing that the Court "addressed and resolved" the issue of notice at that time. (Dkt. No. 235 at 10-11.) Providers misread the Court's reasoning. In the Order on United's motion to dismiss the Second Amended Complaint, the Court held that United waived its argument that anti-assignment provisions foreclosed assignment of claims because United "never denied payment because of an anti-assignment provision." (See Dkt. No. 77 at 6-7.) This reasoning is inapplicable here, as United is not basing its negligent misrepresentation claim on an anti-assignment provision. Similarly, in the Order on United's motion to dismiss the Third Amended Complaint, the Court held that United had an obligation to inform Providers, as assignees, about their appeal rights. (See Dkt. No. 92 at 7.) However, that obligation arose out of ERISA's mandated disclosure requirements. There is no similar provision under ERISA requiring United to inform Providers of the Member Responsible Amount pre-requisite.

For these reasons, the Court **DENIES** Provider's motion as to Count II of United's counterclaim.

5. Conversion

Providers next argue that they are entitled to summary judgment on Count III of United's counterclaim (Conversion). A claim for conversion requires proof of (1) plaintiff's ownership or right to possession of property, (2) defendant's wrongful act toward or disposition of the property, interfering with the plaintiff's possession, and (3) damages. Sanowicz v. Bacal, 234 Cal. App. 4th 1027, 1042 (2015). Additionally, if the claim of conversion is for money, there must be a "specific, identifiable sum," rather than a "generalized claim for money." McKell v. Wash. Mut., 142 Cal. App. 4th 1457, 1491 (2006); Vu v. Cal. Commerce Club, 58 Cal. App. 4th 229, 235 (1997).

As an initial matter, United does not own the money used to pay claims submitted under self-funded plans. However, United may show *either* ownership or right to possession of the property for its conversion claim. See Dep't. of Indus. Relations v. UI Video Stores, Inc., 64 Cal. Rptr. 2d 457, 464 (1997). United has presented evidence of it right to possession, as the plan sponsors entrusted United with the money it used to pay self-funded plan claims. (See Rowe Decl. Exs. U-40 - U-44.) As such, United has met its burden on this prong.

Next, Providers assert that United cannot identify a sufficiently definite sum of money to constitute a conversion claim for each patient at issue. (Dkt. No. 144 at 8.) While Providers are correct that United must be able to specifically identify the sum of money it alleges Providers converted, "it is not necessary that each coin or bill be earmarked." PCO, Inc. v. Christensen, Miller, Fink, Jacobs, Glaser, Weil & Shapiro, LLP, 150 Cal. App. 4th 384, 396 (2007). Here, United argues that the funds at issue are those Member Responsibility Amounts that Providers failed to collect, which caused United to overpay Providers by those specific amounts. (United Opp'n at 11-12.) United has produced substantial evidence of these specific funds, including an accounting of which patients had outstanding Member Responsibility Amounts, as well as the Provider Explanation of Benefits outlining the amounts United paid to Providers. (See Dkt. No. 100, United Counterclaim Appendices; Rowe Decl. Exs. U-1 - 17.) Using these figures, the amount Providers has allegedly converted is readily identifiable.

Finally, Providers contend that United has not, and cannot, point to a "wrongful act" for purposes of a conversion claim; specifically, Providers argue they did not waive Member Responsible Amounts. The Court has previously found that there is a genuine dispute as to whether Providers waived Member Responsible Amounts, and thus Providers cannot succeed on summary judgment on these grounds. Additionally, conversion is a strict liability tort. While the underlying act must be done intentionally or knowingly, "a wrongful intent is not necessary." Taylor v. Forte Hotels Int'l., 1 Cal. Rptr. 2d 189 (1991). Providers intentionally submitted claims which United contends contained false information. Whether these forms actually contained false information is a question of fact for the jury.

Accordingly, the Court **DENIES** Providers' motion for summary judgment on United's conversion claim.

6. Breach of Contract

Providers also seek summary judgment on United's counterclaim for breach of contract to the extent its claim is based on Providers' waiver of Member Responsible Amounts, and that United did not give Providers pre-litigation notice of health plans that permitted United to deny benefits if a provider waived collection of Member Responsible Amounts. As analyzed above, there is a dispute of fact as to whether Providers waived Member Responsible Amounts.

Additionally, Providers again cite to this Court's previous findings that ERISA mandated United give Providers the same notices afforded to members. (Dkt. No. 144 at 10.) However, as the Court has previously analyzed, ERISA does not require United to provide pre-litigation notice of Providers' obligation to collect Member Responsible Amounts. Providers have not presented any authority to the contrary, nor would it have any bearing on whether Providers misrepresented their services in claims submissions to United.

Therefore, Providers' motion for summary judgment on United's counterclaim for breach of contract is **DENIED**.

7. Intentional Interference with Contractual Relations

Providers argue they are entitled to summary judgment on United's claim for intentional interference with contractual relations. Intentional interference with contractual relations requires a showing of "(1) a valid contract between plaintiff and a third party; (2) defendant's knowledge of this contract; (3) defendant's intentional acts designed to induce a breach or disruption of the contractual relationship; (4) actual breach or disruption of the contractual relationship; and (5) resulting damage." Pacific Gas & Electric Co. v. Bear Stearns & Co., 50 Cal. 3d 1118, 1126 (1990).

Providers' argument is premised entirely on the fact that Providers, as the patients' assignees, are parties to the contract with United and therefore cannot be liable under a theory of contractual interference. See Applied Equipment Corp. v. Litton Saudi Arabia Ltd., 7 Cal. 4th 503, 513-14 (1994) ("[T]he tort cause of action for interference with a contract does not lie against a party to the contract."). It is uncontested that Providers are assignees of the health benefit plans at issue. (SGD ¶¶ 9, 10.) Additionally, much of United's counterclaim for intentional interference with contractual relations is based on the contracts between United and its members, the individual patients. (See Dkt. 99 ¶¶ 211-216.) United did not oppose Providers' motion on these grounds. (See Dkt. No. 207 at 11-12.) Therefore, to the extent that United's counterclaim is based on interference with members' contracts to which Providers are parties by virtue of assignment, Providers' motion is **GRANTED**.

However, United's claim for interference with contractual relations is also based on the Administrative Service Agreements between United and third-party

plan sponsors. (Dkt. No. 207 at 11-12.) Providers argue that United's claim nonetheless fails because they did not have knowledge of the Administrative Service Agreements prior to this litigation. See Pacific Gas & Electric Co., 50 Cal. 3d at 1126 (noting one element of intentional interference of contractual relationships is knowledge of a contract between plaintiff and a third party). In response, United points to Providers' own pleadings, in which they alleged United administered ERISA plans "pursuant to an administrative service agreement." (Dkt. No. 207 at 13; Dkt. No. 80 ¶ 211.) Notwithstanding this contention, the Court finds there is no genuine dispute of material fact that Providers did not know of the Administrative Services Agreement prior to this litigation. The quoted language from the Third Amended Complaint, filed on January 18, 2021, was not present in Providers' initial complaint, filed on March 19, 2020. (Dkt. No. 235 at 12.) Accordingly, United has not presented evidence that Providers were aware at any time prior to this action that United was a party to an Administrative Service Agreement. The Court therefore **GRANTS** Providers' motion for summary judgment on United's claim for intentional interference with contractual relations.

8. Violation of UCL

Providers move for partial summary judgment on Count VI of United's counterclaim which alleges a violation of California's Unfair Competition Law, specifically to the extent the claim is premised on violations of various anti-kickback statutes. (Dkt. No. 144 at 13-14; California Business & Professional Code Section 650, California Insurance Code Section 750, and the Federal SUPPORT Act, 18 U.S.C. § 220.)

Providers first challenge United's standing to bring a UCL claim with regard to claims based on self-funded plans, alleging that United has not suffered an injury in fact. California's UCL requires the party bringing the claim "to be the one 'who has suffered injury in fact and has lost money or property as a result of the unfair competition." Amalgamated Transit Union, Local 1756, AFL-CIO v. Superior Ct., 46 Cal.4th 993, 1002 (2009) (quoting Cal. Bus. & Prof. Code § 17204). "The law seems to be well settled that every bailee or person clothed with the exclusive right of possession has a temporary or qualified ownership in the property to the extent of enabling him to maintain actions in respect thereto against third parties." Armstrong v. Kubo & Co., 88 Cal. App. 331, 334 (1928). "There are innumerable ways in which economic injury from unfair competition

may be shown," including depriving a party of "money or property to which he or she has a cognizable claim." Kwikset Corp. v. Superior Ct., 51 Cal. 4th 310, 323 (2011). Accordingly, a party may bring a UCL claim to recover assets it did not own, but over which it had legal control. It is under this theory that United brings its UCL claim. United does not purport to own the money from self-funded plans; rather, it maintains lawful possession over it and pays claims from it. (Dkt. No. 207 at 13.) Therefore, should a jury find that Providers violated one of the predicate statutes United alleges, United would be entitled to recover the sums it overpaid as a result of Providers' conduct.

Providers next contend that they are not "licensees," or "persons licensed" under Section 650.01 or Section 654.1, and therefore cannot be liable under them. (Dkt. No. 144 at 12-13.) Section 650.01 states in relevant part that "it is unlawful for a licensee to refer a person for laboratory . . ." services. Cal. Bus. & Prof. Code § 650.01(a). It defines "licensee" as a "physician," a "nurse practitioner," and a "certified nurse-midwife." Id., § 650.01(b)(4). Section 654.1 similarly applies to "[p]ersons licensed under Chapter 4 . . . or licensed under Chapter 5 . . . or licensed under any initiative act referred to in this division relating to osteopath." Id., § 654.1. Chapter 4 governs dentists and dental professionals, and Chapter 5 governs physicians and medical professionals. See id., §§ 1625, 2041.

It is clear that Providers, as substance use disorder treatment centers, are none of the individuals identified as "licensees" or "persons licensed" by the statutes. United nevertheless asserts that Providers employ physicians and other individuals who fall under these statutes' purview. (Dkt. No. 207 at 15.) However, United has not named these individuals in their counterclaims, nor do they assert a theory of vicarious liability. Providers further state that they are "nonmedical [substance use disorder] treatment providers licensed and certified by the California Department of Health Care Services under the Health and Safety Code," which has the "sole authority" to license such entities. (Dkt. No. 144 at 13.) United argues that the California Health & Safety Code prohibits the same activity prohibited by the Business and Professional Code, and the Court should therefore apply it to Providers. (Dkt. No. 207 at 15.) However, United did not include that provision as a predicate statute in its Counterclaim and cannot raise it for the first time on summary judgment.

Finally, Providers argue United cannot support its allegations of "making or receiving kickbacks for the referral of patients" with admissible evidence. (Dkt.

No. 144 at 12.) As the Court has dispensed with United's UCL claim predicated on a violation of California Business & Professional Code Section 650 and 654, the Court will only address the evidence pertaining to California Insurance Code Section 750 and 18 U.S.C. § 220. Both statutes criminalize essentially the same conduct: giving or receiving kickbacks in exchange for patient referrals. Under both statutes, kickbacks need not be in the form of monetary payment, but "in cash or in kind,"18 U.S.C. § 220, or "any consideration." Cal. Ins. Code § 750. However, United must present some evidence that Providers are engaging in an illegal kickback scheme. The Court finds that United has not done so based on the record now before it.

It is undisputed that some Providers were jointly owned and shared administrative offices and staff. (See Dkt. No. 220 ¶¶ 6-11.) Additionally, United proffers evidence that these Providers referred patients to each other on occasion. (See Dkt. No. 207-1 at 43-44.) However, the only case United cites to support the proposition that this practice violates the anti-kickback statutes is inapposite. In Alborizi v. University of Southern California, the court found allegations that defendants entered into a below-market contract for hospitalist services, it benefitted from the scheme by saving money, and it entered into the contract for that purpose. 55 Cal. App. 5th 155, 183-84 (2020). While the court noted the plaintiffs' allegation of shared ownership and self-referral of patients, the court did not base its findings on those facts. Id. Here, United does not explain how the practice of referring patients is illegal. United cites to no evidence, disputed or otherwise, that Providers paid one another for their referrals, nor that simply referring patients without expectation of receipt of "compensation or inducement" violates the statutes. Cf. Dual Diagnosis Treatment Center, Inc. v. Centene Corp., 2021 WL 4464204, at *5-6 (C.D. Cal. May 1, 2021) (noting a state court finding that defendants violated Insurance Code section 750 by paying referral fees ranging from $2,500 to $7,000 for each patient who received services for more than seven days). Moreover, the plaintiffs in Alborizi alleged that the defendants' actions violated California Business & Professional Code Section 650, which the Court has found inapplicable to Providers.

Additionally, United puts forth evidence that Providers "routinely paid for transportation costs for out-of-state patients." (Dkt. No. 207-1 at 44-45.) Again, however, United provides no authority that this practice, in and of itself, constitutes a violation of the cited statutes. On the contrary, the deposition testimony United cites in support of its argument supports Providers' assertions

that they pay for flights and transportation costs when the patient demonstrated financial hardship, and required patients to sign a promissory note agreeing to repay the costs. (Rowe Decl. Ex. U-53 at 112:23-115:19.) This testimony is consistent across Providers' depositions to which United cites. (See Rowe Decl. Exs. U-45, U-47, U-50.) Furthermore, California permits laboratories and certified outpatient alcohol and drug treatment programs to pay for transportation and discount housing in certain circumstances. See Cal. Health & Safe. Code § 11831.65 (2019). United has not presented any evidence indicating that Providers did not comply with this statute's requirements.

Accordingly, the Court finds there is no genuine dispute of material fact as to United's UCL claim. For these reasons, the Court **GRANTS** Providers' motion for summary judgment as to Count VI of United's counterclaim to the extent it is predicated on a violation of California Business & Professional Code Sections 650.01 or 654.1, California Insurance Code Section 750, or the Federal SUPPORT Act.

9. Equitable Relief under ERISA

Providers move for summary judgment on United's claims for equitable relief under ERISA Section 502(a)(3) because Providers did not waive Member Responsible Amounts, and United cannot establish an equitable lien by agreement. ERISA provides an avenue for equitable relief where the party seeking such relief can prove "a remediable wrong, *i.e.*, that the plaintiff seeks relief to redress a violation of ERISA or the terms of a plan; and (2) that the relief sought is 'appropriate equitable relief.'" Gabriel v. Alaska Elec. Pension Fund, 773 F.3d 945, 954 (9th Cir. 2014). United seeks restitution through the imposition of an equitable lien by agreement and a constructive trust over the amounts United alleges it overpaid to Providers as a result of Providers' misrepresentations. (Dkt. No. 207 at 8.) Providers assert that there is no remediable wrong because Providers did not waive Member Responsible Amounts. (Dkt. No. 144 at 13.) Further, Providers contend that United cannot establish the elements of an equitable lien by agreement. The Court previously found a genuine dispute of material fact as to whether Providers waived Member Responsible Amounts and will not address this argument again here.

An equitable lien by agreement requires establishment of three elements: "*First*, there must be a promise by the beneficiary to reimburse the fiduciary for

benefits paid under the plan in the event of a recovery from a third party. *Second*, the reimbursement agreement must 'specifically identify] a particular fund, distinct from the [beneficiary's] general assets,' from which the fiduciary will be reimbursed. *Third*, the funds specifically identified by the fiduciary must be 'within the possession and control of the [beneficiary].'" Bilyeu, 683 F.3d at 1092-93 (quoting Sereboff v. Mid Atl. Med. Servs., Inc., 547 U.S. 356, 363-64 (2006) (internal citations omitted).

As discussed in the Court's analysis of United's affirmative motion, no genuine dispute exists as to the first two prongs of the Bilyeu analysis. However, a dispute remains as to the third prong both for United and Providers. Under Bilyeu's third prong, United must show that Providers still possess the money it seeks in restitution. United asserts that its expert, Josiah Lamb, "traced funds paid by United for specific patients into specific bank accounts" of Providers. (Dkt. No. 207 at 10.) However, Lamb's report indicates that, after Providers deposited the funds paid by United into their accounts, they used the money to pay current and former owners of Providers. (Lamb Decl. at 2.) As no former or current owners of Providers are parties to this action, using funds to pay them means that money is no longer in Providers' possession. See Bilyeu, 683 F.3d at 1094 (if the funds are no longer in "the defendant's possession, then there is no *res* against which the equitable lien can be enforced.") Lamb's report further concludes that money paid by United was "transferred the funds to related-entity bank accounts." (Lamb Decl., 6-9.) Although Lamb's report but does not identify these accounts "related-entity" or explain whether or how they are controlled by Providers, his declaration suffices to present a triable issue of fact as to whether the funds United paid Providers are still in Providers' possession.

For these reasons, the Court **DENIES** Providers' motion on Count VII of United's counterclaim. As Providers' grounds for challenging Count VIII of United's counterclaim (Injunctive and Declaratory Relief under ERISA) are the same, the Court similarly **DENIES** Providers' motion on that count.

IV. CONCLUSION

For the foregoing reasons, the Court **GRANTS** in part and **DENIES** in part the motions.

IT IS SO ORDERED.