UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES - GENERAL

Case No.	ML 9-2074 PSG (FFMx)	Date	July 19, 2016
Title	In re Wellpoint, Inc., Out of Network "UCR" Rates Litigation		

Present: The Honorable	Philip S. Gutierrez, United States District Judge

Wendy Hernandez	Not Reported
Deputy Clerk	Court Reporter
Attorneys Present for Plaintiff(s):	Attorneys Present for Defendant(s):
Not Present	Not Present

Proceedings (In Chambers): **Order DENYING Plaintiff's Motion for Partial Summary Judgment and GRANTING Defendants' Motion for Summary Judgment**

Before the Court are Plaintiff Mary Cooper's motion for partial summary judgment and Defendants WellPoint, Inc.; Blue Cross of California; Anthem, Inc.; WellPoint Health Networks, Inc.; WellChoice, Inc.; WellChoice Insurance of New Jersey; Empire Blue Cross Blue Shield, Inc.; Anthem Health Plans of Virginia, Inc.; and Empire HealthChoice Assurance, Inc.'s motion for summary judgment. Dkts. #649, #652. After considering the arguments made at the hearing, as well as the moving, opposing, and reply papers, the Court DENIES Plaintiff Cooper's motion and GRANTS Defendants' motion.

I. Background

From 2001 to 2007, Plaintiff Mary Cooper ("Cooper") and her now-deceased husband Robert (collectively, "the Coopers") were insured by WellChoice Insurance of New Jersey under a WellChoice Small Group Health Benefits PPO Option C Policy issued through the Coopers' employer, Landmark I Appraisal, LLC. *See Haviland MSJ Mot. Decl.* ¶¶ 4, 8, Exs. A, E; *Answer to Fourth Consolidated Amended Complaint* ("*FCAC Ans.*") ¶¶ 27, 247–51; *Wells Decl.* ¶ 5, Exs. A–E; *Berge MSJ Mot. Decl.* ¶ 7, Ex. C ["Ds' Cooper Depo. Excerpts"] at 44:13–45:6, 53:9–17. The Coopers' insurance plan allowed them to use out-of-network ("OON") healthcare providers, with reimbursement based on a "reasonable and customary" standard. *See Wells Decl.*, Ex. A at 13, 21, 28, Ex. B. at 84; *see also Plaintiffs' Statement of Genuine Disputes in Opposition to Summary Judgment* ("*Ps' SGD*") at ¶ 13 ("Mrs. Cooper concedes there is no genuine issue that her plan provided for ONS reimbursement based on a 'Reasonable and Customary' standard.").[1] From 1992 to 2007, Plaintiff Darryl Samsell ("Darryl Samsell") and his three children were covered by Anthem Virginia under Blue Cross and Blue Shield

[1] OON is also referred to as out-of-network services ("ONS"). *See, e.g.*, Dkt. #389 (July 19, 2013 order).

Comprehensive Major Medical and Dental Policy No. 226767971. *See Ward Decl.* ¶ 2, Exs. A–D. Darryl Samsell's insurance plan allowed him and his children to use OON healthcare providers, with reimbursement based on the lesser of "the Company's allowance for a specified Covered Service or the Provider's charge for that service" (referred to as the "Allowable Charge"). *Ward Decl.* ¶ 3, Ex. A at 11, 14–15, 41, Ex. B at 52–53, 57–58.

Darryl Samsell and his wife, Plaintiff Valerie Samsell ("Valerie Samsell," collectively, "the Samsells") brought suit against Defendants WellPoint, Inc., WellPoint Health Networks, Inc., and Anthem, Inc. in February 2009 in the District of New Jersey. *See Darryl Samsell, et al. v. WellPoint, Inc., et al.*, CV 9-6079 PSG (FFMx), Dkt. #1 (C.D. Cal. Feb. 13, 2009); *Ds' MSJ Mot.* 3. In April 2009, Plaintiffs filed an amended complaint that added Cooper, individually and on behalf of the estate of her husband, and former party Ivy Seigle-Epstein. CV 9-6079, Dkt. #21; *Ds' MSJ Mot.* 3.[2] This lawsuit, along with a number of other lawsuits filed by subscribers, providers, and medical associations during the same period, challenged certain insurance companies' (the "WellPoint Defendants") policies for reimbursement of OON services. *See* Dkt. #1 (JPML Aug. 2009 Order).[3] In August 2009, these lawsuits were all sent to this Court (where three of the lawsuits were pending) by the United States Judicial Panel for Multidistrict Litigation ("JPML") for coordinated or consolidated pretrial proceedings under the name "In re: Wellpoint, Inc. Out-of-Network 'UCR' Rates Litigation." *Id.*[4]

In November 2009, the plaintiffs in the multidistrict litigation case ("MDL Plaintiffs") filed a consolidated complaint. Dkt. #12. Over the next several years, the parties filed a series of amended complaints and motions to dismiss. *See* Dkts. #36–37, 105, 107, 113, 124, 134, 142, 243, 274, 304–05, 322–23, 365, 373, 379–80, 389. The operative complaint, the Fourth Consolidated Amended Complaint ("FCAC"), was filed on November 5, 2012. Dkt. #373. On July 19, 2013, the Court granted in part and denied in part WellPoint Defendants' motions to dismiss. Dkt. #389 ("7/19/13 Order"). The Court allowed a few claims to survive, including an Employee Retirement Income Security Act ("ERISA") claim under 29 U.S.C. § 1132(a)(1)(B) for unpaid benefits for Subscriber Plaintiffs (which included Cooper), and the Samsells' claim

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[2] The Court will refer to Cooper and the Samsells collectively as "Plaintiffs."

[3] The remaining WellPoint Defendants are WellPoint, Inc.; Blue Cross of California; Anthem, Inc.; WellPoint Health Networks, Inc.; WellChoice, Inc.; WellChoice Insurance of New Jersey; Empire Blue Cross Blue Shield, Inc.; Anthem Health Plans of Virginia, Inc.; and Empire HealthChoice Assurance, Inc.

[4] "UCR" refers to a system in which reimbursement rates for provider services are calculated based on the usual, customary, and reasonable rates for those services. *See Berge MSJ Mot. Decl.*, Ex. 10 ["Frech Expert Report"] at 22–34.

for breach of the implied covenant of good faith and fair dealing. *Id.* In November 2013, Cooper, the Samsells, and the remaining MDL Plaintiffs filed a motion for class certification for viable claims from the FCAC. Dkt. #414. On September 3, 2014, the Court denied class certification. Dkt. #549.

In the period since the denial of class certification, all plaintiffs other than the Samsells and Cooper have been dismissed. *See* Dkt. #645 (Order Denying Renewed Motion for Suggestion of Remand); *Ds' MSJ Mot.* 1. On March 4, 2016, Cooper filed a motion for partial summary judgment on her ERISA claim. Dkt. #649. That same day, WellPoint Defendants filed a motion for summary judgment on all claims. Dkt. #652.

II. Legal Standard

A motion for summary judgment must be granted when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). A disputed fact is material if it might affect the outcome of the suit under the governing law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

A party seeking summary judgment bears the initial burden of informing the court of the basis for its motion and identifying those portions of the pleadings and discovery responses which demonstrate the absence of a genuine issue of material fact. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). If the nonmoving party will have the burden of proof at trial, the movant can prevail by pointing out that there is an absence of evidence to support the nonmoving party's case. *See id.* If the moving party meets its initial burden, the nonmoving party must set forth, by affidavit or as otherwise provided in Rule 56, "specific facts showing that there is a genuine issue for trial." *Anderson*, 477 U.S. at 250.

In judging evidence at the summary judgment stage, the court does not make credibility determinations or weigh conflicting evidence. Rather, it draws all inferences in the light most favorable to the nonmoving party. *See T.W. Elec. Serv., Inc. v. Pac. Elec. Contractors Ass'n*, 809 F.2d 626, 630–31 (9th Cir. 1987). The evidence presented by the parties must be admissible. Fed. R. Civ. P. 56(e). Conclusory, speculative testimony in affidavits and moving papers is insufficient to raise genuine issues of fact and defeat summary judgment. *See Thornhill Pub. Co., Inc. v. GTE Corp.*, 594 F.2d 730, 738 (9th Cir. 1979).

III. Discussion

A. Cooper

Cooper's remaining cause of action is an ERISA claim for unpaid benefits for OON services under 29 U.S.C. § 1132(a)(1)(B). Cooper argues that WellPoint Defendants improperly reduced her OON benefits via two mechanisms: "(1) undisclosed exceptions which had the effect of reducing Mrs. Cooper's ONS payments at the claim level, and (2) employment of low OON rates based upon Ingenix data." *Ps' MSJ Opp.* 8; *see also P's MSJ Mot.* 2 n.2.[5] Cooper moves for summary judgment solely on the former theory; she argues that "the myriad of disputed issues of fact surrounding [WellPoint Defendants]'s use of Ingenix rates" makes summary judgment on that theory inappropriate. *Id.* WellPoint Defendants argue that summary judgment in their favor is proper under either theory because Cooper lacks standing. *D's MSJ Mot.* 11–13; *Ds' MSJ Opp.* 18–19.[6]

[5] "Ingenix data" refers to a set of data used by WellChoice (among others) in setting the reimbursement rate for OON services. *See Frech Expert Report* at 34–38. Cooper believes that the Ingenix data is flawed and leads to impermissibly low reimbursement rates. *See generally FCAC*.

[6] Cooper repeatedly argues that WellPoint Defendants' motion is solely based on the second theory of liability (Ingenix), and that WellPoint Defendants have waived any challenge at the summary-judgment stage as to the first theory (undisclosed exceptions). S*ee Ps' MSJ Opp.* 8, 22–23. This argument is disingenuous because WellPoint Defendants specifically address this theory in their motion for summary judgment:

> Defendants note that Cooper's expert also calculated "damages" based on a brand-new theory of liability never before asserted in seven years of litigation—that WellChoice applied undisclosed multiple surgery and multiple services reductions or 'edits' to certain of her OON claims. According to Cooper's expert, this resulted in, at most, $184.77 in damages before pre-judgment interest. Cooper cannot proceed to trial on those claims because they are nowhere alleged in the FCAC and were never pursued in this case. Should Cooper press these claims on summary judgment, Defendants will explain in their opposition to Cooper's summary judgment motion and/or their reply in support of this motion the multiple reasons those claims fail.

Ds' MSJ Mot. 19 n.6 (citations omitted). In their opposition to Cooper's partial motion for summary judgment, WellPoint Defendants make a nearly identical standing challenge. *See Ds' MSJ Opp.* 18–19. The Court thus believes that WellPoint Defendants have adequately challenged all of Cooper's claims on standing grounds.

"At the core of the Article III case-or-controversy requirement is the doctrine of standing." *Habeas Corpus Res. Ctr. v. U.S. Dep't of Justice*, 816 F.3d 1241, 1248 (9th Cir. 2016). The "irreducible constitutional minimum of standing" requires the establishment of three elements—injury in fact, causation, and redressability. *Id.*; *see also Nw. Requirements Utilities v. F.E.R.C.*, 798 F.3d 796, 804–05 (9th Cir. 2015). "A plaintiff can establish injury in fact by showing that he suffered 'an invasion of a legally protected interest which is (a) concrete and particularized; and (b) actual or imminent, not conjectural or hypothetical.'" *Hajro v. U.S. Citizenship & Immigration Servs.*, 811 F.3d 1086, 1102 (9th Cir. 2016) (quoting *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992)). The burden is on the plaintiff to establish standing. *See Ctr. for Biological Diversity v. U.S. Fish & Wildlife Serv.*, 807 F.3d 1031, 1043 (9th Cir. 2015) ("As the plaintiff in the underlying action, CBD has the burden of proving the existence of Article III standing at all stages of the litigation."); *Paulsen v. CNF Inc.*, 559 F.3d 1061, 1072 (9th Cir. 2009) (stating that the employee plaintiffs must satisfy the standing requirements in a suit against ERISA fiduciary defendants); *accord N. Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, 781 F.3d 182, 191 (5th Cir. 2015) ("North Cypress appeals the district court's rejection of its ERISA claims for lack of standing. As the party invoking federal jurisdiction, North Cypress bears the burden of showing that it has standing to assert a legal claim for each of the benefit claims at issue."). "At the summary judgment stage, the plaintiff can no longer rest on mere allegations but must set forth by affidavit or other evidence specific facts, which for purposes of the summary judgment motion will be taken to be true." *Hajro*, 811 F.3d at 1102 (alterations and internal quotation marks omitted) (quoting *Lujan*, 504 U.S. at 561).

Cooper's claims are premised on the assertion that WellChoice employed methodologies that improperly reduced the amount of money she received as reimbursement for OON services. *See Ps' MSJ Mot.* 3–17; *Ps' MSJ Opp.* 22–29. WellPoint Defendants argue that Cooper can only demonstrate the requisite injury in fact for her ERISA claim if she either has been billed or will likely be billed by the OON provider for the difference between the actual cost of the services and the amount of reimbursement offered by WellChoice (which is known as "balance billing"). *Ds' MSJ Mot.* 11; *see Berge MSJ Mot. Decl.*, Ex. 10 ["Frech Expert Report"] at 24 ¶ 28 ("In a UCR system, the physician contractually agrees to accept the allowed charge as payment in full and, therefore, not to bill the patient for amounts beyond the UCR level of fees. Billing for amounts above the UCR is called 'balance billing' in the U.S."). Plaintiffs do not challenge WellPoint Defendants' definition of injury in fact.

Multiple courts have also held similarly. *See, e.g.*, *Bryant v. Am. Seafoods Co.*, 348 F. App'x 256, 257 (9th Cir. 2009) ("Because the seamen did not receive balance bills from their medical providers until after they filed their third amended complaint, the seamen had suffered no injury-in-fact at the time the third amended complaint was filed and therefore lacked standing

to bring their complaint."); *Am. Med. Ass'n v. United HealthCare Corp.*, No. 00 CIV. 2800 (LMM), 2007 WL 1771498, at *18–19 (S.D.N.Y. June 18, 2007) (holding that the plaintiffs lacked standing for claims (other than those for fiduciary duty seeking injunctive relief) where the plaintiffs never suffered or faced the threat of suffering out-of-pocket expenses); *Owen v. Regence Bluecross Blueshield of Utah*, 388 F. Supp. 2d 1318, 1325–26 (D. Utah 2005) ("The threat that KCI may attempt to collect, more than four years after the debt was incurred and in the face of evidence to the contrary, is not so imminent as to confer standing."). At least one court, however, has found that the mere award of an improperly low reimbursement is a sufficient injury for standing purposes. *See Prof'l Orthopedic Assocs., Pa., Cohen v. Horizon Blue Cross Blue Shield of N.J.*, No. CIV.A. 14-4731 SRC, 2015 WL 5455820, at *2 (D.N.J. Sept. 16, 2015) ("Taking the Complaint's factual allegations as true, injury in fact occurred when Horizon determined reimbursement for the claim related to Dr. Cohen's surgical services in an amount that gave P.G. a lesser benefit than the health care plan entitled her to receive.").

The Court agrees with WellPoint Defendants that the existence (or likely future existence) of balance billing is needed to confer injury in fact. An improperly low OON reimbursement from an insurer means that an insured will owe more money to the OON provider than he or she should under the insurance contract. But until an insured is actually or will likely be billed this amount by the OON provider, he or she experiences no risk of out-of-pocket loss from the improperly low reimbursement. *See Am. Med. Ass'n*, 2007 WL 1771498, at *18; *Owens*, 388 F. Supp. 2d at 1325–26. The Court also agrees with the *American Medical Association* court that other possible injuries arising from an award of improperly low benefits, including an injury to contract expectations and an injury to the relationship between an insured and his or her OON provider, are insufficient for standing purposes. *See* 2007 WL 1771498, at *18. The Court thus respectfully disagrees with the *Professional Orthopedic* court's determination that an improperly low reimbursement award alone is sufficient for injury in fact. *See Clapper v. Amnesty Int'l USA*, 133 S. Ct. 1138, 1147 (2013) ("Thus, we have repeatedly reiterated that threatened injury must be *certainly impending* to constitute injury in fact, and that allegations of *possible* future injury are not sufficient." (alteration and internal quotation marks omitted)); *Warth v. Seldin*, 422 U.S. 490, 501 (1975) (explaining that an injury must be "distinct and palpable").[7]

[7] In *Spinedex Physical Therapy USA Inc. v. United Healthcare of Arizona, Inc.*, the Ninth Circuit held that providers who were assigned the rights to benefits from their patients had standing to sue for unpaid benefits from the insurers, even if the providers had not sought or were not seeking reimbursement from the patients. 770 F.3d 1282, 1288–91 (9th Cir. 2014), *cert. denied sub nom. United Healthcare of Ariz. v. Spinedex Physical Therapy USA, Inc.*, 136 S. Ct. 317 (2015). The Ninth Circuit explained that "[a]s assignee, Spinedex took from its assignors what they had at the time of the assignment," and that "[a]t the time of the assignment, Plan beneficiaries had the legal right to seek payment directly from the Plans for charges by non-network health care providers." *Id.* at 1291. *Spinedex* does not address, however, whether a

The question is thus whether Cooper can establish that she has or will likely be balance billed by her providers in light of the reimbursements provided by WellChoice. Cooper's ERISA claim is based on nineteen instances from which she is allegedly owed unpaid benefits. *See Frech Expert Report* at 44 ¶ 60, Ex. 6; *Oluwasanmi Decl.* ¶¶ 3–4, Exs. 1–15 (WellChoice Explanation-of-Benefit forms). Eighteen of these OON service claims were for laboratory services rendered by Nationwide Lab Services. *See Frech Expert Report*, Ex. 6; *Oluwasanmi Decl.*, Exs. 1–14. The final OON service claim was for a surgical service rendered by Vohra Health Services PA. *See Frech Expert Report*, Ex. 6; *Oluwasanmi Decl.*, Ex. 15. WellPoint Defendants argue that Cooper cannot meet her burden to establish standing because she has failed to adduce any evidence of balance billing (either in the form of bills or receipts), could not recall whether she had ever been balance billed by Nationwide Lab or Vohra when questioned at her deposition, and has produced no evidence that balance billing is likely to occur in the future. *See Ds' MSJ Mot.* 12–13; *Ds' Cooper Depo. Excerpts* at 225:1–9, 233:10–13. WellPoint Defendants also note that the statutory limitations periods have long since passed for providers to pursue payment from Cooper. *See Ds' MSJ Mot.* 12–13 (citing N.J. Stat. Ann. § 2A:14-1). Finally, WellPoint Defendants argue that Cooper lacks standing for injunctive and declaratory relief because her insurance with WellPoint Defendants ceased prior to filing suit. *See Ds' MSJ Mot.* 13 n.4 (citing *Nechis v. Oxford Health Plans, Inc.*, 421 F.3d 96, 101 (2d Cir. 2005)).

Plaintiffs solely challenge WellPoint Defendants' assertion that Cooper has failed to establish that she has been balance billed, arguing that there is at least a disputed issue of fact as to whether such billing occurred. *See Ps' MSJ Opp.* 10–12. Plaintiffs base this challenge on a series of exchanges from Cooper's deposition:

> Q. Do you see the second sentence, "WellChoice inhibited the Coopers use of ONS providers by artificially low UCRs, **thereby increasing unpaid amounts for which the Coopers were liable**." Do you see that sentence?
>
> A. Yes, uh-huh.
>
> Q. **Do you have an understanding as to what that allegation means?**

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beneficiary or insured who has not assigned his or her rights has standing to sue for unpaid benefits if there is no threat of charge from the provider. *Cf. HCA Health Servs. of Ga., Inc. v. Emp'rs Health Ins. Co.*, 240 F.3d 982, 991 (11th Cir. 2001) ("One of our reasons for allowing provider-assignees derivative standing is so that providers will not balance bill participants, thereby requiring participants to bring suit against their insurance company for unpaid benefits.").

A. **Well, it means that they didn't pay the -- the fair amount, and we were liable to pay the balance**.

Q. Do you have an understanding as to what the portion of the sentence is that says "WellChoice inhibited the Coopers' use of ONS providers"? Do you have an understanding of that sentence?

A. **Well, just that they didn't pay. And then we were liable—**

Q. Okay.

A. **--for the balance.**

* * *

Q. Do you have any understanding as to what the thousands of dollars in out-of-pocket expenditures represents?

A. Well, I gave whatever I had to my attorneys, and they were the ones who calculated.

Q. Do you have any understanding as to whether the thousands of dollars in out-of-pocket expenditures could represent -- could include coinsurance payments?

A. I don't understand that.

Q. Do you have any understanding as to whether the out-of-pocket expenditures could include expenses for services that were denied for medical necessity reasons?

MR. DONOHUE: Objection to the form.

A. I don't recall.

Q. The out-of-pocket expenditures, do you have any understanding as to whether that represents payments that you actually made in 2005?

A. **I -- I paid. I got bills and I paid some. I don't remember which ones, but I did.**

Q. Do you know whether the thousands of dollars in out-of-pocket expenditures could include amounts that you may have been responsible for, but didn't actually pay?

MR. DONOHUE: Objection to the form.

A. I don't know. I gave my attorneys everything they, you know -- that -- I don't know.

* * *

Q. After that, after you learned that those services from Morris Heart Associates were rendered on an out-of-network basis, did you understand that you could be billed for amounts not covered by WellChoice?

A. **When I was paying out-of-network**, I thought that they would pay the doctor for whatever bills had to be paid, **since I was paying for their service**. I just thought that they would pay whatever.

Q. Okay. So you didn't understand that you could be billed by a provider for differences between -- between the allowed amount and the billed amount?

A. Okay. Pertaining to Dr. Barton right now? We are pertaining to Dr. Barton?

Q. Yeah, yes.

A. Oh, okay. I just thought that he would be paid.

Q. Because you thought he was par?

A. Because I thought what?

Q. Because you thought he was par, or because you thought that out-of-network would be paid in full?

A. That out-of-network would pay him in full.

Q. Okay. **There came a point where you understood that you could be billed for amounts that weren't covered by WellChoice; correct?**

A. **Uh-huh.**

MR. DONOHUE: Objection to the form.

Q. Is that yes?

A. Well, when I started to understand the situation is when **I started to pay doctors from the hospital**. It is then I really started to understand. Otherwise, I -- it was hard to -- to look at that book and understand the whole thing, you know.

Q. Do you recall paying Morris Heart Associates?

A. Well, **I got bills, and whatever bills I had received, I paid**. I don't know exactly what I paid Dr. Barton.

* * *

Q. **You stated that you made payments for out-of-network services; correct?**

A. **Yes.**

Q. How did you make the payments? And what I mean is: Was it through a checking account or a credit card?

A. I don't remember at the time how I paid them.

Q. Could it have been through a checking account?

A. It could have been.

Q. Could it have been through a credit card?

A. It could have been.

Q. Have you contacted any banks or credit card companies to obtain records relating to payments for services in this litigation?

A. No, no, I have not.

Ps' MSJ Opp. 11–14 (quoting *Haviland MSJ Opp. Decl.*, Ex. C ["Cooper Depo."] at 72:2–21, 75:15–76:16, 139:13–140:24, 141:19–142:9). Plaintiffs state that Cooper "clearly testified that not only was she balance billed for her husband's OON services, but that she paid any and all such bills which were sent to her," and "clearly testified that whatever proof she had in her

possession of her payment of balance bills were turned over and produced in this matter." *Id.* 14.

The Court does not share Plaintiffs' assessment of Cooper's deposition testimony. To survive the motion for summary judgment, Plaintiffs must, at a minimum, establish that there is a genuine issue of fact as to whether Cooper was balance billed for the nineteen OON services at issue. But even when considered in the light most favorable to Plaintiffs, *see Lowry v. City of San Diego*, 818 F.3d 840, 846 (9th Cir. 2016), Cooper's deposition testimony fails to meet this standard. First, much of the cited testimony merely addresses Cooper's understanding of her pleaded claims. *See, e.g.*, *Cooper Depo.* at 72:8–12 ("Q. Do you have an understanding as to what that allegation means? A. Well, it means that they didn't pay the -- the fair amount, and we were liable to pay the balance."). Second, nothing in the cited testimony ameliorates Cooper's statements that she could not recall whether she had received or paid balance bills from Nationwide Lab or Vohra. *See Fed. Election Comm'n. v. Toledano*, 317 F.3d 939, 950 (9th Cir. 2002) ("[F]ailure to remember and lack of knowledge are not sufficient to create a genuine dispute."). Although the testimony does appear to discuss balance bills related to a Morris Heart Associates, a Dr. Barton, and an unnamed hospital, *see Cooper Depo.* at 141:19–142:9, the Court is not aware of any evidence tying these physicians or entities to Nationwide Lab or Vohra. *See Ds' MSJ Reply* 5 ("In the third excerpt, Cooper testified that she recalled making payments for unspecified amounts ***to a provider that did not render the healthcare services for any of the 19 OON claims.***").

Third, Plaintiffs place great emphasis on Cooper's statements that she received and paid bills related to OON services. At best, these statements create a genuine dispute of fact as to whether Cooper received or paid balance bills for OON services at some point while covered by WellChoice. But Cooper is not challenging every reimbursement for OON services, so the mere fact that she may have received or paid a balance bill is insufficient. Rather, she must establish that she paid or received a balance bill related to the nineteen claims at issue. The Court does not believe Cooper's vague, general statements about being billed create a genuine dispute of fact regarding balance bills for any of these nineteen claims, especially when, as discussed above, Cooper discusses OON services beyond those that form the basis for her ERISA claim. Moreover, it is not even clear that Cooper is referring to *balance* bills in her testimony; as WellPoint Defendants explain, there are a number of legitimate reasons that Plaintiff could be billed for OON services, including coinsurance or deductible payments. *Ds' MSJ Opp.* 19; *Ds' MSJ Reply* 5.[8]

[8] At the hearing, Plaintiffs' attorney argued that Cooper's statements about paying all bills received should be understood as statements that Cooper paid her providers the full amounts listed on the explanation-of-benefits forms she received, which would include the nineteen claims at issue. Plaintiffs base this on an affirmative response from Cooper when asked if her

Finally, the Court is not entirely sure of the relevance of Plaintiffs' statement that Cooper "clearly testified that whatever proof she had in her possession of her payment of balance bills were turned over and produced in this matter." The burden to establish standing is clearly on Plaintiffs, *see Ctr. for Biological Diversity*, 807 F.3d at 1043; *Paulsen*, 559 F.3d at 1072, so the question is whether Cooper has evidence sufficient to create a genuine dispute as to injury in fact, not whether she did her best to show standing. Similarly, Plaintiffs' statement that "WellPoint has failed to provide any evidence of a *lack of* balance bills, or any proof of *lack of* payment for such bills by Mrs. Cooper" ignores that the burden to establish standing is on Plaintiffs, not WellPoint Defendants. The Court thus finds that Cooper lacks standing to bring the ERISA claim because Plaintiffs failed to create a genuine dispute of fact as to whether Cooper received or paid any balance bills related to the nineteen OON claims at issue. *See Am. Med. Ass'n*, 2007 WL 1771498, at *18–19; *Owen*, 388 F. Supp. 2d at 1325–26.[9]

Plaintiffs request that they be allowed limited discovery if the Court finds the present record insufficient to create a genuine dispute of fact. Federal Rule of Civil Procedure 56(d) states:

> **When Facts Are Unavailable to the Nonmovant**. If a nonmovant shows by affidavit or declaration that, for specified reasons, it cannot present facts essential to justify its opposition, the court may:
>
> (1) defer considering the motion or deny it;
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> (2) allow time to obtain affidavits or declarations or to take discovery; or
>
> (3) issue any other appropriate order.

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statements about bills referred to explanation-of-benefits forms. *See Cooper Depo.* at 28:5–20. The Court finds this argument unpersuasive. The explanation-of-benefits forms for the nineteen claims specifically state: "**THIS IS NOT A BILL**." *Oluwasanmi Decl.*, Exs. 1–9, 11–15. And, perhaps more importantly, Cooper could not recall if she had done anything other than endorse the checks that came with the explanation-of-benefits forms. *See Cooper Depo.* at 234:8–20. This testimony is thus insufficient to meet Plaintiffs' burden of showing that Cooper paid additional amounts out of pocket to her providers for the nineteen claims at issue.

[9] WellPoint Defendants also argue that Cooper failed to exhaust her administrative remedies, Cooper's undisclosed exceptions theory is barred because it was not pleaded in the FCAC, and Cooper's claim fails on the merits. *See Ds' MSJ Mot.* 13–26; *Ds' MSJ Reply* 8–26; *Ds' MSJ Opp.* 13–18, 20–38. The Court need not consider these arguments in light of its determination that Cooper lacks standing.

Plaintiffs believe such additional discovery is appropriate because WellPoint Defendants waited "until long after the close of discovery to raise an issue of payment for balance bills as 'uncontested,'" so Plaintiffs would need limited discovery to try to subpoena paper records of bills or payment from Cooper's OON providers, credit card companies, and/or banks that would show evidence of balance bills. *See Rule 56(d) Affidavit* ¶¶ 17–28, 45–46.

The Court does not believe that additional discovery is appropriate or warranted. Rule 56(d) relief is only warranted if "the movant diligently pursued its *previous* discovery opportunities," and "the movant can show how allowing *additional* discovery would have precluded summary judgment." *Qualls By & Through Qualls v. Blue Cross of Cal., Inc.*, 22 F.3d 839, 844 (9th Cir. 1994); *see also Pfingston v. Ronan Eng'g Co.*, 284 F.3d 999, 1005 (9th Cir. 2002); *Nordstrom, Inc. v. Chubb & Son, Inc.*, 54 F.3d 1424, 1436 (9th Cir. 1995), *as amended* (Aug. 1, 1995). This case has been active for more than seven years (with multiple years of discovery), and Cooper has been on alert since at least her deposition in 2011 that WellPoint Defendants were investigating whether she had actually been balance billed. Plaintiffs blame Cooper's failure to conduct the appropriate discovery in part on the appointed lead counsel, *see Rule 56(d) Affidavit* ¶ 27, but gloss over that Cooper has had ample additional time to try to get this evidence. Further, it is a "rigid constitutional requirement that plaintiffs must demonstrate an injury in fact to invoke a federal court's jurisdiction." *Lopez v. Candaele*, 630 F.3d 775, 785 (9th Cir. 2010) (quoting *Dream Palace v. Cty. of Maricopa*, 384 F.3d 990, 999 (9th Cir. 2004)). The Court thus finds unpersuasive an argument that Plaintiffs were somehow ambushed by WellPoint Defendants' standing arguments. And, as Plaintiffs themselves seem to admit, it is not at all clear that limited discovery would turn up any additional material. *See Rule 56(d) Affidavit* ¶ 24.

The Court thus finds that Cooper lacks standing to bring her ERISA claim. The Court therefore denies her motion for partial summary judgment and grants summary judgment in WellPoint Defendants' favor.

B. The Samsells

The Samsells sole remaining claim is for breach of the implied covenant of good faith and fair dealing for unpaid benefits from the Anthem Virginia plan. WellPoint Defendants argue that summary judgment should be granted in their favor because: (1) the Samsells lack standing to bring their claims, and (2) their claims are time-barred. *See Ds' MSJ Mot.* 26–30. Although the Court agrees with Plaintiffs that there is a genuine dispute of fact as to standing, it agrees

with WellPoint Defendants that summary judgment in their favor is proper because the Samsells' claim is untimely.[10]

i. Standing

The Court must first begin by addressing WellPoint Defendants' standing argument. *See Equity Lifestyle Props., Inc. v. Cty. of San Luis Obispo*, 548 F.3d 1184, 1189 n.10 (9th Cir. 2008) ("The jurisdictional question of standing precedes, and does not require, analysis of the merits."); *accord City of San Jose v. Office of the Com'r of Baseball*, 776 F.3d 686, 692 (9th Cir.), *cert. denied sub nom. City of San Jose, Cal. v. Office of the Com'r of Baseball*, 136 S. Ct. 36 (2015); *Maya v. Centex Corp.*, 658 F.3d 1060, 1068 (9th Cir. 2011). WellPoint Defendants contend that the Samsells lack standing because they cannot establish that they retained the right to sue. *Ds' MSJ Mot.* 26–28. Specifically, WellPoint Defendants argue that the record evidence indicates that the Samsells assigned their rights to their OON providers. *Id.* 27–28. As the Court previously explained, "[o]nce a claim has been assigned, . . . the assignee is the owner and the assignor generally lacks standing to sue on it." Dkt. #365 ["9/6/12 Order"] at 8; *see also Ds' MSJ Mot.* 27.

The Court agrees with the Samsells that there is at least a disputed issue of fact as to whether they assigned their claims (and thus lack standing). *See Ps' MSJ Opp.* 29–33. At their depositions, neither Samsell could affirmatively state that they retained benefits. *See Berge MSJ Mot. Decl.*, Ex. 7 ["Ds' D. Samsell Depo. Excerpts"] at 117:20–24, 118:1–5 (Darryl Samsell stating that he did not recall assigning any benefits or having any discussions about assignments), Ex. 8 ["Ds' V. Samsell Depo. Excerpts"] at 117:8–22, 118:3–11 (Valerie Samsell expressing a lack of understanding about the concept of assignments). As with Cooper, WellPoint Defendants claim that the Samsells have not met their burden of showing standing because their testimony fails to establish that they did, in fact, retain their benefits. *See Ds' MSJ Mot.* 27–28; *Ds' MSJ Reply* 30–31. The Court, however, views these situations as distinct. The Court previously found that Cooper's statements that she did not recall receiving or paying bills to the relevant OON providers were insufficient to create a triable issue of fact as to whether she actually received or paid those bills. *See* Section III.A. The analogous situation for assignments would be if an OON provider stated that he or she could not recall whether an insured assigned his or her rights. WellPoint Defendants want to use the Samsells' testimony as support for the proposition that it is undisputed that the Samsells in fact assigned their rights, but that is a step too far. Read in the light most favorable to the Samsells, *see Lowry*, 818 F.3d at 846, the

[10] WellPoint Defendants also challenge the merits of the Samsells' claim. *See Ds' MSJ Mot.* 31–42; *Ds' MSJ Reply* 31–38. The Court need not consider this argument in light of its determination that the Samsells' claim is untimely.

Samsells' statements about assignments suggest that they retained their rights, not that they assigned them.

WellPoint Defendants argue that the only other evidence in the record, a claim form that shows that the Samsells allowed Anthem Virginia to pay their provider directly and payment forms that show that Anthem Virginia so paid, suggests that assignments were made. *Ds' MSJ Mot.* 27–28 (discussing *Berge MSJ Mot. Decl.*, Exs. 13–15); *Ds' MSJ Reply* 29–30 (same). But read in the light most favorable to the Samsells, these documents merely show that the Samsells agreed to allow payments to be made directly to their providers, not that they assigned all legal rights to benefits to their providers. WellPoint Defendants also argue that the Samsells failed to provide evidence that they retained their rights, *id.* 29, but do not explain what such evidence would look like. Finally, WellPoint Defendants note that they have shown that "subscribers routinely assign their rights to benefits to their providers." *Ds' MSJ Reply* 29; *see also Ds' MSJ Mot.* 27. Even if true, the fact that subscribers routinely assign their benefits does not mean that the Samsells must have assigned their rights.

The Court therefore finds that summary judgment in WellPoint Defendants' favor on standing grounds is inappropriate.

ii. Timeliness

WellPoint Defendants also argue that summary judgment should be granted in their favor because the Samsells' claims were untimely. *Ds' MSJ Mot.* 28–30; *Ds' MSJ Reply* 26–29. Specifically, they argue that the Samsells' insurance contract provided for a three-year limitations period, the contract specified the limitations period began when the Samsells submitted "written proof" of the OON claim to Anthem Virginia, and the Samsells failed to file their lawsuit within three years of the submission of any written proof. *D's MSJ Mot.* 28–30.

The Samsells' insurance contract states in a section entitled "Legal Action": "You cannot bring legal action to recover on this Policy before at least 60 days have passed from the time written proof has been given to the Company. No action can be brought after three years from the time written proof has been given to the Company." *See Ward Decl.*, Ex. A at 45 (Article VIII, § GG). WellPoint Defendants contend that this provision sets a contractual limitations period of three years. *Ds' MSJ Mot.* 28. Plaintiffs do not directly dispute the application of this provision, *see Ds' MSJ Reply* 26, but offhandedly state that "Virginia provided a five-year limitations period which also was met," *Ps' MSJ Opp.* 36. Although it is not clear that this statement is accurate, *see Corinthian Mortg. Corp. v. ChoicePoint Precision Mktg., LLC*, No. 1:07CV832 (JCC), 2008 WL 2776991, at *3 (E.D. Va. July 14, 2008) (holding that a three-year statute of limitations exists for breaches of the implied covenant of good faith and fair dealing,

as opposed to the five-year period for written contracts); *accord Hurst v. Harbert*, No. 5:15-CV-00033, 2015 WL 3505557, at *4 (W.D. Va. June 3, 2015) (citing *Corinthian*), *aff'd*, 630 F. App'x 209 (4th Cir. 2016), it is irrelevant because Virginia law allows parties to set limitations periods in contracts that vary from those set in statutes, *see Allstate Prop. v. Ploutis*, 290 Va. 226, 234 (2015); *Massie v. Blue Cross & Blue Shield of Va.*, 256 Va. 161, 164–66 (1998); *Sethi v. Citizens Ins. Co. of Am.*, No. 7:15-CV-00479, 2016 WL 80245, at *2–5 (W.D. Va. Jan. 6, 2016).[11] Because Plaintiffs offer no other reason not to enforce the provision, the Court applies a three-year limitations period to the claims at issue.[12]

The insurance contract stated that the three-year period began at the time when "written proof ha[d] been given to the Company." *See Ward Decl.*, Ex. A at 45 (Article VIII, § GG). WellPoint Defendants contend that "written proof" refers to the "written proof of loss that is submitted to Anthem Virginia by a member or a member's provider for reimbursement for covered services." *D's MSJ Mot.* 28–29 & n.9 (citing *Ward Decl.*, Ex. A at 42, Ex. B at 79). The Court previously refused to grant a motion to dismiss on timeliness grounds because "it [wa]s unclear what 'written proof' means in the provision provided." Dkt. #243 ["8/11/11 Order"] at 11 n.5. WellPoint Defendants argue that the parties had not briefed the Court on the meaning of "written proof" at the time of that ruling, and that a review of the insurance contract as a whole, the relevant statutory definitions, and case law support the WellPoint Defendants' interpretation of the phrase. *See Ds' MSJ Mot.* 28–30 & n.8. Plaintiffs do not contest WellPoint Defendants' interpretation. *See Ds' Reply* 26–27. The Court will thus use this definition in determining whether the Samsells' lawsuit was timely filed.

WellPoint Defendants state that the Samsells' breach of the implied covenant claim against Anthem Virginia is based on five OON claims—four for oral surgical services that took place on July 30, 2004, and one for oral surgical services that took place on May 14, 2005. *See Ward Decl.* ¶¶ 7–8, Exs. K–L (Anthem Explanation of Benefits); *Frech Expert Report* at 44 ¶ 59

[11] In a previous order, the Court noted that the parties did not address choice of law, but appeared to agree that Virginia law applied. *See 7/19/13 Order* at 38 n.6. The parties again appear to agree that Virginia law applies. *See generally Ds' MSJ Mot.*; *Ps' MSJ Opp.*; *Ds' MSJ Reply*. The Court will do the same.

[12] At the hearing, Plaintiffs' attorney suggested that the contractual limitations period might not apply to the breach of the implied covenant claim because it is an extra-contractual cause of action. The Court is skeptical of this argument because the insurance plan specifically states that no action based on the policy can be brought more than three years after a submission of written proof. *See Ward Decl.*, Ex. A at 45 (Article VIII, § GG). Moreover, as noted, Virginia law appears to set the same period of time (three years) for a breach of the implied covenant claim. *See Hurst*, 2015 WL 3505557, at *4; *Corinthian Mortg.*, 2008 WL 2776991, at *3.

& Ex. 5; *FCAC* ¶ 403; Dkt. #20 ["Plaintiffs' RICO Case Statement"] at 23–25. WellPoint Defendants also contend that the Samsells (or their provider) must have submitted a written proof of loss to Anthem Virginia sometime prior to May 27, 2005, because an explanation-of-benefits form based on the May 14, 2005 procedure was issued to the Samsells on that date. *See Ward Decl.*, Ex. L (Anthem Explanation of Benefits Form); *Ds' D. Samsell Depo. Excerpts* at 190:1–20, *Berge MSJ Mot. Decl.*, Ex. 11 (May 27, 2005 Anthem Explanation-of-Benefits Form Produced by Darryl Samsell). WellPoint Defendants thus contend that the Samsells' lawsuit was untimely filed because the latest OON reimbursement the Samsells dispute was submitted to Anthem Virginia in May 2005, but the Samsells did not file their case until February 2009. *Ds' MSJ Mot.* 30.

Plaintiffs argue that "WellPoint Defendants merely focus on the Samsells' claims through 2005, and they completely ignore the Samsells' *other* OON benefit claims, including, specifically, the 2008 and 2009 claims for Darryl Samsell . . . ." *Ps' MSJ Opp.* 35–36. But as WellPoint Defendants note, these 2008 and 2009 claims related to a United Healthcare insurance plan, not the Anthem Virginia insurance plan (which ended in 2007) that is the basis of the implied covenant of good faith and fair dealing claim. *See Ds' MSJ Reply* 28; *FCAC* ¶¶ 385, 394–412, 510–19; *7/19/13 Order* at 42–43 (discussing the Samsells' breach of the implied covenant claim solely in the context of the Anthem Virginia plan); *Frech Expert Report* at 44 ¶ 59 (basing the Samsells' damage calculation for the breach of the implied covenant claim solely on the 2004 and 2005 claims). The Court thus agrees with WellPoint Defendants that the relevant OON written proofs of loss occurred in July 2004 and May 2005, and the implied covenant claim against WellPoint Defendants (which was filed in February 2009, more than three years after May 2005) is untimely.

Plaintiffs offer a number of arguments for why the Court should deny summary judgment, none of which the Court finds persuasive. First, Plaintiffs state in the table of contents and a section header in their brief that the time period should be "tolled or rendered inapplicable due to WellPoint's concealment of its breach." *See Ps' MSJ Opp.* at TOC, 33. Plaintiffs, however, do not actually expand on (or even address) this argument in the text of the brief. *See Ds' MSJ Reply* 28–29 (citing *Lexington Ins. Co. v. Silva Trucking, Inc.*, No. 2:14-CV-0015 KJM CKD, 2014 WL 1839076, at *3 (E.D. Cal. May 7, 2014)). Plaintiffs also argue that the contractual limitations argument is raised here "for the very first time in this litigation by the WellPoint Defendants as to the Samsells." *Ps' MSJ Opp.* 33. But this is demonstrably false, as WellPoint Defendants raised timeliness on a number of occasions. *See, e.g., 8/11/11 Order* at 11 n.5; *FCAC Ans.* 55 (Sixteenth Affirmative Defense); Dkt. #495 ["Ds' Opp. to Class Cert."] at 65 (arguing that the Samsells were not adequate or typical class representatives because their claims were time-barred).

Third, Plaintiffs argue that any limitations period was tolled by the filing of a similar class action in the Southern District of Florida. *Ps' MSJ Opp.* 33–34. In April 2000, the JPML ordered the creation of the MDL case *In re Managed Care Litigation*. *See Managed Care Litig. v. Humana Inc.*, 2010 U.S. Dist. LEXIS 142863, at *30–31 (S.D. Fla. Aug. 15, 2010). Plaintiffs note that "the class action in Florida was filed before the 2004 and 2005 for OON claims for services for the Samsells even occurred," and "[t]here is no legal question about the effect of a class action filing on the running on the limitations period for all members of a putative class: the period of limitations is tolled." *Ps' MSJ Opp.* 34. Although statutes of limitations are tolled for putative class members when a class action is commenced, *see Hatfield v. Halifax PLC*, 564 F.3d 1177, 1187 (9th Cir. 2009) ("In [*American Pipe & Construction Co. v. Utah*, 414 U.S. 538 (1974)], the Supreme Court held that 'the commencement of a class action suspends the applicable statute of limitations as to all asserted members of the class who would have been parties had the suit been permitted to continue as a class action.'"), Plaintiffs ignore that the subscribers' motion for class certification was denied in 2002, *see In re Managed Care Litig.*, 209 F.R.D. 678, 694 (S.D. Fla. 2002), *aff'd in part, rev'd in part and remanded sub nom. Klay v. Humana, Inc.*, 382 F.3d 1241 (11th Cir. 2004), and all of the individual subscribers' claims were dismissed in 2003, *see In re Managed Care Litig.*, 00-1334-MD-Moreno, Dkt. #2382 (S.D. Fla. Sept. 19, 2003), so tolling cannot help them, *see, e.g.*, *Stiller v. Costco Wholesale Corp.*, No. 3:09-CV-2473-GPC-BGS, 2014 WL 4955695, at *1–3 (S.D. Cal. Oct. 1, 2014) (holding that *American Pipe* tolling ended after a decertification order); *In re Countrywide Fin. Corp. Mortg.-Backed Sec. Litig.*, No. 2:11-CV-07166-MRP, 2012 WL 1097244, at *4 (C.D. Cal. Mar. 9, 2012) ("The Court agrees with Defendants that *American Pipe* tolling ends when the trial court issues a decision that strips the action of its status as a putative class action."). Plaintiffs also fail to argue that the Samsells were or would have been putative class members in the *In re Managed Care Litigation* class action. *See Ds' MSJ Reply* 27–28.

Fourth, and relatedly, Plaintiffs argue that WellPoint Defendants' conduct in the *In re Managed Care Litigation* case should estop them from disputing standing in this case. *See Ps' MSJ Opp.* 34–35. Plaintiffs argue that WellPoint Defendants argued in the Southern District of Florida that an injunction was needed to prevent providers (who had settled with WellPoint Defendants) from joining this case, and that now claiming that *In re Managed Care Litigation* does not affect standing here is an "about-face" and a "clearly inconsistent position" that should be barred by the doctrine of judicial estoppel. *Id.*; *see United States v. Liquidators of European Fed. Credit Bank*, 630 F.3d 1139, 1148 (9th Cir. 2011) (discussing the elements of judicial estoppel). But the Court cannot ascertain why WellPoint Defendants' arguments in the Southern District of Florida relating to settling providers have anything to do with the Samsells' claim for benefits in this case. In other words, Plaintiffs have not pointed to any conduct that merits judicial estoppel in regards to the Samsells.

The Court thus finds that summary judgment in WellPoint Defendants' favor on the Samsells' implied covenant claim is proper because the Samsells failed to file their case within the three-year limitations period established in their insurance contract.

C. Remaining Defendants

Finally, WellPoint Defendants request that the Court grant summary judgment in favor of the WellPoint Defendants against whom Plaintiffs are not asserting claims. *See Ds' MSJ Mot.* 42. Plaintiffs do not generally oppose this request, *see Ps' MSJ Opp.* 41, but the parties dispute whether WellPoint, Inc. should be included as a WellPoint Defendant against whom Plaintiffs are asserting claims, *compare id.* ("Plaintiffs do not contest the dismissal of any Defendant not responsible for their claims in this case, provided that 'WellPoint' (n/k/a 'Anthem') is not dismissed, as the party responsible for its wholly-owned subsidiaries."), *with Ds' MSJ Reply* 38–40 (challenging Plaintiffs' assertion that WellPoint, Inc. is a proper defendant). The Court need not resolve this debate because the Court previously granted summary judgment in WellPoint Defendants' favor on all of Plaintiffs' claims. Thus, the Court grants WellPoint Defendants' request to the extent that there are any remaining claims against any of the WellPoint Defendants.

IV. Conclusion

The Court therefore DENIES Cooper's motion for partial summary judgment and GRANTS WellPoint Defendants' motion for summary judgment. WellPoint Defendants must submit a judgment to the Court consistent with this Order by **August 18, 2016**.

IT IS SO ORDERED.