UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

**#379/380**

**CIVIL MINUTES - GENERAL**

| Case No. | MDL 09-2074 PSG (FFMx) | Date | July 19, 2013 |
|---|---|---|---|
| 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 / Recorder |
| Attorneys Present for Plaintiffs: | | Attorneys Present for Defendants: |
| Not Present | | Not Present |

**Proceedings:** **(In Chambers) Order Granting in Part and Denying in Part Defendants WellPoint, Inc., United HealthGroup, Inc., and Ingenix, Inc.'s Motions to Dismiss**

Pending before the Court are Defendants WellPoint, Inc. ("WellPoint"), UnitedHealth Group, Inc. ("UHG"), and Ingenix, Inc.'s ("Ingenix," with WellPoint and UHG, "Defendants") Motions to Dismiss the Corrected Fourth Consolidated Multi-District Litigation Complaint ("CFAC"). *See* Dkts. # 379, 380. Having read and considered the moving and opposing papers, as well as the arguments advanced at the June 12, 2013 hearing, the Court GRANTS in part and DENIES in part the motions to dismiss.

## I. Background

This case concerns insurance subscribers and healthcare providers who claim that the nation's largest healthcare insurer failed to properly reimburse them for covered out-of-network services ("ONS"). Plaintiffs allege that WellPoint – along with UHG and other insurers who allegedly participated in the scheme ("Insurer Conspirators") – orchestrated a scheme to artificially reduce and set "usual, customary, and reasonable" ("UCR") schedules for ONS reimbursements using the Ingenix Database, which UHG acquired through a wholly-owned subsidiary in 1998.[1] Subscribers were allegedly promised a "usual, customary, and reasonable" rate of reimbursement for services rendered by non-participating providers, but were underpaid due to "scrubbed" UCR data generated by Ingenix. The Insurer Conspirators who use the Ingenix Database for UCR reimbursement determinations collectively cover approximately 93.5 million privately-insured individuals in the United States. The factual background with respect to WellPoint's ONS coverage, the genesis and criticism of the Ingenix Database, and the

[1] Ingenix and UHG will also be referred to collectively as the "UHG Defendants."

procedural history of the present litigation is set forth in the Court's August 11, 2011 Order granting in part and denying in part Defendants' motion to dismiss the Second Consolidated Amended Complaint ("SAC"). *See* Dkt. # 243 (hereinafter, the "August 11, 2011 Order").

Since early 2009, subscriber, provider, and association plaintiffs have filed lawsuits against WellPoint, its subsidiaries, UHG, and Ingenix challenging WellPoint's use of the Ingenix Database and the adequacy of WellPoint's ONS reimbursements. These actions were consolidated into the current Multi-District Litigation, *In re WellPoint, Inc., Out-of-Network "UCR" Rates Litigation*, 2:09-ml-02074-PSG-FFM. Following issuance of the August 11, 2011 Order, Plaintiffs filed a Third Consolidated Amended Complaint on October 17, 2011, and a Corrected Third Consolidated Amended Complaint ("CTAC") on October 26, 2011. *See* Dkts. # 274, 279-1. On September 6, 2012, the Court granted in part and denied in part Defendants' Motion to Dismiss the CTAC (hereinafter, the "September 6, 2012 Order"). Shortly thereafter, Plaintiffs filed the Fourth Consolidated Amended Complaint, and a Corrected Fourth Consolidated Amended Complaint ("CFAC"). *See* Dkts. # 373, 377-1.

The CFAC states causes of action for (1) violation of Section 1 of the Sherman Act, 15 U.S.C. § 1; (2) unpaid benefits under group plans governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B); (3) breach of fiduciary duty under ERISA, 29 U.S.C. § 1132(a)(2); (4) failure to provide full and fair review or requested disclosures as required under ERISA, 29 U.S.C. § 1132(a)(3); (5) violation of the Racketeer Influenced and Corrupt Organizations Act ("RICO") based on predicate acts of mail and wire fraud, 18 U.S.C. § 1962(c); (6) violation of RICO for predicate acts of embezzlement, 18 U.S.C. § 1962(c); (7) conspiracy to violate RICO, 18 U.S.C. § 1962(d); (8) breach of contract; (9) breach of the implied covenant of good faith and fair dealing; (10) violation of California's Unfair Competition Law ("UCL"), Cal. Bus. & Prof. Code § 17200; (11) violation of California's Unfair Competition Law and California Health and Safety Code § 1371.4; and (12) violation of California's Cartwright Antitrust Act. Plaintiffs no longer pursue a claim for failure to provide accurate records under ERISA, 29 U.S.C. § 1132(c).

In asserting their various claims, Plaintiffs are divided into several categories. First, the "Subscriber Plaintiffs" are Michael Roberts ("Roberts") (on behalf of himself and as guardian for his daughter, D. Roberts), J.B.W. (a minor by and through his parent and guardian *ad litem*), Darryl and Valerie Samsell (the "Samsells"), Mary Cooper ("Cooper"), Ivy Seigle-Epstein ("Epstein") and Ivette Rivera-Giusti ("Rivera-Giusti"). *See CFAC* ¶¶ 24-29. The Subscriber Plaintiffs each allegedly had an insurance policy with WellPoint or one of its subsidiaries, received ONS medical care, were reimbursed at a depressed rate, and incurred "more out-of-pocket expense [than they] would have absent the unlawful conduct alleged." *See id.*

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Second, the "Provider Plaintiffs" are as follows: Dr. Stephen D. Henry ("Dr. Henry") is a primary care internist, Dr. James G. Schwendig ("Dr. Schwendig") is a trauma surgeon, Dr. James Peck ("Dr. Peck") is a clinical psychologist, Dr. Michael Pariser ("Dr. Pariser") is a licensed psychologist, Dr. Carmen Kavali ("Dr. Kavali") is a plastic surgeon, and Dr. Stephanie Higashi ("Dr. Higashi") is a chiropractic doctor. *See id.* ¶¶ 30-35. The Provider Plaintiffs allegedly provided ONS to WellPoint subscribers, were assigned the reimbursement benefits of the subscribers' policies, and received deflated UCR reimbursements. *See id.* ¶¶ 271, 278, 288, 295, 309.

Third, the "Association Plaintiffs" are the American Medical Association ("AMA"), the California Medical Association ("CMA"), the Medical Association of Georgia ("MAG"), the Connecticut State Medical Society ("CSMS"), the American Podiatric Medical Association ("APMA"), the California Chiropractic Association ("CCA"), and the California Psychological Association ("CPA"). *See id.* ¶¶ 36-50. The AMA, CMA, MAG, APMA, CCA, and CPA sue WellPoint in their individual and representative capacities to redress injuries sustained by them and their members. *See id.* ¶¶ 36-42, 44-50. The CSMS brings suit against Defendants only in its representative capacity. *See id.* ¶ 43.

On December 21, 2012, WellPoint and the UHG Defendants filed separate motions to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6). *See* Dkts. # 379, 380. Plaintiffs filed an omnibus opposition collectively opposing both motions. *See* Dkt. # 383. Defendants replied, and the motions are now before the Court. *See* Dkts. # 384, 385.

As a threshold matter, the Court notes that Plaintiffs continue objecting to many of WellPoint and the UHG Defendants' arguments on the grounds that they either were or could have been raised in connection with their motions to dismiss the CTAC and Defendants have not met the high reconsideration standards. As this Court acknowledged in its September 6, 2012 Order, the law is clear in this Circuit that an "amended complaint supersedes the original, the latter being treated thereafter as nonexistent." *Forsyth v. Humana, Inc.*, 114 F.3d 1467, 1474 (9th Cir. 1997), *overruled on other grounds by Lacey v. Maricopa Cnty.*, 693 F.3d 896 (9th Cir. 2012). Courts in this Circuit therefore have permitted defendants moving to dismiss an amended complaint to make arguments previously made and to raise new arguments that were previously available. *See In re Sony Grand WEGA KDF-E A10/A20 Series Rear Projection HDTV Television Litig.*, 758 F. Supp. 2d 1077, 1098 (S.D. Cal. 2010) ("When [p]laintiffs filed the FACC, it superseded their previous complaint, and [defendant] was therefore free to move again for dismissal."); *Stamas v. Cnty. of Madera*, No. CV F 09-0753 LJO SMS, 2010 WL 289310, at *4 (E.D. Cal. Jan. 15, 2010); *Migliaccio v. Midland Nat'l Life Ins. Co.*, No. CV 06-1007 CASMANX, 2007 WL 316873, at *2-3 (C.D. Cal. Jan. 30, 2007) (rejecting plaintiffs' argument

that Federal Rule of Civil Procedure 12(g)(2)'s ban on successive Rule 12 motions barred the defendants from raising new arguments or resurrecting arguments considered by the Court in their first motion to dismiss). Moreover, the CFAC contains new allegations relevant to the viability of several of Plaintiffs' causes of action; for example, the CFAC has alleged that Defendants were "lower rung" participants in a RICO enterprise, has added allegations relating to 29 U.S.C. § 1104 of ERISA, and has added a new theory as to the Samsells' breach of contract claim. Having chosen to amend their complaint in lieu of proceeding with their remaining claims, the CFAC supersedes the original and Defendants are not held to the reconsideration standards. *See Migliaccio*, 2007 WL 316873, at *3.

Plaintiffs also contend that the arguments this Court has previously rejected are barred by the law of the case doctrine. *Opp.* 5:3-7. A court may have discretion to depart from the law of the case where: (1) the first decision was clearly erroneous; (2) an intervening change in the law has occurred; (3) the evidence on remand is substantially different; (4) other changed circumstances exist; or (5) a manifest injustice would otherwise result. *United States v. Alexander*, 106 F.3d 874, 876 (9th Cir. 1997). However, as with Rule 12(g), "an amended pleading is a new round of pleadings . . . and is subject to the same challenges as the original." *In re Sony Grand Wega*, 758 F. Supp. 2d at 1098 (quoting *Stamas*, 2010 WL 289310, at *4). Further, "the law of the case doctrine is discretionary, and 'is in no way a limit on a court's power to revisit, revise, or rescind an interlocutory order prior to entry of final judgment.'" *In re Sony Grand Wega*, 758 F. Supp. 2d at 1098 (quoting *Los Angeles v. Santa Monica Baykeeper*, 254 F.3d 882, 888 (9th Cir. 2001)). Thus, to the extent Plaintiffs have amended their complaint, the CFAC supersedes the original and the law of the case doctrine does not apply. *Id.* With this in mind, the Court turns to the merits of Defendants' motions.

## II. Legal Standard

Under Rule 12(b)(6) of the Federal Rules of Civil Procedure, a defendant may move to dismiss a cause of action if the plaintiff fails to state a claim upon which relief can be granted. *See* Fed. R. Civ. P. 12(b)(6). In evaluating the sufficiency of a complaint under Rule 12(b)(6), courts should be mindful that the Federal Rules of Civil Procedure generally require only that the complaint contain "a short and plain statement of the claim showing that the pleader is entitled to relief." *See* Fed. R. Civ. P. 8(a)(2). Although detailed factual allegations are not required to survive a Rule 12(b)(6) motion to dismiss, a complaint that "offers 'labels and conclusions' or 'a formulaic recitation of the elements of a cause of action will not do.'" *Ashcroft v. Iqbal*, 566 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007)). Rather, the complaint must allege sufficient facts to support a plausible claim to relief. *See id.*

In evaluating a Rule 12(b)(6) motion, the court must engage in a two-step analysis. *See id.* at 1950. First, the court must accept as true all non-conclusory, factual allegations made in the complaint. *See Leatherman v. Tarrant Cnty. Narcotics Intelligence & Coordination Unit*, 507 U.S. 163, 164 (1993). Based upon these allegations, the court must draw all reasonable inferences in favor of the plaintiff. *See Doe v. U.S.*, 419 F.3d 1058, 1062 (9th Cir. 2005). Second, after accepting as true all non-conclusory allegations and drawing all reasonable inferences in favor of the plaintiff, the court must determine whether the complaint alleges a plausible claim for relief. *See Iqbal*, 556 U.S. at 679. Despite the liberal pleading standards of Rule 8, conclusory allegations will not save a complaint from dismissal. *See id.* at 678-79.

## III. Discussion

The Court first addresses the standing issues raised in WellPoint and the UHG Defendants' motions before evaluating the sufficiency of the individual claims pleaded in the CFAC.

### A. Plaintiffs' Standing

Defendants again make several challenges to the Association and Subscriber Plaintiffs' Article III and statutory standing. Article III standing is a jurisdictional prerequisite to a federal court's consideration of any claim. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992). A plaintiff in federal court must show three things: (1) injury-in-fact; (2) causation, and (3) redressibility. *Allen v. Wright*, 468 U.S. 737, 750-51 (1984).

WellPoint challenges the Association Plaintiffs' Standing to sue under both ERISA 29 U.S.C. § 1132(a)(1)(B) and § 1132(a)(2) and (a)(3). This is relevant to Plaintiffs' second, third, and fourth causes of action under ERISA for violations of the same statutes. WellPoint alleges that Association Plaintiffs do not have standing to bring claims under § 1132(a)(1)(B) because litigation of the claims would require excessive individual member participation. *WellPoint Mot.* 27:11-13. It also alleges that Plaintiffs lack standing under § 1132(a)(2) and (a)(3) because the CFAC does not allege facts showing that the Association Plaintiffs' members "would otherwise have standing to sue in their own right." *Id.* 27:26-28:1. Finally, both WellPoint and UHG Defendants challenge the Subscriber Plaintiffs' statutory standing under the Sherman Act and Cartwright Act. *Id.* 4:4-17, 44:8-11; *UHG Mot.* 5:1-9, 15:10-24. The Court addresses each argument in turn.

*i. Standing of the Association Plaintiffs to Assert non-Ingenix "ONS Benefit Reduction" Claims under 29 U.S.C. § 1132(a)(1)(B) (Second Cause of Action)*

The Court has not previously addressed Association Plaintiffs' Representative Standing with regard to Association Plaintiffs' standing to assert non-Ingenix "ONS Benefit Reduction" claims under 29 U.S.C. § 1132(a)(1)(B). WellPoint contends that the Association Plaintiffs lack standing to bring claims under ERISA 29 U.S.C. § 1132(a)(1)(B). WellPoint argues that the Association Plaintiffs have no standing because they bring the ERISA claims solely "on behalf of their members." *WellPoint Mot.* 27:2-10.

In *Hunt*, the Court noted that an association has standing to bring suit on behalf of its members when: (1) its members would otherwise have standing to sue in their own right; (2) the interests it seeks to protect are germane to the organization's purpose; and (3) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit. *Hunt v. Wash. State Apple Adver. Comm'n,* 432 U.S. 333, 343 (1977)). WellPoint argues that the Association Plaintiffs lack standing because litigation of the § 1132(a)(1)(B) claim would require the participation of individual members in the lawsuit. *WellPoint Mot.* 27:11-13.

Plaintiffs clarify in their Opposition that as to the Association Plaintiffs' Section 1132(a)(1)(B) claim, they are only seeking injunctive and declaratory relief, and any claims maintained for benefits are solely for the purposes of preserving their rights on appeal. Plaintiffs appear to concede that the claims for benefits would require substantial individual participation. *See Ala. Dental Ass'n v. Blue Cross & Blue Shield of Ala., Inc.*, No. 205–CV–1230–MEF, 2007 WL 25488, *9-10 (M.D. Ala. Jan. 3, 2007) ("[A]n association may have standing to seek 'a declaration, injunction, or some other form of prospective relief' on behalf of its members, [but] it does not enjoy standing to seek damages for monetary injuries peculiar to individual members where the fact and extent of injury will require individualized proof."). As such, because the Association Plaintiffs' claim for benefits based on non-Ingenix ONS under-reimbursements would necessarily require participation of individual members, the claim is DISMISSED WITH PREJUDICE.

As to the claims for declaratory and injunctive relief, other courts have recognized that where plaintiffs bring claims only for declaratory and injunctive relief, representative standing may be proper. *See Warth v. Seldin*, 422 U.S. 490, 515-16 (1975) ("If in a proper case the association seeks a declaration, injunction, or some other form of prospective relief, it can reasonably be supposed that the remedy, if granted, will inure to the benefit of those members of the association actually injured. Indeed, in all cases in which we have expressly recognized

standing in associations to represent their members, the relief sought has been of this kind."); *United Broth. of Carpenters & Joiners of Am. v. Metal Trades Dep't, AFL-CIO*, No. 11–CV–5159–TOR, 2012 WL 3817789, *2-3 (E.D. Wash. Sept. 4, 2012) ("Plaintiffs do have associational standing to bring claims for injunctive and declaratory relief because these claims do not require the participation of individual members.").

Nonetheless, WellPoint argues that Plaintiffs' concession that they seek only declaratory and injunctive relief is insufficient to confer standing because Plaintiffs have failed to show that individual member participation is unnecessary. Specifically, WellPoint contends that individual relief will be necessary to show that the assignments that providers received included claims for prospective relief. While the Court is mindful of Defendants' concern that individual participation will be necessary to show the validity of the assignments, other courts have recognized that the allegation that individual participation is unnecessary is sufficient for purposes of a motion to dismiss. *See Pa. Psychiactric Society v. Green Spring Health Servs.*, 280 F.3d 278, 286 (3d Cir. 2002) ("If the Pennsylvania Psychiatric Society can establish these claims with limited individual participation, it would satisfy the requirements for associational standing. While we question whether the Society can accomplish this, at this stage of the proceedings on a motion to dismiss for lack of standing, we review the sufficiency of the pleadings and must accept as true all material allegations of the complaint and must construe the complaint in favor of the plaintiff. For this reason, we believe the Society's suit should not be dismissed before it is given the opportunity to establish the alleged violations without significant individual participation.") (internal citation and quotation marks omitted); *Spinedex Physical Therapy USA, Inc. v. United Healthcare of Ariz.*, 661 F. Supp. 2d 1076, 1084-85 (D. Ariz. 2009) ("Plaintiffs' ability to obtain the necessary evidence of assignment without involving every ACS member is questionable. However, Rule 12(b)(6) requires all reasonable factual inferences to be interpreted in Plaintiffs' favor."). This is partly because the "threshold for satisfying the third prong of *Hunt* is not high." *Id.* at 1084.

Still, if Plaintiffs are ultimately unable to adequately demonstrate Defendants' alleged conduct with limited individual participation, the claims will be dismissed. *Pa. Psychiatric*, 280 F.3d at 286-87*; see also Am. Med. Ass'n v. United HealthCare Corp.*, No. 00Civ.2800 (LMM) (GWG), 2002 WL 31413668, at *3 (S.D.N.Y. Oct. 23, 2002) ("If, however, the Medical Association Plaintiffs are unable to establish their representative claims with limited individual participation, or they attempt to involve themselves in claims for damages, their claims will be dismissed.").

Accordingly, to the extent Plaintiffs seek declaratory and injunctive relief as to Association Plaintiffs' claims under Section 1132(a)(1)(B), they have adequately pleaded the

requisite standing at this stage of the litigation. As such, WellPoint's motion to dismiss Association Plaintiffs' claims for lack of standing regarding the claims for declaratory and injunctive relief under § 1132(a)(1)(B) is DENIED.

*ii. Standing of Association Plaintiffs to bring claims under § 1132(a)(2) and (a)(3) (Third and Fourth Causes of Action)*

WellPoint also challenges Plaintiffs' allegations that Association Plaintiffs have standing to bring their claims under § 1132(a)(2) and (a)(3). WellPoint argues that the Association Plaintiffs do not have standing to bring claims under § 1132(a)(2) and (a)(3) because the Provider Plaintiffs do not have standing to bring claims under § 1132(a)(2) and (a)(3), and an association can only have representative standing if its members "would otherwise have standing to sue in their own right." *WellPoint Mot.* 27:26-28:1 (citing *Hunt*, 432 U.S. at 343. The Court ruled in its September 6, 2012 Order that the Provider Plaintiffs lacked standing to bring claims under § 1132(a)(2) and (a)(3) because the Provider Plaintiffs failed to allege they were assigned the right to bring causes of action under § 1132(a)(2) and (a)(3). *See* September 6, 2012 Order at 7. WellPoint contends that the Association Plaintiffs cannot have standing because their members, the Provider Plaintiffs, do not have standing. *WellPoint Mot.* 28:1-12.

In the CFAC, Plaintiffs explain:

> In its September 7, 2012 ruling on Defendants' motions to dismiss the CTAC, the Court dismissed this Count as to the Subscriber Plaintiffs for failure to state a claim, and as to the Provider Plaintiffs for lack of standing. (ECF No. 365 at 8-9, 38-40, 50 51). Plaintiffs have not amended their allegations concerning Provider Plaintiffs' standing to assert this Count. Nonetheless, they also re-plead this Count on behalf of the Provider Plaintiffs in order to preserve it as to those plaintiffs for appeal.

*CFAC* at 147, n.5 and 149, n.6. Thus, Plaintiffs appear to acknowledge that because the Association Plaintiffs' claims are brought on behalf of their members, and the Court has already ruled that the Provider Plaintiffs lack standing, the Association Plaintiffs lack standing. As Plaintiffs have not amended their allegations to suggest that the Provider Plaintiffs should have standing, nor have Plaintiffs proffered any reason in their Opposition as to why the Court should amend its ruling, the Association Plaintiffs lack standing under § 1132(a)(2) and (a)(3) and the claims are DISMISSED WITH PREJUDICE. As such, the Court will only consider the merits of the § 1132(a)(2) and (a)(3) claim as to the ERISA Plaintiffs and their Respective Plans.

*iii. Subscriber Plaintiffs' Antitrust Standing (First Cause of Action)*

Section 1 of the Sherman Act prohibits "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade." 15 U.S.C. § 1. Like prior complaints, the CFAC alleges violations of Section 1 of the Sherman Act on behalf of Subscriber Plaintiffs under both a rule of reason and a *per se* analysis. In the Order on the Motion to Dismiss the SAC, the Court upheld Plaintiffs' *per se* and rule of reason claims. In so holding, the Court noted that several of Defendants' arguments appeared to be directed at Plaintiffs' standing, but that standing to assert the Sherman Act claims was not specifically raised in the papers. *See* August 11, 2011 Order at 21. In the Order on the Motion to Dismiss the CTAC, the Court addressed the issue of antitrust standing. *See* September 6, 2012 Order at 12-23. The Court found that the Association and Provider Plaintiffs lacked standing and dismissed their Sherman Act claims with prejudice. *Id.* at 16. As to the Subscriber Plaintiffs, the Court found that the Subscriber Plaintiffs had not sufficiently alleged that they suffered a direct injury of the type the antitrust laws were intended to forestall, and therefore lacked standing to pursue their claims. *Id.* at 22-23. Nonetheless, the Court granted the Subscriber Plaintiffs leave to amend. *Id.*

Subscriber Plaintiffs have amended the CFAC as to antitrust standing, and Defendants contend that Plaintiffs have failed again to allege that they suffered a direct injury sufficient to confer antitrust standing.

Antitrust standing is a jurisdictional prerequisite to a Section 1 claim under both the rule of reason and the *per se* rule. *See In re ATM Fee Antitrust Litig.*, 686 F.3d 741, 744 (9th Cir. 2012) ("Because Plaintiffs lack antitrust standing, we do not address Plaintiffs' appeal regarding the district court's [] determination that the rule of reason, and not the per se rule, applies here"). Under § 4 of the Clayton Act, "any person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue…and shall recover threefold the damages by him sustained, and the cost of suit, including a reasonable attorney's fee." 15 U.S.C. § 15(a). However, "[t]he Supreme Court has interpreted that section narrowly, thereby constraining the class of parties that have statutory standing to recover damages through antitrust suits." *Del. Valley Surgical Supply Inc. v. Johnson & Johnson*, 523 F.3d 1116, 1120 (9th Cir. 2008) (citing *Illinois Brick v. Illinois*, 431 U.S. 720 (1977)); *accord Am. Ad Mgmt., Inc. v. Gen. Tel. Co. of Cal.*, 190 F.3d 1051, 1054 (9th Cir. 1999) (noting that § 4 is not to be read to "afford relief to all persons whose injuries are causally related to an antitrust violation;" rather, "courts have constructed the concept of antitrust standing, under which they 'evaluate the plaintiff's harm, the alleged wrongdoing by the defendants, and the relationship between them,' [in order] to determine whether a plaintiff is a proper party to bring an antitrust claim.") (citations omitted). As a result, "[a]ntitrust standing is distinct from Article III standing," and a "plaintiff who

satisfies the constitutional requirement of injury in fact is not necessarily a proper party to bring a private antitrust action." *Id.* at 1054, n.3. The issue may be raised at any stage of litigation. *R.C. Dick Geothermal Corp. v. Thermogenics, Inc.*, 890 F.2d 139, 145 (9th Cir. 1989).

The Supreme Court has identified certain factors for determining whether a plaintiff who has borne an injury for Article III standing has suffered injury for antitrust purposes. *Am. Ad Mgmt.*, 190 F.3d at 1054. These factors include: (1) the nature of the plaintiff's alleged injury; that is, whether it is the type the antitrust laws were intended to forestall; (2) the directness of the injury; (3) the speculative measure of the harm; (4) the risk of duplicative recovery; and (5) the complexity in apportioning damages. *Amarel v. Connell*, 102 F.3d 1494, 1507 (9th Cir. 1996); *accord Assoc. Gen. Contractors of Calif., Inc. v. Calif. State Council of Carpenters*, 459 U.S. 519, 538-45 (1983).

Although Courts have stated that "no single factor is decisive," *R.C. Dick Geothermal*, 890 F.2d at 146, and that it is "virtually impossible to announce a black-letter rule that will dictate the result in every case," *Am. Ad Mgmt.*, 190 F.3d at 1054, the first factor is of such "tremendous significance" in determining whether a plaintiff has antitrust standing that its presence is necessary, though not always sufficient. *Bhan v. NME Hosps., Inc.*, 772 F.2d 1467, 1470 n.3 (9th Cir. 1985); *accord Glen Holly Entm't, Inc. v. Tektronix, Inc.*, 352 F.3d 367, 372 (9th Cir. 2003) ("to acquire 'antitrust standing,' a plaintiff must adequately allege and eventually prove 'antitrust injury.'").

The first factor, antitrust injury, demands a showing of: "(1) unlawful conduct, (2) causing an injury to the plaintiff, (3) that flows from that which makes the conduct unlawful, and (4) that is of the type the antitrust laws were intended to prevent." *Glen Holly Entm't*, 352 F.3d at 372 (quoting *Am. Ad Mgmt.*, 190 F.3d at 1055). In addition, Courts generally impose a fifth requirement that the injured party be a participant in the same market as the alleged malefactors. *Id.* "In other words, the party alleging the injury must be either a consumer of the alleged violator's goods or services or a competitor of the alleged violator in the restrained market." *Id.* (quoting *Eagle v. Star-Kist Foods, Inc.*, 812 F.2d 538 (9th Cir. 1987)). Courts have recognized "a narrow exception to the market participant requirement for parties whose injuries are 'inextricably intertwined' with the injuries of market participants." *Am. Ad Mgmt.*, 190 F.3d at 1057, n.5 (citations omitted).

In the Order on the Motion to Dismiss the CTAC, the Court dismissed the Subscriber Plaintiffs' claims because the Subscriber Plaintiffs were unable to show that the alleged antitrust injury – decreased ONS reimbursements in the ONS Market – flowed from Defendants'

exclusion of competitors from the Data Market.[2] *See* September 6, 2012 Order at 16-23. The Court identified three primary flaws with the Subscriber Plaintiffs' allegations. First, the Subscriber Plaintiffs' theory that the presence of a competitor in the Data Market would have increased UCR rates and increased ONS reimbursements was highly speculative. *Id.* at 17-18. Second, the Subscriber Plaintiffs' allegations that their injuries were attributable to a breakdown of competitive conditions in the Data Market were flawed. *Id.* at 18-19. Third, the Subscriber Plaintiffs neither alleged that they were participants in the Data Market nor that their harm was inextricably intertwined with the harm the conspirators sought to inflict on the market or competitors within the market. *Id.* at 19-23.

Plaintiffs have failed to allege any new information that would modify the Court's analysis. As to the allegation that the Subscriber Plaintiffs' injuries flowed from Defendants' anticompetitive conduct, Plaintiffs maintain the theory espoused in the CTAC that competition in the Data Market would have led to more accurate ONS benchmarking products, which would have, in turn, led to an increase in reimbursements. *See CFAC* ¶ 203. Plaintiffs supply a host of allegations as to how Defendants made the Data Market anticompetitive, but they do not actually show how the Subscriber Plaintiffs' alleged loss in the ONS Market "flows from an anticompetitive aspect or effect of the [Defendants'] behaviour." *See Rebel Oil Co. v. ARCO*, 51 F.3d 1421, 1433 (9th Cir. 1995); *Atl. Richfield Co. v. USA Petroleum Co.*, 495 U.S. 328, 343 (1990) ("The antitrust injury requirement, however, ensures that a plaintiff can recover only if the loss stems from a competition-*reducing* aspect or effect of the defendant's behavior.") (emphasis in original). While Plaintiffs have rephrased their allegations, they maintain that absent a conspiracy, it would be in the "best interest of each insurer conspirator to encourage a competing data provider." *See CFAC* ¶ 203. They contend that the presence of a competitor could lower an insurer's cost of providing UCR information and could provide an individual insurer with a competitive advantage because the insurer could offer its subscribers "fair" reimbursements for ONS. *Compare CFAC* ¶ 203 *with CTAC* ¶ 90. Plaintiffs newly allege that the presence of a competitor would cut down on administrative costs of subscriber complaints, appeals, and litigation. *CFAC* ¶ 203.

The Court has previously recognized that the first two allegations are insufficient because it is not self-evident that the emergence of new entrants in the Data Market would result in an

[2] The Data Market is defined in the CFAC as "the market for data used to calculate UCRs for reimbursement of claims by health insurance beneficiaries for out-of-network, non-negotiated medical services in the United States." *CFAC* ¶ 176. Plaintiffs do not specifically define the ONS Market in the CFAC, though they describe it as "the downstream market involving delivery of ONS" to subscribers. *CFAC* ¶ 187.

*increase* in the UCR rates or even the development of "more accurate benchmarking products." September 6, 2012 Order at 18 (citing *Dominguez v. UAL Corp.*, 666 F.3d 1359, 1364 (D.C. Cir. 2012) (rejecting even Article III standing where plaintiffs' theory of antitrust injury "pile[d] speculation atop speculation" in assuming that United Airlines "would continue to offer discounted tickets if it could no longer price discriminate"); *Summit Tech., Inc. v. High-Line Med. Instruments, Co., Inc.*, 922 F. Supp. 299, 304 (C.D. Cal. 1996) ("[A] Court need not accept as true unreasonable inferences, unwarranted deductions of fact, or conclusory legal allegations cast in the form of factual allegations.")). Plaintiffs recognize in their CFAC that insurers directly *benefit* from decreased ONS reimbursement expenses, which calls into question the theory that increased competition in the Data Market would result in increased ONS reimbursement expenses. *See CFAC* ¶ 187 ("For every dollar that the Insurer Conspirators are able to decrease their ONS reimbursement costs through their unlawful conspiracy, there is a corresponding dollar of increase to the affected consumer's healthcare costs."). If new entrants into the Data Market sought to cater to the needs of market participants – insurers – the allegations suggest that new entrants would compete for insurers' business by offering *lower* reimbursement expenses, which would benefit the insurers. Because Plaintiffs' theory of the impact of new participants in the Data Market is at odds with the allegations of the CFAC, Plaintiffs are still unable to show that the absence of a competitor resulted in lower ONS reimbursement expenses.

Plaintiffs' new allegation – that the presence of a competitor would cut down on administrative costs of subscriber complaints, appeals, and litigation – is similarly flawed. *See CFAC* ¶ 205. It appears that Plaintiffs are trying to argue that subscribers will be more satisfied if they receive higher ONS reimbursements and will be less likely to complain. The allegation is necessarily tied to Plaintiffs' speculative assumption that the presence of a competitor would result in higher ONS reimbursements. Moreover, Plaintiffs' allegation depends on the additional assumption that higher ONS reimbursements necessarily lead to happier subscribers and fewer subscriber complaints, appeals, and litigation. They fail to establish that subscribers would be aware that they were receiving higher ONS reimbursements and that this awareness would lead to greater satisfaction with insurers. Thus, the Court need not accept Plaintiffs' conclusion that higher ONS reimbursements necessarily decrease administrative costs.

Second, Plaintiffs maintain the allegations that cut against the idea that the Subscriber Plaintiffs' injuries are attributable to the breakdown of competitive conditions in the Data Market. Plaintiffs continue to allege that the four datapoints in the Ingenix database point to the lack of competition and innovation in the Data Market. However, the Court already recognized that the presence of the four datapoints predates Ingenix's obtaining dominance in the Data Market. *See* September 6, 2012 Order at 18; *CFAC* ¶¶ 201-02. Thus, if anything, Plaintiffs'

allegation that the four datapoints are insufficient shows that the alleged anticompetitive position of Ingenix did not change the nature of the market.

The same is true of Plaintiffs' allegation that the New York Attorney General ("NYAG") database has the potential to improve the anticompetitive nature of the market. Not only have Plaintiffs failed to allege that the NYAG database has actually redressed the harms of the anticompetitive market, but the allegations as to why the NYAG database could "theoretically" improve the market are specious. *See CFAC* ¶ 207. Plaintiffs allege that the NYAG database is overseen by an independent third party, *id.*, but as the Court critiqued in its September 6, 2012 Order, Plaintiffs fail to proffer any explanation as to why it is beneficial to replace one monopoly power with another. *See* September 6, 2012 Order at 18-19.

Third, Plaintiffs neither allege that they were participants in the Data Market nor that their harm was inextricably intertwined with the harm the Insurer Conspirators allegedly sought to inflict on the Data Market or competitors within the Data Market. To meet the market participant requirement, the Subscriber Plaintiffs "must be either [consumers] of the alleged violator's goods or services or [competitors] of the alleged violator in the restrained market." *Glen Holly Entm't*, 352 F.3d at 372 (quoting *Eagle*, 812 F.2d at 538). The Subscriber Plaintiffs are not participants in the Data Market because unlike the Insurer Conspirators, they are not consumers of the Data Market; rather, they are consumers of the "linked ONS Market." *See CFAC* ¶¶ 186-87.

Further, the Subscriber Plaintiffs also do not fall within the narrow exception to the typical rule that those alleging antitrust injury must be market participants. As explained in *McCready*, the market participant requirement can also be satisfied by showing that plaintiffs' injuries were "inextricably intertwined" with the injuries of the actual market participants. *Blue Shield of Va. v. McCready*, 457 U.S. 465, 484 (1982); *see also Am. Ad Mgmt., Inc.*, 190 F.3d at 1057, n.5 (9th Cir. 1999) (noting that even those parties "whose injuries, though flowing from that which makes the defendant's conduct unlawful, are experienced in another market do not suffer antitrust injury," unless they fall within the narrow exception to this rule applicable to "parties who[se] injuries are 'inextricably intertwined' with the injuries of market participants") (citing *McCready*, 457 U.S. at 484); *accord Ostrofe v. H.S. Crocker Co.*, 740 F.2d 739, 745-46 (9th Cir. 1984). Other Courts have emphasized that *McCready* only applies where the injuries are "inextricably intertwined" with those of a market participant. *See In re Digital Music Antitrust Litig.*, 812 F. Supp. 2d 390, 402-03 (S.D. N.Y. 2011) (rejecting linked market theory because "both CD purchasers and Internet Music purchasers allegedly were harmed by higher prices of CDs and Internet Music, respectively, and CD purchasers' alleged injury [was] thus

distinct from and not intertwined with Internet Music purchasers' injury" because there was no "physical and economic nexus between the alleged violation and harm to the plaintiff").

As the Court explained in its analysis of the CTAC, Plaintiffs have failed to explain how participants in the Data Market, *i.e.*, the Insurer Conspirators, experienced any injury as a result of the conspiracy. Rather, Plaintiffs' allegations show that the Data Market participants *benefitted* from the alleged conspiracy by decreasing ONS reimbursements. *See CFAC* ¶ 187. Additionally, although the Court previously found that "the 'linked ONS market' is inadequately defined and is problematic in that there is no allegation that a provider who is out-of-network under one Insurer Conspirator's plans will be out-of-network under another's," Plaintiffs have failed to amend their allegations to correct this deficiency. *See* September 6, 2012 Order at 19-20. Plaintiffs have merely alleged that the Data Market "is directly linked to ONS reimbursements such that, for antitrust purposes, there is no distinction between them." *CFAC* ¶ 209. However, this conclusory allegation does not change the problem with the market definition identified in the September 6, 2012 Order. *See Franco v. Conn. Gen. Life Ins. Co.*, 818 F. Supp. 2d 792, 840 n.22 (2011) (rejecting linked market theory in part because the complaint failed to identify what interchangeable products or services the ONS market comprises, and there was "no allegation, nor [could] any reasonable inference be drawn, that a provider who is [out-of-network] for one insurance company is also [out-of-network] for all other insurance companies").

Plaintiffs base their argument as to why the Subscriber Plaintiffs' injury is "inextricably linked" to the alleged injury of Data Market participants on the relationship between UCR calculation and ONS reimbursement. Plaintiffs claim that Subscriber Plaintiffs are members of the ONS Market, and the Data Market is necessarily linked to the ONS Market because the UCR calculations in the Data Market are directly responsible for the ONS reimbursement amounts. *Opp.* 21:7-20. Plaintiffs analogize to *In re TFT-LCD (Flat Panel) Antitrust Litig.*, Nos. M 07-1827 SI, MDL 1827, C 10-0117 SI, C 10-4572 SI, C 10-4945 SI, C 11-0058 SI, C 09-4997 SI, C 10-5452 SI, 2012 WL 4808447, *2 (N.D. Cal. Oct. 9, 2012).

In *In re TFT-LCD*, the Court reasoned that the market for LCD panels had "no independent utility" outside of "the demand for LCD products," and determined that the injuries felt by participants in the market for LCD panels were identical to the injuries felt by the participants in the market for LCD products. *Id.* Plaintiffs attempt to argue that like in *In re TFT-LCD*, there is no use for UCR calculations outside the allegedly linked ONS Market. However, this case differs from *In re TFT-LCD* because there are no allegations that participants in the Data Market experienced any injury. Indeed, the allegations in the CFAC suggest that if anything, the allegedly anticompetitive conduct benefitted the Insurer Conspirators because it

enabled them to offer lower ONS reimbursements. Because Data Market participants experienced no injury, the Subscriber Plaintiffs cannot complain that injury to the ONS Market participants is linked to injury experienced by Data Market participants. Moreover, *In re TFT-LCD* differs from this case because in *In re TFT-LCD*, Plaintiffs purchased downstream goods (that is, the LCD panels were integrated into the LCD products). *In re TFT-LCD (Flat Panel) Antitrust Litig.*, 586 F. Supp. 2d 1109, 1118 (N.D. Cal. 2008). As the Court explained in its Order on the CTAC, the *McCready* exception "is generally limited to those who have been injured in a physical goods market by a restraint imposed on the futures market for the same good, or vice versa, and cases involving vertically integrated products in which competition for a necessary component has been restrained." *See* September 6, 2012 Order at 20 (citing *Amarel*, 102 F.3d at 512). Thus, citing to *In re TFT-LCD*, a case involving vertically integrated products, highlights the type of situation in which the *McCready* exception might apply. However, because this case does not involve a vertically integrated product, Plaintiffs' comparison is necessarily misguided.

Additionally, Plaintiffs argue that the ONS Market and Data Market are "inextricably linked" because they "move in lockstep." *Opp.* 20:19-21. However, the allegations in the CFAC are unchanged from those in the CTAC in that they continue to reveal that the method of reimbursement does not necessarily move in lockstep with the Ingenix database. The CFAC cites to other ways of determining ONS reimbursement, such as Medicare rates and in-network fee schedules. *CFAC* ¶ 221. For example, sometimes ONS is based on Medicare-based Centers of Medicare and Medicaid Services ("CMS") fee schedules, which represent government-driven, below market-rates. *Id.* ¶ 222. The fact that the ONS reimbursement is also based on other determinations, like internal fee schedules, discounted in-network rates, and undisclosed low percentages of CMS rates, which Plaintiffs have not alleged are comparable to Ingenix determinations, indicates that the Data Market and ONS reimbursement do not necessarily move in lockstep. *Id.* ¶¶ 16, 221-225. For example, Plaintiffs allege that ONS is sometimes reimbursed "based on an undisclosed percentage of extremely low and unrepresentative Medicare rates," *Id.* ¶ 309, which indicates that the Medicare rates are not in line with other ONS reimbursement calculations. Thus, Plaintiffs have failed to allege that the market for ONS reimbursement and the Data Market necessarily "move in lockstep."

As such, Plaintiffs fail to allege that their injury is inextricably linked to the alleged injury felt by Data Market participants because they neither allege that Data Market participants experienced any injury, nor that the markets "move in lockstep." Accordingly, Plaintiffs do not fall within the narrow *McCready* exception. Because Plaintiffs have not pleaded antitrust injury, the Court need not consider the other factors in determining antitrust standing.

Thus, in sum, Plaintiffs have again failed to allege that the Subscriber Plaintiffs have standing to sue under the Sherman Act. Plaintiffs have failed to show that they suffered the type of injury that the antitrust laws were designed to prevent. They have failed to explain that their injuries flow inexorably from Defendants' efforts to reduce competition in the Data Market. Further, they have neither alleged that they participated in the Data Market nor that their injuries are inextricably intertwined with the harm the Insurer Conspirators allegedly sought to inflict on the Data Market. Therefore, Plaintiffs fail to plead an antitrust injury sufficient to confer standing. Thus, the Subscriber Plaintiffs' Sherman Act cause of action is DISMISSED WITH PREJUDICE.

*iv. Subscriber Plaintiffs' Standing under the Cartwright Act (Twelfth Cause of Action)*

As explained in the Order on the Motion to Dismiss the CTAC, September 6, 2012 Order at 22-23, n.4, the Cartwright Act "is California's version of the federal Sherman Act and sets forth California's antitrust laws." *Cellular Plus, Inc. v. Superior Court of San Diego Cnty.*, 14 Cal. App. 4th 1224, 1232, n.2, 18 Cal. Rptr. 2d 308 (1993). Standing under the Cartwright Act is broader than standing under the Sherman Act insofar as the Cartwright Act explicitly permits indirect purchasers to bring suits for damages and injunctive relief. *Id.* at 1234; *accord Clayworth v. Pfizer, Inc.*, 49 Cal. 4th 759, 763, 111 Cal. Rptr. 3d 666 (2010) ("[I]n direct response to *Illinois Brick*, the [California] Legislature amended the state's Cartwright Act ([Cal.] Bus. & Prof. Code[] § 16700 *et seq.*) to provide that unlike federal law, state law permits indirect purchasers as well as direct purchasers to sue."). Nonetheless, a plaintiff must still prove antitrust injury, "which is to say injury of the type the antitrust laws were intended to prevent and that flows from that which makes defendants acts unlawful." *Cellular Plus*, 14 Cal. App. 4th at 1234; *Langer Juice Company, Inc. v. Yantai North Andre Juice Co., Ltd.*, No. CV 06-1354 SVW (CWx), 2006 WL 5207229, at *2 (C.D. Cal. Aug. 16, 2006) ("[t]he Cartwright Act does require that Plaintiff plead an injury that is the type of injury that the antitrust laws target, the first and most important factor in federal antitrust standing[.] If Plaintiff does not allege an antitrust injury, that is the end of the inquiry") (citations omitted). Moreover, such injury must not be "secondary, consequential, or remote, but the direct result of the unlawful conduct." *Cellular Plus*, 14 Cal. App. 4th at 1233 (citation omitted).

Plaintiffs also argue that California law differs from the Sherman Act in that courts do not require a showing on the *Associated General* factors in order to show standing under the Cartwright Act. In *Vinci v. Waste Mgmt., Inc.*, 36 Cal. App. 4th 1811, 43 Cal.Rptr.2d 337 (1995), a state appellate court applied the *AGC* factors in determining whether the particular plaintiff before it had standing. *Id.; see also In re Flash Memory Antitrust Litig.*, 643 F. Supp.

2d 1133, (N.D. Cal. 2009) (same); *In re Dynamic Random Access Memory (DRAM) Antitrust Litig.*, 536 F. Supp. 2d 1129, (N.D. Cal. 2008) (same). *Cf. In re Graphics Processing Units Antitrust Litig.*, 540 F. Supp. 2d 1085, 1097 (N.D. Cal. 2007) ("some California appellate courts have used the *AGC* test .... [but t]his is not the same as showing that *AGC* has been adopted"); *In re TFT–LCD (Flat Panel) Antitrust Litig.*, 586 F. Supp. 2d 1109, 1120-24 (N.D. Cal. 2008) (suggesting that courts need a clear directive from the state legislature or high court, but finding that plaintiffs had standing under the *Associated General* factors anyway); *In re Optical Disk Drive Antitrust Litig.*, No. 3:10–md–2143 RS, 2011 WL 3894376, at *11–12 (N.D. Cal. Aug. 3, 2011) (finding plaintiff had standing based on reasoning in *In re TFT–LCD*).

While neither the California Supreme Court nor the Ninth Circuit have explicitly held that the *Associated General* factors apply to claims under the Cartwright Act, the Ninth Circuit has applied the *Associated General* factors in determining standing under the Cartwright Act. *Knevelbaard Dairies v. Kraft Foods, Inc.*, 232 F.3d 979, 987 (9th Cir. 2000). The Ninth Circuit acknowledged that distinctions exist between both laws, and the limited role that federal law provides in furnishing precedent under the Cartwright Act. Nonetheless, the court still found that "[a]ntitrust standing is required under the Cartwright Act." *See id.* at 987. The court reconciled the differences in California law by stating that, within the framework of the antitrust standing inquiry, "California law affords standing more liberally than does federal law." *Id.* The Ninth Circuit then proceeded to analyze the case within the framework of the *Associated General* factors, and when the time came to consider the "directness of injury" factor, took into account the broader principles relating to indirect purchasers provided by state law. Importantly for purposes of this Motion to Dismiss, the Ninth Circuit's analysis with regard to the "antitrust injury" factors established in *American Ad Management* was the same for the Sherman Act and Cartwright Act claims.

Thus, in view of the Ninth Circuit and California authorities discussed above, the court finds that Plaintiffs proceeding under the Cartwright Act are required to satisfy the general antitrust standing requirements enunciated by the Supreme Court in *Associated General*, and embraced by the Ninth Circuit in *Knevelbaard.*

Accordingly, having failed to plead an "injury of the type the antitrust laws were intended to prevent," the Cartwright Act's more liberal standing requirements do not avail Plaintiffs here, and this cause of action, too, is DISMISSED WITH PREJUDICE.

B. RICO Causes of Action Brought on Behalf of the Subscriber Plaintiffs (Fifth, Sixth, and Seventh Causes of Action)

The Court next considers Plaintiffs' fifth, sixth, and seventh causes of action for violations of RICO, 18 U.S.C. § 1962, *et seq*. The CFAC alleges RICO violations predicated on (1) mail fraud, on behalf of the Subscriber Plaintiffs and the Subscriber Classes against WellPoint and Ingenix under 18 U.S.C. § 1962(c); (2) embezzlement on behalf of all ERISA Plaintiffs and the ERISA Plaintiff Classes against all WellPoint and Ingenix under 18 U.S.C. § 1962(c); and (3) conspiracy to violate RICO, 18 U.S.C. § 1962(d), on behalf of the Subscriber Plaintiffs and the Subscriber Classes against all Defendants. The Court will address the allegations in that order.

*i. Participation in a RICO Enterprise – 18 U.S.C. § 1962(c) (Fifth Cause of Action)*

As the Court stated in its September 6, 2012 Order, section 1962(c) of RICO states that: "[i]t shall be unlawful for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity or collection of unlawful debt." 18 U.S.C. § 1962(c). For a plaintiff to state a claim under § 1962(c), he or she must allege "(1) conduct (2) of an enterprise (3) through a pattern (4) of racketeering activity." *Sedima, S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 496 (1985); *Walter v. Drayson*, 538 F.3d 1244, 1247 (9th Cir. 2008). "RICO is to be read broadly" and "liberally construed to effectuate its remedial purposes." *Sedima*, 473 U.S. at 497-98; *Odom v. Microsoft Corp.*, 486 F.3d 541, 547 (9th Cir. 2007) (citation omitted).

In the Order on the Motion to Dismiss the CTAC, the Court determined that the Provider and Association Plaintiffs lacked standing to pursue their RICO causes of action. *See* September 6, 2012 Order at 24. The Court also determined that the Subscriber Plaintiffs failed to plead that WellPoint had conducted the affairs of the Enterprise, though it did find that the Subscriber Plaintiffs adequately pleaded that the UHG Defendants conducted the affairs of the enterprise. *Id.* at 24-28. The Court found that the CTAC adequately identified predicate mailings by Ingenix but not by UHG, and dismissed the RICO action predicated on mail fraud as to UHG with prejudice. *Id.* at 28-30. The Court also determined that the Subscriber Plaintiffs failed to show proximate cause for their RICO cause of action predicated on mail fraud. *Id.* at 30-32. WellPoint and the UHG Defendants continue to argue that Plaintiffs have failed to adequately amend the Complaint to sustain a cause of action under RICO.

a. *Defendants' Conduct*

Liability for participating in the "conduct" of a RICO enterprise extends only to those who "have some part in directing [the enterprise's] affairs." *Reves v. Ernst & Young*, 507 U.S. 170, 179 (1993). In the RICO context, "directing" has a different meaning than is commonly understood. A defendant need not be in charge of or have "significant control over or within [the] enterprise." *Reves*, 507 U.S. at 179, n.4 (citation omitted). However, more is required than "simply being involved," and "[s]imply performing services for the enterprise does not rise to the level of direction." *Walter*, 538 F.3d at 1249. Similarly, it "is not enough that [a defendant] failed to stop illegal activity." *Id.* at 1248. Relevant considerations include whether the defendant "occup[ies] a position in the 'chain of command'…through which the affairs of the enterprise are conducted," whether the defendant "knowingly implement[ed] the decisions of upper management," and whether the defendant's "participation was 'vital' to the mission's success." *See id.* at 1249. Finally, RICO liability requires a "showing that the defendants conducted or participated in the conduct of the '*enterprise's* affairs,' not just their *own* affairs." *Reves*, 507 U.S. at 185.

As indicated above, the Court has previously determined that Plaintiffs have adequately alleged that the UHG Defendants conducted the affairs of the enterprise. However, the Court has not found that Plaintiffs have adequately alleged that WellPoint conducted the affairs of the enterprise. As with the Motions to Dismiss the SAC and the CTAC, WellPoint argues that Plaintiffs failed to plead that WellPoint directed the affairs of the enterprise. *See WellPoint Mot.* 16:16-22.

In the August 11, 2011 Order, the Court noted that Plaintiffs' allegation that "WellPoint and UnitedHealth 'knowingly participated in the formation and maintenance of the Ingenix Database'" was "as specific as Plaintiffs [got] with respect to WellPoint Defendants' RICO conduct." *See* August 11, 2011 Order at 27. The SAC also contained allegations that WellPoint submitted false data to Ingenix for the purpose of determining flawed UCRs. *Id.* The Court held that WellPoint's submission of its own data did not show that WellPoint controlled the other members of the associated-in-fact enterprise, but only established that WellPoint was acting on its own by submitting data. *Id.* The Court also found that a business relationship among WellPoint, Ingenix, and the Insurance Defendants was not sufficient to show that WellPoint conducted the enterprise. *Id.* (citing *Goren v. New Vision Intern., Inc.*, 156 F.3d 721, 727-28 (7th Cir. 1998) (holding that an established business relationship between the defendants and the enterprise was insufficient to state a claim that the defendants directed the affairs of the alleged fraudulent marketing enterprise). The Court acknowledged that a conclusory statement that WellPoint and United Health were involved in decisionmaking regarding the Ingenix database did not meet *Twombly*'s pleading requirements. *See* August 11, 2011 Order, at 27 (citing

*Kearney v. Foley & Lardner*, 05-cv-2112 (LSP), 2011 WL 1119020, at *6 (S.D. Cal. Mar. 28, 2011)).

In the September 6, 2012 Order, the Court noted that Plaintiffs had failed to provide allegations that changed its analysis. The Court acknowledged Plaintiffs' allegations that WellPoint executives held upper management positions within the HIAA, and later with AHIP, HIAA's successor organization. *See* September 6, 2012 Order at 26. The Court also noted the allegations that various committees composed of HIAA members developed what became the PHCS database, and that the HIAA "*via* its committees and Board of Directors" consciously decided to limit the amount of information received by contributors to four datapoints. *Id.* Also present were allegations that HIAA members, including WellPoint, agreed to sell the PHCS to Ingenix; that Leonard Schaeffer, the then-CEO of WellPoint, was the number two official in charge at the time; and that when the PHCS was sold to Ingenix, HIAA and Ingenix agreed to have member companies participate in an ongoing Ingenix PHCS Advisory Committee, "which would have input as to what data Ingenix used and how Ingenix used it." *Id.* The Court also recognized that Ingenix and HIAA set up a Liaison Committee to advise and evaluate Ingenix. *Id.*

The Court criticized the CTAC to the extent that it did not allege that WellPoint ever served on either the Advisory or Liaison Committee that "had input" into the data used by Ingenix and played a role in advising and evaluating the database. *Id.* The Court also noted that the only real change between the SAC and the CTAC were the allegations that WellPoint's then-CEO was second in command of the HIAA at the time the PHCS database was sold to Ingenix and that other high-ranking officers at WellPoint served on the Board of Directors of HIAA/AHIP from 1988 to the present. *Id.* Ultimately, because Plaintiffs did not tie any of the executives at WellPoint with any decision-making on behalf of Ingenix, the Court found Plaintiffs' allegations insufficient. *Id.* at 26-27.

The CFAC also fails to allege facts that suggest that WellPoint directed the enterprise. Plaintiffs repeat many of their prior allegations and fail to adequately allege that WellPoint was controlling the enterprise. For example, Plaintiffs continue to allege that a WellPoint executive was on the HIAA Board of Directors at the time of the sale of the database. *See CFAC* ¶ 356; *CTAC* ¶¶ 302-304. Plaintiffs also allege that various WellPoint executives served on the Board of Directors of the HIAA/AHIP from 1988 to the present. *See CFAC* ¶ 358; *CTAC* ¶¶ 302-04. Additionally, Plaintiffs allege that Advisory and Liaison Committees were created in connection with the sale of the database from AHIP to Ingenix. *See CFAC* ¶ 357; *CTAC* ¶¶ 302-04. However, Plaintiffs are still unable to allege that WellPoint participated in any decision-making on behalf of Ingenix. Plaintiffs claim that they newly allege that various HIAA members served

on the Advisory and Liaison Committee. However, this allegation appeared in the CTAC. *Compare CFAC* ¶ 357 *with CTAC* ¶¶ 302-04. While Plaintiffs allege the conclusory allegation that "HIAA members participated in the continued development, operation, and direction of the database after its sale by HIAA to Ingenix," *see CFAC* ¶ 357, they continue to fail to allege that WellPoint was a member of any committee that participated in decision-making on behalf of Ingenix. *Cf. Franco*, 818 F. Supp. 2d at 827 (sustaining plaintiffs' mail and wire fraud-based RICO claims because defendant had a "decisionmaking role with regard to the use of Ingenix to determine CNET claims."). As with the CTAC, the Court notes that there is a difference between alleging that WellPoint is an HIAA member and that HIAA members were on the Advisory and Liaison Committees, and specifically alleging that WellPoint was on the Advisory and Liaison Committees.

Plaintiffs also allege that WellPoint operated the enterprise as a "lower rung" participant. However, such a theory is without merit because Plaintiffs are unable to show that WellPoint knowingly implemented the decisions of upper management. "Lower-rung" members of the enterprise can be deemed liable if they "knowingly implemented" decisions of upper management, thereby "enabling the enterprise to achieve its goals." *MCM Partners, Inc. v. Andrews-Bartlett & Assocs., Inc.*, 62 F.3d 967, 979 (7th Cir. 1995).

In *Walter*, a trust beneficiary sued trustees and attorneys who provided legal services for the trust, asserting violations for RICO and breach of fiduciary duty. *Walter*, 538 F.3d at 1244. The plaintiff alleged that the attorney conducted the affairs of the enterprise by writing emails, giving advice, and taking positions on behalf of her clients in a way that facilitated the wrongful taking of trust assets. *Id.* at 1248. The court determined that the attorney's performance of services did not make her a lower rung participant in the enterprise. *Id.* The Court noted that "she and her firm were not acting under direction from the trust or the trustees, at least, not so far as we can tell from the pleadings." *Id.*

By contrast, in *MCM Partners*, 62 F.3d at 978, the court found that defendants were properly characterized as "lower-rung participants who are under the direction of upper management." In *MCM Partners*, a rental equipment company alleged that exhibition contractors violated the Sherman Act and RICO when they refused to rent forklifts and other material handling and equipment from plaintiff. *Id.* at 969. The court determined that defendants were "lower-rung participants" acting "under the direction of upper management" because they acted "'at the direction of' one or more of the other members of the enterprise." *Id.* at 978-79. It noted that defendants were following orders of the enterprise where they were subject to discipline, including threats of strikes and damage to property, for failing to exclude plaintiffs from the market. *Id.* at 978.

Here, Plaintiffs contend that WellPoint participated in the enterprise because there was a *quid pro quo* arrangement whereby WellPoint agreed to provide its data only to Ingenix and to no other companies. However, this deficient allegation was present in the other complaints. *See CFAC* ¶ 359, *CTAC* ¶ 306, *SAC* ¶ 299. Plaintiffs attempt to argue that the noncompete agreement between the HIAA and Ingenix makes its *quid pro quo* allegations sufficient to establish that WellPoint was acting at the direction of Ingenix when it allegedly did not submit data elsewhere. However, WellPoint did not sign the agreement, and the language of the Agreement does not indicate that the signatories intended to treat HIAA members as parties to the agreement. *See UHG Mot.*, Ex. A, §1(b) (referring to HIAA members as "third parties"); *Cf. In re Ins. Brokerage Antitrust Litig.*, 618 F.3d 300, 374 (3d Cir. 2010) (finding a RICO violation where each insurer had entered into an agreement with the broker not to disclose the details of its contingent-commission agreements).[3] Additionally, to the extent Plaintiffs argue that WellPoint implemented the decisions of Ingenix, the allegations in the CFAC actually establish that at times, WellPoint directly ignored the directions of Ingenix. For example, the CFAC alleges that when Ingenix asked WellPoint to submit more datapoints, WellPoint refused to do so. *CFAC* ¶¶ 153-54. This further establishes that WellPoint was acting independently and was not a "lower rung" participant under Ingenix.

Finally, the Court notes that Plaintiffs' allegations do not establish that WellPoint was "vital" to the alleged scheme. The allegations in the CFAC establish that WellPoint was just one of many insurers upon which Ingenix relied to receive data. The allegations suggest that the quantity of insurers and data received helped to define Ingenix as the "industry standard," but fail to suggest that Ingenix would not have been the "industry standard" absent WellPoint's data submission. In fact, the allegations explain that WellPoint was not even the largest contributor to Ingenix – it was the third largest contributor of data. The CFAC details that when WellPoint's contributions were combined with those of Aetna and CIGNA, the three major insurers' data *combined* contributed to nearly 60% of the billing information. *See CFAC* ¶ 140. This suggests

[3] In ruling on a motion to dismiss, a court may consider certain documents outside the pleadings without the proceeding turning into summary judgment. *See Lee v. City of L.A.*, 250 F.3d 668, 688-89 (9th Cir. 2001). In particular, a court may consider: (a) documents that are properly submitted as part of the complaint; (b) documents upon which plaintiff's complaint necessarily relies and whose authenticity is not contested; and (c) matters of public record of which the court may take judicial notice under Rule 201 of the Federal Rules of Evidence. *See id.* The Agreement attached to UHG's Motion as Exhibit A is classified as a document upon which Plaintiffs' CFAC necessarily relies, *see CFAC* ¶ 361, and whose authenticity is not contested. The Court may therefore consider the document in ruling on the motion to dismiss.

that, even if WellPoint failed to contribute to Ingenix, Ingenix would have received ample data from Aetna, CIGNA, and other insurers. At best, Plaintiffs' allegations indicate that if WellPoint had not been involved, Ingenix would have had fewer data submissions. The allegations do not, however, indicate that Ingenix could not have continued with the alleged scheme absent WellPoint's participation. *Cf. VFI Assocs., LLC v. Lobo Mach. Corp.*, No. 1:08CV00014, 2012 WL 975705, *3 (W.D. Va. Mar. 22, 2012) (holding that defendant's actions of manipulating books and records, creating false invoices, signing kickback checks, and obstructing access to accurate data and documents were "directing the enterprise" because had defendant not committed these acts, the enterprise could not have achieved its goal); *Decatur Ventures, LLC v. Stapleton Ventures, Inc.*, 373 F. Supp. 2d 829, 839 (S.D. Ind. 2005) (recognizing that mortgage broker was integral to a scheme to fraudulently induce people into making investment purchases of residential real estate properties because without the broker's services and ordering appraisals, the scheme could not have been successful).

Thus, having again failed to plead any non-conclusory facts showing that WellPoint played "some part in directing the enterprise's affairs," as opposed to "simply being involved" in them, the CFAC again fails to plead that WellPoint conducted the enterprise and the Subscriber Plaintiffs' fifth cause of action against WellPoint is DISMISSED WITH PREJUDICE.

*b. "Pattern" of "Racketeering Activity"*

Although the allegations as to WellPoint are insufficient to state a RICO cause of action because they do not allege that WellPoint conducted the affairs of the enterprise, the Court has previously determined that Plaintiffs adequately pleaded that UHG Defendants conducted the affairs of the enterprise. September 6, 2012 Order at 26-27. Thus, for UHG Defendants to state a RICO cause of action, the UHG Defendants must also show a pattern of racketeering activity. To show a pattern of racketeering activity, a plaintiff must both allege at least two acts of racketeering activity, 18 U.S.C. § 1961(5), and that the RICO predicate acts were the proximate cause of plaintiffs' injuries. *Hemi Grp., LLC v. City of N.Y.*, 130 S. Ct. 983, 989 (2010).

The Court held in its September 6, 2012 Order that Plaintiffs' allegations sufficiently alleged racketeering activity as to Ingenix, but dismissed Plaintiffs' allegations regarding a pattern of mail fraud as to UHG. September 6, 2012 Order at 30. The Court also found that Plaintiffs did not allege that the RICO predicate acts were the proximate cause of Plaintiffs' injuries. *Id.* at 30-31. In the CFAC, Plaintiffs do not maintain their allegations regarding a pattern of mail fraud as to UHG. *CFAC* at 154. Thus, the only remaining issue is whether

Plaintiffs have pleaded that Ingenix's racketeering activity was the proximate cause of Subscriber Plaintiffs' alleged injuries.

*1. Mail and Wire Fraud Proximate Causation*

Although Plaintiffs have adequately alleged a pattern of mail fraud as to Ingenix, the Court determined in both prior Orders that Plaintiffs failed to adequately allege proximate causation. *See* August 11, 2011 Order at 31; September 6, 2012 Order at 30-31. As indicated in the September 6, 2012 Order, an injury "by reason of" a RICO violation requires plaintiffs "to show that a RICO predicate offense 'not only was a 'but for' cause of [their] injury, but was the proximate cause as well.'" *Hemi Grp., LLC v. City of N.Y.*, 130 S. Ct. 983, 989 (2010) (quoting *Holmes v. Sec. Investor Prot. Corp.*, 503 U.S. 258, 268 (1992)). "When a Court evaluates a RICO claim for proximate causation, the central question it must ask is whether the alleged violation led directly to the plaintiff's injuries." *Anza v. Ideal Steal Supply Corp.*, 547 U.S. 451, 461 (2006).

In the CTAC, the Subscriber Plaintiffs alleged that their RICO injury was overpaying for health insurance coverage due to false reimbursement rates. *See* September 6, 2012 Order at 30. They alleged that these injuries resulted from Defendants' alleged RICO violations of transmitting flawed data among one another. *Id.* at 31. The Court noted that in order to maintain a cause of action under RICO, Plaintiffs needed to show that someone relied on some aspect of Defendants' fraudulent scheme. *Id.*

Plaintiffs continue to allege that their RICO injury was overpaying for health insurance coverage due to false reimbursement rates. *CFAC* ¶ 438. They also continue to allege that their injuries resulted from "predicate acts that involved transmissions *between Defendants* regarding the flawed data." *Opp*. 31:25-28. Plaintiffs contend that because they are alleging that the injuries resulted from transmissions between Ingenix and the Insurer Conspirators, and not from reliance on Defendants' alleged misrepresentations to Plaintiffs, they need not show reliance to prove proximate cause. However, the Supreme Court has definitively held that in order to show RICO causation, one must prove that at least *someone* relied on the predicate mail fraud. *Bridge v. Phoenix Bond & Indem. Co.*, 553 U.S. 639, 658 (2008). Moreover, the Court squarely rejected this exact argument in its September 6, 2012 Order: "That the CTAC now identifies data transmissions between Ingenix and the Insurer Conspirators as the predicate mailings does not alter the fundamental character of Defendants' fraudulent scheme or change the fact that this is a case where proof of reliance, and likely first-party reliance, is 'a mile post on the road to causation.'" *Id.* at 31. (citing *Negrete v. Allianz Life Ins. Co.*, No. CV 05-6838 CAS (MANx), 2011 WL 4852314, at *11, n.8 (C.D. Cal. Oct. 13, 2011) (internal quotation marks omitted)).

Thus, although Plaintiffs allege that the RICO predicate acts are data transmissions between Ingenix and the Insurer Conspirators, without a showing that someone relied on some aspect of Defendants' fraudulent scheme, Plaintiffs cannot show that the alleged scheme caused their injuries.

Plaintiffs also argue that "to the extent courts have imposed a RICO 'reliance' requirement after *Bridge*, they have generally done so in a non-Rule 12(b)(6) context and where reliance on a misrepresentation was an integral and pleaded component of the plaintiff's RICO claim." *Opp*. at 31:19-21. However, the cases cited by Plaintiffs are unavailing because not only have Plaintiffs failed to cite any cases where the Court did *not* impose the reliance requirement in the 12(b)(6) context, Plaintiffs fail to cite to any cases where the courts have not determined that a reliance requirement was integral to the plaintiff's RICO claim. *Opp.* at 31:19-26. *See Hoffman v. Zenith Ins. Co.*, 487 F. App'x 365, 366 (9th Cir. Nov. 7, 2012) (finding that the district court properly granted summary judgment where the evidence showed that plaintiffs did not rely on defendants' misrepresentations); *UFCW Local 1776 v. Eli Lilly and Co.*, 620 F.3d 121, 132-33 (2d Cir. 2010) ("We find ourselves in a similar position here: while reliance may not be an element of the cause of action, there is no question that in this case the plaintiffs allege, and must prove, third-party reliance as part of their chain of causation."); *Negrete*, 2012 WL 6737390 at *14 & n.9 ("Without proving reliance in some form, plaintiffs will be unable to demonstrate the causal linkage between the defendant's alleged misrepresentations and the class members' injuries."). Plaintiffs have failed to adequately explain why misrepresentation is not an integral and pleaded component of the Subscriber Plaintiffs' RICO claim. Indeed, because Plaintiffs still allege the RICO injury that the Subscriber Plaintiffs overpaid for health insurance coverage due to false reimbursement rates, this requires a showing that *someone* relied on misrepresentations about reimbursement rates.

Also, Plaintiffs fail to establish that there is any relationship between data transmissions between Ingenix and Insurer Conspirators and the Insurer Conspirators' independent decisions to under-reimburse subscribers. For example, if WellPoint misrepresented its ONS reimbursement policies to subscribers, such conduct may be the proximate cause of subscribers' injury. However, Plaintiffs made it clear that they "do not allege their injuries resulted from obtaining Defendants' health insurance policies in reliance on misrepresentations." *Opp*. 31:25-26. Similarly, Plaintiffs have failed to prove that either an Insurer Conspirator or Ingenix relied on one another's misrepresentations; indeed, it appears that the alleged scheme depended on both parties knowing that the other was transmitting false data. As such, Plaintiffs have failed to plead that someone relied on Defendants' misrepresentations and therefore cannot sustain a cause of action as to mail fraud.

Plaintiffs also claim that Defendants have inappropriately ignored the correct proximate cause test adopted by the Ninth Circuit. *Opp.* 32:11-26. In *Sybersound Records, Inc. v. UAV Corp.*, 517 F.3d 1137, 1147-48 (9th Cir. 2008), the Ninth Circuit explained three "non-exhaustive" factors that can be used to determine whether a plaintiff has established proximate cause: (1) whether there are more direct victims of the alleged wrongful conduct who can be counted on to vindicate the law as private attorneys general; (2) whether it will be difficult to ascertain the amount of the plaintiff's damages attributable to defendant's wrongful conduct; and (3) whether the courts will have to adopt complicated rules apportioning damages to obviate the risk of multiple recoveries. *Id.* While these factors assist courts in determining proximate cause, they are irrelevant absent an initial showing of reliance. *Bridge* recognized that "[i]n most cases, the plaintiff will not be able to establish even but-for causation if no one relied on the misrepresentation." 553 U.S. at 658. If Plaintiffs are unable to show that anyone relied on Defendants' allegedly wrongful conduct, they cannot show that they were injured by reason of a RICO predicate offense. Thus, absent an initial showing that there is a relationship between the injury suffered and the alleged wrongful conduct, the utility of the proximate cause factors is limited. Moreover, Plaintiffs fail to explain in their Opposition how the allegations in the CFAC satisfy the proximate cause test.

Thus, having once again failed to plead reliance in any form, the Subscriber Plaintiffs' and Subscriber Class' fifth cause of action predicated on mail fraud is DISMISSED WITH PREJUDICE. To the extent the UHG Defendants argue in their Motion that the Samsells and J.B.W. have additional difficulties stating a RICO claim, because the RICO claims are being dismissed with prejudice, the arguments are rendered moot and the Court need not address them at this time.

*ii. RICO Predicated on Embezzlement (Sixth Cause of Action)*

In the Motion to Dismiss the SAC, the Court declined to dismiss the ERISA Subscribers' embezzlement-based RICO cause of action against WellPoint and Ingenix. The Court determined that WellPoint's interpretation of 18 U.S.C. § 664, which relates to embezzlement under RICO, was unduly narrow. *See* August 11, 2011 Order at 31-32. Section 664 of Title 18 of the United States Code reads as follows:

> Any person who embezzles, steals, or unlawfully and willfully abstracts or converts to his own use or to the use of another, any of the moneys, funds, securities, premiums, credits, property, or other assets of any employee welfare benefit plan or employee pension benefit plan, or of any fund connected therewith, shall be fined under this title, or imprisoned not more than five years, or both.

18 U.S.C. § 664. In the Motion to Dismiss the CTAC, Defendants asked the Court to revisit its holding in light of *United States v. Wiseman*, 274 F.3d 1235 (9th Cir. 2001).

The Court reasoned that traditionally, embezzlement "encompasses the use of property, placed in one's custody for a limited purpose, in an unauthorized manner or to an unauthorized extent." September 6, 2012 Order at 33 (citing *United States v. Andreen*, 628 F.2d 1236, 1241 (9th Cir. 1980). The Court explained that *Andreen* noted that the "common thread" uniting violations punishable under § 664 was that "the defendant, at some stage of the game, has taken another person's property or caused it to be taken, knowing that the other person would not have wanted that to be done." *Id.* The Court determined that ERISA Subscribers failed "to explain how by under-reimbursing them for ONS, WellPoint and the UHG Defendants 'convert[ed] to [their] own use…any of the moneys… or other assets of any employee welfare benefit plan or employee pension benefit plan.'" September 6, 2012 Order at 32 (citing 18 U.S.C. § 664). The allegations as to RICO embezzlement in the CFAC do not warrant a different interpretation. The CTAC alleged that:

> [f]or fully insured healthcare plans, in which WellPoint both administered the plans and paid the benefits from their own assets, Defendants benefited from the conversion of assets from their ERISA plans. Whereas these assets should have been held by WellPoint in its fiduciary capacities under ERISA and non-ERISA plans and paid to its members, WellPoint improperly withheld such funds and maintained them as part of its own assets for its own benefit. For self-funded healthcare plans, WellPoint made final appeal decisions and intentionally caused underpayment of benefits to Plaintiffs and the ERISA Subscriber and Provider Subclasses in order to justify receipt of administrative fees.

*CTAC* ¶ 433. The allegations in the CFAC are nearly identical:

> For fully insured healthcare plans, WellPoint administered the plans and benefited from the conversion of assets from the plans. Specifically, whereas these assets should have been held by WellPoint in its fiduciary capacity under ERISA plans and paid to its Members, WellPoint improperly withheld and converted such funds and maintained them as part of its own assets for WellPoint's own benefit; its actions resulted in a taking or appropriation of the funds that was not authorized. The plan funds that WellPoint unlawfully converted were those plan funds specifically earmarked as guaranteed benefits for the ERISA Subscriber Plaintiffs and the Subscriber Classes, for which WellPoint made or caused to be made a false payment on claims for reimbursement of out-of-network charges. By making

> improperly reduced payments on claims, WellPoint intentionally caused the ERISA Subscriber Plaintiffs and Subscriber classes to be underpaid benefits to which they were entitled to in accordance with the terms of their group health plans. WellPoint caused these funds to be withheld for its own financial gain, as well as from the revenues generated from its administration (as either plan administrator or claim administrator) of certain of the WellPoint Healthcare Plans. For self-funded healthcare plans, WellPoint made final appeal decisions and intentionally caused underpayment of benefits to Plaintiffs and the ERISA Subclasses in order to justify its receipt of administrative fees.

CFAC ¶ 378. This allegation still "amounts to nothing more than an allegation that WellPoint denied Subscribers healthcare benefits to which they purportedly were entitled under the terms of their plans." September 6, 2012 Order at 33. Plaintiffs simply allege that WellPoint decreased its own expenses. They do not allege that Subscribers paid their premiums into a trust with the understanding that the funds paid in to the trust were reserved for ONS reimbursements, or that WellPoint improperly diverted assets from such funds. Plaintiffs' allegation that WellPoint converted assets that were "specifically earmarked as guaranteed benefits for the ERISA Subscriber Plaintiffs and the Subscriber Classes" is also insufficient. *CFAC* ¶ 378. Plaintiffs alleged that the funds were "earmarked" in the CTAC, *see CTAC* ¶¶ 324, 436, and the Court did not find that the fact that funds were "earmarked within the applicable plan" meant that the funds were plan funds, as opposed to WellPoint assets.

Plaintiffs have cited authority to suggest that embezzlement occurs where funds have been "earmarked" for beneficiaries. *Opp.* 34:14-25 (citing *Am. Med. Ass'n v. United Healthcare Corp.*, 588 F. Supp. 2d 432, 444 (S.D.N.Y. 2008) (finding the allegation that Plaintiffs delineate "plan funds *specifically earmarked as guaranteed benefits for the Section 664 Plaintiffs and the Section 664 Class on each and every occasion upon which UH made or caused to be made a false payment on claims for reimbursement of out-of-network charges ...*" sufficient)). However, the Court is not persuaded that labeling the funds as "earmarked" automatically warrants a finding of conversion.

This Court disagrees with *American Medical Association* because there is a distinction between finding that funds have been converted from an established fund and finding that a defendant's own funds have been "earmarked." In *United States v. Whiting*, 471 F.3d 792, 800 (7th Cir. 2006), the court found that once contributions were withheld from employee paychecks and were not actually delivered to their benefit plans, the money no longer belonged to the company and instead belonged to the employees. *Id.* As such, the fact that money had been

"earmarked for an intended recipient" and was directed to an alternate purpose warranted a finding of conversion. *Id.*

Here, although Plaintiffs have alleged that funds were "earmarked," they do not present any allegations suggesting that the earmarked funds were ever converted from the *beneficiaries*' assets. Because embezzlement requires a finding of conversion of another's assets, the fact that WellPoint allegedly "earmarked" its own assets for the beneficiaries does not change the Court's conclusion that WellPoint withheld its own funds. *See* September 6, 2012 Order at 33. Thus, as with the CTAC, the allegations in the CFAC do not state a plausible basis by which WellPoint converted assets from the ERISA plans. *See Franco*, 818 F. Supp. 2d at 828. Rather, the allegations merely suggest that WellPoint wrongfully lowered its own expenses. *Id.*

Accordingly, because Plaintiffs have not meaningfully changed the allegations pertaining to RICO embezzlement from the CTAC to the CFAC, the Court DISMISSES the RICO embezzlement cause of action WITH PREJUDICE.

*iii. RICO Conspiracy (Seventh Cause of Action)*

As with the Motions to Dismiss the SAC and CTAC, Subscriber Plaintiffs and Subscriber Classes have failed to adequately plead a substantive violation of RICO. Therefore, the Subscribers' necessarily have failed to plead that they were injured by an "overt act" that was itself a substantive RICO violation. *See Howard*, 208 F.3d at 751 ("Plaintiffs cannot claim that a conspiracy to violate RICO existed if they do not adequately plead a substantive violation of RICO."); *accord Stearns v. Select Comfort Retail Corp.*, No. 08-2746 JF, 2009 WL 1635931, at *15 (N.D. Cal. June 15, 2009). Accordingly, the cause of action for RICO conspiracy, too, is DISMISSED WITH PREJUDICE.

C. ERISA Claims (Second, Third and Fourth Causes of Action)

ERISA was enacted primarily to "protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting . . . of financial and other information" and to establish "standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans." 29 U.S.C. § 1001(b). To meet those goals, Congress empowered participants, beneficiaries, and fiduciaries of qualified ERISA benefit plans, along with the Secretary of Labor, to sue for, *inter alia*, benefits owed. *See* 29 U.S.C. § 1132(a). The CFAC states causes of action for violations of ERISA under 29 U.S.C. § 1132(a)(1)(B), (a)(2), and (a)(3). These three causes of action are pleaded

against WellPoint only. Plaintiffs no longer allege their cause of action for violation of 29 U.S.C. §1132(c) that was in pleaded the SAC and CTAC.

The § 1132(a)(1)(B) action is brought on behalf of the ERISA Plaintiffs, and by the Association Plaintiffs on behalf of their members.[4] The § 1132(a)(2) action is brought on behalf of the ERISA Plaintiffs, and by the Association Plaintiffs on behalf of their members. The § 1132(a)(3) action is brought on behalf of the ERISA Plaintiffs, their respective Plans, and by the Association Plaintiffs on behalf of their members. As stated in Section III.A.i, the Court finds that Association Plaintiffs lack standing to bring an action for benefits under § 1132(a)(1)(B), and as stated in Section III.A.ii, the Court finds that Provider Plaintiffs and Association Plaintiffs lack standing to bring the causes of action under §§ 1132(a)(2) and (a)(3). With this in mind, the Court addresses each section in turn.

*i. Section 1132(a)(1)(B) Claim Based on Non-Ingenix Methodologies (Second Cause of Action)*

Defendants maintain their challenge as to the sufficiency of the ERISA Plaintiffs' and Association Plaintiffs' § 1132(a)(1)(B) cause of action as it relates to ONS reimbursements priced according to Non-Ingenix methodologies. As indicated in Section III.A.i, Association Plaintiffs lack standing to bring claims under § 1132(a)(1)(B). As to ERISA Plaintiffs, Defendants claim both that ERISA Plaintiffs have failed to state a claim and that ERISA Plaintiffs have failed to allege that they exhausted administrative remedies. In the August 11, 2011 Order, the Court held that Plaintiffs adequately pleaded the futility of administratively appealing ONS reimbursements priced using the Ingenix database in light of the experiences of "Subscriber X" and Dr. Peck, who allegedly appealed Ingenix-based determinations without success. In the September 6, 2012 Order, the Court held that Plaintiffs had failed to plead exhaustion of administrative remedies as to ERISA Plaintiffs whose ONS reimbursements were priced using methods other than Ingenix, because those Plaintiffs were not "similarly situated" to Subscriber X and Dr. Peck, and the CTAC failed to allege exhaustion of administrative remedies by any other ERISA Plaintiff. *See* September 6, 2012 Order at 36. In the CFAC, Plaintiffs added allegations only as to Dr. Kavali. WellPoint argues in its Motion

[4] Although Plaintiffs do not specifically define "ERISA Plaintiffs," the term appears to refer to Subscriber Plaintiffs who are members of ERISA plans, and Provider Plaintiffs who were assigned benefits by members of ERISA plans. Because WellPoint focuses on the individual Provider Plaintiffs mentioned in the CFAC, the Court refers to those Plaintiffs as "ERISA Provider Plaintiffs." The ERISA Provider Plaintiffs include Drs. Henry, Schwendig, Peck, Pariser, and Kavali.

that the CFAC fails to allege that Dr. Kavali exhausted her administrative remedies, and also fails to state a claim.

*a. Exhaustion of Administrative Remedies*

As explained in the September 6, 2012 Order, Courts in this Circuit have placed the burden on a "plaintiff seeking excuse from the exhaustion requirement [to] provide support for [the] excuse" at the motion to dismiss stage. *See Foster v. Blue Shield of Cal.*, No. CV 05-03324 DDP (SSx), 2009 WL 1586039, at *5 (C.D. Cal. June 3, 2009). The futility exception "is designed to avoid the need to pursue an administrative review that is demonstrably doomed to fail." *Diaz v. United Agr. Emp. Welfare Benefit Plan and Trust*, 50 F.3d 1478, 1485 (9th Cir. 1995). In order to come under the futility exception to the exhaustion requirement a plaintiff must show that "it is certain that [her] claim will be denied on appeal, not merely that [she] doubts that an appeal will result in a different decision." *Smith v. Blue Cross & Blue Shield United of Wis.*, 959 F.2d 655, 659 (7th Cir. 1992) (emphasis added). A plaintiff can demonstrate futility by pointing to a similarly situated plaintiff who exhausted administrative remedies to no avail. *See In re Managed Care Litig.*, 595 F. Supp. 2d 1349, 1353-54 (S.D. Fla. 2009) (finding class plaintiffs demonstrated the futility of administrative appeals because another plaintiff had unsuccessfully exhausted administrative remedies). The Court notes, however, that "bare assertions of futility" are not enough to invoke the futility exception, *Diaz v. United Agric. Emp. Welfare Benefit Plan & Trust*, 50 F.3d 1478, 1485 (9th Cir. 1995), and that "a Plan's refusal to pay does not, by itself, show futility." *Foster v. Blue Shield of Ca.*, No. CV 05-03324 (DDP), 2009 WL 1586039, at *5 (C.D. Cal. June 3, 2009).

Plaintiffs allege "the pursuit of an administrative appeal to WellPoint of its UCR determinations that are based on Non-Ingenix methodologies is futile." *CFAC* ¶ 341. First, Plaintiffs rely on allegations that WellPoint inadequately disclosed grievance procedures. *See CFAC* ¶ 310-12. However, these deficient allegations were present in the CTAC. *Compare CFAC* ¶¶ 310-12 *with CTAC* ¶¶ 263-65.

Additionally, Plaintiffs argue that because administrative appeals "are either not permitted or a perfunctory, pro forma exercise that changes nothing," any appeals were futile. *Opp.* at 38. For example, the CFAC suggests that "[i]f an appeal or inquiry related to the UCR determination was coded correctly, a form script is provided, informing the appealing party that he or she is liable for the amount charged." *CFAC* ¶ 339. It goes on to allege that "[n]o further appeal is permitted." *Id.* Plaintiffs also allege that UniCare, a subsidiary of WellPoint has "expressly stated . . . in its appeals guidelines" that it does not permit "any appeals of its decisions as to the amount of 'usual and customary charges.'" *CFAC* ¶ 336. The CFAC

explains that when an appeal is initiated, "UniCare routinely uses a standard form that is sent in response to any such appeal. The form announces the appeal has been denied, explaining that the UCR was calculated using internal fee schedules or a percentage of CMS and that the internal appeals process is complete." *Id.* ¶ 337. Additionally, the CFAC alleges that "[o]ther divisions of WellPoint have similar written policies," explaining that "[f]or the Central Region at WellPoint, its own appeal guidelines reflect that as long as no clerical errors were made, the reimbursement levels stand and no appeal is permitted. Even if pursued, the appeal results in automatic *pro forma* denial." *Id.* ¶ 338.

Although Plaintiffs' allegations suggest that an appeal may have resulted in *pro forma* denial, absent the allegation that any Plaintiff actually attempted to follow the administrative procedures, or that any Plaintiff received a *pro forma* denial upon attempting to exhaust administrative remedies, Plaintiffs have failed to show futility. In *Barnett*, the plaintiff allegedly had been told by several members of the management committee that any application she made for benefits would be denied. *Barnett v. Int'l Bus. Machs. Corp.*, 885 F. Supp. 581, 587 (S.D.N.Y. 1995). As a result, the plaintiff never made a formal request for benefits. *Id.* Later, when the plaintiff filed suit, she argued any administrative recourse would have been futile because her claims had been denied *de facto*. *Id.* The court rejected her argument because futility is "applied in a context in which there has been, in some form, an unambiguous application for benefits and a formal or informal administrative decision denying benefits and it is clear that seeking further administrative review of the decision would be futile." *Id.* at 588; *see also Mellor v. Solomon Entities Defined Ben. Pension Plan*, No. CV 11–4396 CAS (JEMx), 2011 WL 4477322, at *4-*5 (C.D. Cal. Sept. 26, 2011) ("The Court finds that plaintiff has failed to adequately allege futility. Nowhere in the FAC does plaintiff allege he formally initiated the administrative process. . . . the mere fact that Kenneth Solomon allegedly indicated to plaintiff that his claim would fail is not sufficient to demonstrate futility without a formal instigation of the administrative procedures."); *Ajayi v. Kaiser Found. Health Plan, Inc.*, 2013 WL 221503, at *1-*2 (E.D. Cal. Jan. 10, 2013) ("Plaintiff urges that the exhaustion principle does not apply since his claim falls within the recognized futility exception to that requirement because 'he was stonewalled.' However, Plaintiff's 'bare assertion[ ] of futility [is] insufficient to bring a claim within the futility exception, which is designed to avoid the need to pursue an administrative review that is demonstrably doomed to fail.'").

Additionally, Plaintiffs argue that an exception is warranted because of the purposes behind the exhaustion doctrine. *Opp.* at 40 (citing *Fallick v. Nationwide Mut. Ins. Co.*, 162 F.3d 410, 420 (6th Cir. 1998)). *Fallick* recognized that "[t]he law does not require parties to engage in meaningless acts or to needlessly squander resources as a prerequisite to commencing litigation." *Id.* However, this case is not like *Fallick*, where the plaintiff "tried repeatedly over a

period of two years to challenge the methodology used by Nationwide to determine its reasonable and customary limitations" but did not technically exhaust his administrative remedies. *Id.* at 414. Rather, Plaintiffs are just citing written policies of insurers and alleging that appeals are not permitted. *See CFAC* ¶¶ 336-40. Unlike *Fallick*, they do not make any allegations suggesting that a Plaintiff actually attempted to appeal and failed.

Accordingly, because Plaintiffs' new allegations as to Dr. Kavali fail allege that any Plaintiff exhausted administrative remedies with regard to non-Ingenix metholodogies, ERISA Plaintiffs cannot state a claim under § 1132(a)(1)(B); as such, the Court need not consider whether Plaintiffs have failed to state a claim. Thus, Defendants' Motion to Dismiss is GRANTED as to ERISA Plaintiffs' claim under § 1132(a)(1)(B) for reimbursement of ONS using non-Ingenix methodologies. Additionally, because Plaintiffs did not modify any of their allegations to the ERISA Subscriber Plaintiffs, all ERISA Plaintiffs' claims regarding non-Ingenix methodologies are DISMISSED WITH PREJUDICE.

*ii. Section 1132(a)(2) and (a)(3) claims based on Non-Disclosure of UCR Data (Third and Fourth Causes of Action)*

Next, the ERISA Subscribers and ERISA Plans assert claims for breach of fiduciary duties under 29 U.S.C. § 1132(a)(2) and for failure to provide a full and fair review or requested disclosures required by ERISA under 29 U.S.C. § 1132(a)(3).[5] Defendants contend that Plaintiffs have failed to adequately state a claim under § 1132(a)(2) and (a)(3) because Plaintiffs have failed to show that ERISA imposes upon insurers an obligation to disclose how reimbursement rates are calculated. In the September 6, 2012 Order, the Court agreed that "[n]o ERISA provision or implementing regulation requires an insurer to provide every bit of data underlying a claim decision and details about the way in which that data was used." September 6, 2012 Order at 37 (quoting *Franco*, 818 F. Supp. 2d at 823). The Court reasoned that Plaintiffs had not shown that there was any ERISA provision that required affirmative disclosure of any reimbursement rate calculations. Specifically, in Plaintiffs' Opposition to the Motion to Dismiss the CTAC, they argued that 29 U.S.C. § 1022(a) mandated such disclosure. The Court disagreed, finding that § 1022, which deals with summary plan descriptions ("SPDs"), listed certain information that must be disclosed, which did not include UCR data. September 6, 2012 Order at 37-38.

[5] "ERISA Subscribers" are not defined in the CFAC, though the term appears to refer to the individual Subscriber Plaintiffs who are members of an ERISA plan. "ERISA Plans" is not defined in the CFAC, though the term appears to indicate the Plans to which the ERISA Subscribers belong.

As explained in the September 6, 2012 Order, courts that have considered the scope of an insurer's affirmative disclosure obligations in similar contexts have concluded that they do not extend to disclosure of UCR methodology or physician reimbursement schedules, and that courts "should not add to the specific disclosure requirements that ERISA already provides." *See, e.g.*, *Ehlmann v. Kaiser Found. Health Plan*, 198 F.3d 552, 555 (5th Cir. 2000) (holding no duty to disclose physician reimbursement schedules under 29 U.S.C. § 1022); *Horvath v. Keystone Health Plan E., Inc.*, 333 F.3d 450, 461-63 (3d Cir. 2003) (same); *accord Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 754 (S.D.N.Y. 1997) ("Had Congress seen fit to require the affirmative disclosure of physician compensation arrangements, it could certainly have done so in ERISA §§ 101-111. The general fiduciary obligations set forth in ERISA § 404 [also] do not refer to the disclosure of information to Plan participants, and it would be 'inappropriate to infer an unlimited disclosure obligation on the basis of general provisions that say nothing' about such duties."); *Krauss v. Oxford Health Plans, Inc.*, 418 F. Supp. 2d 416, 429 (S.D.N.Y. 2005), *aff'd*, 517 F.3d 614 (2d Cir. 2008) (rejecting claim under § 1022 based on defendant's "failure to disclose how it calculates UCR limits," because "the Plan documents clearly disclose[d] that there may be some limitation on the amount of reimbursement, and in particular, where out-of-network providers are involved, that reimbursement will be limited to the lesser of the fee charged by the physician or the amount that Oxford determines to be reasonable"); *DeBartolo v. Blue Cross/Blue Shield of Ill.*, No. 01 C 5940, 2001 WL 1403012, at *7 (N.D. Ill. Nov. 9, 2001) (holding that information regarding "usual and customary charges" is not the type of information an ERISA plan administrator is required to disclose under 29 U.S.C. § 1024(b)(4)); *Franco*, 818 F. Supp. 2d at 822-24 (rejecting claim brought under § 1022 and various other disclosure provisions of ERISA based on CIGNA's failure to disclose its UCR methodology, including the flawed nature of the Ingenix Database).

While Plaintiffs have not added any allegations to modify the Court's analysis as to § 1132(a)(2), as to § 1132(a)(3), Plaintiffs add the allegation that WellPoint breached its disclosure obligations under 29 U.S.C. § 1104 ("Section 404"). In *Franco*, the Court held that a fiduciary has no obligation to disclose UCR data under Section 404. *See Franco*, 818 F. Supp. 2d at 822-24 ("Plaintiffs have not cited, nor has the Court's independent research uncovered, any binding authority holding that the fiduciary duty of disclosure under ERISA requires that a plan fiduciary disclose the data the plan uses to determine what constitutes the UCR or prevailing fee for a service."). *Accord Gates v. United Health Group*, No. 11 Civ. 3487(KBF), 2012 WL 2953050 at *5, *12-*13 (S.D.N.Y. July 16, 2012) (granting motion to dismiss alleged Section 404 violation under Section 1132(c) because "documents pertaining to the methodology for calculating reimbursement rates for OON benefits are not 'formal legal documents that govern or confine [the Plan's] operation.'").

In the CFAC, Plaintiffs allege that WellPoint has failed to provide information in response to a *specific inquiry* from certain Plaintiffs. *See CFAC* ¶ 468 ("As a fiduciary, WellPoint failed to make proper disclosure to Plaintiffs and the members of the ERISA Subclasses as a fiduciary, pursuant to ERISA § 404, 29 U.S.C. § 1104, when it was specifically requested to do so, as in the cases of Plaintiffs Roberts and Subscriber X, detailed above."); *CFAC* ¶ 246 ("Plaintiff Roberts repeatedly requested, in writing and otherwise, that WellPoint provide specifics about its UCR determination and why the provider's charges had been determined to exceed the UCR. Plaintiff Roberts did not receive data, documentation, or adequate redress from WellPoint."); *CFAC* ¶ 328 ("When faced with the denials of her appeals, Subscriber X submitted a specific request for additional information to both her employer and WellPoint concerning WellPoint's UCR determinations.").

Plaintiffs allege that the disclosure requirements following a specific inquiry differ from a fiduciary's general disclosure obligations. Specifically, Plaintiffs argue that where a Plaintiff has specifically requested UCR information from an insurer, the insurer is required to disclose it under Section 404. *See N. Cypress Med. Ctr. Operating Co. v. CIGNA Healthcare*, 782 F. Supp. 2d 294, 310 (S.D. Tex. 2011) ("[A]n allegation that a fiduciary refused to provide UCR information in response to a specific inquiry by a plan beneficiary is sufficient to state a claim under ERISA § 404.").

However, the Court finds the reasoning in *North Cypress* unpersuasive. *North Cypress* does not identify any rationale as to why a specific inquiry from a plan member would require heightened disclosure obligations. While *North Cypress* distinguishes other cases, it fails to specify the precedent upon which it relies to ultimately reach a conclusion that a specific inquiry requires disclosure. The Court is particularly concerned by how *North Cypress* distinguished *Mondry v. Am. Family Mut. Ins. Co.*, 557 F.3d 781 (7th Cir. 2009) ("The courts holding that internal guidelines and memoranda do not constitute plan documents within the scope of section 1024(b)(4) have reasoned that however relevant such guidelines and memoranda may be to a plan beneficiary's entitlement to benefits, as internal interpretative tools they are not binding on the claims administrator and therefore do not formally govern the operation of the plan."). The defendant in *North Cypress* cited *Mondry* for the proposition that "ERISA requires disclosure of only the 'formal legal documents governing a plan.'" *North Cypress*, 782 F. Supp. 2d at 310 (citing *Mondry*, 557 F.3d at 797). *North Cypress* dismissed defendant's reliance on *Mondry* on the grounds that *Mondry* dealt with disclosure requirements under Section 104, and not Section 404. However, the *Mondry* court's interpretation of Section 104 is highly persuasive because it concerns the sort of disclosure required given a specific inquiry from a plan member. Section 104(b)(4) requires that:

> The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated. The administrator may make a reasonable charge to cover the cost of furnishing such complete copies. The Secretary may by regulation prescribe the maximum amount which will constitute a reasonable charge under the preceding sentence.

29 U.S.C. § 1024(b)(4). The Ninth Circuit has indicated that the disclosure obligations of Section 404 are limited by those enumerated in Section 104:

> Other circuits, applying a similar analysis, have recognized that an ERISA fiduciary's duty to disclose information to beneficiaries is not limited to the dissemination of the documents and notices specified in 29 U.S.C. sections 1021-1031, but may in some circumstances extend to additional disclosures where the interests of the beneficiaries so require. However, common law trust duties regarding the disclosure of information to beneficiaries may be read into ERISA through section 404(a) only to the extent that they relate to the provision of benefits or the defrayment of expenses, and only insofar as they do not contradict or supplant the existing reporting and disclosure provisions.

*Acosta v. Pacific Enterprises*, 950 F.2d 611, 619 (9th Cir. 1991) (holding that participants had no right to the names and addresses of other participants, even though that knowledge would have facilitated litigation that might in turn have increased benefits). The Ninth Circuit has determined that Section 104 should be interpreted narrowly. *See Shaver v. Operating Eng'rs Local 428 Pension Trust Fund*, 332 F.3d 1198, 1202 (9th Cir. 2003) (determining that Section 104 did not require the disclosure of records that explain expenditures that the government allows to be aggregated on forms that are submitted to the IRS and to the Department of Labor because "[b]arring indicia to the contrary, the broad term, 'other instruments,' should be limited to the class of objects that specifically precedes it."). Similarly, other courts have specifically recognized that UCR data need not be disclosed under Section 104. *DeBartolo*, 2001 WL 1403012, at *7 ("The information Dr. DeBartolo requested from each of the plans was the plan's "usual and customary" charges for medical services. "Usual and customary" charges is not one of the types of information expressly enumerated in § 1024(b)(4)."). Because Section 104 specifically addresses information that must be disclosed upon a written request from a plan participant, the Court finds the limited construction of Section 104 highly persuasive. Because the *North Cypress* court failed to explain why Section 404 should be treated differently from Section 104, and failed to attempt to explain a rationale for requiring broader disclosures once a

plan participant submitted a written request, the Court finds the decision in *North Cypress* unpersuasive.

Furthermore, the Court declines to follow *North Cypress* because the Ninth Circuit has expressly held that there should be no distinction between a fiduciary's obligation to disclose material information based on a participant's inquiry:

> We believe that once an ERISA fiduciary has material information relevant to a plan participant or beneficiary, it must provide that information whether or not it is asked a question. We see no reason why the duty to disclose material information straightforwardly and accurately should apply in a case involving affirmative misrepresentations about an existing or proposed plan, and in a case involving a participant or beneficiary who asks about a proposed plan, but not in a case involving a participant or beneficiary who fails to ask about a proposed plan. A rule penalizing a person who fails to ask the right question at the right time would have a number of bad consequences . . .

*Bins v. Exxon Co., U.S.A.*, 189 F.3d 929, 939 (9th Cir. 1999) (internal citations omitted). *See also Acosta*, 950 F.2d at 619 (holding that participants had no right to the names and addresses of other participants, even though that knowledge would have facilitated litigation that might in turn have increased benefits). The Court notes that the allegations pertaining to Section 404 were alleged only as to Section 1132(a)(3); however, Plaintiffs did not assert any additional allegations as to Section 1132(a)(2) that would modify the Court's analysis from the September 6, 2012 Order. Thus, Plaintiffs' claims under Section 1132(a)(2) and (a)(3) relating to failure to disclose UCR data are DISMISSED WITH PREJUDICE.

D. Breach of Contract (Eighth Cause of Action)

The Non-ERISA Plaintiffs bring a claim for breach of contract against WellPoint. In the Order on the Motion to Dismiss the CTAC, the Court denied WellPoint's claim that Plaintiffs had not stated a breach of contract as to J.B.W. *See* September 6, 2012 Order at 41. The Court granted WellPoint's motion to dismiss the CTAC as to the Samsells' breach of contract claim. *Id.* at 42. The Court determined that the Samsells failed to state a breach of contract. *Id.*

WellPoint does not currently seek to dismiss the breach of contract claim as to J.B.W. However, WellPoint argues that Plaintiffs' allegations as to Provider Plaintiffs Drs. Henry, Schwendig, Peck, Pariser, and Kavali, are preempted by ERISA; that Provider Plaintiff Dr.

Higashi fails to state a claim; and that the Subscriber Plaintiffs the Samsells have failed to sufficiently amend the CFAC to state a claim for breach of contract.

As to Provider Plaintiffs Drs. Henry, Schwendig, Peck, Pariser, Kavali, and Higashi, Plaintiffs acknowledged at oral argument that they were only preserving the claims as to Provider Plaintiffs for purposes of appeal. *See* June 12, 2013 Tr. at 31:16-21. Thus, as to Provider Plaintiffs Drs. Henry, Schwendig, Peck, Pariser, Kavali, and Higashi, the breach of contract claims are DISMISSED WITH PREJUDICE.

As to Subscriber Plaintiffs, the Samsells, Plaintiffs maintain many of their existing allegations that the Court deemed insufficient in the Motion to Dismiss the CTAC.[6] *Compare CFAC* ¶¶ 397, 401, 404 *with CTAC* ¶¶ 342, 345, 348. The Samsells allege a breach of contract as to reimbursement for oral surgery services for the Samsells' children. *Id.* ¶ 398. The Court previously determined that the allegations in the CTAC were insufficient because the Samsells failed to demonstrate "how reimbursing a subscriber in accordance with the terms of a policy amounts to a breach of that policy." September 6, 2012 Order at 42. Further, the Court noted that the Samsells failed to tie their allegation of injury – decreased ONS reimbursement – to any provision in the contract that required WellPoint to pay an "objectively reasonable ONS amount, as opposed to merely its 'allowable charge' as set forth in the policy." *Id.*

Specifically, in the September 6, 2012 Order, the Court found that the term "Allowable Charge" was defined by Section C.1 of the Samsells' plan as "the Company's allowance for a specified Covered Service or the Provider's charge for that service, whichever is less." *See CTAC* ¶ 342. The Court determined that this definition of "Allowable Charge" did not require WellPoint to pay an "objectively reasonable amount." September 6, 2012 Order at 42.

In the CFAC, Plaintiffs aver that WellPoint breached its contract with the Samsells because Section C.3 of the Samsells' plan should apply, which defines "Allowable Charge" as "the amount which the Company determines, in its sole discretion, is reasonable for the Covered Service provided." *See CFAC* ¶¶ 397-98. Section C.3 only applies "[w]ith respect to charges for Covered Services supplied by other than Covered Facilities or Providers." *Id.* at ¶ 397. Plaintiffs suggest that Section C.3 applies to this case because the provider of oral surgery

[6] The parties also do not address choice of law as to Samsells; however, the moving papers appear to agree that Virginia law applies to the Samsells, whose policies are with Anthem Blue Cross and Blue Shield, Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield, and Trigon Blue Cross Blue Shield. For purposes of the Motion to Dismiss, the Court assumes that Virginia law applies to the Samsells.

services for the Samsells' children was "neither a 'Provider' nor a 'Covered Facility' within the meaning of the Policy or Endorsement." *Id.* at ¶ 398. Plaintiffs contend that as an oral surgeon, the provider of oral surgery services was not a dentist, and therefore not a provider. According to Plaintiffs, because of the newly applicable provision, the analysis as to whether WellPoint breached its contract to the Samsells should require an analysis of whether WellPoint's ONS determination was reasonable.

This argument is without merit. In their Opposition, Plaintiffs cite the policy as defining "Oral Surgery" as a "Special Surgical Service" covered only when "performed by a Physician." *See* Opp. at 53:13-18. However, such a definition appears disingenuous because the policy actually defines "Oral Surgery" as a "Special Surgical Service" covered only when "performed by a Physician *or Dentist.*" ECF 137-2 (Aug. 6, 2010 Ward Decl., Ex. E at 101, 110-11) (Endorsement to Samsells' policy, art. I, cl. AA)).[7] Thus, oral surgery is only covered by Plaintiffs' policy where performed by a physician or a dentist. The policy defines "Provider" as a "Physician," and also includes the following: Doctor of Osteopathy, Dentist, Doctor of Podiatry, Doctor of Chiropody, Optometrist, Optician, Psychologist, Clinical Social Worker, Professional Counselor, Registered Physical Therapist, Chiropractor, Audiologist, Speech Pathologist, or Clinical Nurse Specialist in Psychiatric Mental Health. ECF 137-1 (Aug. 6, 2010 Ward Decl., Ex. A at 12 (Anthem Blue Cross and Blue Shield Comprehensive Major Medical and Dental Policy, art I., EE).

Thus, if the oral surgery services were covered, the oral surgeon would have to be classified as either a physician or a dentist, both of which are classified as "Providers," which triggers Section C.1 of the policy. Accordingly, Plaintiffs have failed to state a breach of contract claim as to the Samsells because the Court has already determined that WellPoint reimbursed the Samsells in accordance with the terms of the policy, including the term of "Allowable Charge" as "the Company's allowance for a specified Covered Service or the Provider's charge for that service, whichever is less." Because Plaintiffs' argument as to the new definition of "Allowable Charge" is without merit, the breach of contract claim as to the Samsells is DISMISSED WITH PREJUDICE.

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[7] As stated in footnote 3, *supra,* in ruling on a motion to dismiss, a court may consider certain documents outside the pleadings without the proceeding turning into summary judgment. *See Lee v. City of L.A.,* 250 F.3d 668, 688-89 (9th Cir. 2001), including documents upon which plaintiff's complaint necessarily relies and whose authenticity is not contested. *See id.* The policy endorsement is a document upon Plaintiffs' CFAC necessarily relies, *see CFAC* ¶ 397-98, and whose authenticity is not contested. The Court may therefore consider the document in ruling on the motion to dismiss.

E. Implied Covenant of Good Faith and Fair Dealing (Ninth Cause of Action)

The Non-ERISA Plaintiffs bring a claim for breach of the implied covenant of good faith and fair dealing against WellPoint.

In the September 6, 2012 Order, the Court rejected WellPoint's argument relating to breach of the implied covenant of good faith and fair dealing because WellPoint's argument was based on the grounds that Plaintiffs had failed to state a breach of contract. However, the Court found that J.B.W. adequately pleaded a breach of his agreement, and recognized that based on WellPoint's argument, the implied covenant of good faith and fair dealing claim was viable. *See* September 6, 2012 Order at 42.

In this Motion, WellPoint again brings an argument to dismiss Plaintiffs' cause of action for breach of the implied covenant of good faith and fair dealing. WellPoint argues that Provider Plaintiffs Drs. Henry, Schwendig, Peck, Pariser, and Kavali fail to state a claim, in part because the claims are preempted by ERISA; that the Samsells' policy expressly defined the reimbursement they were to receive; that Dr. Higashi fails to allege the existence of a contract upon which an implied covenant claim could be based; and that J.B.W.'s claim is superfluous of his breach of contract claim. *Mot.* 37:17-39:1. Each argument will be addressed in turn.

Under California law, every contract contains an implied covenant of good faith and fair dealing providing that no party to the contract will do anything that would deprive another party of the benefits of the contract. *Wilson v. 21st Century Ins. Co.*, 42 Cal.4th 713, 720, 68 Cal. Rptr. 3d 746 (2007); *Kransco v. Am. Empire Surplus Lines Ins. Co.*, 23 Cal.4th 390, 400, 97 Cal. Rptr. 2d 151, (2000). The implied covenant protects the reasonable expectations of the contracting parties based on their mutual promises. *Carma Developers (Cal.), Inc. v. Marathon Dev. Calif., Inc.*, 2 Cal.4th 342, 373-374, 6 Cal. Rptr. 2d 467 (1992); *Careau & Co. v. Security Pacific Business Credit, Inc.*, 222 Cal. App. 3d 1371, 1395, 272 Cal. Rptr. 387 (1990). The scope of conduct prohibited by the implied covenant depends on the purposes and express terms of the contract. *Carma Developers*, 2 Cal.4th at 373. Although breach of the implied covenant often is pleaded as a separate count, a breach of the implied covenant is necessarily a breach of contract. *Digerati Holdings, LLC v. Young Money Ent., LLC*, 194 Cal. App. 4th 873, 885, 123 Cal.Rptr.3d 736 (2011).[8] If the allegations for breach of the implied covenant "do not go beyond

[8] WellPoint argues that California law does not recognize an implied covenant claim in the absence of a breach of contract. *WellPoint Mot.* 37:19-24. (citing *Smith v. Int'l Bhd. of Elec. Workers, Local Union 11*, 109 Cal. App. 4th 1637, 1644, n.3, 1 Cal. Rptr. 3d 374 (2003) ("A

the statement of a mere contract breach and, relying on the same alleged acts, simply seek the same damages or other relief already claimed in a companion contract cause of action, they may be disregarded as superfluous as no additional claim is actually stated." *Careau,* 222 Cal. App. 3d at 1395.

Under Virginia law, the implied covenant of good faith and fair dealing does not exist absent a valid contract. *See, e.g., Eplus Tech., Inc. v. Nat'l R.R. Passenger Corp.*, 407 F. Supp. 2d 758, 762 (E.D. Va. 2005).[9] Under Virginia law, like under California law, "every contract contains an implied covenant of good faith and fair dealing." *Enomoto v. Space Adventures, Ltd.*, 624 F. Supp. 2d 443, 450 (E.D. Va. 2009) (citing *Virginia Vermiculite, Ltd. v. W.R. Grace*

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breach of the covenant of good faith and fair dealing does not give rise to a cause of action separate from a cause of action for breach of the contract containing the covenant.")). However, the case law does not indicate that a party must prove a breach of contract prior to proving a breach of the implied covenant of good faith and fair dealing. Rather, the case law suggests that a plaintiff can generally only recover contractual remedies under the breach of the implied covenant of good faith and fair dealing under contract law (as opposed to remedies that would be available if the implied covenant were recognized as a tort). *See Marsu, B.V. v. Walt Disney Co.*, 185 F.3d 932, 937 (9th Cir. 1999) (holding that Disney's fulfillment of contract's express merchandising obligations to enter into certain kinds of licensing agreements and payment of minimum guarantees under the contract did not preclude finding of breach of covenant of good faith and fair dealing); *Carma Developers*, 2 Cal. 4th at 373 ("To begin with, breach of a specific provision of the contract is not a necessary prerequisite. Were it otherwise, the covenant would have no practical meaning, for any breach thereof would necessarily involve breach of some other term of the contract") (internal citation omitted). "[T]he covenant is implied ... to prevent a contracting party from engaging in conduct which (while not technically transgressing the express covenant) frustrates the other party's rights of the benefits of the contract." *L.A. Equestrian Ctr., Inc. v. City of Los Angeles*, 17 Cal. App. 4th 432, 447, 21 Cal. Rptr. 2d 313 (1993).

[9] WellPoint cites *EPlus* for the proposition that under Virginia law, absent a breach of contract, one cannot have a claim for breach of the implied covenant of good faith and fair dealing. However, *EPlus* only suggests that there is no separate action in tort for the implied covenant of good faith and fair dealing. *EPlus*, 407 F.Supp.2d at 762. While failure to act in good faith does not constitute an independent tort, *see Allaun v. Scott*, 59 Va. Cir. 461, 465, 2002 WL 31990277 (2002), a claim for breach of the implied covenant of good faith and fair dealing is an alternate "vehicle" for a breach of contract claim. *Goodrich Corp. v. BaySys Technologies, LLC*, 873 F. Supp. 2d 736, 741-42 (4th Cir. 2012) (applying Virginia law).

*& Co. – Conn.*, 156 F.3d 535, 541-42 (4th Cir.1998)). "[T]he elements of a claim for breach of an implied covenant of good faith and fair dealing under Virginia law are (1) a contractual relationship between the parties, and (2) a breach of the implied covenant." *Enomoto*, 624 F. Supp. 2d at 450. A breach of the implied covenant generally occurs when a party to a contract exercises its contractual discretion in bad faith. *See Virginia Vermiculite*, 156 F.3d at 542; *Clemons v. Home Savers, LLC*, 530 F. Supp. 2d 803, 812 (E.D. Va. 2008).

First, WellPoint alleges that Provider Plaintiffs Drs. Henry, Schwendig, Peck, Pariser, and Kavali cannot state claims for breach of the implied covenant of duty of good faith and fair dealing because these claims are preempted by ERISA. As with the claims for breach of contract, Plaintiffs acknowledged at oral argument that they were only preserving the claims as to Provider Plaintiffs for purposes of appeal. *See* June 12, 2013 Tr. at 31:16-21. Thus, as to Provider Plaintiffs Drs. Henry, Schwendig, Peck, Pariser, Kavali, and Higashi, the implied covenant of good faith and fair dealing claims are DISMISSED WITH PREJUDICE.

Second, as to the Samsells, WellPoint argues that there is no implied covenant claim because Section C.1 of the Samsells' policy expressly defined the reimbursement they were to receive. The Samsells were insured by WellPoint via Anthem Virginia. *See* ECF 137-1 (Aug. 6, 2010 Ward Decl., Ex. A-L (Anthem Blue Cross and Blue Shield Comprehensive Major Medical and Dental Policy, Endorsements, and Explanations of Benefits). The Samsells' policy described "Allowable Charges" as "the Company's allowance for a specified Covered Service or the Provider's charge for that service, whichever is less." *See CFAC* ¶¶ 397-98. Plaintiffs argue that the Company's "allowance for a specified Covered Service" necessarily involves WellPoint's discretion. Under Virginia law, where contractual language permits a party to exercise discretion, it is implied that the party will exercise good faith in exercising that discretion. *Virginia Vermiculite*, 156 F.3d at 542 ("[I]t is a basic principle of contract law in Virginia, as elsewhere, that although the duty of good faith does not prevent a party from exercising its explicit contract *rights*, a party may not exercise contractual *discretion* in bad faith, even when such discretion is vested solely in that party"). The Court agrees with Plaintiffs that where the contractual language permits Plaintiffs to exercise discretion in determining the allowance, Defendants have a duty to exercise that discretion in good faith.

WellPoint relies on *Skillstorm, Inc. v. Elec. Data Systems, LLC*, 666 F. Supp. 2d 610, 620 (E.D. Va. 2009) to argue that the Samsells cannot state a breach of the implied covenant of good faith and fair dealing because their policy expressly defined the reimbursement they were to receive. *WellPoint Reply* 20:2-7. However, *Skillstorm* is distinguishable. In *Skillstorm*, the contract gave the defendant the right to terminate purchase orders "for any reason without

penalty upon written notice." *Id.* The court recognized that the contract expressly gave defendants the right to terminate purchase orders at will. *Id.*

There is a distinction between explicit contractual language that gives a party the unqualified right to act in a certain way and contractual language that permits a party to exercise discretion. Unlike in *Skillstorm*, the language in the Samsells' policy does not bestow upon WellPoint the right to reimburse at any rate it sees fit, regardless of the circumstances. Rather, it requires Defendants to reimburse based on "the Company's allowance for a specified covered service or the Provider's charge for that service, whichever is less." *CFAC* ¶ 397. Moreover, the Court can reasonably infer that the inclusion of the "Provider's charge" as a potential benchmark indicates some intent to maintain the Company's allowance at a reasonable level. Because the Policy provides for the Company's allowance *or* Provider's charge, whichever is less, it indicates that the company will exercise good faith in setting the discretionary "Company's allowance" at an amount that is reasonably in accordance with a Provider's charge. As such, although the Samsells have not alleged a breach of contract claim, they have sufficiently alleged that there was a contractual relationship between the parties and a breach of the implied covenant, whereby WellPoint did not act reasonably in exercising its discretion in determining allowable charges. *See CFAC* ¶ 517 (alleging that "WellPoint's conduct represents a failure or refusal to discharge its contractual responsibilities, prompted by a conscious and deliberate act, which unfairly frustrates the agreed common purposes and disappoints the reasonable expectations of . . . the Samsells . . . and thereby deprives the same of the benefits of the Agreements in accordance with their agreed-upon terms."). Thus, Defendants' Motion to Dismiss the breach of implied covenant of good faith and fair dealing is DENIED as to the Samsells.

Finally, as to Plaintiff J.B.W., J.B.W. was insured by WellPoint via Blue Cross of California, and Plaintiffs allege that he "received artificially-deflated reimbursement for ONS, resulting in J.B.W. incurring more out-of-pocket expense and receiving a health insurance policy of less value and for which he overpaid than he would have absent the unlawful conduct alleged herein." *CFAC* ¶ 25.[10] While the Court has previously held that J.B.W. sufficiently states a claim for breach of contract, he does not state a claim for the breach of the implied covenant of good faith and fair dealing. This is because an implied covenant claim is appropriately dismissed when the alleged wrongdoing is already governed by contractual terms. *Lansmont*

[10] Though the parties similarly do not address choice of law as to J.B.W., they appear to agree that California law applies to his claims. J.B.W. is a resident of the state of California and was insured by WellPoint via Blue Cross of California. *CFAC* ¶ 25. For purposes of the Motion to Dismiss, the Court assumes that California law applies.

*Corp. v. SPX Corp.*, No. 5:10–cv–05860 EJD (HRL), 2011 WL 2463281, *5 (N.D. Cal. June 20, 2011) (denying claim for implied covenant of good faith and fair dealing where breach of covenant of good faith and fair dealing claim contained examples of how defendants violated express contract terms). Here, J.B.W. alleges that WellPoint breached the implied covenant of good faith and fair dealing by failing "to reimburse ONS based on actual UCRs or a fairly-negotiated rate, and has not provided any additional benefits" to J.B.W. *CFAC* ¶ 515. J.B.W.'s breach of contract claim alleges that WellPoint reimbursed J.B.W. with "less than the agreed-upon percentage of either the provider's actual charges or the UCR," and by using internal fee schedules that "were derived with reference to Ingenix fee schedules and are not the result of any negotiation between WellPoint and Plaintiff J.B.W.'s providers, let alone any other providers." *Id.* ¶ 391. Because J.B.W.'s claim regarding breach of the implied covenant does not go beyond the allegations of the purported breach of contract, it is superfluous. *Lansmont*, 2011 WL 2463281, at *5; *Careau*, 222 Cal. App. 3d at 1395. As such, J.B.W. has not met the pleading requirements for the implied covenant of the duty of good faith and fair dealing and the claim is DISMISSED WITH PREJUDICE.

F. California Unfair Competition and violation of California's Health and Safety Code (Tenth and Eleventh Causes of Action)

In the tenth claim for relief, a single Subscriber Plaintiff, six Provider Plaintiffs, and five Association Plaintiffs state claims against WellPoint under each of the three prongs (fraudulent, unfair, and unlawful) of California's Unfair Competition Law, Cal. Bus. & Prof. Code § 17200 ("UCL").

In the eleventh claim for relief, one Provider and two Association Plaintiffs state a claim for relief against WellPoint Defendants under the UCL attributable to violations of California's Health and Safety Code § 1371.4. The Court previously upheld one of Plaintiffs' two fraud-based UCL claims as to Plaintiff J.B.W. and upheld Plaintiffs' unlawful conduct claim, while dismissing the other fraud-based UCL claims and unfair conduct claims. The Court also determined that the Provider and the two Association Plaintiffs' cause of action under California Health and Safety Code § 1371.4 was preempted by ERISA.

*i. UCL (Tenth Cause of Action)*

In the September 6, 2012 Order, the Court identified two types of fraudulent conduct alleged by Plaintiff J.B.W.: (1) WellPoint's alleged deceiving Plaintiffs into purchasing plans providing ONS coverage by misrepresenting in its advertising and promotional pamphlets that subscribers would be reimbursed based on actual billed cost or the UCR, and (2) inducing

Plaintiffs to utilize and pay more for ONS than was represented in the agreements. *See* September 6, 2012 Order at 44 (citing *CTAC* ¶¶ 363-64, 478). The Court found that, as to the WellPoint's alleged deceiving Plaintiffs into purchasing plans providing ONS coverage, Plaintiffs had again failed to assert their fraud-based UCL claims with particularity. *See id.* at 44-45. The Court noted that Plaintiffs failed to allege that any Plaintiff relied on WellPoint's alleged misrepresentation of summary plan descriptions, and that the only averments actually tied to an individual plaintiff, Subscriber J.B.W., were deficient. *Id.* However, as to inducing Plaintiffs to utilize and pay more for ONS than was represented in the agreements, the Court found that Plaintiffs adequately stated a claim. *Id.* at 46. The Court found that Plaintiffs' additional fraud-based UCL claims were deficient. *Id.*

The Court also dismissed Plaintiffs' "unfair" UCL cause of action because it was based on Plaintiffs' antitrust claim, which the Court found was not viable. *Id.* at 46. However, the Court held that Plaintiffs adequately pleaded a violation of the UCL's unlawful prong, as J.B.W.'s claim for breach of contract amounted to a violation of California Insurance Code § 332. *Id.* at 47.

The UCL prohibits "unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising," as well as any act prohibited by California's false advertising statute. *See Ariz. Cartridge Remanufacturers Ass'n v. Lexmark Int'l, Inc.*, 421 F.3d 981, 985 (9th Cir. 2005) (*quoting* Cal. Bus. & Prof. Code § 17200). An "unlawful" business act under § 17200 is any business practice that is prohibited by law, whether "civil or criminal, statutory or judicially made . . . , federal, state or local." *McKell v. Washington Mutual, Inc.*, 142 Cal. App. 4th 1457, 1474, 49 Cal. Rptr. 3d 227 (2006) (citations omitted). A business act is "unfair" under § 17200 "if it violates established public policy or if it is immoral, unethical, oppressive or unscrupulous and causes injury to consumers which outweighs its benefits." *See id.* at 1473. Finally, a "fraudulent" business practice under § 17200 is "one which is likely to deceive the public," and "may be based on representations to the public which are untrue, and also those which may be accurate on some level, but will nonetheless tend to mislead or deceive." *See id.* at 1471. UCL claims based on fraud are subject to the heightened pleading requirements of Rule 9(b). *See Kearns v. Ford Motor Co.*, 567 F.3d 1120, 1124-25 (9th Cir. 2009). Plaintiffs must plead "the who, what, when, where, and how of the alleged fraudulent conduct" and explain "why [a] statement or omission complained of was false and misleading." *In re Actimmune Mktg. Litig.*, No. C 08–02376 MHP, 2009 WL 3740648, at *13 (N.D. Cal. Nov. 6, 2009).

In addition, Plaintiffs must specifically allege that the fraudulent conduct caused them injury. *See In re Tobacco II Cases*, 46 Cal. 4th 298, 326-27, 93 Cal. Rptr. 3d 559 (2009). This

is an issue of a plaintiff's standing to assert a UCL claim and requires a "twofold showing: he or she must demonstrate injury in fact and a loss of money or property caused by unfair competition." *Peterson v. Cellco P'ship*, 164 Cal. App. 4th 1583, 1590, 80 Cal. Rptr. 3d 316 (2008). In cases of fraud, the fraudulent conduct must be an "immediate cause" of injury and plaintiffs must allege that, but-for the fraudulent statements, "the plaintiffs in all reasonable probability would not have engaged in the injury-producing conduct." *In re Tobacco II*, 46 Cal. 4th at 326 (internal citations omitted).

As the Court indicated in both prior Orders, two of Plaintiffs' claims sound in fraud, and therefore must be pleaded with particularity. *See* August 11, 2011 Order at 44; September 6, 2012 Order at 43-44.

*a. J.B.W.'s Fraud-Based UCL Claims*

While the Court has already determined that J.B.W.'s fraud-based UCL claim as to WellPoint's allegedly deceiving Plaintiffs into purchasing plans providing ONS coverage by misrepresenting UCR reimbursements in its advertising and promotional pamphlets was deficient, it also determined that J.B.W.'s fraud-based claim that WellPoint induced him to utilize and pay more for ONS than was represented in the agreements was sufficient. *See* September 6, 2012 Order at 44-46. Here, Plaintiffs have amended the deficient allegations as to J.B.W. such that the first fraud-based claim also meets the pleading requirements of Rule 9(b) and maintained the allegations as to the second fraud-based claim. *See CFAC* ¶¶ 419-20. WellPoint avers that Plaintiffs' allegations are unchanged. However, the CFAC now contains a specific date, the specific document containing the alleged misrepresentation, and the misrepresentation upon which J.B.W. relied. *Compare CFAC* ¶ 420 ("[I]n or about September 2008 (prior to becoming a plan member), Plaintiff J.B.W. reviewed WellPoint's SPDs on the WellPoint Website. The SPDs stated that ONS would be reimbursed based on a percentage of the actual costs of services in J.B.W.'s geographic area. Based on his review of the website, J.B.W. reasonably believed that ONS would be based on a percentage of the actual costs of services in his geographic area.") *with CTAC* ¶ 364 ("For example, prior to becoming a plan member, Plaintiff J.B.W. reviewed WellPoint's SPDs on the WellPoint website and reasonably believed that ONS would be reimbursed based on a percentage of the actual costs of services in his geographic area.").

WellPoint contends that Plaintiffs need to allege the exact language of the misrepresentation; however, a plaintiff alleging exposure to a long-term advertising campaign is not required to "plead with an unrealistic degree of specificity…[the] particular advertisements or statements" upon which he or she relied. *See In re Tobacco II cases*, 46 Cal. 4th at 328.

Because the amended allegations contain a date, the specific allegation upon which J.B.W. relied, and why the representation was misleading, the amended allegation is sufficient. *Cf. Murphy v. Int'l Bus. Machs. Corp.*, No. 10 Civ. 6055 (LAP), 2012 WL 566091, at *2, *5, *5 (S.D.N.Y. Feb. 21, 2012) (finding that allegations were insufficient under 9(b) where plaintiff only alleged that SPDs were "misleading and materially false and inaccurate" and failed to identify "a specific misrepresentation or omission of material fact").

Further, as the Court already noted in its September 6, 2012 Order, J.B.W. adequately pleads causation and injury by alleging that "because ONS was extremely important to Plaintiff J.B.W.," he was "enticed into becoming a member of WellPoint's plan based on his understanding that ONS would be available and affordable." *See* September 6, 2012 Order (citing *Kwikset Corp. v. Superior Court*, 51 Cal. 4th 310, 328-30, 120 Cal. Rptr. 741 (2011) (observing that a plaintiff's reliance is shown by allegations that the substance of a misrepresentation "matters" to consumers, and causation and injury are satisfied by "alleging, as plaintiffs have here, that he or she would not have bought the product but for the misrepresentation")); *CFAC* ¶ 420.

WellPoint argues that the Court should revisit its conclusion that J.B.W. has adequately alleged injury on the grounds that J.B.W. fails to allege that he lost any money or property as a result of WellPoint's alleged unlawful conduct. Only a person who "has lost money or property as a result of the unfair competition" has standing to bring a UCL claim. Cal. Bus. & Prof. Code § 17204. However, the economic injury required for standing under the UCL is shown where "the consumer has purchased a product that he or she *paid more for* than he or she otherwise might have been willing to pay if the product had been labeled accurately." *Kwikset*, 51 Cal. 4th at 328-30. WellPoint contends that the CFAC fails to show that J.B.W. lost money or property as a result of WellPoint's alleged conduct. The CFAC alleges that J.B.W. was "obligated to pay not only his deductible, but also that part of the provider's bill charge that exceeded the reimbursement amount determined by WellPoint." *CFAC* ¶ 391. WellPoint alleges that this allegation falls short of actually saying that J.B.W. *paid* these obligations. However, the CFAC clearly alleges that J.B.W. "performed [his] obligations under the Agreements by paying WellPoint the dues, deductibles, and co-payments required by the Agreements." *CFAC* ¶ 518. The CFAC also alleges that J.B.W. "would not even have purchased" ONS coverage had he "been adequately informed of its true cost." *Id.* ¶ 519. Because J.B.W. necessarily "paid more" by purchasing coverage than he would had he not purchased coverage, this economic loss is sufficient to show standing under the UCL. *See Kwikset*, 51 Cal. 4th at 328-30. Thus, the Court finds that J.B.W. has adequately pleaded that WellPoint deceived J.B.W. into purchasing a plan providing ONS coverage by misrepresenting in its advertising and promotional pamphlets that subscribers would be reimbursed based on actual billed cost or the UCR. Because the Court also

previously found that J.B.W. had sufficiently pleaded that WellPoint induced him to utilize and pay more for ONS than was represented in the agreements was sufficient, J.B.W. has successfully pleaded both fraud-based claims. Accordingly, WellPoint's motion to dismiss this cause of action is DENIED.

*b. J.B.W.'s Unfair and Unlawful UCL Claims*

As to J.B.W.'s unfair and unlawful UCL claims, WellPoint argues that J.B.W.'s UCL claim under the unfair prong should be dismissed because the CFAC fails to state an antitrust claim. While the Court has previously held that J.B.W.'s unfair claim fails because it is based on the antitrust claim, the CFAC also alleges that the "unfair business practices include, but are not limited to, when WellPoint has used Ingenix and other ONS Benefit Reductions to determine the amount of reimbursement for ONS." *CFAC* ¶ 524. Although the Court has determined that Plaintiffs cannot state a viable antitrust claim because they do not allege antitrust standing, assuming Plaintiffs' allegation that WellPoint "fail[ed] to reimburse ONS based on the actual price or the UCR as promised in their Agreements" to be true, Plaintiffs could show that WellPoint's conduct was unfair even if it did not violate antitrust laws. *See id.* Because the alleged unfair conduct is not related solely to the antitrust claim, the motion to dismiss the unfair UCL claim is DENIED.

With regard to J.B.W.'s unlawful UCL claim, WellPoint argues that the claim should be dismissed with prejudice because the alleged violation of California Insurance Code § 332 does not give rise to an unlawful act or practice for purposes of the UCL. Section 332 provides:

> Each party to a contract of insurance shall communicate to the other, in good faith, all facts within his knowledge which are or which he believes to be material to the contract and as to which he makes no warranty, and which the other has not the means of ascertaining.

Cal. Ins. Code § 332. This Court has previously recognized that a violation of section 332 can serve as a predicate act for purposes of J.B.W.'s unlawful UCL claim:

> The CTAC adequately pleads a breach of J.B.W.'s contract, and that such breach amounted to a violation of California Insurance Code § 332, which requires that "[e]ach party to a contract of insurance shall communicate to the other, in good faith, all facts within his knowledge which are or which he believes to be material to the contract and as to which he makes no warranty, and which the other has not the means of ascertaining." *See* CTAC ¶ 472. Because Plaintiffs have adequately

> pleaded a breach of contract claim, and pleaded that the breach is independently unlawful under the California Insurance Code, the eleventh cause of action properly states a claim under the UCL's unlawful prong.

September 6, 2012 Order at 47. Also, other courts have suggested that section 332 can serve as a predicate act for purposes of a UCL "unlawful" claim. *See Pastoria v. Nationwide Ins.*, 112 Cal. App. 4th 1490, 1496, 6 Cal. Rptr. 3d 148 (2003). In *Pastoria*, plaintiffs sued their insurers for unfair competition, fraud, and negligent failure to disclose imminent material changes in a health insurance policy prior to plaintiffs' purchase of the insurance policy. *Id.* at 1493. The plaintiffs argued that defendants had a duty to notify them about impending changes in their insurance policy before plaintiffs purchased it. *Id.* The court acknowledged that under California Insurance Code § 332, defendants did have a duty to disclose the changes to plaintiffs, and that a "literal reading" of section 332 indicated that the statutory violation was unlawful. *Id.* at 1496. The court determined that such unlawful behavior could constitute a predicate act under the UCL. *Id.* at 1497.

WellPoint cites *United Guar. Mortg. Indem. Co. v. Countrywide Fin. Corp.*, 660 F. Supp. 2d 1163, 1193 (C.D. Cal. 2009) to suggest that the holding in *Pastoria* is without merit. In *United Guaranty*, an insurer of first-lien securitized subprime mortgages filed an action against the mortgage companies and mortgage securitization trustee asserting contract, tort, and statutory claims. *Id.* at 1168-69. The court criticized the *Pastoria* court's conclusion that a statutory violation of the California Insurance Code could be "unlawful," noting that "the statutes' plain text establishes that they merely 'entitle[ ]' contractual rescission under some circumstances . . . It is somewhat unusual to say that default contract rules can be 'violated' so as to constitute an 'unlawful' business act." Regardless, the Court ultimately recognized that *Pastoria*'s reading of section 332 did not apply to the case. *Id.* The reason *Pastoria* did not apply to *United Guaranty* was that the default "right" to waive or rescind a contract was inapplicable to the "contractual 'mini-universe'" created by the parties in *United Guaranty* that provided United Guaranty with an audit right. *Id.* The Court found that because United Guaranty had "the means of ascertaining" the alleged truth via the audit right, there could be no violation of section 332 for failing to disclose information material to the contract. *Id.* at 1194.

While the Court finds the *United Guaranty* court's reasoning instructive, it also recognizes that the UCL contains "'sweeping language' to include 'anything that can properly be called a business practice and that at the same time is forbidden by law.'" *Bank of the West v. Superior Court*, 2 Cal.4th 1254, 1266–1267, 10 Cal. Rptr. 2d 538 (1992). Furthermore, this case is unlike *United Guaranty* because like in *Pastoria*, J.B.W. is an individual subscriber without the audit rights of the parties in *United Guaranty*. Moreover, because of the disparity of power

between J.B.W. and WellPoint, this is not a case in which the default "right" to waive or rescind a contract would limit WellPoint's alleged unlawful conduct under section 332. *See CFAC* ¶¶ 384-85 (alleging that J.B.W.'s agreement was a "one-sided adhesion contract[ ]" that was "presented on a take-it-or-leave-it basis and [was] not subject to negotiation or alteration by individual members."). Accordingly, like in *Pastoria,* permitting section 332 as a predicate act under the UCL would protect consumers as the UCL intended. Thus, the Court maintains that it is appropriate to acknowledge that Plaintiffs could potentially state a UCL claim using section 332 as a predicate act. Accordingly, to the extent WellPoint seeks to dismiss J.B.W.'s unlawful UCL claim on the basis of the violation of section 332, the motion is DENIED.

*c. Provider and Association Plaintiffs' UCL Claims*

As to the Provider and Association Plaintiffs' UCL claims, Plaintiffs acknowledge that they "re-pled the UCL claims in the [CFAC's] tenth count only to preserve the previously-dismissed claims in that count for appeal." *Opp.* 60:4-8. Accordingly, the Provider and Association Plaintiffs' UCL claims are DISMISSED WITH PREJUDICE.

*ii. California Health and Safety Code § 1371 (Eleventh Cause of Action)*

With regard to the eleventh cause of action, Dr. Schwendig, the CMA, and the AMA again argue that their "unlawful" UCL claim against WellPoint is independently sustained based on a predicate violation of California's Knox-Keene Act. The Knox-Keene Act obligates emergency room providers to treat all emergency patients without regard to whether they are insured or their ability to pay. *See* Cal. Health & Safety Code § 1371. As a corollary to this requirement, health plans are required to "reimburse providers for emergency services and care provided to [] enrollees, until the care results in stabilization of the enrollee." *See id.* § 1371.4(b). The Court previously dismissed this cause of action as completely pre-empted. *See* September 6, 2012 Order at 50. WellPoint again argues that the claim is pre-empted, and Plaintiffs offer no reason in their Opposition why the claim should not be deemed pre-empted. As such, the eleventh cause of action is DISMISSED WITH PREJUDICE.

IV. Conclusion

The Court GRANTS in part and DENIES in part Defendants' Motions to Dismiss. The following claims remain viable:

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

**#379/380**

**CIVIL MINUTES - GENERAL**

| Case No. | MDL 09-2074 PSG (FFMx) | Date | July 19, 2013 |
|---|---|---|---|
| Title | In re WellPoint, Inc. Out-of-Network "UCR" Rates Litigation | | |

1. As to Plaintiffs' second cause of action for violation of ERISA 29 U.S.C. § 1132(a)(1)(B) for unpaid benefits, the Ingenix ONS Benefit Reduction claims of ERISA Subscriber Plaintiffs and ERISA Provider Plaintiffs are still viable;

2. As to Plaintiffs' eighth cause of action for breach of contract, J.B.W.'s claim is still viable;

3. As to Plaintiffs' ninth cause of action for breach of the implied covenant of good faith and fair dealing, the Samsells' claim is still viable; and

4. As to Plaintiffs' tenth cause of action for violation of the UCL, all of J.B.W.'s claims are viable: his fraud-based claims, his unfair claim, and his unlawful claim.

The remaining claims are DISMISSED WITH PREJUDICE.

**IT IS SO ORDERED.**