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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

DAVID WIT, et al.,
Plaintiffs,
v.
UNITED BEHAVIORAL HEALTH,
Defendant.

Case No. 14-cv-02346 JCS
Related Case No. 14-cv-05337 JCS

**ORDER GRANTING MOTION FOR
CLASS CERTIFICATION**

Docket No. 133 (Case No. 14-cv-02346 JCS)
Docket No. 97 (Case No. 14-cv-05337 JCS)

GARY ALEXANDER, et al.,
Plaintiffs,
v.
UNITED BEHAVIORAL HEALTH,
Defendant.

I. INTRODUCTION

Plaintiffs in these putative class actions allege that they were improperly denied coverage for mental health and substance use disorder treatment by Defendant United Behavioral Health (“UBH”), which administers mental health and substance use disorder benefits under their health insurance plans. In *Wit v. United Behavioral Health*, Case No. 14-cv-02346 JCS (hereinafter, “*Wit*”), Plaintiffs allege that they were wrongfully denied coverage for mental health and substance use-related residential treatment; in *Alexander v. United Behavioral Health*, Case No. 14-cv-05337 JCS (hereinafter, “*Alexander*”), Plaintiffs allege that they were wrongfully denied coverage for outpatient and intensive outpatient treatment for mental health and substance use disorders.

1 Presently before the Court is Plaintiffs’ Motion for Class Certification (“Motion”).¹ A
2 hearing on the Motion was held on Wednesday, September 7, 2016 at 9:30 a.m. For the reasons
3 stated below, the Motion is GRANTED.²

4 **II. BACKGROUND**

5 **A. Factual Background**

6 **1. UBH**

7 UBH administers behavioral health plans throughout the country and is “one of the
8 nation’s largest managed healthcare organizations.” Declaration of Jennifer S. Romano in Support
9 of Defendant United Behavioral Health’s Opposition to Motion for Class Certification (“Romano
10 Decl.”), Ex. 2 (Declaration of Lorenzo Triana in Support of Defendant’s Opposition to Motion for
11 Class Certification (“Triana Decl.”)) ¶ 6; *see also* Declaration of Caroline E. Reynolds in Support
12 of Plaintiffs’ Motion for Class Certification (“Reynolds Decl.”), Ex. E (2015 Utilization
13 Management Program Description) (“Optum³ is a Managed Behavioral Health Care Organization
14 designed to assist its members with the management of their behavioral health care needs. Benefits
15 for behavioral health services are reviewed, managed and coverage is determined through offices
16 located throughout the United States.”). Typically, the benefit plans administered by UBH give it
17 “discretion to make coverage determinations for specific treatment for specific members based on
18 the coverage terms of the member’s plan.” Romano Decl., Ex. 2 (Triana Decl.) ¶ 7. UBH is
19 responsible for adjudicating mental health and substance use claims for the named Plaintiffs and
20 all members of the putative classes. *Wit*, Docket No. 67 (Answer) ¶ 3; *Alexander*, Docket No. 44
21 (Answer) ¶ 7.

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¹ Plaintiffs filed identical class certification motions in *Wit* and *Alexander* in which they address the issues relating to class certification in both cases.
² The parties have consented to the jurisdiction of a United States magistrate judge pursuant to 28 U.S.C. § 636(c).
³ Optum and OptumHealth are brand names for United Behavioral Health. *See* Romano Decl., Ex. 2 (Triana Decl.) ¶ 2 (“OptumHealth is a brand name of United Behavioral Health”); Reynolds Decl., Ex. E at UBHWIT0070985 (“Optum is a brand name used by United Behavioral Health and its affiliates”).

1 **2. Plaintiffs’ Health Insurance Plans**

2 The Named Plaintiffs in this action sought coverage for mental health or substance use
3 disorder treatment under ten different health insurance plans.⁴ *See* Romano Decl., Ex. 71 (Chart
4 entitled “Plan Terms that Require More than Adherence to ‘Generally Accepted Standards of
5 Care”). Based on electronic data produced by UBH, however, coverage may have been denied to
6 putative class members under as many as 3,000 different health insurance plans. *See* Romano
7 Decl., Ex. 4 (November 10, 2015 Expert Witness Report (“Edwards Report”) at 7).

8 Because of the large number of claims that UBH denied during the relevant class period
9 for the types of treatment that are at issue in this case, the parties stipulated to a sampling
10 methodology under which health insurance plan documents (“Sample Plans”), as well as other
11 information, were produced for 106 putative class members (“Sample Plaintiffs”) who were
12 denied coverage on claims for residential, outpatient or intensive outpatient treatment by UBH (the
13 “Claim Sample”). *See* Reynolds Decl., Ex. Q (Joint Stipulation Concerning Sampling
14 Methodology) ¶¶ 3, 12-14, 20, 23, 25. UBH also produced to Plaintiffs Exel spreadsheets
15 containing data from UBH’s ARTT and LYNX data systems listing each adverse benefit
16 determination issued for coverage requested in the relevant treatment settings between 2011 and
17 2015 associated with mental health and substance use disorders (hereinafter, the “ABD Data”).
18 *Id.*, Ex. Q (Joint Stipulation Concerning Sampling Methodology), Exs. C & E attached thereto.
19 With the exception of the Sample Plans and the Named Plaintiffs’ health insurance plans,
20 however, UBH did not produce the plan documents for the claims listed in the ABD Data. *Id.*, Ex.
21 Q (Joint Stipulation Concerning Sampling Methodology) ¶ 3.

22 UBH’s expert, Mary Beth Edwards, states that she reviewed the Sample Plans⁵ and the

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24 ⁴ Although there are eleven named Plaintiffs, both David Wit and his daughter Natasha Wit assert
25 claims based on denial of coverage for Natasha Wit, who was a minor at the time she received the
26 treatment at issue. Therefore, their claims are based on the same health insurance plan, of which
27 Natasha Wit is a beneficiary. *See Wit* Docket No. 39 (Complaint) ¶¶ 1, 39.

28 ⁵ Edwards states that she reviewed 110 Sample Plans corresponding to the individuals in the Claim
Sample. Romano Decl., Ex. 4 at 6. As the parties’ stipulation makes clear, however, four of the
individuals included in the original Claim Sample were found not to meet the selection criteria to
which the parties had agreed and were removed from the sample sometime after December 11,
2015, leaving only 106 individuals and relevant health insurance plans. *See* Reynolds Decl., Ex.

1 plan documents for the Named Plaintiffs and that these documents contain “detailed and varying
2 narrative descriptions surrounding” “a) specific covered services associated with certain treatment
3 categories, b) specific exclusions and limitations associated with the benefit, c) any particular
4 medical necessity criteria covered services must meet, and d) any appeal procedures available to
5 the member.” Romano Decl., Ex. 4 at 10. She opines that “the possibility of variation in the
6 terms of coverage” is expanded by the fact that the ABD Data lists “over 3,000 distinct group
7 names.” *Id.* at 12.

8 Notwithstanding these variations, the evidence in the record shows that all of the Sample
9 Plans and the health insurance plans of the Named Plaintiffs require as one (though not the only)
10 condition of coverage that the mental health or substance use disorder treatment at issue must be
11 consistent with generally accepted standards of care. *See* Reynolds Decl. ¶ 13 & Ex. K (Summary
12 of Plan Term Chart).⁶ Although UBH pointed out at oral argument that some plans use somewhat

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14 Q (Joint Stipulation Concerning Sampling Methodology) ¶ 25. Edwards also states that she
15 reviewed the plans of “each of the eight Named Plaintiffs,” Romano Report at 13, apparently
16 counting Natasha and David Wit as a single Named Plaintiff; the Court had not yet permitted
17 Plaintiffs Tillitt and Driscoll to intervene at the time Edwards completed her report.

18 ⁶Exhibit K lists all of the Named Plaintiffs and the Sample Plaintiffs. For each, the relevant plan
19 term documents are listed and in a separate column it is indicated whether the plan requires
20 “[a]dherence to [g]enerally [ac]cepted [s]tandards.” Reynolds Decl., Ex. K. For all of the plans
21 listed on the chart, the answer in this column is “yes.” *Id.* In the Reynolds Declaration,
22 Plaintiffs’ counsel explains that the exhibit “indicates whether the terms of the Named Plaintiffs’
23 plans and each of the plans in the agreed-upon Plan Sample conditions coverage for mental health
24 and substance use disorder treatment upon a finding that the services are consistent with generally
25 accepted standards of care.” Reynolds Decl. ¶ 13. Reynolds goes on to explain that “the chart
26 answers ‘yes’ to this question if the plan terms (a) define Covered Services as services that are
27 consistent with generally accepted standards of care or as services that are Medically Necessary;
28 (b) exclude coverage for services that are *not* consistent with generally accepted standards of care
or services that are *not* Medically Necessary; and/or (c) define Medically Necessary services as
those that are consistent with generally accepted standards of care.” *Id.*

UBH objects to Exhibit K, asserting that it is misleading to the extent Plaintiffs use it to
claim that “coverage [under Plaintiffs’ health insurance plans] is *solely* determined or conditioned
with generally accepted standards.” Defendant United Behavioral Health’s Objections to
Evidence Filed in Support of Plaintiffs’ Motion for Class Certification (“Objections”) at 3-4
(emphasis added). The Court OVERRULES all of UBH’s Objections on the ground that UBH
failed to adhere to Civil Local Rule 7-3(a), which requires that “[a]ny evidentiary and procedural
objections to the motion must be contained within the brief or memorandum.” UBH failed to
include any of its objections in its Opposition brief. Even if the Court were to reach the merits on
UBH’s Objections it would overrule its objection to Exhibit K on the ground that Plaintiffs do not
claim anywhere that adherence to generally accepted standards is the *sole* condition for coverage
under Plaintiffs’ plans. Moreover, UBH implicitly concedes that the health insurance plans listed

1 different phrasing in describing this requirement, it was not able to offer any evidence that these
2 differences were material. Nor did it suggest that the Sample Plans were unrepresentative of the
3 insurance plans of the classes as a whole. Accordingly, the Court finds, as a factual matter, that all
4 of the putative class members' insurance plans require as a precondition for coverage that the
5 treatment at issue must be consistent with generally accepted standards of care.

6 **3. The Claims Administration Process**

7 In making coverage determinations, UBH Peer Reviewers apply criteria that are set out in
8 "Coverage Determination Guidelines" ("CDG Guidelines") and Level of Care Guidelines ("LOC
9 Guidelines"), hereinafter referred to collectively as "Guidelines." Romano Decl., Ex. 2 (Triana
10 Decl.) ¶ 8; Reynolds Decl., Ex. E at E0003 (describing Peer Review Process). The CDG
11 Guidelines "focus on the member's primary diagnosis, while the [LOC Guidelines] focus on
12 particular treatment settings." *Id.* There are "at least 264 CDGs and 42 LOCs that UBH reviewers
13 use or have used in making coverage determinations since 2010." Romano Decl., Ex. 2 (Triana
14 Decl.) ¶ 8. According to UBH's 30(b)(6) witness, Margaret Brennecke, the Guidelines are
15 "reviewed annually and updated as needed." Reynolds Decl., Ex. P, Brennecke Dep. at 154.
16 When they join UBH, reviewers receive extensive training on how the Guidelines are to be
17 applied. Reynolds Decl., Ex. P, Triana Dep. at 155-157. In addition, when Guidelines are
18 updated, reviewers receive notifications of the change and may also receive additional training.
19 *Id.*

20 UBH describes the LOC Guidelines as "objective and evidence-based behavioral health
21 guidelines used to standardize coverage determinations, promote evidence-based practices, and
22 support members' recovery, resiliency, and well-being." Reynolds Decl., Ex. B at B0001 (2016
23 Level of Care Guidelines). According to UBH, the LOC Guidelines are "derived from generally
24 accepted standards of behavioral health practice . . . [which] include guidelines and consensus
25 statements produced by professional specialty societies, as well as guidance from governmental

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27 in the chart incorporate generally accepted standards of care as a condition for coverage (which is
28 exactly Plaintiffs' point) when they argue that this is *but one* of many bases to deny coverage
under the plans.

1 sources” *Id.* The LOC Guidelines “reflect [UBH’s] understanding of current best practices
2 in care” *Id.* at B0006.

3 The LOC Guidelines begin with a set of “Common Criteria and Best Practices for All
4 Levels of Care” (hereinafter, “Common Criteria”). Reynolds Decl., Ex. B (Excerpts of LOC
5 Guidelines 2011-2016) at B0007-13, B0049-55, B0088-93, B0125-29, B0152, B0158-61, B0182,
6 B0187-89, B0210-11. These include “Admissions Criteria,” “Continued Service Criteria” and
7 “Discharge Criteria.” *See id.* There are also specific LOC Guidelines that apply to particular
8 levels of care, including residential treatment, intensive outpatient treatment and outpatient
9 treatment, for both mental illness and substance use disorders. *See id.* at B0016-41, B0058-80,
10 B0094-118, B0130-51, B0162-81, B0191-209. These specific LOC Guidelines expressly
11 incorporate the Common Criteria and also set forth criteria specific to that particular level of care.
12 *See id.*

13 The CDGs are described by UBH as “a set of guidelines that standardize the interpretation
14 and application of the terms of the benefit plan.” Reynolds Decl., Ex. E (Utilization Management
15 Program Description 2015) at E0015. These are organized by diagnosis and expressly incorporate
16 the LOC Guidelines (and particularly the Common Criteria). *See* Reynolds Decl., Ex. C (relevant
17 CDG Guidelines for 2011-2016); *id.*, Ex. A-2 (listing all of the CDG Guidelines that Plaintiffs
18 contend are relevant to their claims and specifying whether each of them incorporates the LOC
19 Guidelines); *see also id.*, Ex. P, Brennecke Dep. at 180, 189-90 (deposition testimony of Margaret
20 Brennecke, UBH 30(b)(6) witness, that Level of Care Guidelines are “embedded” in the CDGs
21 and therefore the coverage determination will be the same regardless of whether the UBH
22 reviewer uses the CDG Guidelines or the LOC Guidelines), Allchin Dep. at 53 (same), Zhu Dep.
23 at 62 (same).⁷ According to Dr. Triana, who is responsible for “the national implementation,

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25 ⁷ UBH objects to Exhibit P on the basis that some of the deposition excerpts do not include
26 questions and answers that UBH believes are relevant, rendering the excerpts “misleading.” The
27 objection is **OVERRULED**. First, as discussed above, UBH failed to comply with Civil Local
28 Rule 7-3(a) as it did not include this objection in its brief. Second, the objection has no merit.
Even in its lengthy Objections to Evidence, UBH does not bother to explain why any of the
omitted portions render the cited testimony misleading, simply stating that the testimony in the
excerpt did not include the complete answers. As UBH had the opportunity to submit its own

1 supervision, oversight, and evaluation of UBH’s utilization management program,” the CDG
2 Guidelines were developed in 2010 or 2011 in response to the enactment of mental health parity
3 laws, which required that determinations of coverage for behavioral treatment had to be aligned
4 with determinations on the “medical side.” Romano Decl., Ex. 20 (Triana Dep.) at 163-64.
5 Because UBH used guidelines for medical treatment that were specific to particular diagnoses, it
6 needed to develop corresponding behavioral guidelines that were also specific to particular
7 diagnoses. *Id.*

8 The Guidelines (LOC and CDG) are used by UBH Peer Reviewers in conducting clinical
9 reviews for the purposes of making coverage determinations. Reynolds Decl., Ex. E (Utilization
10 Management Program Description 2015) at E003. “The role of the Peer Reviewer is to exercise
11 clinical judgment in reviewing the relevant information, and to review the case against the
12 pertinent Level of Care Guidelines, Coverage Determination Guidelines, Psychological and
13 Neuropsychological Testing Guidelines, or other clinical guidelines required by contract or
14 regulation, the member’s benefit plan, available community resources, and individual member
15 need.” *Id.* Clinical denials by the Peer Reviewers are to be based on these criteria and the written
16 notification of denial must “cite to the Level of Care Guidelines, Coverage Determination
17 Guidelines, Psychological and Neuropsychological Testing Guidelines, or other clinical guidelines
18 required by contract or regulation, as appropriate, on which the denial was based, with the
19 rationale written in language that is easily understandable to the member, and that addresses the
20 member’s specific clinical presentation.” *Id.* at E003-4. According to UBH witnesses, this
21 information is conveyed to members in the form of a letter that is generated once the Peer
22 Reviewer enters the information into the member’s electronic case record. *See* Reynolds Decl.,
23 Ex. P, Brennecke Dep. at 132-33, Triana Dep. at 138-40 (describing creation of letters using
24 information and findings from peer review entered into UBH’s electronic database).⁸

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27 deposition excerpts (and did, in fact, submit additional pages of the depositions at issue), there is
28 no basis for striking the evidence in Exhibit P.

⁸Even if the Peer Reviewer finds that the treatment at issue is consistent with the applicable
criteria, coverage may be subject to administrative denial if the treatment is subject to an exclusion

1 According to UBH, while the CDGs and LOCs provide “certain criteria” for UBH
2 clinicians to consider in making coverage determinations they do not “dictate the result.” Romano
3 Decl., Ex. 2 (Triana Decl.) ¶ 10. Nonetheless, one of the purposes of these Guidelines is to ensure
4 consistency with respect to coverage determinations. Reynolds Decl., Ex. P (Triana Dep.) at
5 P0040-41. To verify that this goal is met, UBH conducts audits of its reviewers, which consist of a
6 second review of the same case file by the auditor to determine whether the coverage decision of
7 the auditor matches the decision of the original reviewer. *See* Reynolds Decl., Ex. P, Beaty Dep.
8 at 46, 77. The measure of consistency that is derived from the audits is referred to as inter-rater
9 reliability. Reynolds Decl., Ex. P, Triana Dep. at 171. UBH’s rate of inter-rater reliability for
10 2013, 2014 and 2015 was 96.8%, 98 % and 98.8% respectively. Reynolds Decl., Ex. T (UBH
11 Inter-Rater reliability Reports for 2013, 2014 and 2015) at T0003, T0017 and T0030.

12 **B. Plaintiffs’ Claims**

13 In the operative complaints, Plaintiffs assert two claims: 1) breach of fiduciary duty (the
14 “Breach of Fiduciary Duty Claim” or “Claim One”); and 2) arbitrary and capricious denial of
15 benefits (“the Arbitrary and Capricious Denial of Benefits Claim” or “Claim Two”). *See Wit*

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17 from coverage under the member’s plan. *Id.* at E0004. In that case, the written denial must
18 expressly reference the “member’s relevant plan documents on which the denial was based.” *Id.*;
19 *see also* Reynolds Decl., Ex. P. Brennecke Dep. at P0014 (testifying that a denial based on a plan
20 exclusion would be considered an administrative denial and that the basis for such a denial would
21 be referenced in the communication to the member providing notice of the denial). It is
22 undisputed that the denials of coverage as to the Named Plaintiffs in this case, however, were
23 clinical denials based on the Guidelines, as were the denials of coverage at issue in the Claim
24 Sample. *See* Reynolds Decl., Ex. F (chart reflecting Guidelines cited in Named Plaintiffs’ and
25 Claim Samples’ denial letters).

26 The Court notes that UBH objected to Exhibit F on the basis that it is misleading and
27 contains inaccuracies. Objections at 2-3. As discussed above, the Objections are overruled
28 because UBH failed to adhere to the Local Rules, which require that it raise its evidentiary
objections in its brief. The objection to Exhibit F also fails on the merits. The chart was prepared
using UBH’s own data, which was summarized in spreadsheets that UBH prepared and produced
in discovery. Further, Plaintiffs provided the underlying spreadsheets to the Court as an exhibit in
support of its Motion. *See* Reynolds Decl., Ex. Q. Therefore, UBH’s complaint that the chart is
misleading is to no avail; nor are its objections that some of the information in the chart apparently
is inaccurate given that the errors originated in the spreadsheets that UBH provided to Plaintiffs.

1 Docket No. 39 (“*Wit* Compl.”) ¶¶ 198, 210; *Wit* Docket No. 123 (“*Tillitt* Intervenor Compl.”) ¶¶
2 88, 99 ; *Alexander* Docket No. 1 (“*Alexander* Compl.”) ¶¶ 136, 146; *Alexander* Docket No. 87
3 (“*Driscoll* Intervenor Compl.”) ¶¶ 86, 96. Plaintiffs assert the Breach of Fiduciary Duty Claim
4 under 29 U.S.C. § 1132(a)(1)(B) (Count I in all of the operative complaints) and, to the extent the
5 injunctive relief Plaintiffs seek is unavailable under that section, they assert the claim under 29
6 U.S.C. § 1132(a)(3)(A) (Count III in all of the operative complaints). Similarly, Plaintiffs assert
7 the Arbitrary and Capricious Denial of Benefits Claim under 29 U.S.C. § 1132(a)(1)(B) (Count II
8 in all of the operative complaints) and under 29 U.S.C. § 1132(a)(3)(B) (Count IV in all of the
9 operative complaints).⁹

10 The Breach of Fiduciary Duty Claim is based on the theory that UBH is an ERISA
11 fiduciary under 29 U.S.C. § 1104(a) and therefore owes a duty to discharge its duties “with . . .
12 care, skill, prudence, and diligence” and “solely in the interest of the participants and
13 beneficiaries.” According to Plaintiffs, UBH violated this duty by developing guidelines that are
14 far more restrictive than those that are generally accepted even though Plaintiffs’ health insurance
15 plans provide for coverage of treatment that is consistent with generally accepted standards of
16 care, and by prioritizing cost savings over members’ recovery of benefits. *See Wit* Compl. ¶¶ 198-
17 99; *Tillitt* Intervenor Compl. ¶¶ 88-89; *Alexander* Compl. ¶¶ 136-37; *Driscoll* Intervenor Compl.
18 ¶¶ 86-87. According to Plaintiffs, they “have been harmed by UBH’s breaches of fiduciary duty
19 because their claims have been subjected to UBH’s restrictive guidelines making it less likely that
20 UBH will determine that their claims are covered.” *Wit* Compl. ¶ 201; *see also Alexander* Compl.
21 ¶ 137 (alleging that “[b]y promulgating improperly restrictive guidelines, UBH artificially
22 decreases the number and value of covered claims, thereby benefiting its corporate affiliates at the
23 expense of insureds”); *Tillitt* Intervenor Compl. ¶¶ 89-90 (alleging that “[b]y promulgating
24 improperly restrictive guidelines, UBH artificially decreases the number and value of covered
25 claims, thereby benefiting its corporate affiliates at the expense of insureds” and that “Ms. Tillitt

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27 ⁹ In the Motion, Plaintiffs state that both Counts III and IV are asserted under 29 U.S.C. §
28 1132(a)(3)(A). *See* Motion at 5, fns. 4 & 5. The Court assumes that this is a clerical error.

1 and the members of the Class have been harmed by UBH’s breaches of fiduciary duty because
2 their claims have been subjected to UBH’s restrictive guidelines, making it less likely that UBH
3 will determine that their claims are covered”).

4 The Arbitrary and Capricious Denial of Benefits Claim is based on the theory that UBH
5 improperly adjudicated and denied Plaintiffs’ requests for coverage by, *inter alia*, relying on the
6 overly restrictive Guidelines.¹⁰ *Wit* Compl. ¶ 205 ; *Tillitt* Intervenor Compl. ¶ 94; *Alexander*
7 Compl. ¶¶ 141-142; *Driscoll* Intervenor Compl. ¶ 91. The reliance on these Guidelines was
8 arbitrary and capricious, Plaintiffs allege, because: 1) Plaintiffs’ health insurance plans provided
9 for coverage consistent with generally accepted standards of care; and 2) some of Plaintiffs’ health
10 insurance plans were subject to state laws that explicitly mandate the use of clinical criteria issued
11 by the American Society of Addiction Medicine (“ASAM”) or the Texas Department of Insurance
12 (“TDI”). *See Wit* Compl. ¶ 14. According to Plaintiffs, to prevail on this claim they must establish
13 “1) that those Class members’ plans required UBH to make clinical coverage determinations
14 pursuant to criteria that were consistent with generally accepted standards of care; 2) that UBH’s
15 fatally flawed Guidelines were not, in fact, consistent with those required standards; and 3) that
16 UBH adjudicated and denied the members’ requests for coverage pursuant to a Guideline.”

17 Motion at 6.

18 Plaintiffs seek declaratory and injunctive relief as a remedy for UBH’s alleged ERISA
19 violations. In particular, in connection with Claim One they ask for: 1) a declaration that UBH’s
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21 ¹⁰ In the *Wit* and *Tillitt* Complaints, Plaintiffs also include other theories in support of their claim
22 that UBH’s denial of benefits was improper. In particular, in the *Wit* Complaint, Plaintiffs allege
23 that UBH “also denied these claims, in part, based on its systematic practice of: (i) improperly
24 applying acute inpatient treatment criteria to residential treatment claims; (ii) ignoring the
25 evidence presented to it; (iii) applying undisclosed additional criteria to benefit claims, such as a
26 length of stay “benchmark”; and (iv) relying upon its restrictive CDGs even though CDGs (as
27 opposed to LOCs) are not a recognized basis for denying claims under Plaintiffs’ Plans.” *Wit*
28 Compl. ¶ 205; *see also Tillitt* Compl. ¶ 94 (“[UBH] also denied these claims, in part, based on its
systematic practice of: (i) improperly applying acute inpatient treatment criteria to residential
treatment claims; (ii) ignoring the evidence presented to it; and (iii) relying upon its restrictive
CDGs even though CDGs are not a recognized basis for denying claims under the Lockton
Plan.”). At oral argument, Plaintiffs stipulated that if the Court certifies the proposed classes the
Named Plaintiffs will drop these theories of recovery and will proceed only with the theories that
apply to the entire class, described above.

1 internal Guidelines complained of by Plaintiffs were developed in violation of its fiduciary duties;
2 and 2) an injunction ordering UBH to stop utilizing the Guidelines and instead adopt or develop
3 guidelines that are consistent with those that are generally accepted and with the requirements of
4 applicable state law. In connection with Claim Two, the Arbitrary and Capricious Denial of
5 Benefits Claim, Plaintiffs ask the Court: 1) to declare that UBH’s denial of benefits was improper;
6 2) to order UBH to reprocess claims for residential treatment, intensive outpatient treatment and
7 outpatient treatment that were denied, in whole or in part, pursuant to the Guidelines, using the
8 new guidelines; and 3) to order UBH to apply the new guidelines in processing all future claims.
9 *See Wit Compl. at 65-66; Alexander Compl. at 50-51.*

10 Plaintiffs also ask the Court to impose a surcharge on UBH as an equitable remedy, under
11 either Counts I and II or Count IV. *See Wit Compl. at 66; Alexander Compl. at 51.* In the
12 Complaints, Plaintiffs sought a surcharge in an amount “equivalent to the revenue [UBH]
13 generated from its corporate affiliates or the plans for providing mental health and substance
14 abuse-related claims administration services with respect to claims filed by Plaintiffs and members
15 of the Class, expenses that UBH’s corporate affiliates saved due to UBH’s wrongful denials, the
16 out-of-pocket costs for . . . treatment Plaintiffs and members of the Class incurred following
17 UBH’s wrongful denials, and/or pre-judgment interest.” In their Reply brief, however, Plaintiffs
18 clarify that they are not seeking to recover out-of-pocket expenses as part of the surcharge, at least
19 as to the class members, stating as follows:

To the extent Plaintiffs’ Motion did not make it sufficiently clear to
UBH, Plaintiffs are not seeking to pursue, on a class basis, the
alternative measures of the surcharge identified in their Complaints
and in responses to Interrogatories. Moreover, the fact that certain
named Plaintiffs stated that they want to recover the out-of-pocket
costs that they incurred as a result of UBH’s improper benefit
denials does not alter the prayer for relief set forth in Plaintiffs’
Complaint. All Plaintiffs of course hope that when their benefit
claims are reprocessed, UBH will find that the previous clinical
coverage determination was improper and Plaintiffs will recover any
money that they lost. But that hope is not a prayer for relief[.]

26 Reply at 16 n. 22. At oral argument, Plaintiffs stipulated that if the proposed classes are certified,
27 they will proceed only under the theory that they are entitled to disgorgement of the revenue UBH
28 generated from its corporate affiliates or the plans for providing mental health and substance

1 abuse-related claims administration services in connection with processing of the class members'
2 claims.

3 Finally, Plaintiffs seek an award of attorneys' fees. *Id.*

4 **C. The Class Certification Motion**

5 Plaintiffs ask the Court to certify two classes in *Wit* and one class in *Alexander*. Motion at

6 3. The proposed classes in *Wit* are defined as follows:

7 **The *Wit* Guideline Class**

8 Any member of a health benefit plan governed by ERISA whose
9 request for coverage of residential treatment services for a mental
10 illness or substance use disorder was denied by UBH, in whole or in
11 part, on or after May 22, 2011, based upon UBH's Level of Care
12 Guidelines or UBH's Coverage Determination Guidelines.

12 The *Wit* Guideline Class excludes members of the *Wit* State
Mandate Class, as defined below.

13 **The *Wit* State Mandate Class**

14 Any member of a fully-insured health benefit plan governed by both
15 ERISA and the state law of Connecticut, Illinois, Rhode Island or
16 Texas, whose request for coverage of residential treatment services
17 for a substance use disorder was denied by UBH, in whole or in part,
on or after May 22, 2011, based upon UBH's Level of Care
Guidelines or UBH's Coverage Determination Guidelines and not
upon the level-of-care criteria mandated by the applicable state law.

18 The *Wit* State Mandate Class shall only include denials governed by
19 Illinois law that occurred on or after August 18, 2011, denials
governed by Connecticut law that occurred on or after October 1,
20 2013, and denials governed by Rhode Island law that occurred on or
after July 10, 2015.

21 The *Wit* State Mandate Class excludes members of the *Wit*
22 Guideline Class, as defined above.

23 *Id.*; see also Reply at 21 (amending proposed class definition for *Wit* State Mandate Class to take
24 into account the dates on which the relevant state laws were enacted by adding second paragraph
25 of definition).¹¹ Plaintiffs propose that Named Plaintiffs David and Natasha Wit, Lori Flanzraich,
26 Cecelia Holdnak, Brian Muir, and Linda Tillitt serve as Class Representatives for the *Wit*

27 ¹¹ The *Wit* State Mandate class definition quoted above is the amended version offered in
28 Plaintiffs' Reply brief rather than the version originally proposed in the Motion.

1 Guidelines Class. They propose that Named Plaintiff Brandt Pfeifer serves as Class
2 Representative for the *Wit* State Mandate Class.

3 Plaintiffs propose the following class for certification in *Alexander*:

4 **The *Alexander* Guideline Class**

5 Any member of a health benefit plan governed by ERISA whose
6 request for coverage of outpatient or intensive outpatient services for
7 a mental illness or substance use disorder was denied by UBH, in
8 whole or in part, on or after May 22, 2011, based upon UBH’s Level
9 of Care Guidelines or UBH’s Coverage Determination Guidelines.

10 The *Alexander* Guideline Class excludes any member of a fully
11 insured plan governed by both ERISA and the state law of
12 Connecticut, Illinois, Rhode Island or Texas, whose request for
13 coverage of intensive outpatient treatment or outpatient treatment
14 related to a substance use disorder.

15 Motion at 4. Plaintiffs propose that Named Plaintiffs Gary Alexander, David Haffner, Corinna
16 Klein, and Michael Driscoll serve as Class Representatives for the *Alexander* Guideline Class. *Id.*

17 In the Motion, Plaintiffs contend the key facts relating to their claims can be established
18 through common, class-wide evidence. *Id.* at 7. Plaintiffs point to UBH’s development and
19 promulgation of the Guidelines to set forth its understanding of generally accepted standards of
20 care and standardize coverage decisions, the fact that all UBH reviewers are required to adhere to
21 the clinical criteria contained in the Guidelines in making coverage determinations, and the fact
22 that all of the Named Plaintiffs’ claims and all the Sample Claims were denied on the basis of the
23 Guidelines. *Id.* at 8-12.

24 Plaintiffs also contend that they will be able to establish generally accepted standards of
25 care – and that the Guidelines are more restrictive than these standards – using common evidence.
26 *Id.* at 13-15. In particular, they point to criteria and guidelines relating to mental health and
27 substance use disorder treatment that have been adopted by various national organizations,
28 including the American Academy of Child and Adolescent Psychiatry (“AACAP”), the American
Psychiatric Association (“APA”) and the American Society of Addiction Medicine (“ASAM”),
upon which UBH itself claims to have relied in developing the Guidelines. *Id.* at 14; *see also*

1 Reynolds Decl., Ex. D (chart listing sources of generally accepted standards relevant to Guidelines
2 used by UBH, produced by UBH to show the “Evidence Base” for its Guidelines).¹² Using these
3 criteria, Plaintiffs contend, they will be able to establish that the Guidelines used by UBH to make
4 coverage determinations are more restrictive than generally accepted standards in that they
5 “uniformly overemphasize acute criteria and symptoms, while at the same time, they omit criteria
6 for coverage of chronic conditions and ignore factors that are relevant to promoting patients’ long-
7 term recovery.” *Id.* at 14.

8 As one example of alleged over-emphasis on acute symptoms as a criteria for determining
9 coverage, Plaintiffs point to the Guidelines’ emphasis on a patient’s “presenting problems,” that is,
10 the so-called “why-now factors.” *Id.* (citing Reynolds Decl., Ex. A-1 (“Summary of Selected
11 Level of Care Guideline Provisions Over-Emphasizing Acute Criteria”)¹³ & B (LOC Guidelines)).
12 According to Plaintiffs, “UBH Guidelines make clear that the ‘presenting problems’ refer to the
13 specific, acute symptoms that necessitated treatment in a particular level of care, as opposed to the
14 underlying mental health condition(s).” *Id.* As a consequence, they contend, “[a]s soon as the
15 crisis precipitating admission eases (even if the patient’s underlying condition remains
16 unresolved), the Guidelines call for coverage at that level of care to cease, unless the patient can
17 prove that stepping down to a lower level of care would be unsafe.” *Id.* Similarly, they assert, the
18 Guidelines require a patient to show “constant improvement, even over relatively short timeframes

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20 ¹² UBH objects to Exhibit D on the basis that it is not authenticated and contains hearsay.
21 Objections at 2. As discussed above, the Objections are overruled for failure to comply with Civil
22 Local Rule 7-3(a). Moreover, the objection to Exhibit D has no merit. As UBH produced this
23 document, it needs no further authentication at this stage of the case. The chart does not constitute
24 “hearsay” because Plaintiffs are not attempting to prove the truth of any statement contained in it;
25 they are simply using it to demonstrate that the generally accepted standards at issue in this case
26 are subject to common proof.

27 ¹³ UBH objects to Exhibit A-1 on the basis that it does not include all of the provisions of the
28 LOCs that UBH considers to be relevant to whether the Guidelines overemphasize acute criteria
and therefore is misleading. Objections at 1. The objection is **OVERRULED**. First, as discussed
above, UBH failed to comply with Civil Local Rule 7-3(a) as it did not include this objection in its
brief. Second, the objection has no merit. The title of the chart makes clear that it summarizes the
criteria that Plaintiffs believe show that the Guidelines overemphasize acute criteria and does not
purport to be a comprehensive summary of every provision that might be considered relevant to
the question of whether the Guidelines overestimate acute criteria. To the extent UBH seeks to
highlight provisions of the Guidelines that are not included in Plaintiffs’ chart, it is free to do so in
its brief.

1 (every 2-3 days or each week), in order for coverage to continue, demonstrating that the
2 Guidelines’ focus is on addressing short-term acute symptoms, rather than ensuring a patient’s
3 long-term recovery.” *Id.* at 14-15. The Guidelines also do not cover treatment aimed at
4 preventing deterioration or maintaining a level of function, Plaintiffs assert. *Id.* at 15.

5 Rule 23 allows for certification of a class where all of the requirements of Rule 23(a)
6 (numerosity, commonality, typicality and adequacy) are satisfied and one of the requirements of
7 Rule 23(b) is met. Here, Plaintiffs contend the classes can be certified under any of the
8 subsections of Rule 23(b), that is Rule 23(b)(1), (b)(2) or (b)(3), because the requirements for each
9 of them are met. *Id.* at 20-24. Even if the Court were to find that Plaintiffs have not met any of
10 the requirements of Rule 23(b), Plaintiffs ask the Court to certify any issues that it finds are
11 capable of classwide resolution under Rule 23(c)(4).

12 **III. ANALYSIS**

13 **A. General Legal Standards Under Rule 23**

14 A class action may be maintained under Rule 23 of the Federal Rules of Civil Procedure if
15 all of the requirements of Rule 23(a) are satisfied and the plaintiff demonstrates that one of the
16 requirements of Rule 23(b) is met as well. Rule 23(a) requires that a plaintiff seeking to assert
17 claims on behalf of a class demonstrate: 1) numerosity; 2) commonality; 3) typicality; and 4) fair
18 and adequate representation of the interests of the class. Fed. R. Civ. P. 23(a).

19 Rule 23(b)(1)(A) allows a class to be certified where “prosecuting separate actions by or
20 against individual class members would create a risk of . . . inconsistent or varying adjudications
21 with respect to individual class members that would establish incompatible standards of conduct
22 for the party opposing the class[.]” Fed. R. Civ. P. 23(b)(1)(A).¹⁴ Rule 23(b)(2) allows a class
23 action to be maintained where “the party opposing the class has acted or refused to act on grounds
24 that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is
25 appropriate respecting the class as a whole.” Fed. R. Civ. P. 23(b)(2).

26 Rule 23(b)(3) allows a class action to be maintained where “the court finds that the

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28 ¹⁴ Plaintiffs do not invoke Rule 23(b)(1)(B) and therefore the Court does not address it here.

1 questions of law or fact common to class members predominate over any questions affecting only
 2 individual members, and that a class action is superior to other available methods for fairly and
 3 efficiently adjudicating the controversy.” Fed. R. Civ. P. 23(b)(3). “An individual question is one
 4 where ‘members of a proposed class will need to present evidence that varies from member to
 5 member,’ while a common question is one where ‘the same evidence will suffice for each member
 6 to make a prima facie showing [or] the issue is susceptible to generalized, classwide proof.”
 7 *Tyson Foods, Inc. v. Bouaphakeo*, — U.S. —, 136 S. Ct. 1036, 1045 (2016) (quoting 2 W.
 8 Rubenstein, *Newberg on Class Actions* § 4:50, pp. 196-197 (5th ed. 2012) (internal quotation
 9 marks omitted)).

10 In addition to the explicit requirements of Rule 23, courts have sometimes read into that
 11 rule an ascertainability requirement. *Joyce v. City & County of San Francisco*, No. C-93-4149
 12 DLJ, 1994 WL 443464, at *3 (N.D. Cal. Aug. 4, 1994) (“A threshold inquiry in determining
 13 whether a proposed class is appropriately certified is whether the class is sufficiently definite so as
 14 to render it ‘administratively feasible to determine if a given individual is a member of the
 15 class.’”) (quoting *Aiken v. Obledo*, 442 F. Supp. 628, 658 (E.D. Cal. 1977) (citing 7 Wright &
 16 Miller, *Federal Practice and Procedure*, § 1760 at 582)). In addressing ascertainability, courts
 17 have considered at least three types of concerns: “1) whether the class can be ascertained by
 18 reference to objective criteria; 2) whether the class includes members who are not entitled to
 19 recovery; and 3) whether the putative named plaintiff can show that he will be able to locate
 20 absent class members once a class is certified.” *Dudum v. Carter’s Retail, Inc.*, No. 14-cv-00988-
 21 HSG, 2016 WL 946008, at *5 (N.D. Cal. Mar. 14, 2016).

22 Ascertainability concerns relate primarily to classes certified under Rule 23(b)(3). As one
 23 district court has noted, quoting the Manual of Complex Litigation:

24 Because individual class members must receive the best notice
 25 practicable and have an opportunity to opt out, and because
 26 individual damage claims are likely, Rule 23(b)(3) actions require a
 class definition that will permit identification of individual class
 members, while Rule 23(b)(1) or (b)(2) actions may not.

27 *Santomenno v. Transamerica Life Ins. Co.*, No. CV1202782DDPMANX, 2016 WL 1158449, at
 28 *17 (C.D. Cal. Mar. 14, 2016) (quoting Federal Judicial Center, *Manual for Complex Litigation*,

1 Fourth, § 21.222 (2004)). Thus, although the Ninth Circuit has not decided the question of
 2 whether the ascertainability requirement is limited to Rule 23(b)(3) classes, in *In re Yahoo Mail*
 3 *Litig.*, 308 F.R.D. 577 (N.D. Cal. 2015), Judge Koh, of this Court, found that the ascertainability
 4 requirement does not apply to classes that are certified under Rule 23(b)(2).

5 “At class certification, a court does not accept at face value a plaintiff’s theory of the case;
 6 the court must engage in a ‘rigorous analysis . . . [into whether] . . . the prerequisites of Rule 23(a)
 7 have been satisfied,’ and ‘frequently that “rigorous analysis” will entail some overlap with the
 8 merits of the plaintiff’s underlying claim.’” *Rodman v. Safeway, Inc.*, No. 11-cv-03003-JST, 2014
 9 WL 988992, at *6 (N.D. Cal. Mar. 10, 2014) (quoting *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S.
 10 338, 351 (2011) (quoting *Gen. Tel. Co. of Sw. v. Falcon*, 457 U.S. 147, 161 (1982))). “While the
 11 trial court has broad discretion to certify a class, its discretion must be exercised within the
 12 framework of Rule 23.” *Zinser v. Accufix Research Inst., Inc.*, 253 F.3d 1180, 1186 (9th Cir.),
 13 *opinion amended on denial of reh’g*, 273 F.3d 1266 (9th Cir. 2001) (citing *Doninger v. Pac. Nw.*
 14 *Bell, Inc.*, 564 F.2d 1304, 1309 (9th Cir. 1977)).

15 **B. Legal Standards Under ERISA**

16 “ERISA protects employee pensions and other benefits by providing insurance . . . ,
 17 specifying certain plan characteristics in detail . . . , and by setting forth certain general fiduciary
 18 duties applicable to the management of both pension and nonpension benefit plans.” *Varity Corp.*
 19 *v. Howe*, 516 U.S. 489, 496 (1996)). The basic purpose of ERISA is “to protect . . . the interests
 20 of participants . . . and . . . beneficiaries . . . by establishing standards of conduct, responsibility,
 21 and obligation for fiduciaries . . . and . . . providing for appropriate remedies . . . and ready access
 22 to the Federal courts.” *Id.* at 513 (quoting ERISA § 2(b), 29 U.S.C. § 1001(b)). The fiduciary
 23 duties established in ERISA “draw much of their content from the common law of trusts, the law
 24 that governed most benefit plans before ERISA’s enactment.” *Id.* at 496. However, “trust law
 25 does not tell the entire story” because “ERISA’s standards and procedural protections partly
 26 reflect a congressional determination that the common law of trusts did not offer completely
 27 satisfactory protection.” *Id.* (citations omitted). “Congress painted with a broad brush, expecting
 28 the federal courts to develop a ‘federal common law of rights and obligations’ interpreting

1 ERISA’s fiduciary standards.” *Bins v. Exxon Co. U.S.A.*, 220 F.3d 1042, 1047 (9th Cir. 2000) (*en*
2 *banc*) (citing *Varity*, 516 U.S. at 497). In developing this common law, “courts may have to take
3 account of competing congressional purposes, such as Congress’ desire to offer employees
4 enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a
5 system that is so complex that administrative costs, or litigation expenses, unduly discourage
6 employers from offering welfare benefit plans in the first place.” *Varity*, 516 U.S. at 497.

7 Pursuant to ERISA § 404(a)(1)(B), a “fiduciary shall discharge his duties with respect to a
8 plan solely in the interest of the participants and beneficiaries and . . . with the care, skill,
9 prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like
10 capacity and familiar with such matters would use in the conduct of an enterprise of like character
11 and with like aims.” 29 U.S.C. § 1104(a)(1)(B). Section 3(21)(A) provides, in part, that “a person
12 is a fiduciary with respect to a plan to the extent . . . he exercises any discretionary authority or
13 discretionary control respecting management” of the plan or “has any discretionary authority or
14 discretionary responsibility in the administration of such plan.” 29 U.S.C. § 1002(21)(A).

15 The remedial provisions of ERISA are set forth in § 502, 29 U.S.C. § 1132. Section 502(a)
16 governs the initiation of a civil action and provides, in relevant part, as follows:

17 A civil action may be brought–

18 (1) by a participant or beneficiary–

19 . . .

20 (B) to recover benefits due to him under the terms of his plan, to
21 enforce his rights under the terms of the plan, or to clarify his rights
22 to future benefits under the terms of the plan;

23 . . .

24 (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act
25 or practice which violates any provision of this subchapter or the
26 terms of the plan, or (B) to obtain other appropriate equitable relief
(i) to redress such violations or (ii) to enforce any provisions of this
27 subchapter or the terms of the plan;

28 ERISA § 502(a)(1) & (3), 29 U.S.C. § 1132(a)(1) & (3).

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C. Rule 23(a)

1. Numerosity

Rule 23(a)(1) requires that the size of the proposed class be “so numerous that joinder of all the class members is impracticable.” That requirement is satisfied here. Plaintiffs have offered evidence that there are likely hundreds of individuals who fall within the class definition for the *Wit* State Mandate Class and thousands of individuals who satisfy the requirements of the *Wit* and *Alexander* Guideline Classes (collectively, the “Guideline Classes”). See Reynolds Decl. ¶ 19 (describing how spreadsheets provided by UBH in connections with Joint Stipulation Concerning Sampling Methodology were used to determine that there were approximately 296 denials of coverage within the *Wit* State Mandate Class, 13,205 denials of coverage within the *Wit* Guideline Class, and 16,171 denials of coverage within the *Alexander* Guideline Class). UBH does not dispute that the numerosity requirement is met.

2. Adequacy

Rule 23(a)(4) requires that the class representatives “fairly and adequately protect the interests of the class.” “Determining whether the representative parties adequately represent a class involves two inquiries: (1) whether the named plaintiff and his or her counsel have any conflicts of interest with other class members and (2) whether the named plaintiff and his or her counsel will act vigorously on behalf of the class.” *Calvert v. Red Robin Int’l, Inc.*, No. C 11-03026 WHA, 2012 WL 1668980, at *2 (N.D. Cal. May 11, 2012) (citing *Lerwill v. Inflight Motion Pictures, Inc.*, 582 F.2d 507, 512 (9th Cir. 1978)). UBH has not identified any conflicts of interest on the part of the named Plaintiffs or their counsel and the Court has no reason to doubt that they will prosecute this case diligently. In addition, Plaintiffs’ counsel have offered evidence that they are experienced in prosecuting class actions involving insurance companies and denial of mental health benefits in particular. See Reynolds Decl., Ex. U. The adequacy requirement is satisfied.

3. Commonality

The commonality requirement of Rule 23(a)(2) is met where “the class members’ claims ‘depend upon a common contention’ such that ‘determination of its truth or falsity will resolve an issue that is central to the validity of each [claim] with one stroke.’” *Mazza v. Am. Honda Motor*

1 *Co.*, 666 F.3d 581, 588 (9th Cir. 2012) (internal citation omitted) (quoting *Wal-Mart Stores, Inc. v.*
2 *Dukes*, 564 U.S. 338, 350 (2011)). Thus, plaintiffs seeking to certify a class must “demonstrate
3 ‘the capacity of classwide proceedings to generate common answers’ to common questions of law
4 or fact that are ‘apt to drive the resolution of the litigation.’” *Id.* (quoting *Wal-Mart*, 564 U.S. at
5 350). “[C]ommonality only requires a single significant question of law or fact.” *Id.* at 589
6 (citing *Wal-Mart*, 564 U.S. at 359). “The commonality preconditions of Rule 23(a)(2) are less
7 rigorous than the companion requirements of Rule 23(b)(3).” *Hanlon v. Chrysler Corp.*, 150 F.3d
8 1011, 1019 (9th Cir. 1998). “The existence of shared legal issues with divergent factual predicates
9 is sufficient, as is a common core of salient facts coupled with disparate legal remedies within the
10 class.” *Id.*

11 a. Contentions of the Parties

12 Plaintiffs contend the claims of the putative classes turn on a common core of factual and
13 legal issues arising from the fact that UBH “developed and used its overly-restrictive Guidelines
14 to make clinical coverage determinations” for all class members. Motion at 16. Among the
15 “central questions” that Plaintiffs assert will be the same for all class members in the Guideline
16 Classes are: 1) was UBH acting as a fiduciary when it adopted the Guidelines and the policy and
17 practice of applying them to all coverage determinations; 2) are UBH’s Guidelines consistent with
18 generally accepted standards; 3) did UBH breach its fiduciary duties when it developed the
19 Guidelines and/or when it applied them to adjudicate and deny claims; and 3) what remedies are
20 available to the class. *Id.* at 17. As to the *Wit* State Mandate Class there is also an “overarching
21 issue,” according to Plaintiffs, namely, whether UBH “abuse[d] its discretion by applying its
22 fatally-flawed Guidelines to deny claims for substance use disorder treatment where a state law
23 mandated the use of ASAM or TDI criteria.” *Id.* Not only are the questions the same but the
24 answers will also be the same for all class members, Plaintiffs assert. *Id.* Plaintiffs also contend
25 their request for declaratory and injunctive relief will raise common questions because they claim
26 UBH has “acted or refused to act on grounds that apply generally to the class” and the question of
27 whether injunctive or declaratory relief is appropriate for the class as a whole also presents a
28 common question. *Id.*

1 UBH argues that the commonality requirement is not met because Plaintiffs’ claims turn
2 on “1) thousands of different insurance plans, 2) 169 different coverage guidelines, and 3) the
3 unique clinical presentation of each class member.” Opposition at 13.

4 With respect to the variations in plans, UBH contends, “Courts have rejected class
5 certification motions seeking to unite members of different health plans under the umbrella of a
6 single ERISA action.” *Id.* at 14 (citing *Lipstein v. UnitedHealth Group*, 296 F.R.D. 279, 282-83,
7 286 (D.N.J. 2013); *In re Wellpoint, Inc. Out-of-Network “UCR” Rates Litig.*, No. MDL 09-2074
8 PSG, 2014 WL 6888549 at *1 (C.D. Cal. Sept. 3, 2014); *Bond v. Marriott Int’l, Inc.*, 296 F.R.D.
9 403, 411 (D. Md. 2014)). Here, they argue, the class members’ claims raise individualized issues
10 because they turn on coverage determinations made under different plans with different exclusions
11 and limitations. *Id.* at 14-15. Some plans expressly permit denial of coverage based on UBH’s
12 levels of care guidelines, according to UBH, and as to these plans, denial of coverage under the
13 Guidelines was entirely consistent with its fiduciary duty to administer the plan in accordance with
14 its terms. *Id.* at 15. As another example of variation in plans, UBH points out that some putative
15 class members’ plans exclude coverage for treatment that does “not result in outcomes
16 demonstrably better than other available treatment alternatives that are less intrusive or more cost
17 effective.” *Id.* at 16 (citing Romano Decl., Ex. 71 (Plan Chart) at 5, 19, 21). Yet another variation
18 in insurance plans is the contractual limitations period for pursuing a claim, UBH contends. *Id.*
19 (citing Romano Decl., Ex. 77 (Sample Plan 8988) at 65-66 & Ex. 73 (Plaintiff Driscoll insurance
20 plan) at 76). UBH argues that because of all of these variations, even if the question of whether
21 the Guidelines are consistent with generally accepted standards of care can be resolved on a
22 classwide basis, it will not drive the resolution of the case as a whole “because an individualized
23 inquiry would still be needed to determine whether a denial based on those guidelines was
24 improper or gives rise to any relief.” *Id.*

25 UBH also challenges Plaintiffs’ characterization of the Guidelines, arguing that Plaintiffs
26 (wrongly) suggest that the Guidelines “amount to a cohesive policy, applied to every class
27 member” and that “such a policy is measurable against a uniform generally accepted standard of
28 care.” *Id.* at 17. According to UBH, Plaintiffs focus in their brief on the theory that the

1 Guidelines overemphasize “acute criteria and symptoms” but in fact, they contend that the
2 Guidelines diverge from generally accepted standards of care in at least six different ways. *Id.*
3 (citing Romano Decl., Ex. 5 (Plaintiffs’ Supp. Responses to Rog. No. 17)).¹⁵ Moreover, UBH

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5 ¹⁵Plaintiffs offered the following six ways in which the Guidelines are more restrictive than
6 generally accepted standards of care in response to UBH’s interrogatory:

- 7 • In contrast to generally accepted standards of care, UBH’s Guidelines overemphasize acute
8 criteria and symptoms, indicating that coverage for mental health or substance abuse
9 treatment is only available to address specific crises and that, as soon as the crisis
10 precipitating admission has passed, coverage is no longer available.
 - 11 ○ For example, the level of care criteria contained in UBH’s Guidelines focus heavily on
12 addressing the member’s “presenting problems” (also called the “‘why now’ factors”).
13 UBH’s Guidelines make clear that the “presenting problems” refer to the specific,
14 acute symptoms that necessitated treatment in a particular level of care, as opposed to
15 the underlying mental health condition(s). As soon as the “presenting problems”
16 improve enough to safely transition the patient to a lower level of care (or to cease
17 treatment altogether), UBH’s Guidelines make clear that treatment is no longer covered
18 for the requested level of care.
- 19 • In contrast to generally accepted standards of care, UBH’s Guidelines fail to provide
20 coverage for the treatment of chronic conditions in the absence of an acute crisis
21 precipitating admission to care. This is true with respect to residential treatment, intensive
22 outpatient treatment and even outpatient treatment. From at least 2012 forward, UBH’s
23 Guidelines do not provide for UBH to consider criteria that, under generally-accepted
24 standards, should be taken into account in determining whether coverage is available for
25 treatment at a proposed level of care, including but not limited to: (a) the presence of co-
26 morbid mental health conditions; (b) patient resiliency; (c) the member’s age and/or
27 developmental progression; and (d) with respect to substance use disorders, the member’s
28 motivation to recover.
- UBH’s Guidelines reverse the burden of proof for selection of the appropriate level of care,
providing that coverage is only available at a lower level unless a member or provider can
prove that a higher level of care is necessary because a lower level would be unsafe.
Generally accepted standards, by contrast, err on the side of caution and call for selection
[of] a higher level of care unless a lower level will be both safe and effective.
- Under UBH’s Guidelines, both residential and intensive outpatient treatment must focus on
rapid stabilization of the specific, acute symptoms precipitating admission (that is, the
“presenting problems” or “‘why now’ factors”) with the goal of transitioning the member
as soon as possible to a lower level of care. According to generally accepted standards,
however, the goals of treatment include promoting the patient’s long-term recovery and
resiliency and preventing deterioration or relapse.
- In contrast to generally accepted standards of care, UBH’s Guidelines do not include
prevention of deterioration as a goal for covered treatment. UBH’s Guidelines for
residential treatment incorporate an overly-expansive definition of “custodial care” that
precludes coverage for continued treatment if a member fails to show constant

1 asserts, the degree to which the CDGs emphasize acuity varies widely “depending on the
2 diagnosis and clinical circumstances at issue.” *Id.* at 17-18 (citing as examples 2015 CDG for
3 Substance-Related & Addictive Disorders (“SRAD”) (Romano Decl., Ex. 42 at 5-6, 9, 13, 30-31);
4 2015 CDG for Anorexia Nervosa (Romano Decl., Ex. 31 at 14); 2015 CDG for Generalized
5 Anxiety Disorder (“GAD”) (Romano Decl., Ex. 36 at 9); 2015 CDG for Bipolar Disorder
6 (Romano Decl., Ex. 32 at 5-6); 2015 CDG for Depressive Disorders (Romano Decl., Ex. 34 at 5-
7 6); 2013 CDG for Major Depressive Disorder (Romano Decl., Ex. 34 at 6); 2015 CDG for
8 Bulimia Nervosa (Romano Decl., Ex. 33 at 10-14); 2015 CDG for Specific Phobias (Romano
9 Decl., Ex. 41 at 14); 2015 CDG for Schizophrenia (Romano Decl., Ex. 40 at 30, 33); 2015 CDG
10 for Disruptive Mood Dysregulation Disorder (Romano Decl., Ex. 35 at 22, 26)). Even the
11 Common Criteria of the LOCs are applied flexibly according to the clinician’s “sound judgment,”
12 UBH contends, taking into account the particular circumstances and diagnosis at issue and
13 allowing “exceptions where case-specific circumstances warrant.” *Id.* at 18 (citing 2013 LOC
14 Common Criteria (Romano Decl., Ex. 45 at 8); 2014 LOC Common Criteria (Romano Decl. Ex.
15 46 at 6-7); 2011 LOC at 3, 2012 LOC at 3-4, 2013 LOC at 4, 2014 LOC at 5, and 2015 LOC at
16 5-6 (Romano Decl., Exs. 43-47)).

17 UBH further contends that Plaintiffs’ challenges to the Guidelines raise a multitude of
18 diverse issues that defeat commonality because they “rely on a host of different sources for what
19 they view as the standard of care.” *Id.* at 19. According to UBH, there are “dozens of third-party
20 guidelines” promulgated by the national organizations cited by Plaintiffs but Plaintiffs have not
21 specified which of them constitute the standards of care for the 169 Guidelines that they challenge
22 in this case. *Id.* at 20. UBH argues that Plaintiffs must offer enough evidence to show that they

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improvement. Generally accepted standards of care, by contrast, provide that
“improvement” may include maintaining a level of function. Generally accepted standards
also take into account that the process of recovery may include periods of stability or even
regression, especially with respect to patients with chronic conditions or co-morbid
conditions, and that such periods do not indicate that treatment is ineffective or
unnecessary.

Romano Decl., Ex. 5 at 4-5.

1 can prove a “class-wide standard of care” in order for the classes to be certified and that Plaintiffs
2 have failed to meet this burden. *Id.*

3 UBH makes several additional arguments relating to commonality as to the *Wit* State
4 Mandate Class. Opposition at 32-33. First, the members of this class will be governed by
5 different legal rules, UBH contends, because Illinois and Rhode Island require the use of ASAM
6 criteria in certain circumstances while Connecticut and Texas do not. *Id.* at 32. In particular, they
7 assert, “Texas law requires the application of Texas-specific guidelines (referred to as ‘TDI’
8 guidelines) for substance abuse treatment” whereas “Connecticut law provides that ‘a health
9 carrier may develop its own clinical review criteria,’ provided that it ‘is consistent with the most
10 recent edition’ of ASAM.” *Id.* (citing Conn. Gen. State. Ann. § 38a-591c(a)(2), (3)(A)). Second,
11 they argue, Plaintiffs have failed to take into account the fact that “the four state laws specifying
12 coverage criteria were enacted at different times, with the Connecticut, Illinois and Rhode Island
13 laws being enacted at various times *after* the start of the class period (and in Rhode Island, after
14 the *Wit* case was filed).” *Id.* at 32-33 (emphasis in original).¹⁶ Third, they contend, UBH
15 reviewers look to a variety of sources for guidance and there is evidence (acknowledged by
16 Plaintiffs in their brief) that UBH did in fact look to the TDI guidelines in at least two cases from
17 the Claim Sample. *Id.* at 33 (citing Motion at 13, Reynolds Ex. F at 3 & Romano Decl., Ex. 61
18 (Sample ID 8873 ABD Letter)). This evidence demonstrates that individualized inquiries will be
19 necessary as to the *Wit* State Mandate Class, UBH asserts. *Id.*

20 Plaintiffs counter that none of the alleged variations that UBH says defeat commonality is
21 material. Reply at 2-12. First, with respect to UBH’s reliance on alleged variations in class
22 members’ plans, Plaintiffs contend that UBH has mischaracterized their argument by stating in its
23 Opposition brief that Plaintiffs’ claims are based on the assertion that each plan requires UBH to
24 “cover *all* treatment that is consistent with generally accepted standards of care.” *Id.* at 2
25 (quoting Opposition at 15) (emphasis added in Reply brief). UBH then knocks down this “straw

26 _____
27 ¹⁶ This argument was aimed at the original definition of the *Wit* State Mandate Class, which did
28 not include language taking into account the dates on which the various state laws were enacted.
That additional language was proposed in Plaintiffs’ Reply brief.

1 man,” Plaintiffs contend, by pointing to the varying limitations and exclusions contained in
2 individual plans that preclude coverage *even if* a treatment is consistent with generally accepted
3 standards of care. *Id.* Plaintiffs emphasize in their Reply brief that they do not claim that
4 compliance with generally accepted standards of care is the *only* requirement for coverage; rather,
5 they contend such compliance is a “baseline requirement for coverage under all Class Member
6 plans.” *Id.* at 3. Plaintiffs argue that their Breach of Fiduciary Duty Claim is based on the theory
7 that UBH breached its fiduciary duty by developing Guidelines that are intended to reflect
8 generally accepted standards and that variations in class members’ insurance plans are irrelevant
9 to that theory. *Id.* They further contend that the variations in insurance plans are also irrelevant to
10 Claim Two, which is based on application of the Guidelines to coverage determinations, because it
11 is undisputed that all of the insurance plans required that coverage determinations must be
12 consistent with generally accepted standards of care. *Id.*

13 Addressing the specific variations in insurance plans that UBH highlighted in its
14 Opposition brief, Plaintiffs reject UBH’s reliance on the fact that some insurance plans expressly
15 permit denials based on the Guidelines. *Id.* at 2-3. These Guidelines were supposed to be based
16 on generally accepted standards of care, Plaintiffs contend. *Id.* Were the “guideline” exclusion to
17 be read to give UBH “unfettered discretion to adopt *any* deadline it please[d]” it would conflict
18 with the mandate, common to all of the plans, that “coverage requires compliance with generally
19 accepted standards,” Plaintiffs assert. *Id.* at 3.

20 Plaintiffs also reject UBH’s reliance on alleged variations in limitations periods in class
21 members’ insurance plans. *Id.* at 4. According to Plaintiffs, of the two examples UBH offers one
22 (Sample Plan 8988) does not even apply to coverage decisions made by UBH and the other
23 contains a limitations period that is longer than the three-year period contained in the proposed
24 class definition. *Id.* at 4 (citing Opposition at 15-16 & Romano Decl., Ex. 73 (Driscoll Plan)¹⁷ at

25 _____
26 ¹⁷ The Driscoll insurance plan provides that a claim for coverage must be submitted within 15
27 months of receiving treatment and also sets forth a series of deadlines for pursuing internal
28 appeals, including a six-month deadline. Romano Decl., Ex. 73 (Driscoll Plan) at 72-77. It
further provides:

1 72, 77; Ex. 77 (Sample Plan 8988)¹⁸ at 65-66). Plaintiffs further assert that even if the limitations
2 periods of class members' insurance plans varied, these variations would be irrelevant to the
3 Breach of Fiduciary Duty claim because that claim is subject to a statutory limitations period
4 under ERISA that cannot be shortened by plan terms. *Id.* at 4 (citing 29 U.S.C. § 1113 (providing
5 that limitations period for breach of fiduciary duty claim under ERISA is "(1) six years after (A)
6 the date of the last action which constituted a part of the breach or violation, or (B) in the case of
7 an omission the latest date on which the fiduciary could have cured the breach or violation, or (2)
8 three years after the earliest date on which the plaintiff had actual knowledge of the breach or
9 violation" except in cases of fraud or concealment); *Kramer v. Smith Barney*, 80 F.3d 1080, 1085
10 (5th Cir. 1996)).

11 Plaintiffs also reject UBH's reliance on variations as to the clinical presentations of class
12 members, which UBH contends raise "individualized issues of medical necessity." *Id.* at 5
13 (quoting Opposition at 20). Plaintiffs argue that the clinical presentations of class members have
14

15
16 If you want to bring a legal action against [the Plan Administrator]
17 or the Claims Administrator, you must do so within three years
18 from the expiration of the time period in which a request for
reimbursement must be submitted or you lose any rights to bring
such an action against [the Plan Administrator] or the Claims
Administrator.

19 *Id.* at 76. At oral argument, UBH conceded that this limitations period has no bearing on class
20 certification because it is *longer* than the three-year limitations period contained in the class
21 definitions.

22 ¹⁸ Sample Plan 8988 provides for a "Plan Administrator Appeals process" whereby a member can
23 submit a coverage dispute to the "Plan Administrator." Romano Decl., Ex. 77 at 66. The "Plan
24 Administrator" for Sample Plan 8988 is Metropolitan Life Insurance Company. *Id.* at 66, 112.
25 One of the rules that governs such appeals (highlighted by UBH in the exhibit attached to its
26 Opposition and cited in its Opposition brief) is that "[n]o civil action can be brought challenging
27 the denial of the claim on appeal more than six months following the date on which the written
28 response to your Plan Administrator Appeal is sent to you." *Id.* at 66. Under this plan, however,
Plan Administrator Appeals "cannot include review of medical determinations by the Claims
Administrator," that is, UBH. *Id.* at 65. At oral argument, UBH conceded that the cited provision
does not apply to appeals of medical determinations by the Claims Administrator and therefore is
not relevant to the question of class certification. UBH's counsel stated that the citation in its brief
was incorrect and that the limitations period it had meant to cite was found on a different page of
the insurance plan. As Plaintiffs have not had an opportunity to respond to this argument, which is
untimely, the Court does not address it here. In any event, this potential variation in one plan is
insufficient to disprove commonality, especially in light of the common statutory statute of
limitations.

1 no bearing on the Breach of Fiduciary Duty Claim because that claim is based on UBH's
2 development of the Guidelines and addresses only the validity of the Guidelines. *Id.* Similarly,
3 they contend, individual issues relating to medical necessity have no relevance to Claim Two, the
4 Arbitrary and Capricious Denial of Benefits Claim, because that claim is based on the use of what
5 Plaintiffs contend are flawed Guidelines in making coverage determinations and does *not* ask the
6 Court to “determine whether Class members were owed benefits or whether UBH should be
7 ordered to cause its plans to pay such benefits.” *Id.* Instead, Plaintiffs point out, they are only
8 seeking as a remedy the reprocessing of claims in a manner that is consistent with generally
9 accepted standards of care. *Id.* Consequently, they contend, they “need not prove at trial that
10 UBH reached the wrong outcome in every single one of its coverage determinations.” *Id.*

11 Indeed, Plaintiffs assert, courts are reluctant to usurp the role of the claims administrator
12 and therefore, where a denial of coverage is found to be arbitrary and capricious under ERISA, the
13 preferred remedy is to remand the claim for evaluation on the merits. *Id.* at 6 (citing *Saffle v.*
14 *Sierra Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 460 (9th
15 Cir. 1996) (“[R]emand for reevaluation of the merits of a claim is the correct course to follow
16 when an ERISA plan administrator, with discretion to apply a plan, has misconstrued the Plan and
17 applied a wrong standard to a benefits determination.”)). For this reason, Plaintiffs assert, UBH's
18 reliance on *Dennis F. v. Aetna Life Insurance*, No. 12-cv-2819 SC, 2013 WL 5377144, at *4 (N.D.
19 Cal. Sept. 25, 2013) and *Graddy v. Blue Cross Blue Shield of Tennessee, Inc.*, No. 09-cv-84, 2010
20 WL 670081 (E.D. Tenn. Feb. 19, 2010) is misplaced. *Id.* at 7. In both cases, Plaintiffs contend,
21 the plaintiffs sought “court-ordered benefit payments,” which would have required individualized
22 inquiries as to the medical necessity of treatment for each class member. *Id.* & n. 9. Plaintiffs
23 also distinguish *Dennis F.* on the basis that the plaintiffs in that case – unlike Plaintiffs here – did
24 not challenge the guidelines used by the insurance company to make coverage determinations but
25 instead only challenged the application of those guidelines. *Id.*

26 Plaintiffs also argue that UBH's reliance on the variations in the Guidelines themselves is
27 misplaced. *Id.* at 8-12. While UBH emphasizes that there are “169 different CDGs and LOCs,” it
28 ignores the fact that all of the CDGs expressly incorporate the LOCs, including the Common

1 Criteria, for all Levels of Care, Plaintiffs assert. *Id.* at 8-9 (citing Reynolds Decl., Ex. A-2 (chart
2 identifying CDGs that incorporate LOCs)). Moreover, Plaintiffs assert, while the LOCs are
3 updated on a yearly basis, there are only six versions of the LOCs during the class period and
4 UBH does not even argue that the LOC criteria “differ substantively from year to year.” *Id.* at 9.
5 In fact, Plaintiffs contend, for any given year the LOCs “suffer from the same defects, which
6 means that Plaintiffs’ evidence challenging those defects will also be the same for all LOCs.” *Id.*
7 at 10 (citing Reynolds Decl., Ex. A-1).¹⁹ UBH’s argument that the Court will be required to
8 address the LOCs for many specific levels of care is overstated, Plaintiffs contend, because the
9 Court will only be required to examine the levels of care that are relevant to the *Wit* and *Alexander*
10 cases, that is, residential treatment, intensive outpatient treatment and outpatient treatment. *Id.* at
11 10.

12
13

¹⁹ The chart in Exhibit A-1 identifies fifteen LOC requirements that Plaintiffs contend
14 overemphasize acute care criteria for each version of the LOCs in the class period (2011 – 2016).
15 They are as follows:

- 16 • Treatment must focus on the acute crisis precipitating admission (i.e., the “presenting
17 problems” or the “‘why now’ factors”);
- 18 • Coverage requires finding that member’s acute symptoms cannot be treated in a lower
19 level of care;
- 20 • Treatment must be expected to improve presenting symptoms “within a reasonable period
21 of time”;
- 22 • “Improvement” defined as reduction or control of the symptoms precipitating admission;
- 23 • Coverage requires a finding that the member’s current condition cannot be safely and
24 effectively treated in a lower level of care;
- 25 • Goal of treatment should be to improve the presenting symptoms enough so that step-down
26 to a lower level of care is safe;
- 27 • Coverage is available only for “active” treatment;
- 28 • “Active” treatment must focus on addressing the crisis precipitating admission (i.e., the
“critical presenting problems” or the “‘why now’ factors”);
- Coverage for residential treatment is excluded if UBH deems services “custodial”;
- “Custodial” defined to include services provided during any periods when the member is
not making ongoing progress (i.e., member’s condition is “not changing” or “not
improving,” or member is “maintaining a level of function”);
- Preventing deterioration/relapse is not a permissible goal of treatment;
- Maintaining a level of function is not a permissible goal of treatment;
- Coverage for continued service requires that the admission criteria still be met;
- Guideline omits criteria providing for treatment of chronic conditions in the absence of an
acute crisis;
- Guideline omits consideration of co-morbid conditions as a factor necessitating a more
intense level of service.

Reynolds Decl., Ex. A-1 (based on Level of Care Guidelines for 2011-2016, found at
Reynolds Decl., Ex. B).

1 Plaintiffs also contend that UBH improperly relies on the “Clinical Best Practices” sections
2 of some of the CDGs to show that “some of the factors Plaintiffs identified as missing from
3 UBH’s level-of-care criteria are actually present in some CDGs.” *Id.* According to Plaintiffs, “the
4 Clinical Best Practices do not provide the criteria on which UBH conditions coverage – rather,
5 they set forth standards of practice UBH expects *treatment providers* to meet.” *Id.* (emphasis in
6 original). Thus, for example, even if some of the Best Practices Guidelines acknowledge that
7 certain behavioral health conditions may be chronic, coverage will not be approved under the
8 Guidelines unless the member experiences “acute changes in . . . signs and symptoms and/or
9 psychosocial and environmental factors (*i.e.* the “why now” factors leading to admission).” *Id.*
10 (quoting Romano Decl., Ex. 31 (2015 CDG Treatment of Anorexia Nervosa) at 24 § 1.4 and
11 contrasting with “Clinical Best Practices” section of same CDG, at pp.13-14, offering criteria for
12 provider to determine whether member’s anorexia condition is “Acute” or “Chronic”). In any
13 event, Plaintiffs contend, to the extent there is language in the LOCs that UBH contends meets the
14 requirements of general accepted standards with respect to treatment of chronic, the significance
15 of this language is a common question that may be adjudicated on a classwide basis. *Id.* at 12.

16 Plaintiffs argue further that the fact that the Guidelines are to be applied in a “flexible
17 manner” does not mean that UBH does not follow a common course of conduct in applying the
18 Guidelines to all coverage determinations. *Id.* To the contrary, Plaintiffs contend, the evidence in
19 the case shows that UBH requires all Peer Reviewers to apply the Guidelines and to cite to those
20 Guidelines in their coverage decision and that any exceptions must be approved by UBH
21 management. *Id.* (citing Romano Decl., Ex. 43 (2011 LOC Guidelines) at 3 (“It is expected that
22 exceptions be carefully thought out, documented and approved by the responsible level of
23 management”).

24 Finally, Plaintiffs assert that the variations among the guidelines and criteria of such
25 organizations as the American Academy of Child and Adolescent Psychiatry (“AACAP”), the
26 American Association of Community Psychiatrists (“AACP”) and ASAM, some of which are
27 condition-specific, do not defeat commonality, as UBH contends. *Id.* at 13. According to
28 Plaintiffs, they will “submit evidence at trial from multiple sources sufficient to show that the

1 Guidelines are inconsistent across the board with generally accepted standards.” *Id.* The sources
2 have already been identified in their complaint and their interrogatory responses, Plaintiffs
3 contend, and therefore UBH’s “feign[ed] confusion” about which sources will be used in support
4 of Plaintiffs’ claims should be rejected. *Id.* Nor is UBH correct in its assertion that it is
5 Plaintiffs’ burden to establish which of the third-party standards of care represent the relevant
6 generally established standards as this is a merits question, Plaintiffs assert, and at this stage of the
7 case they need only demonstrate that the requirements of Rule 23 are met. *Id.* at 13-14.

8 Plaintiffs also reject UBH’s argument specific to the *Wit* State Mandate Class that the
9 variations among the laws of the four states make certification inappropriate, arguing that these
10 variations are not material because the theory of Plaintiffs’ claims for this class is that the laws of
11 the four states “prohibit UBH from using its own Guidelines and . . . common evidence can prove
12 that it did just that.” *Id.* at 21. Plaintiffs concede that the variations as to the dates on which the
13 state laws were enacted must be taken into account, however, and have proposed an amendment to
14 the class definition, as noted above. *Id.*

15 b. Discussion

16 The Court concludes that Plaintiffs meet the commonality requirement as to both the
17 Guideline Classes and the *Wit* State Mandate Class. The theory of Plaintiffs’ claims is, in essence,
18 that UBH breached its fiduciary duty and abused its discretion by developing and applying
19 Guidelines that were more restrictive than either: 1) the generally accepted standards all class
20 members’ insurance plans required UBH to follow (the Guideline Classes); or 2) the applicable
21 standards under state law (the *Wit* State Mandate Class). The resolution of these claims will turn
22 on several common legal and factual questions, including whether UBH was acting as an ERISA
23 fiduciary when it developed the Guidelines and adopted a policy of applying them to all coverage
24 determinations, whether the Guidelines are consistent with generally accepted standards, whether
25 UBH breached its fiduciary duty by using its Guidelines to adjudicate claims for coverage, and
26 what remedies are available to the classes. These common questions of law and fact are sufficient
27 to satisfy the permissive requirements of Rule 23(a).

28 The Court is not persuaded by Defendants’ assertions that variations relating to the

1 putative class members’ insurances plans, medical necessity determinations or the Guidelines
2 themselves defeat commonality. These variations are not material to the theories upon which
3 Plaintiffs’ claims are based. The harm alleged by Plaintiffs – the promulgation and application of
4 defective guidelines to the putative class members – is common to all of the putative class
5 members. Similarly, whether Plaintiffs are entitled to the requested remedy – adoption of new
6 Guidelines that are consistent with generally accepted standards and/or state law and reprocessing
7 of claims that were denied under the allegedly defective guidelines– can be addressed on a
8 common basis. Of particular significance is the fact that Plaintiffs do not ask the Court to make
9 determinations as to whether class members were *actually* entitled to benefits (which would
10 require the Court to consider a multitude of individualized circumstances relating to the medical
11 necessity for coverage and the specific terms of the member’s plan). Instead, Plaintiffs seek only
12 an order that UBH develop guidelines that are consistent with generally accepted standards and
13 reprocess claims for coverage that were denied under the allegedly faulty guidelines. For this
14 reason, *Dennis F. v. Aetna Life Insurance*, on which UBH relies in support of its contention that
15 Plaintiffs have not satisfied the commonality requirement, is not on point.

16 In *Dennis F.*, Judge Conti found that commonality under Rule 23(a)(2) had not been
17 established where the plaintiffs sought to certify two classes of individuals who had allegedly been
18 denied coverage for care at residential treatment centers (“RTCs”) based on incorrect tabulation of
19 their Level of Care Assessment Tool (“LOCAT”) score. 2013 WL 5377144, at *1. The plaintiffs
20 did not challenge the validity of the levels of care guidelines used to assign the numeric values that
21 went into tabulating the overall score but rather, asserted that the tabulation method described on
22 the LOCAT Scoring Form was not followed by the insurer, resulting in denials of coverage in
23 some cases. *Id.* at *2. The court found that while the LOCAT scores were “strongly correlated
24 with the level of care approved by” the insurer and that they “might be probative” of medical
25 necessity, they were not “dispositive.” *Id.* at *4. As a consequence, the court concluded, a
26 classwide proceeding on the insurer’s scoring practices would not “generate common answers apt
27 to drive resolution of the litigation.” *Id.* Although the court in *Dennis F.* did not address in any
28 detail the remedy sought in that case, the complaint reflects that Plaintiffs sought not only an

1 injunction requiring the insurer to fix the problem with its tabulation method but also an award of
2 the class members' denied benefits. *See* Northern District of California Case No. C-12-2819,
3 Docket No. 1 (Complaint) ("This case seeks correction of Aetna's systematic misapplication of the
4 LOCAT criteria and compensation for whom coverage for mental health treatment has been
5 improperly denied."). It was the latter that would have required the court to grapple with the
6 variations in class members' specific medical circumstances.

7 Other cases cited by UBH also are distinguishable because the courts in those cases found
8 that it would have been necessary to conduct individualized inquiries as to medical necessity to
9 determine liability. For example, in *Graddy v. Blue Cross Blue Shield of Tennessee, Inc.*, the
10 court found that a breach of fiduciary duty claim based on an alleged policy of a health care plan
11 of denying coverage for Applied Behavior Analysis ("ABA") to individuals with Autism
12 Spectrum Disorder ("ASD") could not proceed on a class basis because "an individualized
13 assessment as to the ultimate propriety of the benefits decision affecting each and every class
14 member" would have had to have been conducted to resolve the plaintiffs' claims. 2010 WL
15 670081, at *9 (E.D. Tenn. Feb. 19, 2010). Similarly, in *Pecere v. Empire Blue Cross and Blue*
16 *Shield*, the court found that the plaintiffs' challenge under ERISA to an alleged policy of routinely
17 denying coverage for pain treatment without regard to medical necessity did not meet Rule 23's
18 commonality requirement because the claim "hinge[d] on whether or not the treatment for each of
19 their individual conditions was 'medically necessary.'" 194 F.R.D. 66, 71 (E.D. N.Y. 2000).

20 The Court also rejects UBH's reliance on *In re Wellpoint* in support of its position that
21 Plaintiffs have not satisfied the commonality requirement because of the multitude of insurance
22 plans at issue in this case. In *In re Wellpoint*, the plaintiffs sought to certify several classes
23 asserting claims under ERISA for wrongly withheld benefits based on the allegation that the
24 insurer failed to reimburse providers and members the "usual, customary and reasonable" rate for
25 services, as required under the plaintiffs' insurance plans. No. MDL 09-2074 PSG, 2014 WL
26 6888549, at *1 (C.D. Cal. Sept. 3, 2014). The court, however, concluded that the commonality
27 test was a "major hurdle for class certification" because of the "contractual nature" of the
28 plaintiffs' claims and in particular, the fact that there was material variation in the exemplar

1 ERISA plans regarding the meaning of the term “usual, customary, and reasonable.” *Id.* at *4-8.
2 As a consequence, the court concluded, the “common nature” of what the plaintiffs cited as the
3 “overarching issue”— whether the insurer “artificially deflated” the usual, customary and
4 reasonable rates paid to members and providers – would “fragment[]” because the court would
5 first have to determine what rates the plaintiffs *should* have been paid, which varied across plans.
6 *Id.* at *4.

7 The court in *In re Wellpoint* did not, however, suggest that the mere fact that class
8 members were insured under different plans precluded commonality. To the contrary, it
9 recognized that it is possible to satisfy the commonality requirement when there are multiple
10 ERISA plans, for example, where the “ERISA plans at issue had terms that were common across
11 the proposed class.” *Id.* at 11. Under the facts of that case, however, the plaintiffs had not
12 demonstrated “uniformity or at least substantial similarity in key plan language as to the entire
13 ERISA Class.” *Id.* at *8. In contrast, Plaintiffs here have demonstrated, as a factual matter, that
14 the insurance plans for the putative class members are substantially the same in a key respect,
15 namely, that they require as a condition of coverage adherence to generally accepted standards
16 and/or state law.

17 The Court also rejects UBH’s reliance on the fact that some class members’ health
18 insurance plans excluded coverage for treatment that is “not consistent with the Mental Health/
19 Substance Use Disorder Designee’s level of care guidelines or best practices as modified from
20 time to time” (the “guidelines exception”). *See* Romano Decl., Ex. 71 (Health plan chart) at 6, 10,
21 20, 25). To the extent it is undisputed that all Named Plaintiffs’ and Sample Plaintiffs’ insurance
22 plans incorporated generally accepted standards, UBH has pointed to nothing in any plan that
23 would suggest that the “guidelines exception” would permit insurance plans to adopt rules that are
24 inconsistent with those standards. Nor has UBH pointed to any Sample Plan or insurance plan of
25 a Named Plaintiff with a limitations period that would require the Court to make any
26 individualized inquiries related to these alleged variations.

27 The Court also concludes that UBH’s emphasis on the large number of LOCs and CDGs
28 that are at issue in this case exaggerates the problems that will be associated with adjudicating

1 Plaintiffs’ claims on a classwide basis. To the extent this argument is even relevant to
2 commonality (as opposed to predominance), Plaintiffs offer evidence that the CDGs incorporate
3 the LOCs. Moreover, all of the LOCs contain the same Common Criteria, which are at the heart
4 of Plaintiffs’ challenge to the Guidelines. Because of this overlap, the challenges Plaintiffs bring
5 to the Guidelines do not appear to be unmanageable.

6 Finally, while the variations in state law as to the *Wit* State Mandate Class may warrant the
7 creation of subclasses to address possible variations in state laws (and particularly, the possible
8 need to fashion discrete remedies that are tailored to each of the states’ laws), the Court concludes
9 that the class shares sufficient common issues to meet the commonality requirement. At oral
10 argument, the parties disagreed whether the *Wit* State Mandate Class will be required to prove that
11 the Guidelines are more restrictive than the standards that must be applied under state law or
12 simply different. Either way, these questions may be answered on a classwide basis and do not
13 require the Court to examine individualized issues such as the terms of class members’ insurance
14 plans or medical necessity.

15 4. Typicality

16 Rule 23(a)(3) requires that “the [legal] claims or defenses of the representative parties [be]
17 typical of the claims or defenses of the class.” Fed. R. Civ. P. 23(a)(3). “Under the rule’s
18 permissive standards, representative claims are ‘typical’ if they are reasonably co-extensive with
19 those of absent class members; they need not be substantially identical.” *Hanlon v. Chrysler*
20 *Corp.*, 150 F.3d 1011, 1020 (9th Cir. 1998). The typicality requirement is satisfied as to all of the
21 proposed classes. With respect to the Guideline Classes, the named Plaintiffs who seek to
22 represent those classes (all of the named Plaintiffs except for Brandt Pfeifer), like the members of
23 those classes, are covered by insurance plans that require coverage consistent with generally
24 accepted standards of care but were denied coverage by UBH under Guidelines that Plaintiffs
25 allege are more restrictive than generally accepted standards of care. *See* Reynolds Decl., Ex. K.
26 Similarly, the named Plaintiff who seeks to represent the *Wit* State Mandate Class, Brandt Pfeifer,
27 asserts a claim that UBH denied coverage under its own Guidelines instead of the allegedly
28 broader standards mandated by State law, just as do the members of the *Wit* State Mandate Class.

1 UBH does not dispute that the typicality requirement is met.

2 **D. Ascertainability**

3 UBH contends the proposed classes are not ascertainable because it is not administratively
4 feasible to determine which UBH benefits plans are governed by ERISA, which claims were
5 denied under the Guidelines, and what specific aspects of the Guidelines were relied upon in
6 denying the claim. Opposition at 23-24 (citing *Daniel F. v. Blue Shield of Cal.*, 305 F.R.D. 115,
7 125 (N.D. Cal. 2014)). According to UBH, none of this information can be obtained by
8 “automated means” and therefore, manual review of thousands of records would be necessary to
9 determine class membership. *Id.*

10 Plaintiffs counter that ascertainability is not a requirement for Rule 23(b)(1) and 23(b)(2)
11 classes. Reply at 22. In any event, they contend, there is evidence that will make determination of
12 which claims were denied under the Guidelines and which plans are governed by ERISA
13 manageable. *Id.* at 22-23. Nor is it necessary to determine what specific aspects of the Guidelines
14 UBH relied upon in making its coverage determination, Plaintiffs assert, as their claims are based
15 on the theory that taken as a whole, UBH Guidelines are overly restrictive. *Id.* The Court
16 concludes that the proposed classes are ascertainable and therefore does not address whether the
17 ascertainability requirement is limited to classes certified under Rule 23(b)(3).

18 “In order for a proposed class to satisfy the ascertainability requirement, membership must
19 be determinable from objective, rather than subjective, criteria.” *Xavier v. Philip Morris USA Inc.*,
20 787 F. Supp. 2d 1075, 1089 (N.D. Cal. 2011) (citing *In re Initial Pub. Offerings Sec. Litig.*, 471
21 F.3d 24, 30 (2d Cir. 2006)). Here, it is undisputed that when a claim for coverage is denied by
22 UBH, a determination letter is sent to the member indicating the basis for the decision. *See*
23 *Romano Decl.*, Ex. 1 (Declaration of Francis R. Bridge in Support of United Behavioral Health’s
24 Opposition to Motion for Class Certification (“Bridge Decl.”)) ¶ 15. According to Bridge,
25 “[t]ypically [the letter] will identify one or more UBH Coverage Determination Guideline
26 (‘CDG’), UBH Level of Care Guideline (‘LOC’), or external guideline . . . that was referenced in
27 making that determination.” *Id.* This information is contained in UBH’s ARTT database, which
28 contains data regarding adverse benefits determinations prior to 2014, and its LINX database,

1 which contains such information for the period starting January 1, 2014. *Id.* ¶ 11. Further, both
2 databases have a field that reflects whether a CDG or LOC was referenced in the determination
3 letter, although only the LINX system has a field that tracks the specific Guideline. *Id.* ¶¶ 16, 23.
4 The Court concludes that these records are sufficient to permit the identification of individuals
5 who were denied coverage in the relevant categories for the purposes of ascertaining class
6 membership. *See Kamakahi v. Am. Soc’y for Reprod. Med.*, 305 F.R.D. 164, 186 (N.D. Cal.
7 2015), leave to appeal denied (May 12, 2015) (“The fact that determining class membership would
8 involve reviewing these records does not render the class unascertainable.”).

9 The Court rejects UBH’s contention that it would take “thousands of hours” to make this
10 determination, *see id.* ¶ 24, because it is based, in part, on the understanding that each of the
11 30,000 member records would have to be reviewed to determine the specific rationale that was
12 used to deny coverage. *See id.* (“UBH would thus need to wade through the clinical records of at
13 least 30,000 members to determine whether each individual member was in an ERISA plan,
14 whether that individual was denied benefits as a result of one of the challenged Guidelines, and if
15 so, *whether the denial relates to the complaints about the guidelines Plaintiffs raise in this case*”)
16 (emphasis added). Under that understanding, Bridge estimates that it would take 45 minutes to
17 review each record. *Id.* Plaintiffs’ challenge, however, and the proposed class definitions, do not
18 require that UBH identify the specific rationale for any particular rejection; rather, UBH simply
19 must identify the members whose claims were rejected under the relevant Guidelines. Given that
20 all of this information is stored in UBH’s databases, the process of identifying the claims that were
21 denied under the Guidelines at the relevant Levels of Care is not so burdensome that it renders the
22 classes unascertainable.

23 The Court also rejects UBH’s contention that the class is not ascertainable because of the
24 difficulty of determining which insurance plans are governed by ERISA. UBH is required to
25 adhere to specific legal obligations for the plans it administers that are governed by ERISA.
26 Therefore, it is not surprising that this information is contained in the member records. *See*
27 *Romano Decl., Ex. 1 (Bridge Decl.)* ¶ 18 (“Both the ARTT database and the LINX database
28 contain a field identifying the plan at issue for each coverage determination. However, neither the

1 ARTT database nor the LINX database contains a field tracking whether ERISA applies to a
 2 particular benefit plan or benefit request.”); *see also* Reynolds Reply Decl., Ex. W at W0007
 3 (Allchin Dep. at 76) (testifying that member records indicate whether the member’s insurance plan
 4 is an ERISA plan). Moreover, as Plaintiffs point out, where plans are covered by ERISA the
 5 plan documents typically state as much. *See, e.g.*, Romano Decl., Ex. 72 at WIT_PTFS_0000637;
 6 Ex. 73 at UBHALEXANDER43979080; Ex. 74 at UBHWIT0042846; Ex. 77 at BHWIT0040972.
 7 The Court concludes that UBH has exaggerated the difficulty of determining which members’
 8 plans are governed by ERISA, which is not of a sufficient magnitude to make the classes
 9 unascertainable.

10 Finally, the Court is not persuaded that Judge Hamilton’s decision in *Daniel F.* supports
 11 UBH’s assertion that the classes here are not ascertainable. In that case, the plaintiffs are
 12 challenging a policy by Blue Shield of California of excluding coverage of residential treatment
 13 for mental health conditions, arguing that it violates California’s Mental Health Parity Act. 305
 14 F.R.D. 115, 118-19 (N.D. Cal. 2014).²⁰ The plaintiffs sought to certify a class that included
 15 “beneficiaries who received residential treatment for mental health and behavior disorders, whose
 16 requests were denied by Blue Shield of California based on a policy exclusion for residential
 17 treatment, and whose health insurance was governed by [ERISA]” and the beneficiaries’ parents to
 18 the extent they were financially responsible for the denied treatment. *Id.* at 123. The court found
 19 that the class proposed by the plaintiffs was not ascertainable because “individualized analysis of
 20 all submitted claims” would be required to determine class membership. *Id.* at 125. The evidence
 21 in that case differed, however, from the evidence here. In addition to the fact that the online
 22 records of the health insurance administrator did not have a field that identified plans that were
 23 subject to ERISA (as is also the case here), Blue Shield also introduced evidence that there was no
 24 code or group of codes that was used by residential treatment service providers that would allow
 25 claims from such providers to be easily distinguished from claims submitted by other types of
 26

27 ²⁰ An appeal of the district court’s denial of the plaintiff’s motion for class certification is currently
 28 pending before the Ninth Circuit.

1 providers. *Id.* at 123. As a consequence, even individualized review of the member records would
2 not be sufficient to determine class membership. Nor was the court persuaded that the plaintiffs’
3 proposed method of identifying residential service providers was workable; the plaintiffs proposed
4 that residential service providers could be identified by searching for providers with residential
5 treatment licenses but Blue Shield presented evidence that this approach would not work because
6 Blue Shield did not contract with out-of-state providers and California residential service
7 providers are not required to obtain a specific license. *Id.*

8 Here, in contrast to *Daniel F.*, class membership is conditioned on denial of benefits under
9 guidelines that must be cited when they are the basis of the denial, and that information is stored in
10 UBH’s electronic databases in the member records. Even assuming each member record would
11 have to be reviewed to ascertain class membership – admittedly a burdensome task –
12 determination of class membership would not entail the type of individualized analysis that would
13 have been required in *Daniel F.* because the member records in this case (unlike in *Daniel F.*)
14 contain the required information to determine class membership.

15 For these reasons, the Court concludes that the classes proposed by Plaintiffs are
16 ascertainable.

17 **E. Rule 23(b)**

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

19 a. Contentions of the Parties

20 Plaintiffs contend certification of the proposed classes is appropriate under Rule
21 23(b)(1)(A) because all of the class members challenge the same Guidelines, which purportedly
22 capture the generally accepted standards that are a precondition for coverage under all of their
23 insurance plans. Motion at 20. Because UBH owes the same obligation to all class members,
24 namely, to provide coverage consistent with generally accepted standards, there is a possibility of
25 inconsistent outcomes if the classes are not certified, Plaintiffs contend. *Id.* (citing *Amchem Prod.,*
26 *Inc. v. Windsor*, 521 U.S. 591, 614 (1997) for the proposition that “Rule 23(b)(1)(A) takes in cases
27 where the party is obliged by law to treat the members of the class alike”). Plaintiffs assert that
28 certification of ERISA class actions under Rule 23(b)(1) has been found by courts to be

1 particularly appropriate “because ERISA plan beneficiaries are all owed the same fiduciary
2 duties.” *Id.* at 21 (citing *Kanawi v. Bechtel Corp.*, 254 F.R.D. 102, 111 (N.D. Cal. 2008); *Z.D. v.*
3 *Grp. Health Coop.*, No C-11-1119 RSL, 2012 WL 1977962, at *7 (W.D. Wash. June 1, 2012)).

4 UBH agrees with Plaintiffs that under *Amchem*, certification under Rule 23(b)(1) is
5 appropriate where a party is obligated to treat all class members alike but contends it does not
6 apply here because UBH’s obligations to the putative class members differ depending on their
7 insurance plan. Opposition at 24 (citing *In re Wellpoint*, 2014 WL 6888549, at *20; *Pipefitters*
8 *Local 636 Ins. Fund v. Blue Cross Blue Shield of Michigan*, 654 F.3d 618, 633 (6th Cir. 2011)).
9 UBH argues further that a class cannot be certified under Rule 23(b)(1) unless monetary relief
10 sought by the class is “incidental” to the class members’ claims. *Id.* at 25 (citing *Wal-Mart Stores,*
11 *Inc. v. Dukes*, 564 U.S. 338, 360 (2011); *Zinser*, 253 F.3d at 1195; *Daskalea v. Wash. Humane*
12 *Soc.*, 275 F.R.D. 346, 364 (D.D.C. 2011); *In re First Am. Corp. ERISA Litig.*, 258 F.R.D. 610, 622
13 (C.D. Cal. 2009); *Ries v. Arizona Beverages USA LLC*, 287 F.R.D. 523, 541 (N.D. Cal. 2012)).

14 UBH argues that the monetary relief sought in this case is *not* incidental to Plaintiffs’ claims. *Id.*
15 UBH points to Plaintiffs’ allegations in the Complaints that they spent significant amounts of
16 money paying for treatment for which UBH denied coverage and argue that they are “suing to
17 recover that money,” citing the deposition testimony of “several” of the Named Plaintiffs that it
18 contends reflects that recovery of the cost of the treatment is their “primary (if not only) interest in
19 this case.” *Id.* at 26 & n. 21 (listing deposition testimony). The fact that some of the named
20 Plaintiffs are no longer members of insurance plans administered by UBH and therefore do not
21 have standing to seek injunctive relief further undermines Plaintiffs’ argument that the monetary
22 relief they seek is incidental to their request for declaratory and injunctive relief, UBH argues. *Id.*
23 at 25 (citing to deposition testimony of Named Plaintiffs David Alexander and David and Natasha
24 Wit).

25 In their Reply brief, Plaintiffs reject UBH’s reliance on variations among class members’
26 plans for the same reasons they argue these differences do not defeat commonality, namely, that
27 they are not material to Plaintiffs’ claims and therefore are not outcome determinative, in contrast
28 with the cases cited by UBH, such as *In re Wellpoint*, *Lipstein*, and *Pipefitters Local 636*

1 *Insurance Fund*. Reply at 14. Plaintiffs also reject UBH’s assertion that their request for
2 monetary relief is not incidental to their request for declaratory and injunctive relief. *Id.* at 15-16.
3 First, they argue that all of the cases cited by UBH are distinguishable because in them the
4 plaintiffs asserted *direct* claims for monetary damages whereas Plaintiffs here do not ask the Court
5 to adjudicate any individualized claims for damages. *Id.* at 15. Nor are Plaintiffs’ claims
6 converted to claims for money damages because the reprocessing of their claims might result in
7 the payment of benefits to some class members, Plaintiffs contend. *Id.* at 16 (citing *Hart v.*
8 *Colvin*, 310 F.R.D. 427 (N.D. Cal. 2015)). This is true even for the Named Plaintiffs who are no
9 longer members of UBH plans, according to Plaintiffs, regardless of whether they may receive
10 benefit payments after their claims are reprocessed. *Id.* at 16 n. 21 (citing *Johnson v. Meriter*
11 *Health Servs. Emp. Ret. Plan*, 702 F.3d 364, 369 (7th Cir. 2012)).

12 Finally, Plaintiffs contend the surcharge they request “cannot be considered anything *but*
13 incidental,” arguing that the class only seeks disgorgement by UBH of the “unjust benefit it
14 received due to its inequitable conduct.” *Id.* (citing *Skinner v. Northrop Gruman Ret. Plan B*, 673
15 F.3d 1162, 1167 (9th Cir. 2012)). As discussed above, Plaintiffs also clarify that they do not seek
16 to use the class members’ out-of-pocket payments for denied treatment as a measure of the
17 surcharge. *Id.* n. 16.

18 b. Discussion

19 As noted above, Rule 23(b)(1)(A) allows a class to be certified where “prosecuting
20 separate actions by or against individual class members would create a risk of . . . inconsistent or
21 varying adjudications with respect to individual class members that would establish incompatible
22 standards of conduct for the party opposing the class[.]” As Judge Breyer noted in *Kanawi v.*
23 *Bechtel Corp.*, “[m]ost ERISA class action cases are certified under Rule 23(b)(1).” 254 F.R.D. at
24 111. Certification under Rule 23(b)(1) is particularly appropriate in cases involving ERISA
25 fiduciaries who must apply uniform standards to a large number of beneficiaries. *See Z.D. ex rel.*
26 *J.D. v. Grp. Health Co-op.*, No. C11-1119RSL, 2012 WL 1977962, at *7 (W.D. Wash. June 1,
27 2012)(stating that “[t]he Court can envision few better scenarios for certification under (b)(1)(A)
28 or (b)(1)(B)” than claims that an ERISA fiduciary’s internal policy or practice was illegal); *see*

1 *also Douglin v. GreatBanc Trust Co.*, 115 F. Supp. 3d 404, 412 (S.D.N.Y. 2015) (“The Supreme
2 Court has observed that actions for breach of fiduciary duties are ‘classic examples’ of Rule
3 23(b)(1) cases, . . . and courts in this Circuit have indeed determined that claims for breach of
4 fiduciary duty brought under ERISA, 29 U.S.C. §§ 1132(a)(2) . . . are well suited to Rule
5 23(b)(1).”).

6 Here, as to the Guideline Classes, Plaintiffs have demonstrated that all class members’
7 plans require as one condition of coverage that the treatment at issue must be consistent with
8 generally accepted standards of care and that UBH Guidelines are intended to embody those
9 standards. Thus, regardless of any differences with respect to other aspects of the class members’
10 insurance plans, this common requirement of all of the plans means that multiple challenges to the
11 Guidelines by putative class members could lead to inconsistent results. Similarly, as to the *Wit*
12 State Mandate Class, UBH’s Guidelines purportedly embody the standards that must be followed
13 under state law as to all members whose claims fall under the laws of the relevant states. As a
14 consequence, challenges to the Guidelines by multiple class members could subject UBH to
15 inconsistent legal obligations with respect to the use of its Guidelines, making certification under
16 Rule 23(b)(1) appropriate.

17 The Court is not persuaded by UBH’s assertion that the relief sought by Plaintiffs involves
18 more than incidental monetary relief and therefore precludes certification under Rule 23(b)(1).
19 The rule that classes may not be certified under Rule 23(b)(1) or (2) if they seek anything more
20 than incidental monetary relief is grounded in the history and purpose of those subsections. In
21 *Wal-Mart v. Dukes*, the Supreme Court explained that “[c]lasses certified under [Rule 23(b)(1) and
22 (b)(2)] share the most traditional justifications for class treatment—that individual adjudications
23 would be impossible or unworkable, as in a (b)(1) class, or that the relief sought must perforce
24 affect the entire class at once, as in a (b)(2) class.” 564 U.S. at 361-62. Certification under these
25 sections is not appropriate “when each individual class member would be entitled to a different
26 injunction or declaratory judgment against the defendant” or “an individualized award of monetary
27 damages.” *Id.* at 360-61. Nor do these types of classes offer the procedural protections of notice
28 or an opportunity to opt out. *Id.* Whereas this has generally been found to be acceptable where “a

1 class seeks an indivisible injunction benefitting all its members at once,” where “a class action [is]
2 predominantly for money damages [the Court has] held that absence of notice and opt-out violates
3 due process.” *Id.* at 362. Consequently, classes whose claims will require individualized inquiries
4 as to money damages “belong in Rule 23(b)(3),” *id.*, which carries the procedural protections of
5 notice and an opportunity to opt out.

6 UBH makes much of the fact that Named Plaintiffs allege they incurred significant out-of-
7 pocket expenses in connection with the treatment that UBH declined to cover and that many of
8 them have testified that they hope to be reimbursed for those expenses as a result of this lawsuit.
9 In essence, it equates a request for an injunction requiring that it reprocess the denied claims under
10 new Guidelines with a request for an award of money damages to compensate the class members
11 for the cost of the treatment for which UBH denied coverage. These two remedies are not
12 equivalent, however. What is of particular significance is that even if Plaintiffs prevail on their
13 request for an injunction requiring that all claims decided under the allegedly faulty Guidelines be
14 reprocessed, the Court will not be required to address individualized claims for damages.
15 Consequently, the absence of notice and an opportunity to opt out of the classes will not raise Due
16 Process concerns and the reasons for precluding certification under (b)(1) and (b)(2) where
17 individualized inquiries as to money damages are required do not apply. The mere possibility that
18 some class members may recover from UBH some of the money they spent on treatment as a
19 result of the reprocessing of their claims under new Guidelines does not mean that their claims are
20 “predominantly for money damages” for the purposes of Rule 23(b)(1) or 23(b)(2). *See Hart v.*
21 *Colvin*, 310 F.R.D. 427, 439 (N.D. Cal. 2015) (Tigar, J.) (holding that proposed class of social
22 security disability claimants whose claims had been denied and whose consultative examinations
23 had been conducted by a doctor who was later disqualified from conducting such examinations
24 could be certified under Rule 23(b)(2), even though the plaintiffs sought an injunction ordering
25 that all of their claims be reprocessed, based in part on conclusion that “[p]laintiffs do not seek
26 monetary damages or individual disability determinations”).²¹

27 _____
28 ²¹ UBH’s reliance on the fact that Alexander and the Wits are no longer members of plans

1 The Court further notes that while Plaintiffs’ attempt to recoup these expenses in the guise
2 of a “surcharge” might raise the kind of individualized issues as to class members’ monetary
3 losses that would preclude certification under Rule 23(b)(1) or (b)(2), Plaintiffs have now
4 stipulated that if the proposed classes are certified they will not pursue that theory as to their
5 request for award of a surcharge. With that modification, the surcharge that Plaintiffs request is
6 based only on the amount UBH was paid to process the claims that were denied. During the
7 sealed portion of the motion hearing, the parties made representations concerning the approximate
8 amount of money UBH is paid to administer the class members’ claims; Plaintiffs’ counsel also
9 offered an estimate of the total amount of the class members’ out-of-pocket costs for denied
10 treatment, the reasonableness of which UBH did not challenge. The latter estimate must be
11 considered in the context of the relief requested in this action, that is, with the understanding that it
12 is the *maximum* possible amount the class members might recover if their claims are reprocessed
13 under the new Guidelines and *all* of them are awarded benefits under those Guidelines. Even with
14 this understanding, though, it is significant that the surcharge Plaintiffs seek is miniscule in
15 comparison with the amount Plaintiffs may be able to recover through the reprocessing of their
16 denied claims. Under these circumstances, the Court finds that the surcharge is incidental to the
17 injunctive and declaratory relief that Plaintiffs seek, namely, the issuance of new Guidelines and
18 the reprocessing of their claims.

19 For the reasons stated above, the Court concludes that Plaintiffs have satisfied the
20 requirements of Rule 23(b)(1).

21 **2. Rule 23(b)(2)**

22 a. Contentions of the Parties

23 Plaintiffs argue that the proposed classes may also be certified under Rule 23(b)(2), which
24 permits certification where there is a “pattern of alleged violations [that] can be remedied for all

25
26 administered by ERISA is also misplaced; these Named Plaintiffs, like the rest of the class
27 members, will be entitled to have their claims reprocessed by UBH if they prevail in this action
28 even if they likely will not submit any further claims for consideration by UBH. This remedy is
not the same as money damages and does not mean that their claims are predominantly for money
damages for the reasons discussed above.

1 putative class members by the same form of injunctive relief.” Motion at 21 (quoting *Unknown*
2 *Parties v. Johnson*, No. 15-cv-00250 TUC DCB, 2016 WL 267009, at *9 (D. Ariz. Jan. 11, 2016);
3 *Lee v. Pep Boys – Manny Moe & Jack of Cal.*, No. 12-cv-05064 JSC, 2015 WL 9480475, at *12
4 (N.D. Cal. Dec. 23, 2015)). Quoting *Walters v. Reno*, 145 F.3d 1032, 1047 (9th Cir. 1998),
5 Plaintiffs point out that predominance is not required in order to certify a class under this section
6 and that “[e]ven if some class members have not been injured by the challenged practice, a class
7 may nevertheless be appropriate” under Rule 23(b)(2). *Id.* Plaintiffs contend the classes that they
8 propose here are “paradigmatic examples of (b)(2) classes because they primarily ‘seek uniform
9 injunctive [and] declaratory relief from policies or practices that are generally applicable to the
10 class[es] as a whole.’” *Id.* (quoting *Parsons v. Ryan*, 754 F.3d 657, 688 (9th Cir. 2014)). The
11 common course of conduct that has affected all class members in the same way, according to
12 Plaintiffs, is the development and application to all class members of faulty Guidelines, in
13 violation of the class members’ insurance plans and ERISA. *Id.* at 22 (citing *Huynh v. Harasz,*
14 *Case No. 14-CV-02367-LHK*, 2015 WL 7015567, at *10 (N.D. Cal. Nov. 12, 2015); *A.F. v.*
15 *Providence Health Plan*, 300 F.R.D. 474, 484-85 (D. Or. 2013); *Berger v. Xerox Corp. Ret.*
16 *Income Guarantee Plan*, 338 F.3d 755, 763-64 (7th Cir. 2003)). They further assert that “[t]he
17 injunctive and declaratory relief sought here – which aims to stop UBH from using its overly-
18 restrictive criteria and to require UBH to use appropriate criteria both going forward and in
19 reprocessing the claims it arbitrarily and capriciously denied – would offer all putative Class
20 members uniform and complete relief from the harm caused by UBH’s common course of
21 conduct.” *Id.*

22 UBH argues that certification under Rule 23(b)(2), as under (b)(1), is inappropriate
23 because Plaintiffs seek more than incidental monetary relief. Opposition at 26. In addition, it
24 argues, the relief requested by Plaintiffs does not meet the requirements under Rule 23(b)(2) that
25 the relief sought by the class must be both “final” and “appropriate.” *Id.* at 27. With respect to
26 the former, UBH argues that the injunction Plaintiffs request does not provide “final” relief
27 because “Plaintiffs do not . . . contend that their new, unspecified guidelines will result in different
28 coverage determinations for all class members, nor is there any reason to believe that they will.”

1 *Id.* (citing *Kartman v. State Farm Mut. Auto. Ins. Co.*, 634 F.3d 883, 892 (7th Cir. 2011)). UBH
2 argues that the “reprocessing” injunction requested by Plaintiffs raises a host of issues, such as
3 what happens in situations in which class members never submitted formal claims for money
4 benefits and how UBH will reprocess claims submitted years ago when the processing of claims
5 turns on “real-time clinical information and medical needs that change over time.” *Id.* at 27-28.
6 UBH also raises the possibility that claimants may want to appeal the determinations that result
7 from the reprocessing of claims, thus “set[ting] the stage for further individual conflicts about
8 whether any particular denial of benefits was permissible under the new guidelines.” *Id.* at 28.

9 UBH also argues that the requested injunctive relief is not “appropriate” because it violates
10 Rule 65(d) of the Federal Rules of Civil Procedure, which “mandates that every injunction “state
11 its terms specifically” and “describe in reasonable detail” the “act or acts restrained or required” so
12 that the enjoined party is fairly apprised of his responsibilities and the court can objectively assess
13 compliance.” *Id.* at 28-29 (quoting *Kartman*, 634 F.3d at 893) (quoting Fed. R. Civ. P. 65(d)(1)).
14 According to UBH, an injunction that requires the defendant “to create and then apply
15 *hypothetical and unspecified* guidelines” violates Rule 65(d). *Id.* at 29 (emphasis in UBH’s brief)
16 (citing *Thomas v. Cnty. of LA*, 978 F.2d 504, 509 (9th Cir. 1992)).

17 Plaintiffs argue that certification under Rule 23(b)(2) is proper because UBH has
18 “breached its fiduciary duties and acted arbitrarily and capriciously *in exactly the same way* with
19 respect to *all* Class members.” Reply at 17. They further contend the injunctive relief they
20 request is both “final” and “appropriate.” *Id.* at 17-19. With respect to finality, Plaintiffs contend
21 the *Kartman* case on which UBH relies is distinguishable because in that case there was no duty to
22 use a particular method to evaluate the claims of the putative class members; here, in contrast,
23 “UBH had a duty under ERISA and the plans to ensure that its Guidelines did what they claimed
24 to do – capture generally accepted standards.” *Id.* at 17. Thus, while the claim in *Kartman* was
25 found to be non-actionable, the claims here can give rise to liability on the part of the class
26 members. *Id.* As a consequence, Plaintiffs contend, an injunction requiring reprocessing is a final
27 remedy here even though it was not a final remedy in *Kartman*. *Id.* at 17-18.

28 Further, Plaintiffs argue, the fact that the reprocessing of the class members’ claims will

1 not result in an award of benefits for all class members does not mean that the remedy is not final.
2 *Id.* at 18. Plaintiffs point to *Hart v. Colvin*, in which Judge Tigar certified a class under Rule
3 23(b)(2) where the injunctive relief requested would require reprocessing of denied disability
4 claims with respect to all individuals whose consultative examinations had been conducted by a
5 subsequently disqualified doctor. *Id.* at 429. In certifying the class, Plaintiffs note, the court
6 acknowledged that not all class members would ultimately be awarded benefits but that this fact
7 did not preclude certification because “the alleged wrong . . . is one of process, not outcome.”
8 *Id.* (quoting *Hart*, 310 F.R.D. at 438-39).

9 Plaintiffs also contend UBH’s reliance on Rule 65(d) to show that the injunction they seek
10 is not “appropriate” is misplaced. *Id.* at 19. They argue that they are not required to “come
11 forward with an injunction that satisfie[s] Rule 65(d) with exacting precision at the class
12 certification stage.” *Id.* (citing *Parsons v. Ryan*, 289 F.R.D. 513, 524 (D. Ariz. 2013), *aff’d* 754
13 F.3d 657 (9th Cir. 2014)). They also argue that both *Thomas* and *Kartman*, cited by UBH, are
14 distinguishable. *Id.* As to *Thomas*, Plaintiffs argue that the court was ruling on a specific
15 injunction and made clear that its holding was limited to the facts before it; nor did it rule out the
16 possibility that it would grant a narrower injunction if the plaintiffs “more fully” developed the
17 record. *Id.* (citing *Thomas*, 978 F.2d at 508). Consequently, *Thomas* has no bearing on this case,
18 Plaintiffs assert. *Id.* With respect to *Kartman*, the court found that the insurer owed no “contract
19 or tort-based duty . . . to use a particular standard,” in contrast to the situation here. *Id.* (quoting
20 634 F.3d at 886). As a result, Plaintiffs contend, the court’s conclusion in that case regarding the
21 requested injunctive relief is not relevant here. *Id.*

22 b. Discussion

23 Rule 23(b)(2) allows a class action to be maintained where “the party opposing the class
24 has acted or refused to act on grounds that apply generally to the class, so that final injunctive
25 relief or corresponding declaratory relief is appropriate respecting the class as a whole.” Fed. R.
26 Civ. P. 23(b)(2). In *Parsons v. Ryan*, for example, the Ninth Circuit held that inmates of Arizona
27 prison facilities who were “allegedly exposed to a substantial risk of serious harm by a specified
28 set of centralized [Arizona Department of Corrections] policies and practices of uniform and

1 statewide application” could proceed as a class under Rule 23(b)(2). 754 F.3d at 688. The court
2 reasoned that even though the challenged policies and practices might not affect every member of
3 the proposed class in exactly the same way, “they constitute[d] shared grounds for all inmates in
4 the proposed class” *Id.* Therefore, the court concluded, “every inmate in the proposed class
5 is allegedly suffering the same (or at least a similar) injury and that injury can be alleviated for
6 every class member by uniform changes in statewide ADC policy and practice.” *Id.*

7 Similarly, certification under Rule 23(b)(2) is appropriate here because all of the class
8 members have been subjected to the same Guidelines which, according to Plaintiffs, are more
9 restrictive than the generally accepted standards that are a precondition for coverage under all of
10 their plans (for the Guideline Classes) or the relevant state law mandates (for the *Wit* State
11 Mandate Class). While application of the Guidelines may not have had an identical impact on
12 every member of the proposed classes, the Guidelines constitute “shared grounds” for all of the
13 members of the proposed classes to proceed on a collective basis. *See id.* Moreover, the
14 Plaintiffs’ injury can be remedied for all class members by requiring UBH to modify its
15 Guidelines and reprocess claims that were denied under the allegedly defective guidelines.

16 The Court is not persuaded by UBH’s argument that the injunctive relief requested here is
17 not “final” for the purposes of Rule 23(b)(2) because the outcome of the reprocessing of claims is
18 uncertain. The Ninth Circuit has held that “remand for reevaluation of the merits of a claim is the
19 correct course to follow when an ERISA plan administrator, with discretion to apply a plan, has
20 misconstrued the Plan and applied a wrong standard to a benefits determination.” *Saffle v. Sierra*
21 *Pac. Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455, 461 (9th Cir.
22 1996). A similar remedy was approved in the class context in *Bowen v. City of New York*, 476
23 U.S. 467 (1986). In that case, the district court certified a class of individuals who alleged that the
24 Social Security Administration had applied an unlawful policy under which it presumed “that a
25 failure to meet or equal [certain criteria] was tantamount to a finding of ability to do at least
26 unskilled work; that the presumption led to routine denials of benefits to eligible claimants; and
27 that such a presumption was arbitrary, capricious, and violative of the Constitution, the Social
28 Security Act, and the applicable regulations.” 476 U.S. at 473. The plaintiffs prevailed and “[a]s

1 a remedy, the District Court ordered the Secretary to reopen the decisions denying or terminating
 2 benefits, and to redetermine eligibility.” *Id.* at 476. The Second Circuit affirmed and while the
 3 scope of the class was challenged on appeal to the Supreme Court, the remedy was not. *Id.* In
 4 *Hart v. Colvin*, the court relied on *Bowen* in certifying a class under Rule 23(b)(2) that sought to
 5 have the class members’ benefits claims reprocessed where their consultative examinations had
 6 been conducted by a subsequently-disqualified doctors and their claims had been denied. 310
 7 F.R.D. 427, 434 (N.D. Cal. 2015)). Based on these cases, the Court concludes that where a
 8 defendant has relied on an unlawful policy to determine eligibility for benefits, ordering the
 9 defendant to redetermine the plaintiffs’ eligibility without the taint of the unlawful policy is a
 10 “final” remedy for the purposes of Rule 65(d).

11 The Seventh Circuit’s decision in *Kartman* does not support a contrary result. In
 12 *Kartman*, the plaintiffs were homeowners who held insurance policies issued by the defendant,
 13 State Farm Fire and Casualty Company (“State Farm”). 634 F.3d at 886. After a severe hail
 14 storm, thousands of policyholders filed claims with State Farm, and several who were dissatisfied
 15 with the insurance payment they received brought a putative class action alleging breach of
 16 contract, bad-faith denial of insurance benefits and unjust enrichment. *Id.* The plaintiffs sought to
 17 certify a damages class under Rule 23(b)(3) and an injunctive relief class under Rule 23(b)(2) to
 18 “determine whether State Farm should be required to reinspect policyholders’ roofs pursuant to a
 19 ‘uniform and objective standard.’” *Id.* The district court declined to certify the damages class but
 20 certified an injunctive relief class under Rule 23(b)(2). *Id.* State Farm appealed and the Seventh
 21 Circuit concluded that the injunctive relief class should not have been certified. *Id.* at 887.

22 The Court of Appeals in *Kartman* concluded that the certification of the injunctive relief
 23 class under Rule 23(b)(2) resulted from a “legal misunderstanding about the nature of the
 24 plaintiffs’ claims.” *Id.* at 888. In particular, the court explained that “[a]lthough the complaint
 25 invokes several legal theories, the plaintiffs have only one cognizable injury – underpayment of
 26 their insurance claims for hail damage to their roofs – and prospective injunctive relief is not a
 27 remedy for that kind of injury. *Id.* at 888-889. To obtain certification under Rule 23(b)(2),
 28 however, the “plaintiffs claimed that they suffered two separate injuries – underpayment of their

1 hail-damage claims *and* a violation of a distinct right to have their hail-damaged roofs evaluated
2 under a uniform and objective standard.” *Id.* at 889. According to the Court of Appeals, “[t]his
3 parsing of remedies gave the plaintiffs a fall-back position on the class-certification question. If
4 they failed to win certification of a damages class under Rule 23(b)(3) based on lack of
5 commonality, they could still argue for an injunction class under Rule 23(b)(2) to adjudicate
6 whether State Farm breached an obligation to use a uniform and objective standard to evaluate
7 hail-damaged roofs.” *Id.*

8 The plaintiff’s approach “[ran] into trouble,” the *Kartman* court explained, because “State
9 Farm had no independent duty – whether sounding in contract or tort – to use a particular method
10 to evaluate hail-damage claims.” *Id.* at 890. The court found that “[a]t bottom, the actionable
11 claims in this case are for State Farm’s alleged underpayment of the plaintiffs’ hail-damage claims
12 – nothing more, nothing less.” *Id.* at 891. As a result, the court concluded, while “the insurer’s
13 use of an ad hoc loss-assessment standard may be *evidence* that it underpaid in some cases [it] is
14 not an independently actionable wrong.” *Id.* at 891-92 (emphasis added). For this reason, the
15 court held that an injunction would not provide a “final” remedy under Rule 23(b)(2), reasoning
16 that “[a]n injunction is not a final remedy if it would merely lay an evidentiary foundation for
17 subsequent determinations of liability.” *Id.* at 893.

18 The situation here differs from *Kartman* in that Plaintiffs are asserting claims to obtain
19 injunctive relief based on an injury that is distinct from the actual denial of benefits and that is
20 cognizable under ERISA, namely, the use of Guidelines that are more restrictive than the plans
21 under which they are insured or the standards mandated by state law in adjudicating their claims.
22 As a result, the conclusion that the injunction in *Kartman* was not “final” does not apply here. In
23 particular, that conclusion was based on the fact that the failure to apply a “uniform and objective
24 standard” to the assessment of roof damage in *Kartman* was not a violation of any legal duty and
25 did not give rise liability. Consequently, the requested injunctive relief of reassessing class
26 members’ roof damage under such a standard was not a remedy for any cognizable claim. That is
27 not the case here.

28 The Court also rejects UBH’s argument that the injunctive relief sought by Plaintiffs in this

1 case does not satisfy Rule 65(d) of the Federal Rules of Civil Procedure because it would require
2 UBH “to create and then apply hypothetical and unspecified guidelines.” Opposition at 29. First,
3 “[P]laintiffs are not ‘required to come forward with an injunction that satisfies Rule 65(d) with
4 exacting precision at the class certification stage.’” *Parsons v. Ryan*, 289 F.R.D. 513, 524 (D.
5 Ariz. 2013), *aff’d*, 754 F.3d 657 (9th Cir. 2014). Second, *Thomas v. County of Los Angeles*, 978
6 F.2d 504 (9th Cir. 1992), cited by UBH, sheds little light on this issue. In that case, the Ninth
7 Circuit struck down a preliminary injunction in a civil rights case based, in part, on the fact that
8 the injunction “direct[ed] compliance, under penalty of contempt, with all department policies and
9 guidelines for conducting searches and for the use of force” without defining “what the policies
10 are, or how they can be identified.” *Id.* at 509 (citing Fed.R.Civ.P. 65(d)). While the court found
11 the injunction in that case to be overbroad, however, it acknowledged that it may be permissible to
12 incorporate specific policies into an injunction where there is some description of the specific acts
13 to be restrained. *Id.* at 511 (citing *Davis v. City and County of San Francisco*, 890 F.2d 1438 (9th
14 Cir. 1989)). The court further made clear that its holding was “limited to the record before it and
15 [did] not preclude the grant of narrower preliminary or permanent injunctive relief on the basis of
16 a more fully developed record.” *Id.* at 508. Nothing in *Thomas* suggests that the injunction
17 requested by Plaintiffs here could not be drafted with sufficient detail to satisfy Rule 65(d) or that
18 Plaintiffs are required to offer the specific language of such an injunction at this stage of the case.

19 UBH’s reliance on *Kartman* for the proposition that an injunction is not “appropriate”
20 under Rule 65(d) if it merely orders UBH to develop and apply unspecified guidelines is also
21 misplaced. There, the court noted that ordering State Farm to reprocess the plaintiffs’ claims
22 applying a “reasonable, uniform and objective standard” would “essentially require the court to
23 write an insurance –adjustment code.” 634 F.3d at 893. That case differed from the facts here,
24 however, because there was no “reasonable, uniform and objective standard” in the plaintiffs’
25 insurance policies, meaning that such a standard would have had to have been created out of
26 whole cloth in order for State Farm to comply with the injunction and the court to enforce it. In
27 contrast, Plaintiffs have pointed to several sets of standards that will provide guidance for UBH in
28 coming up with new Guidelines. Indeed, many of them were the very standards that UBH relied

1 upon in creating the original Guidelines, indicating that there is little or no disagreement that these
2 standards reflect generally accepted standards.²²

3 The Court concludes that Plaintiffs have met the requirements for class certification under
4 Rule 23(b)(2).

5 **3. Rule 23(b)(3)**

6 a. Contentions of the parties

7 Plaintiffs move in the alternative for certification under Rule 23(b)(3) if the Court declines
8 to certify the classes under Rule 23(b)(1) or (b)(2) or finds that Plaintiffs may not seek award of a
9 surcharge under those sections. Motion at 22; Reply at 20. Plaintiffs contend they meet both the
10 predominance and superiority requirements of Rule 23(b)(3). Motion at 22-24. The
11 predominance requirement is met, they assert, because UBH “breached its fiduciary duty to all
12 class members in the same way: by developing Guidelines for its use in making coverage
13 determinations that were inconsistent with generally accepted standards of care and contrary to the
14 terms of the Class members’ plans.” *Id.* at 22. Similarly, they contend, UBH acted in a manner
15 that was arbitrary and capricious – and common to all class members – by applying the Guidelines
16 to class members’ coverage determinations. *Id.* at 23. The remedy Plaintiffs seek is also a
17 common remedy, Plaintiffs, assert, which supports a finding of predominance. *Id.* Plaintiffs argue
18 that the request for a surcharge remedy does not defeat predominance because the surcharge they
19 request does not depend on any particular class members’ injury and would be determined “on a
20 class-wide basis on UBH’s own records.” *Id.*

21 Plaintiffs argue that the superiority requirement also is met, citing the four factors listed in
22 Rule 23(b)(3)(A) – (D). *Id.* at 24. According to Plaintiffs, “[e]ach of these factors favor
23 certification” because “there are overriding common issues in this case that allow for a finding of
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25 ²² Plaintiffs state that they “anticipate that they will submit a proposed injunction after trial, to be
26 briefed by the parties under Rule 65.” They further state that they “currently expect that, based
27 upon the presented evidence and the Court’s findings, the injunction would order UBH to propose
28 new Guidelines that remedy the specific defects that render the current Guidelines inconsistent
with generally accepted standards of care and would set forth a process for the Court to evaluate
such new Guidelines. Reply at 19 n. 24.

1 liability against UBH under ERISA and for the application of a common remedy – injunctive
2 relief to require compliance with UBH’s fiduciary duties and reprocessing of benefit claims.” *Id.*
3 As a result, they assert, “certification would best serve the interest of both the individual Class
4 members and judicial economy.” *Id.*

5 Plaintiffs also argue that the class is ascertainable because membership can be determined
6 from objective rather than subjective criteria. *Id.* In particular, they contend, membership can be
7 ascertained from UBH’s records because UBH “maintains an electronic record of each benefit
8 denial it issues, which identifies the level of care for which coverage was sought; whether
9 coverage was sought for mental health or substance use disorder treatment; the date of the denial;
10 the governing state; and whether the denial was a clinical determination that required the use of
11 clinical criteria.” *Id.* (citing Reynolds Decl., Ex. P at P0016-23).

12 UBH argues that the classes should not be certified under Rule 23(b)(3) because the
13 predominance requirement is not satisfied, pointing to the individualized inquiries that it contends
14 also defeat commonality. Opposition at 29-30. It also argues that the surcharge requested by
15 Plaintiffs involves individualized inquiries to the extent it is based on class members’ out-of-
16 pocket costs for treatment. *Id.* at 30. UBH points to the deposition testimony of Named Plaintiffs
17 that they are seeking to recover the cost of treatment, arguing that the amounts vary widely among
18 class members and that in order to obtain such a surcharge Plaintiffs would have to present
19 individualized proof of harm and causation. *Id.* at 31 (citing *Gabriel v. Alaska Elec. Pension*
20 *Fund*, 773 F.3d 945, 957-58 (9th Cir. 2014)). Not only will there be individualized issues as to the
21 amount of damages, UBH argues, but there will also be individualized issues with respect to the
22 fact of damages. *Id.* (citing *In re Live Concert Antitrust Litig.*, 247 F.R.D. 98, 135 (C.D. Cal.
23 2007)). Specifically, UBH argues that there will be individualized issues because denial of
24 coverage at the authorization stage does not necessarily result in the patient paying out-of-pocket
25 for treatment because a patient may have successfully appealed an adverse benefits determination
26 or received coverage for an alternative treatment. *Id.* In addition, UBH points out that in the case
27 of one Named Plaintiff there is evidence that the provider did not charge for the treatment that was
28 provided after UBH denied coverage. *Id.* Finally, UBH argues that the surcharge precludes

1 certification under Rule 23(b)(3) because Plaintiffs have not offered “any model or explanation for
2 how the surcharge would be calculated or allocated among class members.” *Id.* at 31-32. Without
3 proof that damages are capable of measurement on a classwide basis, UBH asserts, a class cannot
4 be certified under Rule 23(b)(3). *Id.* at 32 (citing *Comcast Corp. v. Behrend*, 133 S. Ct. 1426,
5 1432-33 (2013)).

6 Plaintiffs reject UBH’s argument that the predominance requirement is not met because
7 their claims involve individualized inquiries related to the requested surcharge. Reply at 20. They
8 contend UBH’s argument is based solely on Plaintiffs’ theory based on entitlement to out-of-
9 pocket costs but state that they “do not seek certification to pursue such a surcharge.” *Id.* As to the
10 theory upon which they do seek a surcharge, their entitlement to the money that UBH receives for
11 administering class claims, Plaintiffs argue that there are no individualized issues. *Id.* Plaintiffs
12 emphasize that the harm on which the requested surcharge is based is the defective *process* used in
13 making coverage determinations, which is a cognizable injury under ERISA and is the same for all
14 class members. *Id.* at 20 n. 27 (citing *Cigna Corp. v. Amara*, 563 U.S. 421 (2011)). Moreover,
15 they assert, the amount of the surcharge is capable of being measured on a class-wide basis under
16 *Comcast* because the surcharge can be calculated simply by multiplying the amount UBH is paid
17 to administer class members’ claims by the number of individuals in the class. *Id.* n. 28. Plaintiffs
18 also point to evidence that UBH is paid on a per-member basis for administering claims. *Id.* n. 28
19 (citing Reynolds Reply Decl., Ex. X at UBHWIT0254826-37 (reflecting per member/ per month
20 rates for UBH’s services to United Healthcare Insurance Company)).

21 b. Discussion

22 As discussed above, Rule 23(b)(3) allows a class action to be maintained where “questions
23 of law or fact common to class members predominate over any questions affecting only individual
24 members” and “a class action is superior to other available methods for fairly and efficiently
25 adjudicating the controversy.” The Court finds that the predominance requirement is satisfied for
26 the same reasons the commonality requirement is met, namely, that the case stands or falls based
27 on the question of whether the use of UBH’s Guidelines to adjudicate the class members’ claims
28 constituted a breach of fiduciary duty or was arbitrary and capricious. Nor is the Court persuaded

1 by UBH’s argument that the surcharge sought by Plaintiffs raises individualized issues that
2 preclude certification under Rule 23(b)(3). UBH relies almost exclusively on Plaintiffs’ theory
3 that the surcharge should account for their out-of-pocket costs of treatment, but Plaintiffs have
4 now dropped that theory. Moreover, to the extent Plaintiffs seek a surcharge that reflects the
5 amount of money paid to UBH to administer the Class members’ claims, Plaintiffs have offered
6 evidence showing that that amount can be determined without the need to conduct a class-
7 member-by-class-member inquiry.

8 The Court also finds that a “class action is superior to other available methods for fairly
9 and efficiently adjudicating the controversy.” Fed. R. Civ. P. 23(b)(3). The factors considered in
10 making this determination include “(A) the class members’ interests in individually controlling the
11 prosecution or defense of separate actions; (B) the extent and nature of any litigation concerning
12 the controversy already begun by or against class members; (C) the desirability or undesirability
13 of concentrating the litigation of the claims in the particular forum; and (D) the likely difficulties
14 in managing a class action.” Fed. R. Civ. P. 23(b)(3)(A) – (D). In addition, the Ninth Circuit has
15 explained that “[w]here recovery on an individual basis would be dwarfed by the cost of litigating
16 on an individual basis, this factor weighs in favor of class certification.” *Wolin v. Jaguar Land*
17 *Rover N. Am., LLC*, 617 F.3d 1168, 1175 (9th Cir. 2010) (citation omitted). An overriding
18 concern of the “superiority” inquiry is judicial economy which, in turn, is related to the question
19 of commonality. *Id.*

20 Here, it is in the interest of judicial economy to adjudicate the class members’ challenge to
21 the Guidelines, which is the main issue as to all of the putative class members, in a single forum
22 on a classwide basis. While the amounts spent on treatment by putative class members are not
23 insignificant, they pale in comparison to the expense of bringing a legal challenge to UBH’s
24 Guidelines in an individual legal action. In any event, to the extent that the *Wit* and *Alexander*
25 actions do not require the Court to adjudicate the individualized issues relating to the class
26 members’ coverage but leave those questions to be addressed in the course of the reprocessing of
27 claims and any subsequent appeals, the remedy requested in this case will not directly impact the
28 class members’ ability to recover those amounts. For the same reason, the interests of individual

1 class members in controlling the litigation does not outweigh the advantages of a class action in
2 these related cases.

3 In sum, the Court concludes that Plaintiffs have met the requirements for class certification
4 under Rule 23(b)(3).

5 **4. Rule 23(c)(4)**

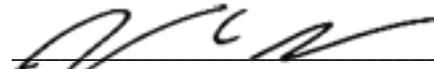
6 Plaintiffs ask the Court to consider certifying “issues” classes under Rule 23(c)(4) if it
7 finds that the proposed classes may not be certified under Rule 23(b). Because the Court
8 concludes that Plaintiffs have met the requirements for class certification under Rule 23(b) it does
9 not need to reach this issue.

10 **IV. CONCLUSION**

11 For the reasons stated above, the Motion is GRANTED.

12 **IT IS SO ORDERED.**

13 Dated: September 19, 2016

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16 JOSEPH C. SPERO
17 Chief Magistrate Judge

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