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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 IN PART AND
DENYING IN PART UNITED
BEHAVIORAL HEALTH’S MOTION
FOR SUMMARY JUDGMENT**

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

Docket No. 248 (Case No. 14-cv-2346 JCS)
Docket No. 205 (Case No. 14-cv-5337 JCS)

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 its September 19, 2016 Order (“Class Certification Order”), the Court certified two classes in *Wit v. United Behavioral Health*, Case No. 14-cv-2346 JCS (hereinafter, “*Wit*”), and one class in *Alexander v. United Behavioral Health*, Case No. 14-cv-5337 JCS (hereinafter, “*Alexander*”). Presently before the Court is UBH’s Motion for Summary Judgment (“Motion”).

1 A hearing on the Motion was held on Friday, July 28, 2017 at 9:30 a.m. For the reasons stated
2 below, the Motion is GRANTED in part and DENIED in part.¹

3 **II. BACKGROUND**

4 **A. Factual Background²**

5 UBH administers insurance benefits for behavioral health services, including services for
6 specific diagnosis and treatment of mental health conditions or substance use disorders, for
7 various health benefit plans. Stipulations of Fact (*Wit* Dkt. No. 257; *Alexander* Dkt. No. 214) at 3,
8 ¶¶ 1, 2. In this role, UBH administers Requests for Coverage on behalf of members of ERISA-
9 governed health benefit plans (“Plans”). *Id.* ¶ 3. It is undisputed that at the time of each named
10 Plaintiff’s Non-Coverage Determination that gives rise to his or her claims in this action, the
11 Plaintiff’s health benefit plan was governed by ERISA. *Id.* ¶ 4. The specific terms and conditions
12 of coverage for mental health and substance use disorder treatment administered by UBH are set
13 forth in the Plan term documents for each Plan, including but not limited to the Certificate of
14 Coverage and/or Summary Plan Description. *Id.* ¶ 5.

15 The claims of putative class members were denied under thousands of health plans that
16 contained different language describing covered services and exclusions. Class Certification
17 Order at 3. *Id.* The Court has found, however, that the Plans of all of the named Plaintiffs and of
18 the Sample Plaintiffs required “as one (though not the only) condition of coverage that the mental
19 health or substance use disorder treatment at issue must be consistent with generally accepted
20 standards of care.” *Id.* at 4. In reaching this conclusion, the Court rejected UBH’s reliance on
21 minor variations as to the words and phrases used to describe this standard, finding that UBH did
22 not point to “any evidence that these differences were material.” *Id.* at 5.

23 UBH developed level of care guidelines (“LOCs”) and coverage determination guidelines
24 (“CDGs”) to help its clinical staff make coverage determinations. Declaration of Jennifer S.

25
26 _____
27 ¹ The parties have consented to the jurisdiction of a United States magistrate judge pursuant to 28
U.S.C. § 636(c).

28 ² A more detailed description of the relevant facts is contained in the Court’s Class Certification
Order at 2-8.

1 Romano in Support of United Behavioral Health’s Motion for Summary Judgment (“Romano
2 MSJ Decl.”), Ex. 3 (Deposition of Andrew Martorana, M.D. (“Martorana Depo.”)) at 76-77.
3 The LOCs are organized by level of care (e.g., inpatient hospitalization, residential treatment, and
4 intensive outpatient and outpatient settings), while the CDGs are organized by diagnosis (e.g.,
5 major depressive disorder, ADHD, and substance use). Romano MSJ Decl., Ex. 2 (Declaration of
6 Dr. Lorenzo Triana in Support of Defendant United Behavioral Health’s Motion for Summary
7 Judgment (“Triana MSJ Decl.”)) ¶¶ 5-6. Both are updated annually. *Id.* All of the CDGs at issue
8 in this case incorporated the LOCs. Romano MSJ Decl., Ex. 3 (Martorana Depo.) at 78. All of
9 the class members’ requests for coverage were denied under UBH’s CDGs and LOCs.

10 Plaintiffs contend the LOCs and CDGs (collectively, “Guidelines”) fell below generally
11 accepted standards of care in the following respects: 1) “the Guidelines required a showing of
12 acute crisis necessitating the level of care requested, and once the crisis passed, the member was
13 no longer eligible for continued coverage”; 2) “UBH’s Level of Care criteria failed to consider
14 co-occurring medical and behavioral conditions as an aggravating factor that could necessitate
15 treatment in a more intensive level of care”; 3) “UBH’s Level of Care criteria precluded coverage
16 for services to prevent deterioration or maintain a level of functioning, but rather required an
17 expectation that services would cause a patient to continually progress toward recovery”; and 4)
18 “UBH failed to adopt any level-of-care criteria tailored to the unique needs of children and
19 adolescents.” Opposition at 4-6. Defendants contend the CDGs and LOCs are consistent with
20 generally accepted standards of care but do not seek summary judgment on that issue, recognizing
21 that there are factual disputes on that question. *See* Reply at 3.

22 **B. Plaintiffs’ Claims**

23 Plaintiffs assert two claims: 1) breach of fiduciary duty (the “Breach of Fiduciary Duty
24 Claim” or “Claim One”); and 2) arbitrary and capricious denial of benefits (“the Arbitrary and
25 Capricious Denial of Benefits Claim” or “Claim Two”). *See Wit*, Docket No. 39 (“*Wit* Compl.”)
26 ¶¶ 198, 210; *Wit* Docket No. 123 (“*Tillitt* Intervenor Compl.”) ¶¶ 88, 99 ; *Alexander*, Docket No. 1
27 (“*Alexander* Compl.) ¶¶ 136, 146; *Alexander* Docket No. 87 (“*Driscoll* Intervenor Compl.”) ¶¶
28 86, 96. Plaintiffs assert the Breach of Fiduciary Duty Claim under 29 U.S.C. § 1132(a)(1)(B)

1 (Count I in all of the operative complaints) and, to the extent the injunctive relief Plaintiffs seek is
 2 unavailable under that section, they assert the claim under 29 U.S.C. § 1132(a)(3)(A) (Count III in
 3 all of the operative complaints). Similarly, Plaintiffs assert the Arbitrary and Capricious Denial of
 4 Benefits Claim under 29 U.S.C. § 1132(a)(1)(B) (Count II in all of the operative complaints) and
 5 under 29 U.S.C. § 1132(a)(3)(B) (Count IV in all of the operative complaints).

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

25 The Arbitrary and Capricious Denial of Benefits Claim is based on the theory that UBH
 26 improperly adjudicated and denied Plaintiffs’ requests for coverage by, *inter alia*, relying on the
 27 overly restrictive Guidelines. *Wit* Compl. ¶ 205 ; *Tillitt* Intervenor Compl. ¶ 94; *Alexander*
 28 Compl. ¶¶ 141-142; *Driscoll* Intervenor Compl. ¶ 91. The reliance on these Guidelines was

1 arbitrary and capricious, Plaintiffs allege, because: 1) Plaintiffs’ health insurance plans provided
2 for coverage consistent with generally accepted standards of care; and 2) some of Plaintiffs’ health
3 insurance plans were subject to state laws that explicitly mandate the use of clinical criteria issued
4 by the American Society of Addiction Medicine (“ASAM”) or the Texas Department of Insurance
5 (“TDI”). *See Wit Compl.* ¶ 14.

6 Plaintiffs seek declaratory and injunctive relief as a remedy for UBH’s alleged ERISA
7 violations. In particular, in connection with Claim One they ask for: 1) a declaration that UBH’s
8 Guidelines were developed in violation of its fiduciary duties; and 2) an injunction ordering UBH
9 to stop utilizing the Guidelines and instead adopt or develop guidelines that are consistent with
10 those that are generally accepted and with the requirements of applicable state law. In connection
11 with Claim Two, the Arbitrary and Capricious Denial of Benefits Claim, Plaintiffs ask the Court:
12 1) to declare that UBH’s denial of benefits was improper; 2) to order UBH to reprocess claims for
13 residential treatment, intensive outpatient treatment and outpatient treatment that were denied, in
14 whole or in part, pursuant to the Guidelines, using the new guidelines; and 3) to order UBH to
15 apply the new guidelines in processing all future claims. *See Wit Compl.* at 65-66; *Alexander*
16 *Compl.* at 50-51.

17 Plaintiffs also ask the Court to impose a surcharge on UBH as an equitable remedy, under
18 either Counts I and II or Count IV. *See Wit Compl.* at 66; *Alexander Compl.* at 51. In the
19 Complaints, Plaintiffs sought a surcharge in an amount “equivalent to the revenue [UBH]
20 generated from its corporate affiliates or the plans for providing mental health and substance
21 abuse-related claims administration services with respect to claims filed by Plaintiffs and members
22 of the Class, expenses that UBH’s corporate affiliates saved due to UBH’s wrongful denials, the
23 out-of-pocket costs for . . . treatment Plaintiffs and members of the Class incurred following
24 UBH’s wrongful denials, and/or pre-judgment interest.” At Class Certification, however,
25 Plaintiffs stipulated that they would proceed “only under the theory that they are entitled to
26 disgorgement of the revenue UBH generated from its corporate affiliates or the plans for providing
27 mental health and substance abuse-related claims administration services in connection with
28 processing of the class members’ claims.” Class Certification Order at 11-12.

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

2 **C. Classes Certification**

3 At the class certification stage of the case, Plaintiffs asked the Court to certify three
4 proposed classes under Rule 23(b)(2) and (b)(3). UBH argued that the proposed classes should
5 not be certified because, *inter alia*, Plaintiffs' claims turned on individualized issues of medical
6 necessity, and therefore, Rule 23(b)'s commonality requirement was not met. *See* Case No. 14-
7 2346, Dkt. No. 149 at 20-21. Plaintiffs rejected that argument in their class certification reply
8 brief, stating as follows:

9 UBH's arguments regarding "individualized issues of
10 medical necessity" also fail. . . . As a threshold matter, UBH does
11 not (and cannot) argue that Class members' individual clinical
12 presentation is relevant to Claim One. Because that claim is focused
13 on UBH's development of the Guidelines, all of the factual and legal
14 questions on which the claim turns will relate solely to the validity
15 of those guidelines.

16 Individual circumstances are equally irrelevant to Claim
17 Two. . . . Plaintiffs are *not* asking this Court to determine whether
18 Class members were owed benefits or whether UBH should be
19 ordered to cause its plans to pay such benefits. Rather, Plaintiffs
20 seek a reprocessing remedy, which stems directly from their
21 allegation that UBH used an arbitrary process, premised on fatally
22 flawed Guidelines, to deny their requests for coverage. For that
23 reason, Plaintiffs need not prove at trial that UBH reached the wrong
24 outcome in every single one of its coverage determinations.

25 Case No. 14-2346, Dkt. No. 153 at 5 (emphasis in original).

26 Similarly, at oral argument, Plaintiffs explained the theories that underpin their claims and
27 asserted that the remedy they seek flows from those theories, stating as follows:

28 So we have two claims in the case. We have a breach of
fiduciary duty claim that's all about how UBH created its guidelines,
the process it followed. Our assertion is that UBH breached
fiduciary duties that it owes to all class members by undertaking to
create guidelines for administering these plans that were consistent
with generally accepted standards, but failing to do so in violation of
its duties of care, prudence, skill, and loyalty.

And we also have a claim for arbitrary and capricious denial
of benefits, and that's a process claim. It's about the fact that UBH
used criteria that were inconsistent with the terms of the members'
plans, and that's what made them arbitrary and capricious. It's a
different – slightly different issue for the State Mandate Class. The
denials were arbitrary and capricious, and, under ERISA, claims
administrators are not allowed to make arbitrary and capricious

1 decisions, and so the use of those criteria injured the class members
2 all in the same way.

3 And the relief that we're seeking really follows from those
4 claims. So our claims are that UBH created bad guidelines and then
5 used them to administer claims. And so we're seeking a declaration
6 from the Court that the guidelines were inconsistent with generally
7 accepted standards, an injunction requiring UBH to go back to the
8 drawing board, do it again, and come up with guidelines that are
9 consistent with generally accepted standards, to use those guidelines
10 going forward, and then, most importantly, to reprocess the claims
11 that it denied pursuant to the bad guidelines. And that is real and
12 substantive and very important relief for the class.

13 Dkt. No. 173 (September 7, 2016 Hearing Transcript) at 13-14.

14 In response to a question by the Court, Plaintiffs acknowledged that the operative
15 complaints include additional theories that would require individualized inquiries as to why
16 UBH's denials of the named Plaintiffs' claims for benefits were wrongful. *Id.* at 4, 7. Plaintiffs
17 stipulated, however, that "if the case is certified as a class case, those individualized additional
18 reasons for why their denials were wrong would not be part of this case." *Id.* at 8. Plaintiffs
19 further stipulated that "while it might be possible in an individual case for a surcharge to be made-
20 whole relief, that's not the measure that we're seeking on behalf of the class. And assuming the
21 class is certified, the individual plaintiffs would not be seeking that – would not be seeking
22 make-whole relief as a surcharge." *Id.*

23 In its Class Certification Order, the Court relied on Plaintiffs' characterization of their
24 claims and requested remedy in support of its conclusion that the commonality requirement of
25 Rule 23(b)(1) was satisfied, reasoning as follows:

26 The Court is not persuaded by Defendant's assertions that
27 variations relating to the putative class members' insurances plans,
28 medical necessity determinations or the Guidelines themselves
defeat commonality. These variations are not material to the theories
upon which Plaintiffs' claims are based. The harm alleged by
Plaintiffs – the promulgation and application of defective guidelines
to the putative class members – is common to all of the putative
class members. Similarly, whether Plaintiffs are entitled to the
requested remedy – adoption of new Guidelines that are consistent
with generally accepted standards and/or state law and reprocessing
of claims that were denied under the allegedly defective guidelines–
can be addressed on a common basis. Of particular significance is
the fact that Plaintiffs do not ask the Court to make determinations
as to whether class members were actually entitled to benefits
(which would require the Court to consider a multitude of

1 individualized circumstances relating to the medical necessity for
2 coverage and the specific terms of the member's plan). Instead,
3 Plaintiffs seek only an order that UBH develop guidelines that are
consistent with generally accepted standards and reprocess claims
for coverage that were denied under the allegedly faulty guidelines.

4 Class Certification Order at 30-31. The Court also highlighted Plaintiff's stipulation to drop their
5 request for a surcharge that would afford "make-whole relief" to the class members, finding that
6 "[w]ith that modification, the surcharge that Plaintiffs request is based only on the amount UBH
7 was paid to process the claims that were denied." *Id.* at 43.

8 The Court granted Plaintiffs' class certification motion on September 19, 2016. UBH filed
9 a motion for leave to file a motion for reconsideration on September 30, 2016, which the Court
10 denied on October 12, 2016.

11 The Court has certified the following classes under Rule 23(b)(2) and (b)(3)³:

12 **The *Wit* Guideline Class**

13 Any member of a health benefit plan governed by ERISA whose
14 request for coverage of residential treatment services for a mental
15 illness or substance use disorder was denied by UBH, in whole or in
part, between May 22, 2011 and June 1, 2017, based upon UBH's
Level of Care Guidelines or UBH's Coverage Determination
Guidelines.

16 **The *Wit* State Mandate Class**

17 Any member of a fully-insured health benefit plan governed by
18 both ERISA and the state law of Connecticut, Illinois, Rhode
19 Island, or Texas, whose request for coverage of residential
20 treatment services for a substance use disorder was denied by UBH,
in whole or in part, within the Class period, 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.

21 With respect to plans governed by Texas law, the *Wit* State
22 Mandate Class includes only denials of requests for coverage of
23 substance use disorder services that were sought or received in
Texas.

24 The Class period for the *Wit* State Mandate Class includes denials
25 governed by Texas law that occurred between May 22, 2011 and
26 June 1, 2017, denials governed by Illinois law that occurred
between August 18, 2011 and June 1, 2017, denials governed by

27 ³ Since the Court granted Plaintiffs' class certification motion, the parties have entered into
28 stipulations making minor modifications to the class definitions. The class definitions quoted
above are the current versions of these definitions.

1 Connecticut law that occurred between October 1, 2013 and June 1,
2 2017, and denials governed by Rhode Island law that occurred
3 between July 10, 2015 and June 1, 2017.

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
7 for a mental illness or substance use disorder was denied by UBH,
8 in whole or in part, between December 4, 2011 and June 1, 2017,
9 based upon UBH's Level of Care Guidelines or UBH's Coverage
10 Determination Guidelines.

11 The Alexander Guideline Class excludes any member of a fully
12 insured plan governed by both ERISA and the state law of
13 Connecticut, Illinois, Rhode Island or Texas, whose request for
14 coverage of intensive outpatient treatment or outpatient treatment
15 [was]⁴ related to a substance use disorder, except that the Alexander
16 Guideline Class includes members of plans governed by the state
17 law of Texas who were denied coverage of substance use disorder
18 services sought or provided outside of Texas.

19 Class Certification Order at 12-13; Stipulation and Order Regarding Amendment of Date
20 Limitation of *Alexander* Guideline Class Definition, Case No. 14-2346, Dkt. No. 256; Order
21 Regarding Supplemental Class Notice, Case No. 14-2346, Dkt. No. 281.

22 **D. Summary Judgment Motion**

23 In its summary judgment motion, UBH asks the Court to dismiss both of Plaintiffs' claims
24 on the basis that Plaintiffs cannot demonstrate that any concrete injury was actually caused by the
25 alleged violations of ERISA. Motion at 10-16. It further contends the claims of certain named
26 Plaintiffs (and likely those of "thousands of class members" as well) fail because their insurance
27 plans expressly exclude coverage for services that are not consistent with the UBH LOCs. *Id.* at
28 16-18. In addition, UBH contends it is entitled to summary judgment as to the claims of the *Wit*
State Mandate Class asserted on the basis of Texas state law because the undisputed evidence
shows that "it has been UBH's policy and practice to apply TDI guidelines – not UBH guidelines
– to coverage decisions for plans subject to Texas law for the entire class period." *Id.* at 18.

UBH also challenges the surcharge remedy Plaintiffs seek. *Id.* at 18-22. In particular,

⁴ At oral argument, the parties stipulated that the *Alexander* Guidelines Class definition proposed by Plaintiffs at class certification and adopted by the Court in its Class Certification Order was grammatically incorrect as a verb was inadvertently omitted from the second sentence of the definition. The Court corrects that error here and will use the corrected version of the class definition going forward.

1 UBH contends the proposed surcharge is not available under traditional equitable principles and is
2 not appropriately tailored to redress a loss flowing from the alleged breach or prevent unjust
3 enrichment. *Id.*

4 **III. ANALYSIS**

5 **A. General Legal Standards Under Rule 56**

6 Summary judgment on a claim or defense is appropriate “if the movant shows that there is
7 no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of
8 law.” Fed. R. Civ. P. 56(a). In order to prevail, a party moving for summary judgment must show
9 the absence of a genuine issue of material fact with respect to an essential element of the non-
10 moving party’s claim, or to a defense on which the non-moving party will bear the burden of
11 persuasion at trial. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). Once the movant has
12 made this showing, the burden then shifts to the party opposing summary judgment to designate
13 “specific facts showing there is a genuine issue for trial.” *Id.* On summary judgment, the court
14 draws all reasonable factual inferences in favor of the non-movant. *Scott v. Harris*, 550 U.S. 372,
15 378 (2007).

16 **B. Legal Framework Under ERISA**

17 “ERISA protects employee pensions and other benefits by providing insurance . . . ,
18 specifying certain plan characteristics in detail . . . , and by setting forth certain general fiduciary
19 duties applicable to the management of both pension and nonpension benefit plans.” *Varity Corp.*
20 *v. Howe*, 516 U.S. 489, 496 (1996)). The basic purpose of ERISA is “to protect . . . the interests
21 of participants . . . and . . . beneficiaries . . . by establishing standards of conduct, responsibility,
22 and obligation for fiduciaries . . . and . . . providing for appropriate remedies . . . and ready access
23 to the Federal courts.” *Id.* at 513 (quoting ERISA § 2(b), 29 U.S.C. § 1001(b)).

24 An ERISA fiduciary must act for the exclusive benefit of plan participants and must
25 exhibit the care, skill, prudence, and diligence that a prudent person acting in like capacity would
26 use in similar circumstances. 29 U.S.C. § 1104(a)(1). Further, a fiduciary must discharge its
27 duties with complete and undivided loyalty to plan participants without any dealing for the
28 fiduciary’s own benefit. 29 U.S.C. § 1104(a)(1)(A); *see Kanawi v. Bechtel Corp.*, 590 F. Supp. 2d

1 1213, 1222 (N.D. Cal. 2008). Under ERISA, “[a]ny person who is a fiduciary with respect to a
2 plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries
3 [under ERISA] shall be personally liable to make good to such plan any losses to the plan
4 resulting from each such breach, and to restore to such plan any profits of such fiduciary which
5 have been made through use of assets of the plan by the fiduciary, and shall be subject to such
6 other equitable or remedial relief as the court may deem appropriate, including removal of such
7 fiduciary.” 29 U.S.C. § 1109.

8 In addition, Section 502 of ERISA allows plan participants or beneficiaries to bring a civil
9 action and sets forth certain remedies available to them. 29 U.S.C. § 1132. In particular, Section
10 502(a) provides, in relevant part, as follows:

11 A civil action may be brought—

12 (1) by a participant or beneficiary—

13 . . .

14 (B) to recover benefits due to him under the terms of his plan, to
15 enforce his rights under the terms of the plan, or to clarify his rights
16 to future benefits under the terms of the plan;

17 . . .

18 (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act
19 or practice which violates any provision of this subchapter or the
20 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
21 subchapter or the terms of the plan;

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

23 C. Causation and Standing

24 1. Background

25 In the Motion, UBH asserts Plaintiffs’ claims must fail in light of their stipulation at the
26 class certification stage of the case that they are not asking the Court to determine whether any
27 class member was actually entitled to benefits. Motion at 7. According to UBH, Plaintiffs
28 “reformulate[ed]” their claims to facilitate class treatment but in doing so, “doom[ed] their claims
on the merits” because they “eschew[ed] any attempt to prove injury or causation.” *Id.* at 1. UBH
argues that Plaintiffs cannot prevail on their claims simply by proving that UBH’s guidelines were

1 “bad”; rather, Plaintiffs must also establish that the guidelines caused them actual injury –
2 something UBH contends is impossible under the theories Plaintiffs have espoused in support of
3 their claims. *Id.* at 1.

4 With respect to the Breach of Fiduciary Duty Claim (Claim One), UBH contends Plaintiffs
5 must demonstrate a “causal link between the alleged breach of fiduciary duty and actual harm
6 suffered by Plaintiffs and the class members.” Motion at 10 (citing *Romberio v. Unumprovident*
7 *Corp.*, 385 F. App’x 423, 429 (6th Cir. 2009)). UBH argues that Plaintiffs cannot meet this
8 burden because they have “affirmatively admitted that they will not offer evidence to prove that
9 each (or any) class member was denied benefits because of the specific flaws they identify in the
10 guidelines.” *Id.* UBH cites *Hein v. F.D.I.C.*, 88 F.3d 210, 224 (3d Cir. 1996) in support of its
11 position. *Id.* at 11. According to UBH, in that case, “[t]he Third Circuit rejected the plaintiff’s
12 breach of fiduciary duty claims because, among other things, he failed to allege facts establishing
13 that the purported breach of duty caused the denial of benefits.” *Id.* UBH also cites *Sedlack v.*
14 *Braswell Servs. Grp., Inc.*, 134 F.3d 219, 225 (4th Cir. 1998) and *Graddy v. Blue Cross BlueShield*
15 *of Tenn., Inc.*, No. 4:09-CV-84, 2010 WL 670081, at *8 (E.D. Tenn. Feb. 19, 2010) in support of
16 the proposition that “a plaintiff asserting a claim for breach of fiduciary duty under ERISA must
17 show that the defendant’s breach of fiduciary duty caused the plaintiff harm.” *Id.*

18 Similarly, UBH argues that the Arbitrary and Capricious Denial of Benefits Claim (Claim
19 Two) fails because a required element of such a claim is the wrongful denial of benefits, which
20 cannot be satisfied on the basis of a “classwide ‘procedural challenge’ to the development
21 and use of allegedly improper coverage guidelines, untethered from any specific benefit decision.”
22 *Id.* at 12 (citing *Payne v. POMCO Grp.*, No. 10 CIV. 7285 (BSJ), 2011 WL 4576545, at *2
23 (S.D.N.Y. Sept. 30, 2011); *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 977 (9th Cir.
24 2006) (Kleinfeld, J., concurring); *Carrier v. Aetna Life Ins. Co.*, 116 F. Supp. 3d 1067, 1079 (C.D.
25 Cal. 2015); *Biba v. Wells Fargo & Co.*, No. C 09-3249 MEJ, 2010 WL 4942559, at *7 (N.D. Cal.
26 Nov. 10, 2010); *Romberio*, 385 F. App’x at 429 (citing *Hein*, 88 F.3d at 224); *Sedlack*, 134 F.3d at
27 225).

28 UBH rejects Plaintiffs’ reliance on *Saffle v. Sierra Pacific Power Company Bargaining*

1 *Unit Long Term Disability Income Plan*, 85 F.3d 455 (9th Cir. 1996) in support of Plaintiffs’
2 position that “because the remedy they seek is ‘reprocessing’ of benefit claims, and not payment
3 of benefits” they “do not need to prove causation.” *Id.* at 13. UBH argues that *Saffle* is
4 distinguishable because the case was not a class action and “[t]he plaintiff offered actual evidence
5 demonstrating that the plan administrator’s arbitrary interpretation of the term ‘total disability’
6 impacted the plan’s decision to deny the plaintiff benefits.” *Id.* (citing 85 F.3d at 458).

7 Finally, UBH argues that Plaintiffs lack standing under Article III of the Constitution
8 because they cannot demonstrate that they have suffered an “injury in fact” or that any injury they
9 suffered was “fairly traceable” to the conduct that is alleged to be wrongful, namely, the
10 development and application of the UBH guidelines. *Id.* at 14 (citing *Lujan v. Defenders of*
11 *Wildlife*, 504 U.S. 555, 560 (1992)). According to UBH, in the class action context, these standing
12 requirements apply fully to named plaintiffs in the case, who “must have standing to bring claims
13 on behalf of the class under all legal theories giving rise to the claims.” *Id.* (citing *Allee v.*
14 *Medrano*, 416 U.S. 802, 828-29 (1974)).

15 With respect to the “injury in fact” requirement, UBH argues that Plaintiffs must
16 demonstrate that they have suffered a “concrete and particularized” injury that is “actual or
17 imminent, not conjectural or hypothetical.” *Id.* at 15 (quoting *Spokeo, Inc. v. Robins*, 136 S. Ct.
18 1540, 1548-49 (2016)). UBH argues that this requirement is not met because Plaintiffs claim only
19 “abstract violations of the law without specifying what actual, concrete harm this conduct caused.”
20 *Id.* According to UBH, Plaintiffs identify merely “the possibility of injury,” which is the sort of
21 conjectural or hypothetical injury the Supreme Court has found to be inadequate to confer
22 standing. *Id.* at 15-16. “It is not enough,” UBH contends, “to speculate that some class members,
23 or some Plaintiffs, may receive additional benefits through reprocessing if it turns out that their
24 earlier denials were caused by the conduct challenged in this case.” *Id.* at 16. Rather, UBH
25 asserts, “Plaintiffs must prove that now, or fail for lack of standing.” *Id.*

26 UBH argues further that to the extent Plaintiffs do not intend to prove a causal link
27 between the Guidelines and any particular denial of benefits, Plaintiffs cannot establish that they
28 have suffered an injury that is “fairly traceable” to UBH’s allegedly wrongful conduct. *Id.*

1 Plaintiffs reject UBH’s challenges regarding causation and standing and in particular, its
2 assertion that Plaintiffs must demonstrate that they would have received benefits if UBH had
3 applied valid guidelines. Opposition at 10-19. As a preliminary matter, they argue that UBH’s
4 arguments are merely a “rehash of the same arguments UBH has already made, and this Court has
5 rejected, several times.” *Id.* at 10. They point to the fact that when the Court certified the
6 proposed classes it recognized that Plaintiffs’ claims were based on “an injury that is distinct from
7 the actual denial of benefits and that is cognizable under ERISA, namely, the use of Guidelines
8 that are more restrictive than the plans under which they are insured or the standards mandated by
9 state law in adjudicating their claims.” *Id.* (quoting Class Certification Order at 49). The Court
10 also rejected the same causation argument when UBH asked it to reconsider its Class Certification
11 Order, Plaintiffs contend. *Id.* Therefore, they argue, under the “law of the case” doctrine, the
12 Court should reject UBH’s arguments here on the basis that these questions have already been
13 decided. *Id.* at 11 (citing *United States v. Alexander*, 106 F.3d 874, 876 (9th Cir. 1997)).

14 Similarly, Plaintiffs argue that all of the arguments raised by UBH are “thinly disguised
15 decertification motions.” *Id.* at 11-12. Plaintiffs point out that the Court instructed UBH that it
16 would not be permitted to bring a motion for decertification without seeking leave and that UBH
17 did not do so. *Id.* at 11 (citing Reynolds Decl., Ex. 68 (Transcript of February 3, 2017 hearing) at
18 41). Thus, Plaintiffs contend, the instant motion is an improper attempt to evade the Court’s order.
19 *Id.* at 12.

20 On the merits, Plaintiffs assert that UBH’s causation and standing arguments are an
21 attempt to improperly “add an element” to Plaintiffs’ claims, requiring them to show not only that
22 UBH applied the wrong standards but also that Plaintiffs would have been entitled to benefits if
23 UBH had applied the *correct* standard. *Id.* at 12. That is not the law, Plaintiffs assert. *Id.* (citing
24 Class Certification Order at 31-35; Order Granting Mot. for Class Cert., *Des Roches v. Cal. Phys.’*
25 *Serv.*, Case No. 16-CV-02848-LHK, Dkt. No. 123, at 12-14 (N.D. Cal. June 15, 2017) (Koh, J.)).
26 Neither is such a showing necessary to establish Article III standing, Plaintiffs contend. *Id.*

27 With respect to Claim One, Plaintiffs assert that UBH’s development and application of its
28 Guidelines breached the following fiduciary duties to Plaintiffs: 1) the duty of due care (29 U.S.C.

1 § 1104(a)(1)(B); 2) the duty of loyalty (29 U.S.C. § 1104(a)(1)(A); and 3) the duty to comply
2 with plan terms (29 U.S.C. § 1104(a)(1)(D)). *Id.* at 13. According to Plaintiffs, UBH’s assertion
3 that they cannot establish causation as to Claim One fails for three reasons. *Id.*

4 First, Plaintiffs assert, the express terms of ERISA contradict UBH’s position to the extent
5 that ERISA “provides that ‘[a] civil action may be brought’ by a plan participant or beneficiary not
6 only to ‘recover benefits due . . . under the terms of [a] plan,’ 29 U.S.C. §§ 1132(a)(1)(B), but also
7 to ‘enforce . . . rights under the terms of [a] plan,’ *id.*, to ‘clarify . . . rights to future benefits under
8 the terms of [a] plan,’ *id.*, to ‘enjoin any act or practice which violates any provision of this
9 subchapter,’ *id.* § 1132(a)(3)(A), and to ‘obtain other appropriate equitable relief (i) to redress
10 such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan,’ *id.*
11 § 1132(a)(3)(B).” *Id.* Moreover, Plaintiffs assert, ERISA contains no provision that requires that
12 a plaintiff who brings a breach of fiduciary duty claim must show that the breach caused the
13 plaintiff to lose benefits to which he or she otherwise would have been entitled. *Id.*

14 Second, Plaintiffs argue, UBH’s position “makes no sense” in light of the remedy Plaintiffs
15 seek, which does not include payment of benefits. *Id.* Furthermore, UBH’s assertion that
16 Plaintiffs must show that the breach of fiduciary duty caused a denial of benefits is inconsistent
17 with *Shaver v. Operating Eng’rs Local 428 Pension Trust Fund*, 332 F.3d 1198, 1203 (9th Cir.
18 2003), in which the Ninth Circuit noted that “Congress intended to make fiduciaries culpable for
19 certain ERISA violations even in the absence of actual injury to a plan or participant.” *Id.* Thus,
20 Plaintiffs contend, in that case the court held that “although the plaintiffs, who alleged a breach of
21 fiduciary duty, ‘did not allege that any loss occurred,’ that ‘is not fatal’ because ‘[t]he question of
22 whether a fiduciary violated his fiduciary duty is independent from the question of loss’.” *Id.* at
23 14.

24 Third, Plaintiffs argue that the case authority does not support UBH’s causation argument
25 and that its reliance on *Hein v. F.D.I.C.*, 88 F.3d 210 (3d Cir. 1996), and *Romberio v.*
26 *Unumprovident Corp.*, 385 F. App’x 423 (6th Cir. 2009) is misplaced. *Id.* at 14. According to
27 Plaintiffs, *Hein* is distinguishable because in that case it was undisputed that the denial of pension
28 benefits was consistent with the terms of the plan and the only benefits the plaintiff claimed on the

1 breach of fiduciary duty claim were damages equal to the denied benefits. *Id.* Plaintiffs further
2 contend *Rombiero* is not on point, because it was a class certification decision and the plaintiffs in
3 that case challenged a “plethora of ‘loosely-defined practices that were *not* applied uniformly.”
4 *Id.* (quoting 385 Fed. App’x at 430). In contrast to this case, where “UBH has applied its
5 Guidelines to every member of the class, in *Rombiero* there was no way to know which class
6 members had been subjected to which of the challenged ‘practices.’” *Id.*

7 Plaintiffs also argue that UBH’s causation argument fails as to the Breach of Fiduciary
8 Duty Claim. *Id.* at 15. On that claim, Plaintiffs contend, they have sufficiently demonstrated
9 causation because they rely not only on the application of overly restrictive guidelines to their
10 disability determinations but also, the fact that the Guidelines were used to deny coverage to the
11 class members. *Id.* According to Plaintiffs, UBH’s argument that causation can only be
12 established by showing that class members would have been awarded benefits but for the flawed
13 guidelines has no basis in ERISA. *Id.* (citing 29 U.S.C. §§ 1132(a)(1)(B), (a)(3)). To the
14 contrary, they argue, the Ninth Circuit’s decision in *Saffle* establishes that “[i]nsofar as ERISA
15 requires causation, it is satisfied by showing that the administrator adopted ‘a wrong standard,’ the
16 administrator ‘applied’ it to the member’s claim, and the claim was denied.” *Id.* (quoting 85 F.3d
17 at 460-61).

18 Plaintiffs reject UBH’s attempt to distinguish *Saffle* on the basis that Plaintiffs have not
19 shown that UBH’s flawed Guidelines “impacted” the denials. *Id.* Rather, Plaintiffs contend, there
20 is “ample evidence that the flaws in the Guidelines were fundamental, and that those flaws
21 infected UBH’s denials of Plaintiffs’ requests for coverage.” *Id.* at 15-16.⁵ Plaintiffs also argue

22
23 ⁵ In Section II(D) of Plaintiffs’ Opposition brief, Plaintiffs describe the specific reasons provided
24 by UBH for denying benefits to the named Plaintiffs to illustrate how the denials were linked to
25 the alleged flaws in the Guidelines. Because the discussion of UBH’s denials of benefits in this
26 section reveals the personal medical history of the named Plaintiffs, this information has been
27 redacted from the publicly-filed version of Plaintiffs’ brief. The Court does not rely on the
28 evidence cited by Plaintiffs in this section of their brief to decide the instant motion and therefore
does not summarize it here. For the same reason, the Court need not reach UBH’s objections to
Plaintiffs’ reliance on coverage decision letters and clinical case notes in support of this argument.
See Reply at 2 (objecting to Reynolds Decl., Exs. 28-49, 57, 58). Similarly, the Court does not
rely on the expert opinions offered by Plaintiffs on the alleged flaws in the UBH guidelines and
therefore does not reach UBH’s objection to those reports. *See* Reply at 2 (objecting to Reynolds

1 that UBH has pointed to no case that holds that a denial of benefits claim can only be successful
2 where the plaintiff demonstrates that benefits would have been awarded but for the flawed
3 guideline. *Id.* at 16. If there *were* such a rule, Plaintiffs contend, remand for reprocessing – which
4 is the “default rule” – would never be a proper remedy. *Id.*

5 Finally, Plaintiffs argue that they have Article III standing to assert their claims because
6 they have suffered injury-in-fact, their injury is fairly traceable to the challenged conduct, and
7 their injury is likely to be redressed by a favorable judicial decision. *Id.* at 16-19. First, with
8 respect to the Breach of Fiduciary Duty Claim, Plaintiffs contend the injury for which they seek
9 redress – the development, adoption and application of improper guidelines – is cognizable under
10 Article III. *Id.* at 17 (citing *Slack v. Int’l Union of Operating Eng’rs*, 2014 WL 4090383, at *12
11 (N.D. Cal. Aug. 19, 2014); *Tourgeman v. Collins Fin. Servs., Inc.*, 755 F.3d 1109, 1116 (9th Cir.
12 2014)). Plaintiffs contend UBH’s argument that such an injury is not cognizable is contradicted
13 by *Northeastern Florida Chapter of Associated General Contractors of America v. City of*
14 *Jacksonville*, 508 U.S. 656 (1993). *Id.* In that case, an association of contractors challenged a city
15 ordinance that gave preferential treatment to minority-owned businesses. According to Plaintiffs,
16 the Court rejected the city’s argument that the association lacked standing because it could not
17 show that “one of its members would have received a contract absent the ordinance,” finding
18 instead that the “injury in fact” was “the denial of equal treatment resulting from the imposition
19 of the barrier, not the ultimate inability to obtain the benefit.” *Id.* (quoting 508 U.S. at 658).

20 Plaintiffs also argue that the Supreme Court’s decision in *Spokeo* is not to the contrary. *Id.*
21 at 18. *Spokeo* instructs that in determining whether an intangible harm provides a basis for
22 standing, courts should consider “whether [the] alleged intangible harm has a close relationship to
23 a harm that has traditionally been regarded as providing a basis for a lawsuit in English or
24 American courts.” *Spokeo*, 136 S.Ct. at 1549. Here, according to Plaintiffs, the harm at issue is
25 grounded in well-established principles of trust law. Opposition at 18. In particular, Plaintiffs
26 argue, “it has long been settled that a trust beneficiary may sue in equity to enforce the terms of a

27 _____
28 Decl., Exs. 50-55).

1 trust, without showing that the trustee’s departure from the trust’s terms diminished the value of
2 the beneficiary’s interest.” *Id.* (citing Restatement (Third) of Trusts § 71 cmt. a (2007) (“[A]s a
3 protection against harm that might be caused by a breach of trust resulting from a mistake
4 concerning the trustee’s powers and duties, a beneficiary may petition to the court to instruct the
5 trustee with regard to the powers and duties of the trusteeship.”); *id.* § 94 cmt b (“A suit to
6 enforce a private trust ordinarily . . . may be maintained by any beneficiary whose rights are or
7 may be adversely affected by the matter(s) at issue.”)). Plaintiffs also note that *Spokeo* was
8 decided “on the heels of *Cigna Corp. v. Amara*, 563 U.S. 421 (2011), which made clear that, in the
9 ERISA context, insofar as a ‘specific remedy’ requires showing ‘harm,’ ‘[t]hat actual harm may . .
10 . come from the loss of a right protected by ERISA or its trust-law antecedents.” *Id.* (quoting 563
11 U.S. at 444).

12 As to Claim Two, Plaintiffs argue that the injury alleged – the arbitrary and capricious
13 denial of benefits – “clearly satisfies Article III’s requirements” because Plaintiffs’ claims were, in
14 fact, denied. *Id.* at 19. Plaintiffs reject UBH’s assertion that this injury will not be “‘established’
15 until ‘after reprocessing is complete,’” *id.* (quoting Motion at 15), arguing that UBH’s argument
16 has “no basis in fact or law.” *Id.* Further, even if some of Plaintiffs’ claims for benefits may be
17 denied for different reasons, this result does not negate Article III standing. *Id.* (citing *Akins*, 524
18 U.S. at 25 (“If a reviewing court agrees that the agency misinterpreted the law, it will set aside the
19 agency’s action and remand the case – even though the agency (like a new jury after a mistrial)
20 might later, in the exercise of its lawful discretion, reach the same result for a different reason.”)).

21 **2. Discussion**

22 a. Whether the Court Should Consider Defendants’ Arguments on the Merits

23 As a preliminary matter, the Court declines Plaintiffs’ invitation to deny the Motion on the
24 basis that it is simply a motion to decertify in disguise. It is true that many of UBH’s arguments
25 regarding causation and standing are closely related to arguments that they made at the class
26 certification stage of the case. Nonetheless, the ultimate question addressed in the Class
27 Certification Order was whether Plaintiffs’ claims were amenable to class treatment under Rule 23
28 when considered in light of Plaintiffs’ theories of the case. While the Court also addressed the

1 legal underpinnings of Plaintiffs’ theories, it did not directly consider the question of whether
2 Plaintiffs could prevail on their claims under those theories or whether there was sufficient
3 evidence to give rise to material disputes of fact under those theories. Therefore, the Court does
4 not find the instant motion to be in violation of the Court’s orders governing the filing of a
5 decertification motion or the “law of the case” doctrine.

6 b. Whether Plaintiffs Can Establish Causation and Article III Standing on their
7 Claims

8 The underlying premise of UBH’s causation and standing arguments is that in order for
9 Plaintiffs’ claims to be actionable Plaintiffs must demonstrate that they were denied benefits as a
10 result of the allegedly flawed Guidelines, that is, that they would have been awarded benefits but
11 for the application of flawed Guidelines. The Court rejects UBH’s narrow reading of the case law
12 governing ERISA and standing, which does not limit the types of injuries that may be actionable
13 to the denial of benefits, and therefore also rejects UBH’s causation arguments.⁶

14 i. Causation of Injury

15 Plaintiffs in this action have stipulated that they do not seek to show in this action that the
16 alleged flaws in UBH’s Guidelines were the “but-for” cause of the denial of their benefits.
17 Consequently, if denial of benefits were the only injury recognized under ERISA, Plaintiffs’
18 claims would fail for lack of causation. The Court concludes, however, that as to both the Breach
19 of Fiduciary Duty Claim and the Arbitrary and Capricious Denial of Benefits Claim, Plaintiffs rely
20 on a different type of injury and that their theories of liability are in line with the plain language of
21 ERISA and existing case law.

22 First, whether an ERISA claim is styled as a breach of fiduciary duty claim or a denial of
23 benefits claim, the plain language of ERISA supports the conclusion that a denial of benefits is not

24 ⁶ The Court notes that to the extent that the surcharge remedy requested by Plaintiffs raises
25 difficult questions regarding causation and standing, the Court need not decide those questions
26 because, as discussed below, it finds that under the specific circumstances of this case that
27 Plaintiffs have not demonstrated that they will be able to establish the amount of the surcharge
28 under the theory on which they sought class certification, which is the only theory the Court will
permit Plaintiffs to pursue. Consequently, the only remedy as to which Plaintiffs must establish
causation and standing is the injunctive relief related to the development of new Guidelines and
reprocessing of denied claims.

1 the only sort of injury that is actionable. ERISA permits a participant to bring an action not only to
2 recover “benefits due” under the plan but also to “enforce [a participant’s] rights under the terms
3 of the plan, or to clarify [a participant’s] rights to future benefits under the terms of the plan.” 29
4 U.S.C. § 1132(a)(1)(B). It further permits a participant to bring an action to “enjoin any act or
5 practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain
6 other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of
7 this subchapter or the terms of the plan.” 29 U.S.C. § 1132(a)(3). This broad remedial provision
8 does not support UBH’s position that Plaintiffs must demonstrate they were actually denied
9 benefits as a result of the alleged flaws in the Guidelines in order to demonstrate causation on their
10 claims.

11 Second, the case law interpreting these provisions also does not support UBH’s causation
12 argument. With respect to claims for breach of fiduciary duty, the Ninth Circuit has found that
13 “Congress intended to make fiduciaries culpable for certain ERISA violations even in the absence
14 of actual injury to a plan or participant.” *Ziegler v. Connecticut Gen. Life Ins. Co.*, 916 F.2d 548,
15 551 (9th Cir.1990); *see also Shaver v. Operating Engineers Local 428 Pension Trust Fund*, 332
16 F.3d 1198, 1203 (9th Cir. 2003) (“The question of whether a fiduciary violated his fiduciary duty
17 is independent from the question of loss.”). Under this authority, it is clear that breach of
18 fiduciary duty claims brought by Plan participants or beneficiaries under Section 1132(a) are not
19 limited to those in which the injury alleged is the actual denial of benefits and therefore, that such
20 a claim does not necessarily require that the breach caused a denial of benefits.

21 In *Shaver*, for example, the plaintiffs alleged that the trustees of an ERISA plan had
22 breached their fiduciary duty by failing to keep adequate records and sought an injunction
23 requiring that the trustees keep better records in the future or that the trustees be removed. 332
24 F.3d at 1202. The plaintiffs did not allege any loss. *Id.* at 1203. The court rejected a challenge to
25 the claim under Rule 12(b)(6), explaining that the plaintiffs were not required to show a loss
26 because they were “seeking purely equitable relief, either to enjoin future misconduct, or to have
27 the trustees removed.” *Id.* It reasoned that “[r]equiring a showing of loss in such a case would be
28 to say that the fiduciaries are free to ignore their duties so long as they do no tangible harm, and

1 that the beneficiaries are powerless to rein in the fiduciaries’ imprudent behavior until some actual
2 damage has been done.” *Id.* The court found that “[t]his result is not supported by the language of
3 ERISA, the common law, or common sense.” *Id.* The Court concludes that *Shaver* is on point, at
4 least insofar as Plaintiffs seek injunctive relief requiring UBH to rewrite its Guidelines to conform
5 with generally accepted standards or, as to the State Mandate Class, to require UBH to use the
6 applicable State law guidelines in making coverage decisions. Under *Shaver*, Plaintiffs may bring
7 an action to enforce UBH’s fiduciary obligations without establishing that the alleged violation
8 has caused an actual loss, such as a denial of benefits.

9 Similarly, the Ninth Circuit’s decision in *Saffle v. Sierra Pacific Power Co. Bargaining*
10 *Unit Long Term Disability Income Plan*, 85 F.3d 455 (9th Cir. 1996) supports the conclusion that
11 an ERISA Plan participant or beneficiary may bring a claim for arbitrary and capricious denial of
12 benefits based on an injury other than the actual denial if the process by which a coverage
13 determination was made was defective. In *Saffle*, a plan participant brought a claim against the
14 plan administrator for benefits she alleged were wrongfully denied. 85 F.3d at 456. The district
15 court found that the Plan administrator had abused its discretion by applying an incorrect standard
16 that conflicted with the Plan terms in making the benefits determination and went on to conclude
17 that the plaintiff was entitled to benefits under the correct standard. *Id.* The Ninth Circuit agreed
18 that the administrator had misconstrued the plan terms but found that district court had erred in
19 addressing whether the plaintiff was actually entitled to benefits under the correct standard. *Id.*
20 The court reasons that because the plan administrator had discretionary authority to interpret and
21 apply the plan, the district court should have given the administrator “the opportunity of applying
22 the plan, properly construed” to the plaintiff’s claim for benefits” in the first instance. *Id.* The
23 implication of the Ninth Circuit’s holding in *Saffle* is that while the plaintiff’s action was based on
24 a denial of benefits, the relevant injury for the purposes of the district court action was the
25 defective *process* that was applied to the determination of the plaintiff’s coverage. Indeed, under
26 *Saffle*, if a court finds that a plan administrator applied an incorrect standard in making a coverage
27 determination, it is improper for the district court to adjudicate whether the claimant would have
28 been entitled to benefits under the correct standard if the administrator has not first been given an

1 opportunity to address that question.

2 UBH attempts to distinguish *Saffle* on the basis that that case was not a class action and
3 there was “actual evidence” that the flawed interpretation of the plan “impacted the plan’s decision
4 to deny the plaintiff benefits.” The Court finds this distinction to be unpersuasive. Plaintiffs have
5 offered evidence that the Guidelines they challenged were expressly referenced in the denial
6 letters sent to each class member. The Court finds that this is sufficient evidence from which to
7 conclude that the flaws alleged in this case, if proven, may warrant the injunctive relief Plaintiffs
8 seek. To require Plaintiffs to prove conclusively that their benefits were denied because of the
9 alleged flaws in the Guidelines rather than as a result of other individualized factors relating, for
10 example, to their medical circumstances, would risk involving the Court in just the sort of inquiry
11 that the Ninth Circuit cautioned in *Saffle* should be left to the administrator, at least in the first
12 instance.

13 *Shaver* and *Saffle* do not, of course, stand for the proposition that ERISA claims *never*
14 require a showing of actual loss. Where a plan participant brings an ERISA claim seeking an
15 award of wrongfully denied benefits – what Plaintiffs in this action refer to as “make-whole” relief
16 – courts require the plaintiff to establish that the ERISA violation actually caused the denial of
17 benefits. *See, e.g., Hein*, 88 F.3d 210, 213 (3d Cir. 1996) (holding that plaintiff who sought an
18 award of compensatory damages in the form of unreduced retirement benefits to which he claimed
19 he was entitled could not prevail on breach of fiduciary duty claim under ERISA because he was
20 not actually entitled to benefits under plain terms of the plan and therefore “there [was] no causal
21 link between the alleged breach of fiduciary duty . . . and the denial of benefits to Hein.”); *Payne*
22 *v. POMCO Group*, No. 10 CIV 7285 BSJ, 2011 WL 4576545, at *2 (S.D.N.Y. Sept. 30, 2011)
23 (holding that where plaintiff asserted a claim under 29 U.S.C. § 1132(a)(1)(B) seeking to recover
24 benefits he claimed were wrongfully denied, the plaintiff failed to state a claim where it was
25 “readily apparent from Plaintiff’s Fund records that Plaintiff could not have qualified for disability
26 benefits.”).

27 In this case, however, Plaintiffs do not seek “make-whole” relief in the form of an award of
28 denied benefits. Rather, they seek to secure rights and obligations owed to them under ERISA,

1 namely, their rights to a plan administrator that acts solely in the interests of plan participants in
2 developing the Guidelines that are used to adjudicate their claims and to have their claims
3 adjudicated under Guidelines that are consistent with the terms of their plans. In other words, the
4 primary harm for which Plaintiffs’ seek redress is not the denial of benefits itself but rather the
5 loss of these rights. Given the case law discussed above, the Court concludes that ERISA permits
6 Plaintiffs to assert such challenges. Consequently, UBH’s argument that Plaintiffs must
7 demonstrate that flaws in their Guidelines actually caused the Plaintiffs’ denial of benefits misses
8 the mark.

9 ii. Standing

10 Closely related to the question of what types of injuries are actionable under ERISA is the
11 question of Article III standing. “To bring an ERISA lawsuit, a plaintiff must not only have
12 standing under the statute, but must also meet the standing requirements of Article III of the U.S.
13 Constitution.” *Wells v. California Physicians’ Serv.*, No. C05-01229 CRB, 2007 WL 926490, at
14 *3 (N.D. Cal. Mar. 26, 2007) (citing *Horvath v. Keystone Health Plan E., Inc.*, 333 F.3d 450, 455
15 (3d Cir. 2003) (citing *Warth v. Seldin*, 422 U.S. 490, 491, 95 S.Ct. 2197, 45 L.Ed.2d 343 (1975));
16 *Cent. States SE & SW Areas Health & Welfare Fund v. Merck-Medco Managed Care, L.L.C.*, 433
17 F.3d 181, 199 (2d Cir.2005); *Bank America Pension Plan v. McMath*, No. C 97-3242 CRB, 2001
18 WL 263290, at *9 (N.D. Cal. March 5, 2001)). “[T]he irreducible constitutional minimum of
19 [Article III] standing” contains three elements, namely, “[t]he plaintiff must have (1) suffered an
20 injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that is
21 likely to be redressed by a favorable judicial decision.” *Spokeo, Inc. v. Robins*, 136 S. Ct. 1540,
22 1547 (2016) (citing *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992)).

23 “To establish injury in fact, a plaintiff must show that he or she suffered ‘an invasion of a
24 legally protected interest’ that is ‘concrete and particularized’ and ‘actual or imminent, not
25 conjectural or hypothetical.’” *Id.* at 1548 (quoting *Lujan*, 504 U.S. at 560). In *Spokeo*, the Court
26 emphasized that concreteness and particularization are separate requirements. “For an injury to be
27 ‘particularized,’ it ‘must affect the plaintiff in a personal and individual way.’” *Id.* at 1548
28 (quoting *Lujan*, 504 U.S. at 560 n. 1). Even where this requirement is met, however, the injury-in-

1 fact requirement will not be satisfied unless the injury is also concrete. *Id.* “A ‘concrete’ injury
2 must be ‘*de facto*’; that is, it must actually exist.” *Id.* (citing Black’s Law Dictionary 479 (9th ed.
3 2009)). An injury may be “concrete” even if it is intangible, the *Spokeo* Court explained, and “in
4 determining whether an intangible harm constitutes injury in fact, both history and the judgment of
5 Congress play important roles.” *Id.* at 1549. With respect to history, the Court said, “it is
6 instructive to consider whether an alleged intangible harm has a close relationship to a harm that
7 has traditionally been regarded as providing a basis for a lawsuit in English or American courts.”
8 *Id.* (citing *Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 529 U.S. 765,
9 775-777 (2000)). The judgment of Congress is also “instructive and important” because
10 “Congress is well positioned to identify intangible harms that meet minimum Article III
11 requirements.” *Id.* Thus, “Congress has the power to define injuries and articulate chains of
12 causation that will give rise to a case or controversy where none existed before.” *Id.* (quoting
13 *Lujan*, 504 U.S. at 580 (Kennedy, J., concurring)).

14 Nonetheless, “Congress’ role in identifying and elevating intangible harms does not mean
15 that a plaintiff automatically satisfies the injury-in-fact requirement whenever a statute grants a
16 person a statutory right and purports to authorize that person to sue to vindicate that right.” *Id.* at
17 1549. Thus, while a procedural violation “can be sufficient in some circumstances to constitute
18 injury in fact,” for example, where there is a “risk of real harm,” a “bare procedural violation,
19 divorced from any concrete harm” does not “satisfy the injury-in-fact requirement of Article III.”
20 *Id.* (emphasis added).

21 The harm Plaintiffs rely upon in support of standing on their claims is the denial of their
22 rights to Guidelines that were developed for their benefit and to a fair adjudication of their claims.
23 While intangible, the Supreme Court has suggested that such harms may be cognizable under
24 ERISA. *See CIGNA Corp. v. Amara*, 563 U.S. 421, 423 (2011) (explaining that while “a fiduciary
25 can be surcharged under § 502(a)(3) only upon a showing of actual harm, . . . such harm . . .
26 might come from the loss of a right protected by ERISA or its trust-law antecedents.”). Certainly,
27 these violations do not appear to be the sort of “bare procedural violation[s] divorced from any
28 concrete harm” that are insufficient to establish Article III standing under *Spokeo*. Rather, the

1 Guidelines that are at the heart of Plaintiffs’ claims were used to deny Plaintiffs’ claims for
2 coverage, allegedly due to flaws that resulted from UBH’s failure to adhere to its duties to plan
3 members as a fiduciary. This undisputed fact points to the conclusion that the rights allegedly
4 denied implicate a “risk of real harm.”

5 Further, with respect to Plaintiffs’ request for injunctive relief, there is a significant body
6 of case law that supports the conclusion that Plaintiffs need not demonstrate an actual loss to have
7 standing to seek injunctive relief under 29 U.S.C. § 1132(a)(3). *See Horvath v. Keystone Health*
8 *Plan E., Inc.*, 333 F.3d 450, 455 (3d Cir. 2003); *Cent. States Se. & Sw. Areas Health & Welfare*
9 *Fund v. Merck-Medco Managed Care, L.L.C.*, 433 F.3d 181, 199 (2d Cir. 2005); *Slack v. Int’l*
10 *Union of Operating Engineers*, No. C-13-5001 EMC, 2014 WL 4090383, at *12 (N.D. Cal. Aug.
11 19, 2014) (finding that ERISA confers statutory standing to seek injunctive relief under 29 U.S.C.
12 § 1132(a)(3) and that a plaintiff need not experience an actual loss to have standing under Article
13 III to assert such a claim); *Wells v. California Physician’ Serv.*, No. C05-01229 CRB, 2007 WL
14 926490, at *3 (N.D. Cal. Mar. 26, 2007) (“courts hold that when plan participants seek injunctive
15 relief for violations of ERISA’s disclosure or fiduciary requirements, they can demonstrate Article
16 III standing by showing a violation of ERISA and need not prove actual injury”).

17 Therefore, the Court concludes that Plaintiffs have Article III standing as to both of the
18 claims they assert in this action.

19 **D. Surcharge Remedy**

20 Because Plaintiffs seek a surcharge as a restitutionary remedy based on disgorgement, the
21 Court looks to the principles of restitution in evaluating whether UBH is entitled to summary
22 judgment as to Plaintiffs’ surcharge remedy. The Court concludes that it is.

23 “The object of the disgorgement remedy - to eliminate the possibility of profit from
24 conscious wrongdoing - is one of the cornerstones of the law of restitution and unjust enrichment.”
25 Restatement (Third) of Restitution and Unjust Enrichment § 51, Comment e (2011). Because this
26 equitable remedy is aimed at preventing unjust enrichment on the part of the wrongdoer rather
27 than compensating the plaintiff for an actual loss, the claimant’s recovery “may potentially exceed
28 any loss to the claimant.” *Id.*, Comment a. The difficulty courts often face, however, is

1 determining “the net increase in the assets of the wrongdoer . . . that . . . is attributable to the
2 underlying wrong.” *Id.*

3 In this case the Court, based on Plaintiffs’ stipulation, limited Plaintiffs’ surcharge claim to
4 “the amount UBH was paid to process the claims that were denied.” Class Certification Order at
5 43. In opposing UBH’s summary judgment motion, however, Plaintiffs did not point to any
6 evidence that would allow the Court to reasonably determine the amount of UBH’s profits that is
7 attributable to the alleged wrongdoing, namely, applying flawed Guidelines to Plaintiffs’ claims.
8 Instead, Plaintiffs assert that they can establish the amount of the surcharge by presenting evidence
9 showing the amount UBH was paid to administer *all* of the class members’ claims, including
10 claims that may have been approved and claims that were denied but did not rely on the
11 Guidelines as the basis for the denial. The measure proposed by Plaintiffs would capture profit
12 that is not attributable to UBH’s creation of the challenged Guidelines and application of those
13 Guidelines to the class members’ claims for coverage. Further, Plaintiffs conceded at oral
14 argument that they have no expert testimony or other evidence that would allow the Court to make
15 a reasonable determination of the amount of the payments received by UBH that were attributable
16 to the alleged wrongful conduct by UBH.

17 The Court therefore concludes that UBH is entitled to summary judgment as to Plaintiffs’
18 request for a surcharge, which is dismissed with prejudice.

19 **E. Exclusion for Services Not Consistent with LOCs**

20 **1. Background**

21 UBH contends it is entitled to summary judgment in its favor with respect to all of the
22 claims asserted by named Plaintiffs and class members whose plans specifically exclude coverage
23 for services that are not consistent with UBH’s LOCs. Motion at 16-17. According to UBH, the
24 plans of all but three of the named Plaintiffs include such exclusions. *Id.* at 17. In particular,
25 according to UBH “[i]t is undisputed that the health plans applicable to Plaintiffs Wit (both David
26 and Natasha), Pfeifer, Holdnak, Muir, Tillitt, Alexander and Driscoll specifically exclude coverage
27 for treatment that is [n]ot consistent with [UBH’s] level of care guidelines or best practices as
28 modified from time to time.” *Id.* UBH contends these are separate and independent exclusions

1 that support UBH’s denial of coverage regardless of whether their Guidelines adhere to generally
2 accepted standards. *Id.*

3 Plaintiffs, on the other hand, argue that UBH’s reliance on the “guidelines exception” is
4 misplaced for several reasons. Opposition at 19. First, Plaintiffs point to the Court’s conclusion
5 in the Class Certification Order that “Plaintiffs had ‘demonstrated, as a factual matter, that the
6 insurance plans for the putative class members. . . require as a condition of coverage adherence to
7 generally accepted standards and/or state law.’” *Id.* at 19-20 (quoting Class Certification Order at
8 33). Plaintiffs note that the Court expressly found that UBH had pointed to “nothing in any plan
9 that would suggest that the ‘guidelines exception’ would permit insurance plans to adopt rules that
10 are inconsistent with those standards.” *Id.* at 20.

11 Second, if the Court were to reconsider this issue, Plaintiffs argue that there is “(at least) a
12 genuine dispute as to the effect of the exclusion.” *Id.* Plaintiffs contend UBH has simply focused
13 on a single phrase from these Plaintiffs’ plans, taken out of context. *Id.* When the exclusion is
14 read in light of the plan language as a whole, Plaintiffs assert, it is apparent that the Guidelines are
15 supposed to be consistent with generally accepted standards and therefore, that the guidelines
16 exception does not constitute a separate and independent basis for denying a claim for benefits.
17 *Id.*

18 With respect to the plans of named Plaintiffs Wit, Tillitt, Pfeifer, Alexander, and Driscoll,
19 Plaintiffs point to the definition of “Covered Health Services” in their plans, which “all inform
20 their members that UBH ‘maintain[s] clinical protocols that describe the . . . prevailing medical
21 standards and clinical guidelines supporting our determinations regarding specific services.’” *Id.*
22 (citing Reynolds Decl., Ex. 18 at 16; Ex. 22 at 11; Ex. 23 at 12; Ex. 24 at 12; Ex. 25 at 16). These
23 plans “define the phrase ‘[p]revailing medical standards and clinical guidelines’ to mean:
24 ‘nationally recognized professional standards of care including, but not limited to, national
25 consensus statements, nationally recognized clinical guidelines, and national specialty society
26 guidelines.’” *Id.* (quoting Reynolds Decl., Ex. 18 at 16; Ex. 22 at 11; Ex. 23 at 12; Ex. 24 at 12;
27 Ex. 25 at 16). As to these plans, Plaintiffs argue, “[r]eading the Guideline[s] Exclusion
28 consistently with the definition of Covered Services, . . . the Court could reasonably conclude that

1 the exclusion did not authorize UBH to adopt any guidelines it wants” but instead “merely
2 underscores that UBH will decide whether the services meet generally accepted standards by using
3 its Guidelines, which describe those standards.” *Id.* at 20-21.

4 The plan of Plaintiff Brian Muir also does not support UBH’s position, Plaintiffs argue,
5 because his plan does not contain the “Guideline[s] Exclusion,” instead containing a “garbled
6 paragraph” that excludes coverage for services that, in UBH’s reasonable judgment, are:

7 (4) Not consistent with [UBH’s] level of care guidelines or best
8 practices as duration of treatment, and considered ineffective for the
9 patient’s Mental Illness, substance use disorder or condition based
on generally accepted standards of medical practice and
benchmarks.

10 *Id.* at 21 (quoting Reynolds Decl., Ex. 21 at 12 (emphasis added)). Plaintiffs contend this
11 exclusion (if it “means anything”), “directly links UBH’s level of care guidelines with generally
12 accepted standards of care.” *Id.*

13 As to the Holdnak plan, Plaintiffs argue that “the exclusion cannot reasonably be
14 interpreted as authorizing UBH to adopt level of care guidelines that grossly restrict the coverage
15 otherwise provided by the Plan” because such an interpretation “would mean that UBH could
16 adopt any Guidelines it chose, subject to no limiting principle, even Guidelines that in effect
17 negated all or substantially all behavioral health coverage.” *Id.* Plaintiffs contend UBH’s own
18 witnesses testified that UBH cannot use the Guidelines to “rewrite the Plan” in this manner. *Id.*
19 (citing Reynolds Decl., Ex. 75 (Dehlin Dep.) at 128, 147, 149).

20 Finally, Plaintiffs argue that UBH’s “self-interested interpretation of the Guideline[s]
21 Exclusion runs afoul of ERISA, as well” because UBH is an ERISA fiduciary and therefore, was
22 “required to discharge its duties – including when it developed guidelines to standardize its Plan
23 interpretations – ‘solely in the interest of the participants and beneficiaries.’” *Id.* at 22 (quoting 29
24 U.S.C. § 1104(a)(1)). Moreover, Plaintiffs assert, under ERISA, “any provision in an agreement
25 or instrument which purports to relieve a fiduciary from responsibility or liability for any
26 responsibility, obligation, or duty under this part shall be void as against public policy.” *Id.*
27 (quoting 29 U.S.C. § 1110(a)). And Plaintiffs argue further that to the extent the Guidelines
28 Exclusion applies only to mental health and substance use disorders, these plan exclusions would

1 violate the Mental Health Parity Act under UBH’s interpretation. *Id.* at 22-23 (citing 29 U.S.C.
2 §1185a(a)(3)(A)(ii) (prohibiting “separate treatment limitations that are applicable only with
3 respect to mental health or substance use disorder benefits”); *id.* § 1104(a)(1)(D) (ERISA fiduciary
4 acts in accordance with plans only “insofar as such documents and instruments are consistent with
5 the provisions of this subchapter and subchapter III of this chapter,” which includes the Parity
6 Act)).

7 **2. Discussion**

8 At the class certification stage of the case, UBH argued that the commonality requirement
9 of Rule 23(a) was not satisfied based, in part on the “myriad exclusions and limitations that give
10 UBH discretion to deny coverage in certain circumstances even if the treatment is consistent with
11 generally accepted standards of care.” *Wit*, Dkt. No. 148 (UBH Opposition to Class Certification
12 Motion). As one example of this, it pointed to class member plans that “excluded coverage when
13 treatment is ‘not consistent with the Mental Health/Substance Use Disorder Designee’s level of
14 care guidelines or best practices as modified from time to time.’” *Id.* UBH argued that “[f]or
15 these members, UBH’s fiduciary duty to administer the plan in accordance with its terms is
16 entirely consistent with UBH’s application of its internal guidelines.” *Id.* The Court expressly
17 rejected that argument, however, stating in its Class Certification Order as follows:

18 The Court . . . rejects UBH’s reliance on the fact that some class
19 members’ health insurance plans excluded coverage for treatment
20 that is “not consistent with the Mental Health/ Substance Use
21 Disorder Designee’s level of care guidelines or best practices as
22 modified from time to time” (the “guidelines exception”). *See*
23 *Romano Decl.*, Ex. 71 (Health plan chart) at 6, 10, 20, 25). To the
extent it is undisputed that all Named Plaintiffs’ and Sample
Plaintiffs’ insurance plans incorporated generally accepted
standards, UBH has pointed to nothing in any plan that would
suggest that the “guidelines exception” would permit insurance
plans to adopt rules that are inconsistent with those standards.

24 Class Certification Order at 33.

25 As the Court has already found that under the named Plaintiffs’ plans the Guidelines
26 exception does not allow UBH to adopt standards that are inconsistent with generally accepted
27 standards, the Court declines to revisit that question here. Therefore, the Court denies UBH’s
28 request for summary judgment on this ground.

1 **F. Claims Asserted Under Texas Law**

2 **1. Background**

3 The *Wit* State Mandate Class covers denials governed by the laws of Texas, Illinois,
4 Connecticut and Rhode Island and is represented by Plaintiff Brandt Pfeiffer. UBH argues that it
5 is entitled to summary judgment with respect to any claims that rely on Texas state law because
6 the undisputed evidence reflects that “it has been UBH’s policy and practice to apply TDI
7 guidelines - not UBH guidelines - to coverage decisions for plans subject to Texas law for
8 the entire class period.” Motion at 18 (citing Romano MSJ Decl., Ex. 17 (Brennecke Depo.) at
9 115-118; *id.*, Ex. 2 (Triana MSJ Decl.) at 2).

10 In addition, UBH asserts, only two of the 110 sample coverage determinations produced in
11 this case were governed by Texas law and Plaintiffs have conceded that Texas law was applied in
12 both cases. *Id.* (citing Motion for Class Certification Order, Dkt. No. 133 at 13 n. 12 (noting that
13 the Claim Sample included some denials that “fell outside the Class definitions,” including “two
14 cases [in which] UBH used Texas Department of Insurance criteria to adjudicate the claims as
15 required under Texas state law for fully-insured plans” and identifying sample claimants as RTC-
16 21 and IOP-01); Reynolds Class Certification Decl., Dkt. No. 129-1, Ex. F (chart listing basic
17 information about named Plaintiffs and Sample Plaintiffs in the putative classes) at 3 (listing for
18 RTC-21, Sample ID No. 8873, noting that denial was based on Coverage Determination Guideline
19 for Treatment of Substance Use Disorders AND Texas Department of Insurance Chemical
20 Dependency Standard) and 9 (listing for IOP-01, noting that denial was based on Texas
21 Department of Insurance Chemical Dependency Standard)).

22 Plaintiffs counter that the question of whether UBH had a policy of applying Texas
23 regulations in adjudicating claims governed by Texas law at least raises questions of fact that
24 cannot be decided on summary judgment. Opposition at 23. According to Plaintiffs, UBH fails to
25 mention that the Sample Plaintiffs included at least one individual whose plan was governed by
26 Texas law and whose denial was based on UBH Guidelines rather than Texas law. *Id.* (citing
27 Reynolds Class Certification Decl., Dkt. No. 129-1, Ex. F, sample claimant RTC-29; Reynolds
28 Opposition Decl., Ex. 57 (denial letter to RTC-29)). Moreover, Plaintiffs assert, the agreed-upon

1 list of *Wit* State Mandate Class Members reflects that UBH applied its own Guidelines to “deny
2 coverage to hundreds of Members of Plans government by Texas Law.” *Id.* (citing Reynolds
3 Decl. ¶ 58 & Ex. 56 (chart listing agreed-upon members of *Wit* State Mandate Class) at 25; Ex.
4 73 (Bridge Dep.) at 82-85).

5 In its Reply brief, UBH argues that as a matter of law, it was not required to apply Texas
6 law to RTC-29 because that claim was for services outside of Texas. Reply at 14 (citing Romano
7 Reply Decl., Ex. 43 (RTC-29 Denial Letter)). UBH also rejects Plaintiffs’ reliance on the
8 information contained in the chart prepared by Plaintiffs’ counsel listing the members of the *Wit*
9 State Mandate Class. *Id.* at 15. In particular, UBH contends the information in this chart, which
10 was produced to Plaintiffs by UBH, merely reflects information stored in UBH’s computer system
11 in various data fields and does *not* show that TDI guidelines were not applied to the claims of
12 these class members. *Id.* (citing Reynolds Decl., Ex. 56). Further, UBH points to testimony of its
13 witnesses that while the systems UBH uses contain a field for the guideline referenced in the
14 denial letter, TDI guidelines must be entered manually and staff members typically enter a CDG or
15 LOC instead, even if the denial was based on TDI Guidelines. *See id.* Romano MSJ Decl., Ex. 1
16 (Bridge 4/28/2016 Decl.) ¶ 17; Ex. 45 (Bridge 6/22/2016 Decl.) ¶ 7. According to UBH, the
17 underlying clinical records show that it applies Texas law to claims for services in Texas and
18 Plaintiffs have not demonstrated the existence of material dispute of fact on this question because
19 they have offered no clinical records to counter UBH’s assertion that its policy is to apply Texas
20 law to services sought in Texas. *Id.*⁷

21 **2. Discussion**

22 The Court denies summary judgment as to claims of the *Wit* State Mandate Class governed
23 by Texas law. UBH has offered the testimony of witnesses Triana and Brennecke that its policy
24

25 ⁷ In a stipulation filed after briefing on the instant motion was complete the parties agreed that
26 “Texas law only applies to class members’ requests for coverage to the extent a class member is a
27 member of a fully-insured plan governed by Texas law, and where Texas law applies, it provides
28 for the application of Texas Department of Insurance guidelines only where the request for
coverage pertains to substance use disorder services sought or received in Texas.” *See* Dkt. No.
279.

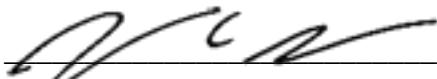
1 is to apply TDI Guidelines (rather than its own Guidelines) to claims governed by Texas law. On
2 the other hand, the records from UBH’s computer system reflect that UBH applied its own
3 Guidelines to claims governed by Texas law. While one UBH witness states that staff “typically”
4 entered CDGs and LOCs even when they in fact applied TDI Guidelines, that witness also states
5 that staff can manually enter the state standards that they actually relied upon. *See* Romano MSJ
6 Decl., Ex. 1 (Bridge Decl.) ¶ 17. Moreover, while UBH asserts that the underlying records show
7 that TDI Guidelines were used even though their computer records state that they were not, UBH
8 has not offered evidence based on these records conclusively establishing that all class member
9 claims that were governed by Texas law were evaluated under that law. Therefore, the Court finds
10 that there is a material dispute of fact as to what law was applied to claims that are governed by
11 Texas law. Accordingly, the Court denies UBH’s request for summary judgment as to the Texas
12 claims.

13 **IV. CONCLUSION**

14 For the reasons stated above, the Motion is GRANTED with respect to Plaintiffs’ claims to
15 the extent that they seek a surcharge remedy. The Motion is DENIED in all other respects.

16 **IT IS SO ORDERED.**

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18 Dated: August 14, 2017

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21 _____
22 JOSEPH C. SPERO
23 Chief Magistrate Judge
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