UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES—GENERAL

Case No. CV 15-01403-MWF (MRWx) **Date: August 1, 2017**
Title: Lorena Armijo, et al. -*v*- ILWU-PMA Welfare Plan, et al.

Present: The Honorable MICHAEL W. FITZGERALD, U.S. District Judge

Deputy Clerk:	Court Reporter:
Rita Sanchez	Not Reported
Attorneys Present for Plaintiff:	**Attorneys Present for Defendant:**
None Present	None Present

Proceedings (In Chambers): ORDER RE MOTION FOR CLASS CERTIFICATION [157]

Before the Court is putative Lead Plaintiffs Kristen Andrich, Nancy Jurevich, Frank Scognamillo, and Kathleen Mitchell's Motion for Class Certification (the "Motion"), filed April 11, 2017. (Docket No. 188). Defendants ILWU-PMA Welfare Plan, Michael H. Wechsler, Robert L. Stephens, and James C. McKenna (collective, "Plan Defendants") and Zenith American Solutions ("Zenith") filed a Joint Opposition on June 27, 2017. (Docket No. 204). Zenith filed a separate Opposition (the "Zenith Opposition") on June 5, 2017. (Docket No. 197). Lead Plaintiffs replied on July 7, 2017. (Docket No. 211). The Court has read and considered the papers filed on the Motion and held a hearing on **July 31, 2017**.

For the reasons set forth below, the Motion is **GRANTED *in part*** and **DENIED *in part***. Lead Plaintiffs' claim for recovery of unpaid benefits requires resolution of numerous individualized issues, including whether each class member's unpaid, preauthorized claims were properly denied. However, Lead Plaintiffs' claims seeking removal of the Plan's fiduciaries raise issues that apply generally to the class, and thus a class can be certified under Rule 23(b)(1).

I. BACKGROUND

On a motion for class certification, "a court must accept the substantive allegations in the complaint as true . . . ." *Vinh Nguyen v. Radient Pharm. Corp.*, 287 F.R.D. 563, 568 (C.D. Cal. 2012). However, the Court must also consider the merits to

the extent that they overlap with the requirements for class certification, as set out in Federal Rule of Civil Procedure 23. *See Ellis v. Costco Wholesale Corp.*, 657 F.3d 970, 979–80 (9th Cir. 2011) (noting that "district courts are not only at liberty to, but must perform 'a rigorous analysis [to ensure] that the prerequisites of Rule 23(a) have been satisfied'" and that "[i]n many cases, 'that rigorous analysis will entail some overlap with the merits of the plaintiff's underlying claim.'") (quoting *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 351 (2011)). The following allegations are drawn from the Third Amended Complaint ("TAC" (Docket No. 169)) as well as various declarations and exhibits submitted by the parties.

Putative Lead Plaintiffs brought this ERISA class action in February 2016. (Docket No. 1). Lead Plaintiffs seek to represent the beneficiaries of Defendant ILWU-PMA Welfare Plan (the "Plan"). (TAC ¶¶ 1–5).

Non-parties International Longshore & Warehouse Union ("ILWU") and Pacific Maritime Association ("PMA"), an employer bargaining association, created the Plan for present and former ILWU members (participants) and their families (beneficiaries). (TAC ¶¶ 6–8). The Plan is administered by representatives of ILWU and PMA through a group of six trustees ("Plan Trustees"), three each selected by ILWU and PMA. (*Id.* ¶ 8). Defendant Zenith became the Plan's third party administrator on January 1, 2013. (*Id.* ¶ 11). Zenith retained non-party TC3 Health ("TC3"), a company that offer certain cost-containment solutions to healthcare plans, to provide "pre-payment fraud detection and prevention for the Plan." (*Id.* ¶ 12). Non-party Innovative Care Management, Inc. ("ICM") reviews providers' requests for pre-authorization of medical services and determines whether those services are medically necessary, on behalf of the Plan. (*Id.* ¶ 13).

When Plan participants and beneficiaries seek medical services from an out of network provider, the provider will often seek to learn in advance whether its services are "preauthorized," *i.e.* covered by the Plan and medically necessary. (TAC ¶ 29). Plan administrators have contracted with ICM to provide preauthorization services; when a provider requests preauthorization, a nurse employed by ICM evaluates the request and makes a determination as to whether the services are medically necessary

and not otherwise excluded under the terms of the Plan. (Declaration of David S. Harris ("Harris Decl."), Ex. C ("Shipley Depo.") 20:6–9 (Docket No. 188-4)). If those criteria are met, ICM sends a letter to the provider and Plan member stating that the services have been preauthorized. (*Id.* at 41:8–11).

After listing the medical services that have been preauthorized, the letter states:

> The ILWU-PMA Welfare Plan has contracted with Innovative Care Management to provide Voluntary Utilization Review Services. Innovative Care Management medical professionals provide an objective review of proposed treatments prior to hospitalization, surgery, outpatient procedures, and diagnostic tests.
>
> An Innovative Care Management registered nurse has reviewed and authorized your requested medical services under the terms of the Coastwise Indemnity Plan subject to the provisions contained in the following paragraphs. Please keep this letter as your documentation for the services and authorizations given regarding your case.
>
> ***This authorization serves as a directive to [Zenith] to pay for the above approved services, but does not determine the amount paid on your claim.*** Benefits are subject to your eligibility at the time you receive the medical services and applicable out-of-network charges. If you need an estimate of the amount that may be paid on your claim, please contact [Zenith at the following phone number] . . . .

(Harris Decl., Ex. F ("Preauthorization Letter") (Docket No. 188-8)) (emphasis added).

Lead Plaintiffs allege that Plan participants, beneficiaries, and providers rely on the language of the Preauthorization Letter when deciding whether to accept treatment. (TAC ¶ 14). However, as was discussed at length in Defendants' papers and at the hearing, this is not the whole story. It is well-understood in the healthcare industry — including by Lead Plaintiffs' own healthcare providers — that issuance of a

preauthorization letter is not a guarantee of payment. (Declaration of John Barton ("Barton Decl.") ¶ 24 (Docket No. 206); Declaration of Daniel L. Blouin ("Blouin Decl."), Ex. G at 65–69 (Docket No. 205-2)). For example, under the terms of the Plan, claims will only be paid upon a determination that the charges actually billed after the service has been rendered are "reasonable." (*Id.* ¶ 29). That is, ICM reviews medical documentation submitted in support of the charges, and screens for fraud, waste, or abuse, before determining whether to reimburse a provider for a procedure, including a preauthorized procedure. (*Id.* ¶¶ 30–31). If the proper documentation has not been provided, or if the procedures have not been billed properly, or if there is some indication that the procedure was not performed, doctors and Lead Plaintiffs understand that the claim may be denied despite having previously been preauthorized. (*See, e.g.*, Blouin Decl., Ex. C at 207:1–208:3 (stating "if somebody bills $20,000 for a $2,000 procedure, they're [*i.e.* the Plan's] not going to pay $20,000 "); Ex. E at 110:7–13 (acknowledging patient would actually need to receive preauthorized procedure for provider to be paid)).

Nevertheless, Lead Plaintiffs contend that Defendants have routinely denied preauthorized claims as not medically necessary or otherwise not covered by the Plain, despite the determination of the nurse during the preauthorization review. (TAC ¶ 30).

Once Zenith has processed a claim, it sends an "explanation of benefits" letter to the Plan member and the healthcare provider, notifying them as to whether the claim would be paid. (Harris Decl., Ex. B ("Barton Depo") (Docket Nos. 188-2, 188-3) at 177:15–20). Lead Plaintiffs contend that these explanation of benefits letters do not contain sufficient explanation of denials under ERISA. (Mot. at 8) (citing 29 U.S.C. § 1133; 29 C.F.R. 2560.503-1). Moreover, sometime after January 2013, an unknown number of explanation of benefits letters were sent out that incorrectly stated that the entire amount billed by the provider had been subjected to a "PPO discount" and that the "total patient responsibility" for the bill was zero dollars. (Barton Depo. at 203:8–17). In fact, the bill had simply not been paid by the Plan, and thus the member actually owed some (unidentifiable, from the letter) amount of money toward the claim. (*Id.*). Plaintiffs allege that by retaining Zenith and TC3 despite the foregoing

problems, among others, and by failing to monitor closely enough the work of Zenith and TC3, including the letters discussed above, the Plan Trustees have acted contrary to the interests of the Plan participants and beneficiaries, in violation of their fiduciary duties under ERISA. (TAC ¶¶ 48–50).

Plaintiffs have three claims remaining in this action: one for recovery of benefits owed on preauthorized claims under 29 U.S.C. § 1132(a)(1)(B), and the other two for removal of the Plan's fiduciaries, alleged to be the PMA Trustees and Zenith, under 29 U.S.C. § 1132(a)(2). Plaintiffs now seek to certify the following class:

> [A]ll [p]articipants in the Plan and their [b]eneficiaries, including both current and former members of the ILWU who are entitled to medical benefits, who had bills for pre-authorized medical or facility services, or for necessary and ancillary services encompassed within such pre-authorization, that have not been paid for over 90 days.

(TAC ¶ 31).

III. DISCUSSION

"Federal Rule of Civil Procedure 23 governs the maintenance of class actions in federal court." *Briseno v. ConAgra Foods, Inc.*, 844 F.3d 1121, 1124 (9th Cir. 2017). To obtain class certification, the putative lead plaintiffs must "satisfy each of the four requirements of Rule 23(a) — numerosity, commonality, typicality, and adequacy — and at least one of the requirements of Rule 23(b)." *Id.* (citing *Ellis v. Costco Wholesale Corp.*, 657 F.3d 970, 979–80 (9th Cir. 2011)). Lead Plaintiffs assert that they primarily seek to certify an injunctive class under Rule 23(b)(1). Lead Plaintiffs additionally seek to certify a damages class under Rule 23(b)(3), which requires putative lead plaintiffs to show the class meets the requirements of predominance and superiority. *Id.*; *see also Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 615 (1997) (discussing relevance of "predominance" and "superiority" requirements of Rule 23(b)(3) to settlement classes).

"The party seeking class certification bears the burden of establishing that the requirements of Rules 23(a) and 23(b) have been met." *In re Wells Fargo Home Mortg. Overtime Pay Litig.*, 268 F.R.D. 604, 609 (N.D. Cal. 2010) (citing, *inter alia*, *Zinser v. Accufix Research Inst., Inc.*, 253 F.3d 1180, 1188 (9th Cir.2001), *amended by* 273 F.3d 1266 (9th Cir. 2001)). "In adjudicating a motion for class certification, the court accepts the allegations in the complaint as true so long as those allegations are sufficiently specific to permit an informed assessment as to whether the requirements of Rule 23 have been satisfied." *Id.* (citing *Blackie v. Barrack*, 524 F.2d 891, 901 n. 17 (9th Cir. 1975)). "Courts must perform a 'rigorous analysis'" of Rule 23(a)'s requirements before concluding that class certification is appropriate. *Alcantar v. Hobart Serv.*, 800 F.3d 1047, 1052 (9th Cir. 2015) (quoting *Dukes*, 564 U.S. at 350–51 (noting that "sometimes it may be necessary for the court to probe behind the pleadings before coming to rest on the certification question")).

Numerosity and adequacy of counsel are present here, and Defendants do not dispute that these requirements are met. Rather, the briefs focus on commonality, typicality, and adequacy of representation of the putative Lead Plaintiffs. The Court concludes that as for the claim for recovery of benefits, individualized issues predominate over common issues, and thus the proposed Class is not appropriate for certification.

A. Claim for Recovery of Benefits

The heart of Lead Plaintiffs' conflict with Defendants is the refusal to pay claims that were previously "preauthorized" by receipt of the Preauthorization Letter. But, as Lead Plaintiffs themselves recognize, preauthorization of a claim is not a categorical promise to pay; it is only a preliminary determination that the claim is medically necessary and not otherwise excluded under the Plan. Accordingly, whether Defendants wrongfully declined to pay for preauthorized claims is an inherently individualized question. (*See* Barton Decl. ¶ 9; Blouin Decl., Ex. A ("Melnykovych Report") at 24–25 and Exs. 2A-6B (Docket No. 205-1)). As Lead Plaintiffs admit, any given decision to deny benefits was made on an individualized basis, not in any systematic manner. (*See* Mot. at 4–7 (describing why the claims were wrongfully

denied, including how in certain cases determinations as to "medical appropriateness," fraud, waste, and abuse could shade into determinations of medical necessity). Thus, determining Defendants' liability as to any individual class member would require an audit of each class member's claims that were preauthorized, and then denied.

The analysis requires even more individualized inquiry because Lead Plaintiffs seek to recover not just for the preauthorized services, but also any ancillary services. It is not only each Plan member but also each set of ancillary services that would require an individualized determination of liability.

At the hearing, counsel for Lead Plaintiffs argued that the plain language of the Preauthorization Letter requires that the liability analysis be limited to the issue of whether the Plan member actually received the services at issue. But even the Preauthorization Letter itself does not necessarily prove this assertion, for the Preauthorization Letter also states that it "serves as a directive to [Zenith] to pay for the . . . approved services, ***but does not determine the amount paid***" on the claim. (Harris Decl., Ex. F). Indeed, the Preauthorization letter adds in the very next sentence, "Benefits are subject to your eligibility at the time you receive the medical services . . . ." (*Id.*). On its face, the Preauthorization Letter contemplates that providers may not receive full compensation for the services rendered.

Additionally, the Court takes into consideration the general industry practice, as described in the expert report submitted by Defendants and understood by Lead Plaintiffs' physicians and, to some extent, Lead Plaintiffs themselves. (*See, e.g.*, Melnykovych Report at 28–29; Blouin Decl., Ex. C at 207:1–208:3; Ex. E at 110:7–13; Ex. G at 65–69). The evidence in the record demonstrates that not even Lead Plaintiffs think that the Preauthorization Letter is an unmitigated guarantee that services will be covered. Rather, the general understanding is that while preauthorization is the first step for some claims, those claims will still be subject to review — and thus, possibly denial — once the claim has actually been submitted. Lead Plaintiffs' proposed alternative reading is thus overly formalistic, and not in line with the general practice.

In *Dukes*, the Supreme Court rejected the previously common formulation that commonality requires the courts to determine whether an action is capable of raising common questions: "What matters to class certification . . . is not the raising of common 'questions' — even in droves — but, rather the capacity of a classwide proceeding to generate common answers apt to drive the resolution of the litigation. Dissimilarities within the proposed class are what have the potential to impede the generation of common answers." 564 U.S. at 350 (quoting Richard A. Nagareda, *Class Certification in the Age of Aggregate Proof*, 84 N.Y.U. L. Rev. 97, 132 (2009)). Here, the answer to the potentially common question of whether Defendants wrongfully declined to pay preauthorized claims would vary from class member to class member, defeating commonality and rendering the putative Lead Plaintiffs atypical in one stroke. Where liability must be determined patient by patient, or even claim by claim, the liability stage of litigation promises to get lost in a sea of individualized issues, and class certification is not appropriate.

Accordingly, the Motion is **DENIED** as to the first claim for relief.

B. Claims for Removal of Plan Fiduciaries

The second and third claims for removal of plan fiduciaries present a closer question. The individualized issues outlined above do not impede the common resolution of the question of whether Zenith and the PMA Trustees breached their fiduciary duties to Plan participants and beneficiaries. Unlike the claim for benefits, any given claim determination would not affect the overall determination of liability, *i.e.* whether Plan Trustees breached their fiduciary duties. Whether Defendants properly administered the Plan as fiduciaries can be resolved irrespective of whether each individual claim was rightly or wrongly denied. Indeed, an individual plaintiff pursuing the same fiduciary claims under § 1132(a)(2) could point to the same evidence to show a pattern of wrongful claim denial as probative of a common scheme or motive under Federal Rule of Evidence 404(b). And Lead Plaintiffs may rely on other evidence as well, including common evidence of Defendants' oversight procedures. Because the underlying issue does not turn on the approval or denial of any given claim for benefits, but rather on Defendants' course of conduct as a whole,

the issues discussed above do not preclude class certification on the fiduciary claims. Commonality is met as to the second claim.

Defendants contend that typicality and adequacy of representation are not met because Lead Plaintiffs have failed to exhaust their administrative remedies. (Joint Opp. at 16–19). It is Lead Plaintiffs' burden to show exhaustion. *See Almont Ambulatory Surgery Ctr. v. UnitedHealth Grp.*, 99 F. Supp. 3d 1110, 1180 (C.D. Cal. 2015). But exhaustion is not required for claims alleging a breach of fiduciary duty. *Spinedex Physical Therapy USA Inc. v. United Healthcare of Arizona, Inc.*, 770 F.3d 1282, 1294 (9th Cir. 2014). Accordingly, exhaustion is no bar to certifying the class, and the requirements of Rule 23(a) are met.

Lead Plaintiffs seek certification of their breach of fiduciary duty claims under Rule 23(b)(1), which provides for certification of a class where "prosecuting separate actions by or against individual members would create a risk of: (A) inconsistent or varying adjudications with respect to individual class members that would establish incompatible standards of conduct for the party opposing the class or (B) adjudications with respect to individual members that, as a practical matter, would be dispositive of the interests of the other members not parties to the individual adjudications or would substantially impair or impede their ability to protect their interests." *Id.*

Certification under Rule 23(b)(1) is appropriate here. As Lead Plaintiffs explained at the hearing, they do not primarily seek monetary damages on their second claim, but rather removal of Zenith and the PMA Trustees. Lead Plaintiffs allege that the Preauthorization Letter approved by Zenith and the PMA Trustees breached their duty of candor by falsely stating that Plan members' medical services had been "approved" and "authorized" when the final determination had not yet been made. (Reply at 15). Lead Plaintiffs further allege that Zenith and the PMA Trustees breached their fiduciary duty to monitor administration of the Plan by failing to oversee or audit the preauthorization process properly. (*Id.*). For example, Plaintiffs have adduced testimony indicating that the PMA Trustees did not follow up on the admittedly misleading explanation of benefits letters to ensure the error had been fixed. (Harris Decl., Ex. B at 220–22 (Docket No. 185-4)). Lead Plaintiffs contend that

Zenith and the PMA Trustees' breach of their fiduciary duty harmed the Plan as a whole by, among other things, causing providers to "no longer provide medical services to [Plan p]articipants and [b]eneficiaries." (TAC ¶ 28). Lead Plaintiffs have alleged a proper claim for injunctive relief under Rule 23(b)(1) and § 1132(a)(2). *Spinedex Physical Therapy USA, Inc. v. United Healthcare of Arizona, Inc.*, 661 F. Supp. 2d 1076, 1091 (D. Ariz. 2009) (explaining that "individuals may sue for breach of fiduciary duty on behalf of a plan if the rights of plan participants and beneficiaries are violated in a willful and systematic way and remedies are sought to redress harms caused to the plan") (citing *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985)).

Defendants further contend that the proposed class is not cohesive, and does not present a substantial risk of inconsistent judgments. The relief requested, however, would benefit all Plan members in the same way, and thus the class is sufficiently cohesive. *See Escalante v. California Physicians' Serv.*, 309 F.R.D. 612, 621 (C.D. Cal. 2015) (finding injunctive class sufficiently cohesive where no individualized inquiry was required and only policy changes were sought). Moreover, the risk of inconsistent judgments is apparent from the face of the claim: If each of the four Lead Plaintiffs brought individual actions seeking removal of Zenith and the PMA Trustees in four separate courts, and half were granted the requested injunctive relief while the other half were not, the Plan would be required both to remove and not to remove Zenith and the PMA Trustees.

Finally, Zenith separately contends that the Court should not certify a class as against it because it is not a proper defendant; that is, in Zenith's view, it is not a plan fiduciary and cannot be liable to the proposed class under § 1132(a)(2). (Zenith Opp. at 9–13). This is a substantive argument that can be better determined on a motion for summary judgment. Indeed, as Lead Plaintiffs explain, the issue of ***whether*** Zenith is a plan fiduciary is another common question supporting class treatment of the breach of fiduciary duty claims.

Accordingly, the Motion is **GRANTED** under Rule 23(b)(1) as to the second and third claims for relief.

IV. CONCLUSION

For the foregoing reasons, Lead Plaintiff's Motion is **GRANTED *in part*** and **DENIED *in part***. The Court certifies the following class for injunctive relief only, and only as to the second and third claims for relief, under Rule 23(b)(1):

> [A]ll [p]articipants in the Plan and their [b]eneficiaries, including both current and former members of the ILWU who are entitled to medical benefits, who had bills for pre-authorized medical or facility services, or for necessary and ancillary services encompassed within such pre-authorization, that have not been paid for over 90 days.

IT IS SO ORDERED.