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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

SUZANNE KISTING-LEUNG, SAMANTHA DABABNEH, RANDALL RENTSCH, and CHRISTINA THORNHILL, individually and on behalf of all other similarly situated,

Plaintiffs,

vs.

CIGNA CORPORATION, CIGNA HEALTH AND LIFE INSURANCE COMPANY, and DOES 1 through 50, inclusive,

Defendant.

Case No. 2:23-cv-01477-DAD-KJN

PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS

Hearing: December 17, 2024
Time: 1:30 p.m.
Judge: Hon. Dale A. Drozd
Courtroom: 4
TAC Filed: June 15, 2024

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I. INTRODUCTION

Plaintiffs assert three causes of action, individually and behalf of Class members, against Defendants Cigna Corporation, Cigna Health and Life Insurance Company, and Does 1–50 (together, "Cigna"), for their unlawful use of an algorithm to wrongfully process claims and issue coverage determinations without the required individualized review. Third Am. Compl. (TAC) ¶ 1. Plaintiffs assert claims under the Employee Retirement Income Security Act (ERISA) and the California Unfair Competition Law (UCL).

Cigna purports to provide health insurance coverage to Plaintiffs through their private employers. Cigna is obligated by its contracts, federal law, and state law to have doctors—not an algorithm—provide an actual review of the merits of Plaintiffs' claims for benefits before denying coverage. Cigna consistently and repeatedly fails to provide this process, instead using its PXDX algorithm to deny hundreds or thousands of claims in bulk, without its doctors even opening the files. As a direct result of Cigna's failure to adequately evaluate Plaintiffs' claims, Plaintiffs have been forced either to forgo necessary care or to pay out-of-pocket for care that Cigna ought to have covered.

Cigna now seeks to avoid liability by (1) prematurely raising a fact dispute over whether several Plaintiffs' claims were reviewed by PXDX; (2) arguing that one Plaintiff's claims are time-barred; (3) arguing Plaintiffs failed to state a claim under ERISA 502(a)(1)(B); (4) arguing Plaintiffs failed to state a claim under ERISA 502(a)(3); and (5) arguing Plaintiffs' UCL claim is insufficiently pleaded under Rules 8 and 9(b), and is preempted by ERISA. For the reasons stated below, Cigna's arguments fail, and this Court should deny Cigna's motion to dismiss in its entirety.

II. FACTUAL BACKGROUND

Cigna covertly and unlawfully uses an algorithm called PXDX to automatically process and deny its insureds' health insurance claims for diagnostic and other procedures without meaningful individualized review. TAC ¶¶ 1–3. Cigna uses this algorithm to deny batches of hundreds or thousands of claims instantaneously. TAC ¶ 3. For example, in 2022 Cigna doctors (called "medical officers") denied over 300,000 requests for payment using the PXDX algorithm, spending an average of just *1.2 seconds* "reviewing" each request before denial. *Id.*

The PXDX algorithm allows Cigna to generate substantial additional profits by: (1) offloading the cost of paying for its insureds' medical care to its insureds by denying claims that would otherwise have to be paid; and (2) eliminating labor costs associated with employing doctors to review claims. TAC ¶ 4. Cigna is able to continue using this blunderbuss process because denials will go largely unchallenged. Indeed, only approximately 0.2% of denied patients will pursue appeals—most patients either pay out-of-pocket or forgo care. TAC ¶ 5. Even the minority of claimants who pursue appeals are unlikely to have their claims paid, due to the futility of Cigna's internal appeals system. *See, e.g.,* TAC ¶¶ 42–47, 87–88. Further, claimants are unable to challenge Cigna's use of PXDX on appeal because Cigna does not disclose its use of PXDX. TAC ¶¶ 7–8. Cigna omits any reference to PXDX in its plan documents, denial letters,[1] explanations of benefits, explanations of payment, or other written documents. TAC ¶¶ 7–8.

Cigna not only fails to disclose its use of PXDX in lieu of doctors; it affirmatively misrepresents its process to its insureds to hide its use of PXDX. For example, Cigna's insurance plans state that only doctors make medical necessity determinations when deciding whether to cover care. TAC ¶ 9. However, Cigna uses the PXDX algorithm to make medical necessity determinations, not doctors—doctors merely use PXDX to deny hundreds or thousands of claims at a time and have their names rubber-stamped onto each denial without having ever opened the claim. TAC ¶ 3. This process falls far short of the individual review by medical doctors that Cigna must provide per its insurance contracts, ERISA, and California state law.

Cigna now argues that it merely uses PXDX to deny claims it "had a right to deny," such as "non-covered claims." Motion to Dismiss (MTD) at 1. However, even pre-discovery, Cigna's distorted use-case of PXDX is inconsistent with the facts. The Declaration of Julie Kessel, a Cigna medical director, indicates that PXDX is not used just to deny payment for non-covered services, but is instead used to deny claims based on medical necessity. Kessel Decl. ¶ 12. Additionally, PXDX denial letters provided by Cigna state that the reason for denying care was lack of medical necessity—further confirming that Cigna uses PXDX to make medical necessity determinations, and to deny claims on

[1] Some denial letters include an internal code, "PXDX-15," in the bottom right corner. This is wholly insufficient to put Plaintiffs on notice that Cigna is using an algorithm, in place of doctors, to deny their claims.

the basis. Tishyevich Decl. Exs. J–L.

Plaintiffs are Cigna insureds who had claims denied by Cigna's PXDX algorithm. TAC ¶ 6. Because Cigna failed to disclose and indeed hid its use of PXDX, Plaintiffs were unaware of the true reason for their denials until ProPublica's article released in March 2023. *See, e.g.,* TAC ¶ 73. After learning about Cigna's unlawful use of PXDX to deny their claims, Plaintiffs filed a complaint against Cigna. Plaintiffs now assert claims under 29 U.S.C. § 1132(a)(1)(B), 29 U.S.C. § 1132(a)(3), and the UCL.

III. ARGUMENT

A. All Plaintiffs Have Article III Standing

Cigna begins with a merits argument thinly disguised as a "standing" challenge. Cigna's standing argument is solely based on the 'injury-in-fact' prong of the Article III standing analysis. MTD at 7. However, Plaintiffs have clearly alleged that they were injured by having their benefits denied by Cigna through its surreptitious use of PXDX, TAC ¶¶ 6, 48, 55, 67, 72, 83, 89-90, 99, and Cigna does not deny that it denied Plaintiffs' claims. Instead, Cigna asserts a lack of Article III standing based on speculation that their claims were not reviewed by the PXDX algorithm—this argument is both equivocal and a fact issue inappropriately premature for resolution on a pleadings challenge.

"To establish standing under Article III, 'a plaintiff must show (i) that he suffered an injury in fact that is concrete, particularized, and actual or imminent; (ii) that the injury was likely caused by the defendant; and (iii) that the injury would likely be redressed by judicial relief.'" *Wit v. United Behav. Health*, 79 F. 4th 1068, 1082 (9th Cir. 2023) (quoting *TransUnion LLC v. Ramirez*, 594 U.S. 413, 423 (2021)). Cigna begins by arguing that Ms. Kisting-Leung, Ms. Thornhill, and Ms. Bredlow have not established an injury-in-fact, while admitting that it denied their claims for benefits. MTD at 5–6. "If a defendant has caused physical or monetary injury to the plaintiff, the plaintiff has suffered a concrete injury in fact under Article III." *TransUnion LLC*, 594 U.S. at 425. This monetary injury is traceable to Cigna because it admits it denied the benefits, not some unrelated third-party. *See Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992). The injury is redressable by the Court because the Court can award benefits. *See* 29 U.S.C. § 1132(a)(1)(B) (granting courts the ability to award benefits due). That is all that is needed for Article III standing.

Cigna's standing arguments depend on underlying merits arguments that Ms. Kisting-Leung, Ms. Thornhill, and Ms. Bredlow were not entitled to benefits because their denials were not connected to PXDX. However, when assessing standing, "Plaintiffs need not have demonstrated that they were, or will be, entitled to benefits to allege a concrete injury." *Wit*, 79 F.4th at 1083 (citing *CIGNA Corp. v. Amara*, 563 U.S. 421, 424–25 (2011)). This is because "it is settled that standing in no way depends on the merits," *Isaacson v. Mayes*, 84 F.4th 1089, 1097 (9th Cir. 2023) (quotation omitted), and the Court "may assume *arguendo* the merits of the plaintiff's legal claim." *In re Google Referrer Header Privacy Litig.*, 465 F. Supp. 3d 999, 1006 (N.D. Cal. 2020). Cigna asserts that these three Plaintiffs suffered no injury based on an employee's affidavit asserting that their claims were not likely denied through PXDX. *See* Kessel Decl. ¶ 12. However, this is a merits argument about *why* Cigna denied certain Plaintiffs' claims, not a standing argument about *whether* Cigna denied Plaintiffs' claims. The Kessel Declaration does not dispute any facts material to Article III standing: the Plaintiffs lost money through claims denials, Cigna denied those claims, and the Court has the power to redress that injury.

Finally, even if Cigna's argument that PXDX was not used was material to the standing analysis, the Kessel Declaration (1) does not establish that Cigna did not use PXDX, (2) contradicts Cigna's own motion, and (3) at most creates a genuine issue of material fact that must be decided in Plaintiffs' favor at the pleading stage. *See Augustine v. United States*, 704 F.2d 1074, 1077 (9th Cir. 1983). Kessel's Declaration does not even plausibly deny that Cigna used PXDX,[2] let alone establish "competent proof." *Hertz Corp. v. Friend*, 559 U.S. 77, 96–97 (2010) ("When challenged on allegations of jurisdictional facts, the parties must support their allegations by competent proof."). According to Kessel, PXDX is *typically* used to issue denials based on medical necessity, and is not *typically* used to indicate lack of coverage. Kessel Decl. ¶ 12 ("This remark code is not the kind of medical necessity denial remark code that is typically used for claims that are reviewed and denied using the PxDx process, and is instead the kind of remark code used to indicate lack of coverage for the service at issue under the member's benefit plan."). At most, this establishes that certain Plaintiffs' claims *may* not

[2] Kessel Decl. ¶¶ 12, 16, 27, 30.

have been adjudicated with PXDX.[3] The declaration also contradicts Cigna's motion, which asserts PXDX is used to "check[] whether specific treatments that providers order are actually covered by the member's benefit plan," not for medical necessity determinations. MTD at 1–2, 4.

All plaintiffs have standing, and the facts asserted by Cigna do not establish that PXDX was not used for Ms. Kisting-Leung, Ms. Thornhill, and Ms. Bredlow.

B. Plaintiff Rentsch's Claims Are Not Time-Barred

Cigna argues that Plaintiff Rentsch's claims are time-barred because his denials occurred in 2018, and the contract sets a limitations period shorter than the ERISA statute of limitations. MTD at 8. These arguments fail. First, Mr. Rentsch's claim for breach of fiduciary duty under ERISA § 502(a)(3) is subject to a six-year limitations period. Second, all his claims are timely because they did not accrue until he discovered the real basis for Cigna's denials: the PXDX algorithm.

A claim cannot be dismissed as time-barred "unless it appears beyond doubt that the plaintiff can prove no set of facts that would establish the timeliness of the claim." *Mujica v. Occidental Petroleum Corp.,* 381 F. Supp. 2d 1164, 1184 (C.D. Cal. 2005) (quoting *Supermail Cargo, Inc. v. United States*, 68 F.3d 1204, 1207 (9th Cir.1995)). When a motion to dismiss is based on the statute of limitations, it can be granted "only if the assertions of the complaint, read with the required liberality, would not permit the plaintiff to prove that the statute was tolled." *Lyms, Inc. v. Millimaki*, 2009 U.S. Dist. LEXIS 136850, at *11–12 (quoting *Jablon v. Dean Witter & Co.*, 614 F.2d 677, 682 (9th Cir. 1980)).

In ERISA actions, "federal courts apply the state statute of limitations for breach of a written contract; California provides a four-year statute of limitations." *Trs. of the Operating Eng'rs Pension Tr. v. Smith-Emery Co.*, 906 F. Supp. 2d 1043, 1058 (C.D. Cal. 2012); *see also* Cal. Code Civ. P. § 337. The UCL also provides for a four-year statute of limitations. Cal. Bus. & Prof. Code § 17208.

However, these limitations periods only start to run after the plaintiff's claim accrues. *See* Cal. Bus. & Prof. Code § 17208 (defining limitations period as four years "after the cause of action

[3] Kessel's statements are particularly dubious because she is not the physician that signed off on any of Plaintiffs' denied claims. If Cigna's assertion was true that doctors, not PXDX, make all medical necessity determinations, then there would be witnesses with personal knowledge of Plaintiffs' denials to state whether PXDX was used. Cigna does not offer any such witnesses.

accrued"); *Operating Eng'rs Pension Tr.*, 906 F. Supp. 2d at 1058 (noting that the ERISA limitations period begins running at accrual). An ERISA claim accrues when "the plaintiff knows or has reason to know of the injury that is the basis of the action." *N. Cal. Retail Clerks Unions & Food Emps. Joint Pension Tr. Fund v. Jumbo Markets, Inc.*, 906 F.2d 1371, 1372 (9th Cir. 1990); *see also Operating Eng'rs Pension Tr.*, 906 F. Supp. 2d at 1058. Importantly, "an ERISA plaintiff's cause of action cannot accrue and the statute of limitations cannot begin to run until the plaintiff has actual knowledge of the breach, regardless of when the breach actually occurred." *Ziegler v. Conn. Gen. Life Ins. Co.*, 916 F.2d 548, 550 (9th Cir. 1990). The accrual of Plaintiff Rentsch's UCL claim is governed by California law—a claim accrues when it is "complete with all of its elements," including "wrongdoing, harm, and causation." *Aryeh v. Canon Bus. Sols.,* 55 Cal. 4th 1185, 1191 (2013).

Under federal and California law, accrual begins only when the plaintiff discovers, or has reason to discover, his claims. *See Operating Eng'rs Pension Tr.*, 906 F. Supp. 2d at 1058 (ERISA limitations period starts to run only when the plaintiff knows or has reason to know of the injury); *Aryeh*, 55 Cal. 4th at 1192 (discovery rule applies to UCL claims, postponing accrual "until the plaintiff discovers, or has reason to discover, the cause of action").

Here, Plaintiffs' claims are based upon Cigna's use of the secret, undisclosed PXDX algorithm to review and deny claims for benefits. TAC ¶¶ 7–9. Because Cigna deliberately concealed its use of PXDX from Plaintiffs, Plaintiffs did not know and had no reason to know of their claims against Cigna for its use. TAC ¶¶ 7–8, 73. Thus, the discovery rule applies, and Plaintiffs' claims did not start to accrue until Plaintiffs were made aware of PXDX's role in reviewing and denying their claims. Plaintiff Rentsch did not discover Cigna's use of PXDX until March 2023, TAC ¶ 73, and he filed his complaint on December 18, 2023, Dkt. 27, less than a year later. Regardless of which statute of limitations applies, Plaintiff Rentsch's claims were filed well within the limitations period after accrual.

Alternatively, 29 U.S.C. § 1113 establishes an exception to the three-year ERISA limitations period for cases of fraud or concealment, extending the limitations period to six years from the date of discovery. *See Lyms, Inc. v. Millimaki*, 2009 U.S. Dist. LEXIS 136850, at *12–15 (S.D. Cal. Aug. 25, 2009) (finding that allegations of concealment and fraud triggered the six-year limitations period).

Even if Rentsch is found to have discovered his claims on the day of denial, Plaintiffs allege

"fraudulent activity or concealment" by Cigna, triggering the fraud or concealment exception to the ERISA limitations period, extending the limitations period to six years from the date of discovery. *See, e.g.*, TAC ¶ 7 (Cigna failed to disclose its use of PXDX); ¶ 8 (Cigna intentionally omitted any reference to PXDX); ¶ 9 (Cigna made deceptive and misleading representations about its claims review process). Rentsch's claim was filed within six years of the 2018 denial. TAC ¶¶ 71–72[4]; Dkt. 27. Thus, Plaintiff Rentsch's claims are not time-barred.

C. Plaintiffs' ERISA 502(a)(1)(B) Claim Should Proceed Because Plaintiffs Identified Breached Plan Provisions and Are Excused from Exhausting Administrative Remedies.

Cigna argues that Plaintiffs' § 502(a)(1)(B) claims should be dismissed for failure to allege any breached plan provisions and failure to exhaust administrative remedies. The Court should reject these arguments. Cigna breached plan provisions guaranteeing medical director review of medical necessity, and by hiding its use of PXDX to make those determinations instead, it violated ERISA claims processing rules, so the exhaustion requirement does not apply.

1. Cigna Breached Plan Provisions About Medical Necessity Determinations

Under ERISA § 502(a)(1)(B), plan participants can sue to "recover benefits due . . . under the terms of [a] plan, to enforce [their] rights under the terms of the plan, or to clarify [their] rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Plaintiffs state a § 502(a)(1)(B) claim by alleging "facts that establish the existence of an ERISA plan" and "provisions of the plan that entitle it to benefits." *Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 99 F. Supp. 3d 1110, 1155 (C.D. Cal. 2015). But Plaintiffs need not "cite to a specific Plan term or provision by page or paragraph." *RJ v. Cigna Behav. Health, Inc.*, 2021 U.S. Dist. LEXIS 55023, at *3 (N.D. Cal. Mar. 23, 2021). Allegations that support a "reasonable inference that [the defendant] is liable for medical care covered by the terms of an ERISA plan" are enough. *Id.* (brackets omitted) (quoting *Glendale Outpatient Surgery Ctr. v. United Healthcare Servs.*, 805 Fed. App'x 530, 531 (9th Cir. 2020)) (allowing a claim to move forward based on such allegations).

Courts have allowed analogous § 502(a)(1)(B) cases to proceed. In *LD v. United Behavioral*

[4] Paragraphs 70 and 71 of the operative complaint contain a scrivener's error, the dates were meant to read "February 23, 2018" and "February 27, 2018." Cigna noted this in its motion, indicating that it is on notice of the proper date. MTD at n.6.

Health, the plaintiffs alleged that their ERISA plans required out-of-network claim reimbursement based on a specific rate calculation. 508 F. Supp. 3d 583, 593–94 (N.D. Cal. 2020). Instead, the defendant "allegedly reimbursed them based on rates generated through [a] pricing tool, which employ[ed] 'a flawed, proprietary database of healthcare claims data that [wa]s wholly unrepresentative of amounts actually charged by or paid to similar medical providers." *Id.* at 594. Because the "database and pricing tool did not generate rates . . . consistent with the plans' requirements," the plaintiffs had sufficiently alleged a breach of plan terms. *Id.*

Here, Cigna violated plan provisions by relying on a similarly flawed tool: PXDX. Plaintiffs' ERISA plans, *see* TAC ¶¶ 16-21, state that Cigna will pay all reasonable and medically necessary expenses incurred by a covered member, *see* TAC ¶ 25, and that medical necessity determinations are made "by a Medical Director," *see* TAC ¶¶ 9, 30. Plaintiffs identified specific language that states that a transvaginal ultrasound—the same procedure Plaintiff Kisting-Leung had denied as not medically necessary—is "medically necessary for the evaluation of suspected pelvic pathology or for screening or surveillance of a woman at an increased risk for ovarian or endometrial cancer." TAC ¶ 42. Nevertheless, despite these clear plan provisions, Cigna denied Plaintiff Kisting-Leung's claim based solely on the PXDX algorithm. TAC ¶¶ 39-51. PXDX denied the other Plaintiffs' medically necessary care too—care that should have been covered based on their ERISA plan terms. TAC ¶¶ 52-58, 59-75, 76-85, 86-93, 94-103. Instead, PXDX denied the claims based on pre-set criteria that failed to consider individualized medical necessity. TAC ¶¶ 1-6, 29-31; *see LD*, 508 F. Supp. 3d at 594 (emphasizing that defendants' proprietary tool "d[id] not reflect . . . nuances" and merely "estimate[d] . . . rates" using data points that were "not sufficiently similar"). Cigna's use of PXDX thus violates Plaintiffs' plan provisions.

Cigna argues that its reliance on the PXDX algorithm complies with plan terms because "Plaintiffs' plans do not lay out any specific method by which medical necessity must be determined." MTD at 12. Cigna then offers a cherrypicked selection of plan terms that support its misreading. *See id.* (referencing exhibits that contain only a handful of pages from each Plaintiffs' respective ERISA plan). But Cigna *does* lay out a specific method for reviewing whether a claim is medically necessary: through a review made "by a Medical Director." TAC ¶ 30. Yet Cigna uses PXDX to "automatically"

deny claims instead. TAC ¶ 29. To the extent a doctor has any involvement, they merely "sign off on the denials in batches without opening each patient's files." TAC ¶ 29. That procedure is a far cry from the plans' guarantee that a medical director will consider an individual's illness or injury, related treatment plan, prior medical history, and other nuances.

Cigna relies on two cases to support its argument, but they are distinguishable. One involved only "general allegations" that did not demonstrate a breach of plan terms, *see Star Dialysis, LLC v. WinCo Foods Emp. Benefit Plan*, 401 F. Supp. 3d 1113, 1139 (D. Idaho 2019), and the other lacked allegations that plaintiffs' services were covered in the first place, *see Almont*, 99 F. Supp. 3d at 1158. As described above, Plaintiffs have avoided both pleading deficiencies here and this Court should allow Plaintiffs' § 502(a)(1)(B) claim to proceed. *See Alexander v. United Behav. Health*, 2015 U.S. Dist. LEXIS 46046, at *2, 5, 9 (N.D. Cal. Apr. 7, 2015) (denying motion to dismiss where plaintiffs adequately alleged that defendant improperly denied outpatient treatment claims due to internal guidelines that were overly restrictive).

2. Plaintiffs Need Not Exhaust Administrative Remedies Because Cigna Violated ERISA Procedures; Alternatively, Exhaustion Would Be Futile

Cigna's other § 502(a)(1)(B) argument applies only to Plaintiffs Dababneh and Rentsch. MTD at 12-13. Cigna argues their claims should not move forward because they never appealed their denials. This argument fails, because both qualify for two exceptions to the exhaustion requirement.

The Ninth Circuit requires ERISA claimants generally to "exhaust available administrative remedies before bringing a claim in federal court." *Barboza v. Cal. Ass'n Prof'l Firefighters*, 651 F.3d 1073, 1076 (9th Cir. 2011); *see Jackson v. Guardian Life Ins. Co. of Am.*, 2023 U.S. Dist. LEXIS 65167, at *3 (N.D. Cal. Apr. 13, 2023) (noting that this requirement is prudential, not jurisdictional). Failure to exhaust, however, "will be excused in two limited circumstances—when resort to administrative remedies would be futile or when the remedy provided is inadequate." *Almont*, 99 F. Supp. 3d at 1178. Moreover, "exhaustion is not needed if a plan administrator fails to comply with ERISA claims procedures" in a way that goes "beyond mere de minimis violations." *Nazarian v. UnitedHealthcare Servs., Inc.*, 2023 U.S. Dist. LEXIS 167711, at *4 (C.D. Cal. Sept. 19, 2023) (quoting *Spinedex Physical Therapy USA Inc. v. United Healthcare of Ariz., Inc.*, 770 F.3d 1282, 1299 (9th Cir.

2014)).

Here, Plaintiffs Dababneh and Rentsch did not need to exhaust administrative remedies because Cigna failed to comply with ERISA claim procedures and appealing their claims would be futile.

a. Exhaustion Does Not Apply Because Cigna Failed To Comply With ERISA Claims Procedures.

Under 29 C.F.R. § 2560.503-1(l), claimants are "deemed to have exhausted [their] administrative remedies" if a plan fails "to establish or follow claims procedures consistent with the requirements of this section." This requirement applies "[e]ven where a plan expressly requires exhaustion of administrative remedies." *Spinedex*, 770 F.3d at 1299.

Courts have found defendants violated ERISA claims procedure when they engaged in similar conduct as Cigna here. For example, in *Nazarian*, the plaintiffs alleged that their plan administrator "violated ERISA claims procedure by failing to, among other things, state the reason for the adverse determinations and specify the plan provision on which the determinations were based." 2023 U.S. Dist. LEXIS 167711, at *4. The court recognized these allegations sufficiently established the defendants' noncompliance with ERISA requirements, so the plaintiffs were "'deemed to have exhausted' administrative remedies." *Id.* (quoting *Barboza*, 651 F.3d at 1076). Similarly, in *Almont*, the plaintiffs alleged that defendants issued EOBs "nearly devoid of information about the benefit plans, the reason a claim was being partially or fully denied, and the plan provisions and any internal rules or guidelines that were being used to deny the claim." 99 F. Supp. 3d at 1181. These omissions ran afoul of 29 C.F.R. § 2560.503–1(g), so the court excused plaintiffs' failure to exhaust. *Id.* at 1181–82.

This Court should do the same. Plan administrators must disclose "[t]he specific reason or reasons for the adverse determination." *See* 29 C.F.R. § 2560.503-1(g)(v)(A). Yet Cigna failed to disclose the true reason for Plaintiffs' claim denials: the PXDX algorithm. TAC ¶¶ 31, 50, 58, 771, 5, 85, 91, 100-101, 118-20. Plan administrators must also provide full and fair review of adverse benefits determinations. *See* 29 C.F.R. § 2560.503–1(h), (j); 29 U.S.C. § 1133(1), (2). But without details about the PXDX algorithm, or Cigna's reliance on the algorithm instead of individualized review to make medical necessity determinations, Plaintiffs and Class Members lacked the ability to contest the denial

of their claims fully and fairly. TAC ¶¶ 111, 117, 121-122.

"One of the purposes of § 1133 is to provide claimants with sufficient information to prepare adequately for any further administrative review or for an appeal to the federal courts." *Almont*, 99 F. Supp. 3d at 1179 (quoting *Brown v. J.B. Hunt Transp. Servs. Inc.*, 586 F.3d 1079, 1086 (8th Cir. 2009)). Where, as here, plan administrators "deprived [plaintiffs] of sufficient information to prepare adequately" by concealing "the identity of critical persons, including the medical and vocational experts who determined" the claim should be denied, or prevented "access to [the plan administrator's] methodologies or reports," the appeals process deprived the plan participants of a full and fair review. *Brown*, 586 F.3d at 1086; *see Grossmuller v. Int'l Union, United Auto., Aero. & Agric. Implement Workers of Am., UAW, Local 813*, 715 F.2d 853, 858 n.5 (3d Cir. 1983) (explaining that "the persistent core" of "full and fair" review "includes knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence"). Plaintiffs who, as here, were denied that full and fair review, are not required to exhaust administrative remedies. *See Brown*, 586 F.3d at 1087; *Almont*, 99 F. Supp. 3d at 1182; *Nazarian*, 2023 U.S. Dist. LEXIS 167711, at *4.

Cigna attempts to handwave Plaintiffs' argument by claiming that the fact that Plaintiffs' letters mentioned PXDX satisfied Cigna's ERISA obligations under 29 C.F.R. § 2560.503-1(g), (h), and (j). *See* MTD at 11–12, 13–14. This argument lacks merit. As an initial matter, some Plaintiffs did not receive letters that explicitly mentioned PXDX at all. *See, e.g.*, TAC ¶¶ 80-83. Other Plaintiffs' only indication that PXDX was used came from a tiny code in the bottom righthand corner of their letter. *See, e.g.*, Ex. L, J, K. These letters shared one commonality: none of them explained what PXDX was, how it operated, or that it supplanted individualized review by a medical director. Indeed, Plaintiffs' letters implied that a medical director did make the medial necessity decision—further obfuscating the role PXDX played. *See, e.g.*, Ex. K at 4 (explaining that, on appeal, a "medical director who *wasn't* involved in making the first decision will review your request" (emphasis added)). As such, Cigna failed to explain the reason for the adverse determination and prevented full and fair review, in violation of 29 C.F.R. § 2560.503-1(g), (h), and (j). Plaintiffs did not need to exhaust administrative remedies as a result.

b. Plaintiffs Kisting-Leung and Bredlow's Appeal Experience Demonstrates the Futility of Exhausting Administrative Remedies

Alternatively, this Court should still excuse Plaintiffs Dababneh and Rentsch's failure to exhaust because appealing would have been futile. To have exhaustion excused on futility grounds, plaintiffs "must show that it is certain that [their] claim will be denied on appeal, not merely that [they] doubt[] that an appeal will result in a different decision." *Id.* (quoting *Brown*, 586 F.3d at 1085). Plaintiffs "can demonstrate futility by pointing to a similarly situated plaintiff who exhausted administrative remedies to no avail." *In re WellPoint, Inc. Out-of-Network UCR Rates Litig.*, 865 F. Supp. 2d 1002, 1041 (C.D. Cal. 2011).

In *In re WellPoint*, the court excused exhaustion based on futility where a subscriber who had been under-reimbursed for a surgery based on flawed data had "appealed the denial of benefits to both her employer and [the defendant] multiple times" to no avail. *Id.* at 1041. This experience established futility at the motion-to-dismiss stage. *Id.* at 1041–42. Similarly, in *Discovery House LLC v. Cigna Corporation*, plaintiffs alleged that "Defendants upheld their denials and underpayments" when "Plaintiffs sought to enforce their assigned appeals rights" and represented those decisions as final. 2024 U.S. Dist. LEXIS 105607, at *4 (C.D. Cal. June 12, 2024). This widespread practice went beyond a mere "refusal to pay." *Almont*, 99 F. Supp. 3d at 1179 (quotation omitted). The defendants also "failed to provide Plaintiffs and the insureds with a reasonable opportunity to engage in a meaningful claims process and procedure that was full and fair." *Discovery House*, 2024 U.S. Dist. LEXIS 105607, at *4 (quotation marks omitted). Together, these allegations sufficiently demonstrated futility. *Id.*

Plaintiffs make similar allegations of futility here. Plaintiff Kisting-Leung, for example, has repeatedly appealed Cigna's decision to deny coverage for two transvaginal ultrasounds—a procedure covered by her plan—and has met with failure at every turn. TAC ¶¶ 41-47. Worse, Plaintiff Bredlow reached continuous dead ends in her attempts to have Cigna pay for her IVF fertility services, "[d]espite attempts to communicate with Defendants via their customer service line and provide the alleged missing information" that had supposedly prompted the denial. TAC ¶¶ 87-88.

Defendants try to sidestep futility, *see* MTD at 14, but the attempt falls short. To start, Defendants misstate the allegations. *See id.* (suggesting futility is unavailable because Plaintiffs "have not alleged any facts that would suggest that Cigna's use of PXDX in any way affects the outcome of

appeals"). Moreover, Plaintiffs need not link the futility of a review system with a specific ERISA violation or the breach alleged in their § 502(a)(1)(B) claim. *See In re Wellpoint*, 865 F. Supp. 2d at 1041 (requiring only a showing of a systematic failure of the appeals process). Regardless, each Plaintiff who appealed a denial lacked details on the role PXDX played, and each Plaintiff who appealed a denial lost, TAC ¶¶ 43-49, 81-84, 95-101—even Plaintiff Bredlow, who submitted information purportedly "missing" from her original claim, TAC ¶¶ 87-89. The mere existence of an appeal system does not guarantee its efficacy, as Cigna suggests. MTD at 14.

Therefore, this Court should apply the futility exception to the exhaustion requirement for Plaintiffs Dababneh and Rentsch.

D. Cigna's Systemic Practice of Mass-Denying Claims Breached Its Fiduciary Obligations to Plan Beneficiaries, in Violation of ERISA § 502(a)(3).

Plaintiffs have stated a viable claim for equitable relief for a breach of fiduciary duty under § 502(a)(3), and Cigna's motion to dismiss this claim should be denied.

ERISA holds "plan fiduciaries to a high standard—in fact, the highest known to the law." *Johnson v. Courtier*, 572 F.3d 1067, 1082 (9th Cir. 2009) (quotation omitted); *Farr v. U.S. West Commc'ns*, 151 F.3d 908, 914 (9th Cir. 1998) ("ERISA requires a 'fiduciary' to 'discharge [its] duties with respect to a plan solely in the interest of the participants and beneficiaries.'" (quoting 29 U.S.C. § 1104(a)(1)). Cigna does not dispute it owes fiduciary duties to Plaintiffs,[5] but instead argues they did not allege a breach, did not state a claim for equitable relief, and that the equitable claim should be dismissed as duplicative. Each argument fails. First, allegations that Cigna created a system that denied claims en masse for a purported lack of medical necessity, and without any meaningful individualized review, states a claim that Cigna failed to discharge its duties solely in the interests of plan participants. Second, Plaintiffs seek equitable relief enjoining Cigna from using PXDX to deny claims without individualized review—in other words, to stop practices that breach its fiduciary obligations to

[5] A functional fiduciary test applies under ERISA—because Cigna exercised discretion with respect to making claims determination with PxDx, it had fiduciary duties to plan participants and their beneficiaries. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 220 (2004) (noting that administrators of employee benefit plans who make benefits determinations, including medical necessity determinations, act as fiduciaries).

Plaintiffs. Third, the claim is not duplicative of the claim for benefits because it seeks a broader remedy to stop Cigna's use of PXDX, a form of relief that would not be available for individual benefit claims.

1. Plaintiffs Have Alleged a Breach of Fiduciary Duty

ERISA imposes numerous fiduciary duties on Cigna. The duty of loyalty requires it to discharge its duties "for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." 29 U.S.C. § 1104(a)(1)(A). It also must follow the law and apply plan terms as written, unless those terms conflict with ERISA. *See* 29 U.S.C. § 1104(a)(1)(D). "ERISA does not purport to 'state expressly' each and every one of a fiduciary's duties," and "the common law of trusts" also establishes the bounds of a fiduciary's conduct. *Harris v. Life Ins. Co. of N. Am.*, 419 F. Supp. 3d 1169, 1173 (N.D. Cal. 2019) (citing *Acosta v. Pac. Enters.*, 950 F.2d 611, 618–19 (9th Cir. 1991), *as amended* (9th Cir. 1992)). For example, fiduciaries have "an obligation to convey complete and accurate information material to the beneficiary's circumstance," and "breach their duties if they mislead plan participants or misrepresent the terms or administration of a plan." *Barker v. Am. Mobil Power Co.*, 64 F.3d 1397, 1403 (9th Cir. 1995).

The Supreme Court has acknowledged that where a denial of benefits was "willful and part of a larger systematic breach of fiduciary obligations," a beneficiary can bring a suit for breach of fiduciary duty. *Mass. Mut. Life. Ins. v. Russell*, 473 U.S. 134, 147 (1985); *see also Ehrman v. Standard Ins. Co.*, 2007 U.S. Dist. LEXIS 35124, at *4 (N.D. Cal. May 2, 2007) (permitting (a)(3) to proceed at the pleading stage based on allegations of systematic wrongful acts by fiduciary). Plaintiffs have alleged that Cigna has systematically adopted and used a claims review process that denies claims on medical necessity grounds without a proper medical review. *See, e.g.*, TAC ¶¶ 3, 4, 6, 29. While the plans Cigna administers require medical necessity determinations to be made "by a medical director," *id.* ¶ 30, Cigna instead uses PXDX to deny claims in batches, *id.* ¶ 29.

Cigna argues that because Plaintiffs have not identified plan terms, there is no fiduciary breach. As explained above, Plaintiffs identified plan terms, and Cigna's systemic failure to make adequate medical necessity findings contradicts plan terms and violates its fiduciary duties. Moreover, a failure to follow plan terms is not the only basis for a breach of fiduciary duty. Denying claims in batches and without review is inconsistent with Cigna's obligation to provide benefits where benefits are owed. If

Cigna short-circuits that review with PXDX, it is not evaluating whether benefits are, in fact, owed.

Courts routinely uphold allegations of a breach of fiduciary duty where the claims administrator systematically failed to provide coverage to which plan beneficiaries were entitled. For example, in *L.D. v. United Behavioral Health*, allegations that a plan fiduciary systematically under-reimbursed claims and failed to disclose that it did so stated a claim for breach of fiduciary duty. 508 F. Supp. 3d at 596. In *Hill v. Blue Cross and Blue Shield of Michigan*, plan beneficiaries alleged that the claims administrator improperly made medical necessity determinations for emergency services "by utilizing an automated claims-processing system that makes claims determinations based on a physician's final diagnosis rather than the claimant's signs and symptoms at the time of treatment." 409 F.3d 710, 714 (6th Cir. 2005). The Sixth Circuit held this was actionable as a breach of fiduciary duty. *Id.* Similarly, in *Z.D. ex rel. J.D. v. Group Health Cooperative*, the plaintiff properly alleged a claim for systemic fiduciary duty violations because the defendant systematically failed to cover claims for certain mental health services, in violation of Washington's Mental Health Parity Act. 829 F. Supp. 2d 1009, 1012 (W.D. Wash. 2011).

In addition to alleging a breach of the duty of loyalty, Plaintiffs have plausibly alleged that Cigna's conduct also violates ERISA. ERISA requires claims administrators to provide reasonable claims procedures, 29 C.F.R. § 2560.503-1(b); proscribes particular claims processing procedures for medical necessity determination, *id.* § 2560.503-1(g)(1)(v)(B); and requires a full and fair review of each adverse benefit determination, *id.* § 2560.503-1(h)(1).

Cigna asserts it complied with these procedures, citing three denial letters. However, those letters do not actually show how a physician determined that the services were deemed not medically necessary. Cigna's letter to Ms. Dababneh simply stated the "treatment is not medically necessary" and that it used a coverage policy. Tishyevich Decl. Ex. J at 1–2. Those conclusory statements are entirely consistent with Plaintiffs' allegations that PXDX was used to deny the claim on medical necessity grounds without review, TAC ¶ 33, and without providing any explanation as to *why* the procedure was deemed not medically necessary. The other two letters cited by Cigna contain boilerplate explanations that similarly do not provide any indication a physician reviewed the claim. Tishyevich Decl. Exs. K–L. The regulations require that a plan describe claim procedures to plan beneficiaries, but Plaintiffs

have alleged (and Cigna does not dispute) that PXDX was not disclosed in the plans. *See* 29 C.F.R. § 2560-503.1(b)(2); TAC ¶¶ 7, 30–31, 148.

Finally, Cigna argues that a violation of ERISA's claims-processing regulations is not a breach of fiduciary duty, citing *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 626–27 (9th Cir. 2008). But *Vaught* merely stands for the proposition that a failure to follow the claims procedures can excuse a failure to exhaust administrative remedies—it does not establish that fiduciaries are somehow exempted from following ERISA with respect to those regulations. A violation of the law, including a violation by failing to follow claims procedures, violates the duty of prudence and the duty to follow plan terms consistent with ERISA. *See* 29 U.S.C. § 1104(a)(1)(B), (D); *see, e.g., Concha v. London*, 62 F.3d 1493, 1504 (9th Cir. 1995) (violations of ERISA stated claim for breach of fiduciary duty); *Wise v. MAXIMUS Fed'l Servs., Inc.*, 445 F. Supp. 3d 170, 200 (N.D. Cal. 2020) (violation of ERISA claims procedures is not a freestanding legal violation, but "may constitute another theory of breach of fiduciary duty"); *Hitchcock v. Cumberland Univ. 403(b) DC Plan*, 851 F.3d 552, 564 (6th Cir. 2017) (plaintiffs properly alleged breach of fiduciary duty claim premised on statutory violations).

2. Plaintiffs Have Pled Equitable Relief Available Under ERISA

Cigna relies on a single case to argue Plaintiffs have failed to plead a theory of equitable relief. That case is distinguishable, as the court dismissed the claim for equitable relief solely because it sought "monetary damages," which is not an available remedy under ERISA. *Physicians Surgery Ctr. of Chandler v. Cigna Healthcare Inc.*, 550 F. Supp. 3d 799, 812–13 (D. Ariz. 2021). By contrast here, Plaintiffs have specified equitable relief cognizable under ERISA, namely: "disgorgement and/or restitution" and "declaratory and public injunctive relief enjoining Cigna from continuing its improper and unlawful claim handling practices." TAC, Prayer for Relief ¶¶ b, d. An injunction to stop a systemic and improper claims-handling practice is appropriate equitable relief under ERISA. *CIGNA Corp. v. Amara*, 563 U.S. 421, 440 (2011) (holding that affirmative and negative injunctions are equitable relief under ERISA); *Concha*, 62 F.3d at 1504 (holding that injunctive relief is an available remedy for equitable claims for breach of fiduciary duty under ERISA); *see Hill*, 409 F.3d at 714; *Z.D. ex rel. J.D.*, 829 F. Supp. 2d at 1012. Equitable restitution is, similarly, an equitable remedy available under ERISA.

See Mertens, 508 U.S. at 248.

3. The Equitable Claim Does Not Duplicate the Claim for Benefits

Cigna asks this Court to construe both ERISA claims as raising the same theory and to dismiss the (a)(3) claim as duplicative. The Court should reject that argument. Where a claims administrator uses an improper claims-handling process, an individual affected by that process can maintain both a claim for benefits and a claim for equitable relief: "Supreme Court and Ninth Circuit authorities have both authorized a claim under section 1132(a)(3) for a fiduciary's improper handling of an individual benefit claim in violation of its fiduciary duties." *Zisk v. Gannett Co. Income Prot. Plan*, 73 F. Supp. 3d 1115, 1118–19 (N.D. Cal. 2014) (citing *Varity Corp.*, 516 U.S. at 510–11; *Paulsen v. CNF Inc.*, 559 F.3d 1061, 1075 (9th Cir. 2009); *Peralta v. Hispanic Bus., Inc.*, 419 F.3d 1064, 1075 (9th Cir. 2005)); *see Moyle v. Liberty Mut. Ret. Benefit Plan*, 823 F.3d 948, 961 (9th Cir. 2016) (permitting both claims "where the relief sought in connection with each claim is distinct").

Courts have found that cases challenging an improper claims process can proceed on a breach of fiduciary duty theory, even where the named plaintiffs have individual benefit claims that resulted from that process. *See, e.g.*, *Keith Feder, M.D., Inc. v. Aetna Life Ins. Co.*, 2024 U.S. Dist. LEXIS 129547, at *2–3 (C.D. Cal. June 25, 2024) (holding that failing to reimburse a physician's claims and unjustifiably putting claims on hold states a claim for breach of fiduciary duty that is not duplicative of benefit claims); *Hill*, 409 F. 3d at 714 (holding automated claims-processing system actionable as fiduciary breach because the plaintiffs' individual claims "will not change the fact that [the administrator] is using an allegedly improper methodology for handling all . . . emergency-medical-treatment claims"). Because Plaintiffs similarly have challenged Cigna's process for making medical necessity determinations, their claim for breach of fiduciary duty is not duplicative and should proceed.

E. Plaintiffs' UCL Claim is Adequately Pleaded and is Not Preempted by ERISA

1. Plaintiffs' UCL Claims Are Pleaded With Rule 9(b) Particularity

Cigna argues that Plaintiffs fail to plead their UCL claims with Rule 9(b) particularity. MTD at 17–19. "Since fraud is not an essential element of a UCL claim, Rule 9(b) heightened pleading requirement applies only to allegations that sound in fraud." *Epperson v. GM, LLC*, 2023 U.S. Dist. LEXIS 222110, at *6 (C.D. Cal. Dec. 13, 2023). Plaintiffs' UCL claim is based on both Cigna's

omission of its use of the PXDX algorithm and its affirmative misrepresentations in the contract and on their website. TAC ¶¶ 7–9, 147–48.

Pleading affirmative misrepresentation claims under Rule 9(b) requires a plaintiff allege the "who, what, when, where, and how" of the misconduct. *Kearns v. Ford Motor Co.*, 567 F.3d 1120, 1124 (9th Cir. 2009). Plaintiffs meet this requirement for the affirmative misrepresentations alleged: Plaintiffs allege the who ("Cigna," TAC ¶ 9); what (represents that medical necessity determinations would be made by a medical director and represents that "we've got you covered," TAC ¶ 9); when (at the time the policies were executed and presently, on Cigna's website); where (in their insurance policies and on their website (hyperlinked), TAC ¶ 9); and how (by using the PXDX algorithm to review and deny claims rather than human doctors, TAC ¶¶ 1–3).

Fraud based on omission requires a lower pleading standard under Rule 9(b). *See Obertman v. Electrolux Home Care Prods.*, 482 F. Supp. 3d 1017, 1024 (E.D. Cal. 2020) ("However, alleging fraudulent omission or concealment, as plaintiff does here, is somewhat different from pleading an affirmative misrepresentation in that a plaintiff cannot generally plead either the specific time of an omission of the place it occurred." (quotations omitted)); *Falk v. Gen. Motors*, 496 F. Supp. 2d 1088, 1098–99 (N.D. Cal. 2007) ("Clearly, a plaintiff in a fraud by omission suit will not be able to specify the time, place, and specific content of an omission as precisely as would a plaintiff in a false representation claim."). Here, Plaintiffs allege that "Cigna intentionally omitted any reference to the PXDX algorithm in the policies provided to Plaintiffs and Class members," TAC ¶ 8, "Cigna failed to disclose to Plaintiffs and Class members that their claims would be reviewed and denied by the PXDX algorithm without any real doctor involvement," TAC ¶ 7, and "Cigna omitted the explanation of its PXDX from its written policies," TAC ¶ 34. These allegations are sufficient to plead an omission theory under Rule 9(b). *See Obertman*, 482 F. Supp. 3d at 1025 (finding fraud adequately pleaded where the allegations "put defendant on notice of what was omitted . . . and where it should have been included").

Cigna also argues that Plaintiffs fail to allege reliance—but Plaintiffs plainly allege reliance on Cigna's misrepresentations, *see* TAC ¶¶ 50, 58, 75, 85, 92, 102, and that Plaintiffs would not have enrolled with Cigna but-for the misrepresentations, *see* TAC ¶¶ 51, 75, 85, 93, 103, 149 ("Plaintiffs and Class members would not have enrolled with Defendants had they known Defendants failed to

diligently pursue submitted claims using a thorough, fair, and objective investigation."). *See also Brown v. Van's Int'l Foods, Inc.*, 622 F. Supp. 3d 817, 826 (N.D. Cal. 2022) (finding reliance where the plaintiff alleged "that had the omitted information . . . been disclosed, she would have been aware of it and behaved differently"); *Myers v. BMW of N. Am., LLC*, 2016 U.S. Dist. LEXIS 175221, at *9–12 (N.D. Cal. Dec. 19, 2016) (same); *see also Miller v. Fuhu, Inc.*, 2015 U.S. Dist. LEXIS 162564, at *16 (C.D. Cal. Dec. 1, 2015) ("[R]eliance may be presumed by demonstrating the materiality of the alleged misrepresentations and omissions.").

Additionally, Cigna argues that Plaintiffs are required to identify the role each defendant played in the fraudulent scheme and failed to do so. MTD at 19. However, joint allegations are sufficient when they are accompanied by an allegation that the multiple defendants "worked in concert as parent and subsidiary entities in the marketing and selling" of the relevant goods. *Brown v. Dynamic Pet Prods.*, 2017 U.S. Dist. LEXIS 172722 (S.D. Cal. Oct. 18, 2017) (applying *Swartz v. KPMG LLP*, 476 F.3d 756 (9th Cir. 2007)). Plaintiffs have alleged this joint conduct. TAC ¶ 151 ("In perpetrating their fraudulent conduct, Defendants acted in concert and participated in exactly the same conduct, as described herein."). Additionally, because the Cigna Defendants are parent/subsidiary entities that are represented by the same counsel, "lumping" them together is "less likely to frustrate notice of the claims as to any particular defendant." *Sussex Fin. Enters. v. Bayerische Hypo-Und Vereinsbank AG,* 2010 U.S. Dist. LEXIS 671 (N.D. Cal. Jan. 6, 2010) (rejecting this argument).

Thus, Plaintiffs satisfy the Rule 9(b) heightened pleading requirement to the extent required.

2. Plaintiffs' UCL Claim Satisfies Rule 8

Cigna argues that Plaintiffs' UCL claim is not plausibly pleaded under Rule 8 because Plaintiffs allegedly rely on California Unfair Insurance Practices Act (UIPA) provisions which cannot premise UCL violations. MTD at 19–20. Cigna claims Plaintiffs "cite alleged violations of California Insurance Code § 790.03(h), California Code of Regulations title 10, § 2695.7, and California Health & Safety Code § 1367.01(e) and (h)(4)." MTD at 19. However, Plaintiffs' UCL claims turns only upon California Health & Safety Code § 1367.01—the allegations pertaining to three prongs (unlawful, unfair, and fraudulent) of Plaintiffs' UCL claim makes no mention of California Insurance Code § 790.03(h) or California Code of Regulations title 10, § 2695.7. Thus, Cigna's arguments pertaining to those codes

are irrelevant.

Cigna's only defense to Section 1367.01 as a predicate for UCL liability is that, according to Cigna, Plaintiffs did not allege a violation of that section. Section 1367.01(e) states:

> No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity.

Cigna's position is that it did not violate this section, because doctors, rather than non-doctor employees, used PXDX to deny thousands of claims *en masse*. MTD at 20. Cigna's position not only ignores the fact that this practice fails to constitute "review" by a doctor, considering the medical directors do not even open or read the claims, but also ignores allegations in Plaintiffs' operative complaint that doctors are not making the medical necessity determinations. *See, e.g.,* TAC ¶ 7 ("[C]laims would be reviewed and denied by the PXDX algorithm without any real doctor involvement"); ¶ 9 ("Cigna's policies falsely claim that determinations related to medical necessity of health care services would be made by a medical director, when in reality the medical directors are not involved in reviewing patients' claims"); ¶ 25 ("Nowhere in these written terms did Cigna disclose that its insurance coverage decisions would be automated or made by computers rather than human doctors"); ¶ 29 ("After the PXDX system denies claims, Cigna doctors then sign off on the denials in batches without opening each patient's files to conduct a more detailed review"). Plaintiffs have clearly alleged a violation of Section 1367.01(e).

Section 1367.01(h)(4) states, in relevant part:

> Responses regarding decisions to deny, delay, or modify health care services . . . shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

Cigna's position is that it did not violate this section because it sent Plaintiffs denial letters. MTD at 21. However, this argument ignores the fact that these denial letters are entirely pretextual—they indicate false reasons for the denial and false "determinations" of medical necessity not made by a doctor—these denial letters fail to accurately and truthfully state the reason Plaintiffs' claims were denied, and they fail to disclose the PXDX algorithm as the actual decisionmaker behind the denials.

TAC ¶¶ 31, 109(e), 118–21, 133, 144. Thus, Plaintiffs have also alleged a violation of Section 1367.01(h)(4).

Cigna also argues that Plaintiffs' "unfair" prong of the UCL claim fails because: (1) it is based on the same theory as the "unlawful" and "fraudulent" prongs, which Cigna claims also fail; and (2) because Plaintiffs "do not plead facts to support their 'unfair' prong allegations." MTD at 22. Neither of these arguments are persuasive. First, as explained above, Plaintiffs do adequately allege the "unlawful" and "fraudulent" prongs. Second, the operative complaint is replete with allegations that describe how Cigna's use of PXDX is unfair and harms consumers. *See, e.g.*, TAC ¶ 2 (Cigna denied claims without even looking at them); ¶ 7 (Cigna failed to disclose why claims were being denied); ¶ 9 (misrepresentations); ¶ 11 (Cigna breached fiduciary duties); ¶ 33 (unlawful failure to disclose the true reason for claim denials); ¶ 146 (Cigna used PXDX to facilitate "rejection of claims in batches without a thorough, fair, and objective investigation offend[s] established public policy and cause[s] harm to consumers that greatly outweighs any benefit associated with those practices. Defendants' actions also violate the unfair prong because they constitute a systematic breach of consumer contracts.").

3. Plaintiffs' UCL Claim is Not Preempted by ERISA

Lastly, Cigna argues that Plaintiffs' UCL claim is preempted by ERISA. MTD at 22. Most of the cases cited by Cigna do not speak to UCL preemption, but to general preemption principles. *See* MTD at 22–23. However, the few cases Cigna cites about preemption of the UCL show only that UCL claims are preempted where they seek plan benefits, or to regulate areas exclusively governed by ERISA. *See* MTD at 23.

Indeed, there are many scenarios in which UCL claims are not preempted by ERISA. *See, e.g.*, *Dist. Council 16 N. Cal. Health & Welfare Tr. Fund v. Sutter Health*, 2015 U.S. Dist. LEXIS 64570 (N.D. Cal. 2015) (concluding plaintiff's UCL claims were not preempted by ERISA where defendants had a state-law based duty to engage in fair business practices, including refraining from the activity alleged, and the obligation to meet that duty was not dependent on the terms of any ERISA plan and arose independently from any contractual duties imposed by ERISA); *Clark v. Grp. Hospitalization & Med. Servs.*, 2010 U.S. Dist. LEXIS 129143 (S.D. Cal. 2010) (UCL claim was not preempted by ERISA

because it sought to enjoin insurer from continuing practice in violation of the Knox-Keene Act).

Here, like in *District Council*, Cigna had state-law duties to engage in fair business practices (as required by the UCL), to allow only doctors to make medical necessity determinations (as required by Section 1367.01(e)), and to provide true and correct reasons for why claims are denied (as required by Section 1367.01(h)(4)), and those duties arose independently from the terms of any ERISA plan or from any contractual duties imposed by ERISA—instead, Cigna's duties are imposed by the UCL and a California insurance statute, Section 1367.01. Also, like *Clark*, Plaintiffs' UCL claim seeks to enjoin Cigna from continuing to use PXDX to review and deny claims in violation of a state insurance statute, Section 1367.01. Additionally, *Clark* held that the Knox-Keene Act (containing Section 1367.01) falls under ERISA's savings clause, and thus is not subject to § 514(a) ERISA preemption. *Clark*, 2010 U.S. Dist. LEXIS at *12–13.

Cigna attempts to force Plaintiffs' claims into ERISA preemption by arguing that Plaintiffs seek benefits and to challenge Cigna's claims review process. MTD at 23–24. However, the remedies sought by Plaintiffs through their UCL claim are expressly laid out in Paragraphs 154 and 155 of the operative complaint and do not seek benefits. First, Plaintiffs seek an injunction, stopping Cigna from using "its scheme involving the PXDX processing system" to deny claims. TAC ¶ 154. This injunctive relief could be awarded to require Cigna to make proper disclosures about its use of the PXDX algorithm or provide individual medical necessity review in conjunction with PXDX. Second, Plaintiffs seek "restitution of the money wrongfully acquired by Defendants by means of responsibility attached to Defendants' failure to disclose the existence and significance of said misrepresentations in an amount to be determined at trial." TAC ¶ 155. Again, this language does not seek an award of benefits—instead, damages could be determined by a price premium of how much Defendants' scheme devalues Plaintiffs' plans.[6] To the extent Plaintiffs seek relief in the form of benefits, that relief is sought by their ERISA claims, not their UCL claim.

IV. CONCLUSION

Plaintiffs respectfully request that the Court deny Cigna's motion to dismiss in its entirety.

[6] The listed examples are merely to illustrate that Plaintiffs' UCL claim does not seek benefits. Plaintiffs reserve the right to request any and all relief permitted by law.

Respectfully submitted,

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