UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS

PENNSYLVANIA CHIROPRACTIC ASSOCIATION, *et al.*, Plaintiffs, -v- BLUE CROSS BLUE SHIELD ASSOCIATION, *et al.*, Defendants.	Case No.: 1.09-cv-05619 Hon. Matthew F. Kennelly Hon. Arlander Keys

PLAINTIFFS' MOTION AND MEMORANDUM OF LAW IN
SUPPORT OF CLASS CERTIFICATION

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INTRODUCTION AND SUMMARY OF ARGUMENT

In this action, Plaintiffs have sued a number of health insurers which license the Blue Cross and Blue Shield ("BCBS") name from the Blue Cross and Blue Shield Association ("BCBSA") (collectively, "Defendants")[1] for violations of the Employee Retirement Income Security Act of 1974 ("ERISA") through common practices and a consistent course of conduct. *See* accompanying Declaration of D. Brian Hufford in Support of Plaintiffs' Motion for Class Certification ("Hufford Decl."), ¶ 1 for a list of the Plaintiffs in this litigation and ¶ 2 for a list of all named BCBS Defendants. ERISA, which governs all group health insurance plans offered as an employee benefit (other than those issued by a government or church), provides the procedures that Defendants must follow when, in administering such plans ("ERISA Plans"), they make an "Adverse Benefit Determination," defined as "a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit . . ." 29 C.F.R. § 2560.503-1(m)(4). ERISA applies to "beneficiaries or participants" under the plans, which includes health care providers who receive benefit payments directly from insurers. *See Kennedy v. Connecticut General Life Ins. Co.*, 924 F.2d 698, 700-01 (7th Cir. 1991) (a provider may sue as a "beneficiary" when he is "designated . . . as the person to receive [the] benefits," and "[t]he possibility of direct payment is enough to establish subject-matter jurisdiction" under ERISA).

Defendants' alleged misconduct arises when they determine after-the-fact that a health insurance benefit should not have been paid and then demand repayment from the provider, frequently recouping such funds by withholding new and unrelated benefits as an offset against the alleged overpayment. Plaintiffs allege that such repayment demands constitute retroactive Adverse Benefit Determinations, which require Defendants to provide the requisite procedural

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[1] On March 17, 2011, Plaintiffs moved to voluntarily dismiss Arkansas Blue Cross and Blue Shield as a defendant in this matter.

protections under ERISA, including a "full and fair review" of the basis for its benefit denial. *See* 29 C.F.R. § 2560.503-1(h) (under ERISA, "a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination").

The reason for the repayment demand is irrelevant, as any time Defendants elect to pay "less than full reimbursement of the submitted expenses," the insureds or their providers are entitled "to challenge the plan's calculation of how much it is required to pay." Hufford Decl., Exhibit ("Ex.") 1 (Department of Labor ("DOL") Frequently Asked Questions ("FAQ"), at Question C-12). As the DOL has stated, "[t]he fact that the plan believes that a claimant's appeal will prove to be without merit does not mean that the claimant is not entitled to the procedural protections of the rule." *Id.*[2] Accordingly, the Court need not adjudicate the validity of the underlying reasons for the repayment demands. Rather, Plaintiffs merely seek to require Defendants to comply with ERISA by providing its "procedural protections" when making retroactive Adverse Benefit Determinations.

Plaintiffs include: a health care facility, Extended Care Treatment, Inc. d/b/a/ Transitions Recovery Program ("Transitions"); an occupational therapist, Ian Barlow ("Barlow"); a clinical social worker, Susanna J. Wood, MSW, LCSA ("Wood"); and eleven Doctors of Chiropractic ("D.C."). Fourth Amended Complaint ("FAC"), ¶¶ 27-50. Concurrently herewith, Plaintiffs have also filed a Motion to Intervene as Plaintiff and Class Representative on behalf of Tri3 Enterprises, LLC ("Tri3"), an institutional provider which offers durable medical equipment

[2] A retroactive denial of previously paid benefits is comparable to termination of benefit payments, which the DOL has made clear constitutes an Adverse Benefit Determination. *See* Hufford Decl., Ex. 2, DOL FAQ at Question C-18 ("Under the regulation, an adverse benefit determination includes any denial, reduction, or termination of a benefit. Accordingly, where a plan terminates the payment of disability benefits under such circumstances, the plan is required to provide the claimant a notification of adverse benefit determination and the right to appeal that determination consistent with the regulation. *See* 29 CFR § 2560.503-1(m)(4), (g) and (h).").

("DME") through its subsidiaries, Wabash Medical Company, LLC ("Wabash"), and Orthoplex Inc. ("Orthoplex"). Collectively, these Plaintiffs are identified herein as the "Individual Provider Plaintiffs" and they seek to be appointed "Class Representatives" to represent a class of similarly situated providers.. In addition, Plaintiffs include a health care subscriber, Katherine Hopkins ("Hopkins"), who seeks to be appointed Class Representative for a subscriber class. Plaintiffs move for certification of the identified classes under Federal Rule of Civil Procedure 23. *See* Hufford Decl., ¶ 5.

To redress Defendants' ERISA violations, Plaintiffs seek appropriate equitable relief, including voiding the current repayment demands, enjoining Defendants from pursuing further repayment demands or recoupments without complying with ERISA, and returning the parties to the *status quo* – *i.e.,* the position they were in before Defendants' findings that there were overpayments – through restitution of all benefit payments that had been improperly recouped or otherwise recovered. Because the Court is not being asked to review the validity of the underlying repayment demands, but only to determine the applicability of ERISA to the *process* and issue appropriate equitable relief, this case is clearly suitable for class certification.

OVERVIEW AND BACKGROUND

The Individual Provider Plaintiffs are each health care providers who have provided services or supplies to patients who have been insured by ERISA health care plans issued or administered by at least one of the Defendants ("BCBS Insureds"). Pursuant to assignments the Individual Provider Plaintiffs obtained from their BCBS Insured patients, and after having filed benefit claims as required under the ERISA health care plans covering the applicable services ("ERISA Plans"), each of the Individual Provider Plaintiffs also received benefit payments directly from at least one of the Defendants. Such payments were made only after one of the Defendants had processed the submitted claims and determined that they represented "Covered

Services" under the terms of the ERISA Plans, such that the BCBS Insureds, and through them their providers, were entitled to the payment of benefits. Plaintiff Hopkins is a BCBS Insured who received Covered Services from a hospital provider, which was paid benefits directly by Defendant WellPoint, pursuant to an assignment given by Ms. Hopkins. FAC ¶ 428.[3]

All of the Defendants operate under a license agreement with BCBSA, pursuant to which they provide services to insureds located in specified coverage areas.[4] When a benefit claim is submitted on behalf of a BCBS Insured to a particular Defendant that issued the applicable ERISA Plan, such Defendant not only processes the claim and issues the payment, but it also makes the determination as to whether the provided treatment was a Covered Service under the ERISA Plan. Frequently, the claim is processed by a BCBS entity where the service was provided, but it is done on behalf of another BCBS entity which issued the policy. In its decision on the motion to dismiss, the Court cogently explained how the claims process works:

> When a doctor provides medical services to a patient who is insured by an out-of-state BCBS entity, he submits a claim for reimbursement to his local BCBS entity (the host plan). The host plan processes the claim and determines the amount of reimbursement due to the doctor. The host plan then consults with the BCBS entity that administers the patient's insurance (the home plan). The home plan determines whether the services that were provided to the patient are "covered services" under her health insurance plan. If the services are covered services, the home plan authorizes the host plan to pay benefits to the doctor. The ultimate financial responsibility for paying the benefits rests with the home plan. Benefits are paid either from the home plan's own assets (in the case of a "fully insured" plan) or from the assets of the patient's employer (in the case of a "self-funded" plan). The process through which BCBS entities collaborate to ensure nationwide

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3 In issuing the benefits on behalf of Ms. Hopkins, WellPoint, Inc. was doing business as Anthem Blue Cross Blue Shield and operating through its wholly owned and controlled subsidiary, Defendant CIC.

4 Most of the Defendants operate in a single state. Defendant WellPoint, Inc. owns and controls a number of subsidiaries and operates in a total of some 14 states. Defendant HCSC operates in four states through its operating divisions, BCBS of Illinois ("BCBSIL"), BCBS of Texas, BCBS of Oklahoma and BCBS of New Mexico. Defendant Regence operates in four states through its wholly owned and operated subsidiaries, Regence Blue Shield of Idaho, Regence BCBS of Oregon, Regence BCBS of Utah and Regence Blue Shield in Washington. *See* Hufford Decl., Ex. 3.

> coverage for BCBS Insureds is known as the BlueCard program. The BlueCard program is implemented and overseen by BCBSA.

Pa. Chiropractic Ass'n ["PCA"] *v. Blue Cross Blue Shield Ass'n* ["BCBSA"], 2010 U.S. Dist. LEXIS 49151, at *11-*12 (N.D. Ill. May 17, 2010). When the BlueCard program is applied, it is the "Home Plan" that issued the policy which makes the benefit determination and authorizes the payments to be made, even though the claim is processed by the local "Host Plan." The Host Plan therefore acts on behalf of, and as the agent for, the Home Plan. FAC ¶ 17.

Each of the Individual Provider Plaintiffs was subjected to the identical conduct engaged in by Defendants – demands to repay previously issued benefits for health care services provided to BCBS Insureds, based on Defendants' determination that such benefits had been overpaid, followed by a forced recoupment of such benefits. Hufford Decl., Ex. 4, 4A (Class Representative list and charts of Defendants and the respective Plaintiffs from whom they recouped), Exs. 5-15, 17-21 (selected responses ot Defendants to Plaintiffs interrogatories).[5] Such recoupments were implemented either through amounts that were withheld as offsets from payments otherwise due and payable for new and unrelated claims or through settlements that had been coerced from Plaintiffs based on threats of using such offsets to withhold future payments. Plaintiff Hopkins was injured by similar conduct after having been balance billed by

5 The Complaint details the repayment demands and recoupments experienced by each of the Individual Provider Plaintiffs. See FAC Korsen and Barlow: ¶¶ 113-23, 153; Leri: ¶¶ 171-75; Askar: ¶¶ 217-22; Tomanek: ¶¶ 243, 250; Barnard: ¶¶ 265-74; Wahner: ¶¶ 279-81; Fava: ¶¶ 302-05; Miggins: ¶¶ 311-14, 317; Reno: ¶¶ 321-26; Dwyer: ¶¶ 321-26; Wood: ¶¶ 372-79; Transitions: ¶¶ 394-98, 423; and Hopkins: ¶ 429.

In addition, as of the date of the filing of this motion, Defendants deposed each of the Individual Provider Plaintiffs with regard to such repayment demands and recoupments, except for Wood and Tri3, which is now moving to intervene in the action. Wood's deposition is scheduled and Plaintiffs agree to make available Tri3 for deposition expeditiously so that Defendants can take the deposition prior to the time by which it must file its papers in opposition to this motion.

her hospital, Miami Valley Hospital ("MVH"), which had been subjected to a repayment demand and recoupment of payments for services it previously provided to Hopkins. FAC ¶¶ 429-33.

While each of the Individual Provider Plaintiffs was subjected to a repayment demand from and recoupment by at least one of the Defendants, a number of those actions were also taken pursuant to the BlueCard program. In such circumstances, a particular BCBS Defendant may have made the repayment demand and recouped benefits, but it did so with regard to benefits that had originally been issued by and on behalf of another BCBS Defendant.

Plaintiff Transitions, for example, is a Residential Treatment Facility which provides alcohol and drug addiction treatment services to numerous BCBS Insureds. Defendant Horizon asserted that it had overpaid Transitions under the terms of its ERISA Plans and demanded repayment of more than $14 million. FAC ¶ 398; Rule 30(b)(6) Deposition of Plaintiff Transitions ("Transitions Dep.,"), Hufford Decl., Ex. 16.[6] These repayment demands – which Horizon made without offering Transitions any right to challenge or otherwise appeal its determinations, FAC ¶¶ 399-400, 412-13; Transitions Dep. at 170:6-20 – related solely to Plans issued by Horizon, and thus did not involve any other Defendants. At the same time, Transitions has also been subjected to numerous recoupments of previously paid benefits by Defendant BCBS of Florida ("BCBSF"), which is the local BCBS entity where Transitions is based. These recoupments, totaling more than $150,000, all related to benefits issued under the BlueCard program, involving benefits payable under ERISA Plans issued by other "Home Plan" BCBS Defendants,, including Defendants IBC, Horizon, BCBSMN, WellPoint (though Defendants Empire and BCCA, two of its state-level subsidiaries), Excellus, BCBSTN, BCBSKS and

6 Horizon filed a separate lawsuit in New Jersey state court seeking to compel Transitions to return the allegedly overpaid benefits. Transitions removed that action to Federal court and a motion to dismiss that action is pending. This Court retained jurisdiction over Transitions' claims in this action.

CareFirst. FAC ¶ 423; Chart attached to BCBSF Response to 1st Set of Interrogatories (Hufford Decl., Ex. 14). Because the BCBS Defendants serving as the Home Plan for those recouped benefits were ultimately responsible for providing the insurance, making the coverage decisions and paying the benefits, the claims asserted by Transitions here are brought not only against BCBSF, but also against each of these other BCBS Defendants on whose behalf BCBSF was acting. The same analysis applies to a number of the Individual Plaintiffs who were subject to repayment demands and recoupments issued by one of the Defendants operating as the Host Plan on behalf of other Home Plan Defendants. *See* Hufford Decl., Ex. 5-15, 17-21.

Plaintiffs' claim is based on their contention that Defendants' repayment demands and forced recoupments violate ERISA, in that they constitute retroactive "Adverse Benefit Determinations" with respect to which Defendants failed to provide the due process protections ERISA makes available to insureds or their providers. As this Court describes the claims:

> Plaintiffs allege that the repayment requests and forced recoupments also violated the terms of ERISA, which governs claims relating to any BCBS insured whose insurance is provided through a private employee benefit plan. . . .
>
> Plaintiffs allege that defendants told the individual plaintiffs that the repayment demands were being made for a variety of reasons. These included: the individual plaintiff used the wrong code when billing for the service provided; the patient was no longer covered by the insurance plan when the service was performed; the patient's claims were covered by another insurer; or the individual plaintiff had mischaracterized the service provided as "mechanical traction" when it was not, in an effort to bring it under the umbrella of "covered services." Plaintiffs argue that despite what defendants say, the repayment demands and subsequent recoupment efforts actually amount to "adverse benefit determinations" – that is, *post hoc* determinations that the services provided were not covered by the terms of the patient's insurance plan. Under ERISA, patients (and, by assignment, their physicians) have certain rights when an insurer makes an adverse benefit determination. These rights include adequate notice and opportunity for a full and fair review of an adverse benefits determination. Plaintiffs allege defendants did not comply with these procedures and that this practice of making *post hoc* adverse benefit determinations without an adequate appeals process violates ERISA, 29 U.S.C. § 1132(a)(1)(B) and 29 U.S.C. § 1132(a)(3).

PCA v. BCBSA, 2010 U.S. Dist. LEXIS 49151, at *15-*16. These claims apply to all types of health care providers who were subjected to similar repayment demands or recoupments of benefits, as well as subscribers who were either subjected to recoupments or who were balance billed by their providers. In addition, Plaintiffs seek a separate class under Florida law on behalf of Doctors of Chiropractic for discriminatory policies.

PROPOSED CLASSES

Plaintiffs move for certification of a "Provider ERISA Class" as defined in the Notice of Motion.[7] That proposed Provider ERISA Class applies to all Defendants.[8] However, the proposed Class Representatives applicable to each Defendant are limited to those Plaintiffs who were subject to repayment demands and recoupments by a particular Defendant, either directly or through the BlueCard program or other indirect method. *See* Hufford Decl., Exs. 4, 4A . For example, as explained herein, and as reflected in Exs. 4 and 4A, Plaintiff Transitions is a Class Representative with regard to claims asserted against Defendants Horizon, BCBSF, IBC, BCBSMN, WellPoint (including Empire and BCCA), Excellus, BCBSTN, BCBSKS and CareFirst, as those are the Defendants which were involved in the repayment demands issued to

7 The proposed Provider ERISA Class assumes a single class involving all Defendants, with specific Plaintiffs serving as Class Representatives for each of the Defendants. *See* Hufford Decl., Ex. 4. Having the class defined in this manner is reasonable since all of the Defendants are tied together through their coordinated conduct, including how the repayment demands were issued and recoupments taken with the BlueCard Program and National Accounts. Plaintiffs Korsen and Barlow, for example, have claims against every Defendant except BCBSMI, BCBSVA, Excellus and Premera. Moreover, the identical common issues apply to all Defendants in terms of whether ERISA applies and, if so, the appropriate equitable relief. In the alternative, the Court may certify the separate Defendant classes detailed in the Hufford Declaration. Given the common issues, handling the case either way is entirely manageable.

8 Excluded from the definition of the Provider ERISA Class are all members of the settlement classes in *Love v. Blue Cross Blue Shield Ass'n*, No. 03-21296-CV (including a separate settlement with Defendant Highmark), *Shane v. Humana, Inc.*, Master File No. 00-1334 (to the extent the settlement involve Defendants WellPoint and BCBSGA), *Dolan v. Excellus, Inc.*, No. 9768-01 (Monroe County, N.Y.), or *Medical Society of the State of New York v. Excellus, Inc.*, No. 9769-01 (Monroe County, N.Y.), who did not opt out of such settlements, and with respect to any repayment demands or offsets arising from health care services and supplies for which benefits were originally paid before the Effective Date of the respective Settlement Agreements of these other class actions.

and recoupments taken from Transitions, whether directly, as with Horizon and BCBSF, or indirectly, through the BlueCard program, as with the other identified Defendants. In the aggregate, there is at least one Class Representative with appropriate ties to each Defendant.

Plaintiffs further move for certification of a "Subscriber ERISA Class" as defined in the Notice of Motion. Plaintiff Hopkins is the Class Representative for this Class, which brings claims against Defendants WellPoint, Inc. and CIC. Finally, Plaintiffs move for certification of a "Florida Chiropractic Discrimination Class" as defined in the Notice of Motion. Plaintiff Dwyer is the Class Representative for this Class, bringing claims against Defendant BCBSF.

ARGUMENT

THIS CASE IS APPROPRIATE FOR CLASS CERTIFICATION

A. Standards for Class Certification

Certification of this class action is appropriate if the Court finds that Plaintiffs have satisfied all of the requirements of Rule 23(a) and one of the requirements of Rule 23(b). *Brieger v. Tellabs, Inc.*, 245 F.R.D. 345, 348 (N.D. Ill. 2007) (Kennelly, J.); *Retired Chicago Police Ass'n v. City of Chicago*, 7 F.3d 584, 598 (7th Cir. 1993); *Neil v. Zell*, No. 08C6833, 2011 U.S. Dist. LEXIS 22038, at *9 (N.D. Ill. Mar. 4, 2011) ("If the requirements of Rule 23 have been satisfied, the court must certify the class action."). Under Rule 23(a), Plaintiffs must prove "that the proposed class is so numerous that joinder of all members is impracticable; there are common questions of law or act; the representatives' claims are typical of those of the class; and the representatives fairly and adequately protect the interests of the class." *Brieger*, 245 F.R.D. at 348-49; *Carnegie v. Household Int'l, Inc.*, 376 F.3d 656, 663-64 (7th Cir. 2004). Once this burden is satisfied, Plaintiffs then must satisfy ***one*** of the requirements of Rule 23(b). *See Brieger*, 245 F.R.D. at 357 (certifying ERISA class of beneficiaries in defendant's profit sharing plan, under Rule 23(b)(1)(B)); *George v. Kraft Foods Global, Inc.*, 270 F.R.D. 355 (N.D. Ill.

2010) (same); *Green v. UPS Health & Welfare Package*, No. 09C616, 2009 U.S. Dist. LEXIS 130000, at *9 (N.D. Ill. Apr. 9, 2009) (Kennelly, J.) (certifying class of beneficiaries in defendant's health care plan, under Rule 23(b)(2)), *aff'd*, 595 F.3d 734 (7th Cir. 2010).

Upon finding that the Rule 23 requirements are met, the Court has "broad discretion to determine whether certification is appropriate in a particular case." *George*, 270 F.R.D. at 363. Moreover, "[i]n deciding motions for class certification, the Court 'should make whatever factual and legal inquiries are necessary under Rule 23.'" *Brieger*, 245 F.R.D. at 349 (quoting *Szabo v. Bridgeport Machs., Inc.*, 249 F.3d 672, 676 (7th Cir. 2001)). *See also Szabo* at 675-676; *George*, 270 F.R.D. at 363 ("factual and legal inquiries" necessary to determine whether Rule 23's requirements are met should be made "even if those considerations overlap the merits of the case"); *Cotton v. Asset Acceptance, LLC*, No. 07C2005, 2008 U.S. Dist. LEXIS 49042, at *9 (N.D. Ill. June 26, 2008) (refusing to "delve into the merits of the ultimate issues")..

B. **<u>The ERISA Plaintiffs Satisfy the Requirements under Rule 23(a)</u>**

1. **<u>Numerosity</u>**

The evidence clearly demonstrates that Defendants issued repayment demands and took recoupments from hundreds, if not thousands, of health care providers nationwide, thereby satisfying numerosity for the Provider ERISA Class. Some Defendants admit to numerosity in their interrogatory responses; others, in response to Plaintiffs' interrogatories, identify sufficient numbers of providers affected by recoupment practices to satisfy the numerosity element. Given the number of providers who have been subjected to such practices, it is clear that numerosity is satisfied for the Subscriber ERISA Class by the number of subscribers affected by Defendants' recoupment practices, and for the Florida discrimination class brought on behalf of Florida-based chiropractors.

2. **Commonality**

Rule 23(a)(2)'s commonality element requires "that there be questions of law *or* fact common to the class," which is "usually" satisfied where, as this Court has held, there is "'[a] common nucleus of operative fact." *Brieger*, 245 F.R.D. at 349 (quoting *Rosario v. Livaditis*, 963 F.2d 1013, 1018 (7th Cir. 1992)); *Keele v. Wexler*, 149 F.3d 589, 594 (7th Cir. 1998). Moreover, "[a] common set of operative facts is usually present when defendants are claimed to have engaged in 'standardized conduct toward the members of the proposed class.'" *Brieger*, 245 F.R.D. at 349 (quoting *Keele* at 594). Significantly, "[c]lass certification cannot be defeated merely because there are some factual variations among class members' grievances." *George*, 270 F.R.D. at 366 (citing *Rosario*, 963 F.2d at 1017). In fact, "'[n]ot all factual or legal questions raised in the litigation need to be common if at least one issue is common to all class members.'" *Id.; Randolph v. Crown Asset Mgmt., LLC*, 254 F.R.D. 513, 517 (N.D. Ill. 2008); *Brieger*, 245 F.R.D. at 349 ("Though there is some factual variation among the class members, these variations will not defeat commonality under Rule 23(a)(2) so long as there is at least one question of law or fact common to the class."); *In re FedEx Ground Package Sys., Inc.*, No. 3:05-MD-527RM (MDL-1700), 2007 U.S. Dist. LEXIS 76798, at *33 (N.D. Ill. Oct. 15, 2007) ("Claims arising from a defendant's standardized conduct towards members of the proposed class or from the interpretation of a standard contract often present a case for treatment as a class action.")(citations omitted). As a result, "[t]he threshold for commonality is not high." *Rogers v. Baxter Int'l Inc.*, No. 04C6476, 2006 U.S. Dist. LEXIS 12926, at *8 (N.D. Ill. Mar. 22, 2006).

This case comes down to a single overarching issue: whether ERISA governs Defendants' practices in making repayment demands and forcing recoupments of previously paid health insurance benefits. Since all members of the proposed ERISA Classes were subjected to Defendants' common practices, this issue is clearly a common one that is applicable on a

classwide basis. Plaintiffs' expert, Dr. Steven Foreman, opined in his expert report and in his deposition (Hufford Decl., Exs. 22, 75) that Defendants' recoupment processes are "nearly identical," and suffer from the same intractable problems:

> The recouping BCBS Entity Defendants act as investigator, judge and jury – by investigating the claim, making a finding that there has been an overpayment and initiating actual recoupments to recover the alleged overpayments, all without there being an external or independent source to validate or uphold the right to recover such previously paid amounts – and [have] a financial stake in the outcome of the process.

Foreman Expert Report, at 17. Dr. Foreman identified a number of common questions or law or fact involving recoupment in addition to those alleged in the FAC. He concluded:

> [T]he core issues in this matter involve the validity of the recoupment audit process that each of the defendants rely upon without compliance with ERISA. The question before the Court does not involve the underlying validity of the basis for the repayment demands, which arguably might involve individual issues, but solely the predominant common issue of whether ERISA governs the recoupment audit process and, if so, how such process should be implemented and what due process protections should be offered to providers. Since it is the *process* for undertaking recoupment audits that is at issue, this case easily involves questions that are appropriate for class-wide determination.

Foreman Expert Report, at 28.

The fact that the BCBS Insureds whose services were subject to repayment demands were in different health insurance plans does not impact the commonality of the claims. In the context of ERISA, "commonality can be satisfied despite class members' participation in numerous plans." *Mulder v. PCS Health Sys., Inc.*, 216 F.R.D. 307, 315 (D.N.J. 2003). Moreover, if the answer to the legal question of the applicability of ERISA is in the affirmative, then the Court can decide, on a classwide basis, whether Defendants' practices violated ERISA, as Plaintiffs allege, and, if so, what is the appropriate remedy. As a result, of these common legal and factual issues, Plaintiffs easily satisfy the commonality requirement of Rule 23(a).

a. **Whether ERISA Governs Defendants' Efforts to Recoup Alleged Prior Benefit Overpayments is a Common Issue**

Under ERISA, an "Adverse Benefit Determination" is broadly defined to include any reduction in benefits below the amount that had been claimed. As the ERISA regulations state:

> The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

29 C.F.R. § 2560.503-1(m)(4). Thus, if a BCBS Entity finds that a bill submitted by the provider should not be paid in full, this constitutes an Adverse Benefit Determination.

The scope of ERISA's Adverse Benefit Determination definition is further clarified by the Department of Labor ("DOL"). In responding to a query as to whether a reduction of a claim based on the application of a plan's copayment or deductible requirements constitutes an Adverse Benefit Determination, the DOL made clear that it does, because ***any*** decision not to pay a submitted claim in full requires compliance with ERISA procedural requirements, stating:

> In any instance where the plan pays less than the total amount of expenses submitted with regard to a claim, while the plan is paying out the benefits to which the claimant is entitled under its terms, the claimant is nonetheless receiving less than full reimbursement of the submitted expenses. Therefore, in order to permit the claimant to challenge the plan's calculation of how much it is required to pay, the decision is treated as an adverse benefit determination under the regulation. Providing the claimant with the required notification of adverse benefit determination will give the claimant the information necessary to understand why the plan has not paid the unpaid portion of the expenses and to decide whether to challenge the denial, *e.g.,* the failure to pay in full. This approach permits claimants to challenge whether, for example, the plan applied the wrong co-payment requirement or deductible amount. The fact that the plan believes that a claimant's appeal will prove to be without merit does not mean that the claimant is not entitled to the procedural protections of the rule. . . .

DOL FAQ C-12, http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html (Hufford Decl., Ex. 1), Question C-12. The common issue arising in the case is therefore whether Defendants' repayment demands and recoupment practices constitute Adverse Benefit Determinations and thus require compliance with ERISA's rules and regulations.

i. **Withholding Benefits to Offset a Prior Overpayment Constitutes an Adverse Benefit Determination**

When Defendants withhold payment on new benefits as an offset against an alleged overpayment, that in and of itself constitutes an ERISA Adverse Benefit Determination, because the new benefit claim is not, in fact, being paid in full. *See Cherene v. First Am. Fin. Corp. Long-Term Disability Plan*, 303 F. Supp. 2d 1030, 1036 n.1 (N.D. Cal. 2004) ("Whether the reduction is taken prior to plaintiff's monthly payment or as a claim for reimbursement, [a recoupment] is either a reduction from her full benefits or a failure to provide for a benefit. Accordingly, Hartford's claim for reimbursement is an adverse benefit determination that triggers the requirements of section 503 [of ERISA]."). Therefore, when Defendants withhold payments by offsetting benefits that would otherwise be paid to apply to an alleged overpayment, they are required to comply with ERISA's rules and regulations. This is a common question of law.

ii. **A Dispute over an Overpayment or Recoupment Constitutes A Claim for "Benefits Due" under ERISA**

The fact that Defendants seek a return of previously paid benefits rather than making an initial benefit determination does not alter the conclusion that a dispute remains a claim for "benefits due" under an ERISA Plan, and thereby subject to ERISA requirements. In *Arana v. Ochsner Health Plan,* 338 F.3d 433 (5th Cir. 2003) (*en banc*), for example, an insured objected to an insurer's effort to recover proceeds from a tort settlement to offset previously paid health care benefits. The initial panel had concluded that the claim did not arise under ERISA because it was "not a claim 'to recover benefits'" since the insurer had "already paid Arana all of the health

benefits due and Arana is not seeking additional benefits." *Id.* at 436. In an *en banc* decision, the Fifth Circuit reversed, finding that ERISA governed the dispute, stating:

> [The defendant] is asserting a right to be reimbursed for the benefits it has paid for [plaintiff's] account. It could be said, then, that although the benefits have already been paid, Arana has not fully "recovered' them because he has not obtained the benefits free and clear of [the insurer's] claims. Alternatively, one could say that Arana seeks to enforce his rights under the terms of the plan, for he seeks to determine his entitlement to retain the benefits based on the terms of the plan.

Id. at 438. *See also Levine v. United Healthcare Corp.*, 402 F.3d 156, 163 (3d Cir. 2005) ("Where, as here, plaintiffs claim that their ERISA plan wrongfully sought reimbursement of previously paid health benefits, the claim is for 'benefits due' and federal jurisdiction under section 502(a) is appropriate."). As held in *Levine* and *Arana*, when there is a dispute over whether previously paid benefits must be reimbursed, it remains one for "benefits due" under ERISA and the denial of such benefits therefore constitutes an Adverse Benefit Determination, whether that denial was prospective or retrospective. Similarly, Plaintiffs' claims here are for "benefits due," since Plaintiffs allege that Defendants "wrongfully sought reimbursement of previously paid health benefits," so that "federal jurisdiction under section 502(a) is appropriate." *Levine*, 402 F.3d at 163. This, too, is a common question of law.

iii. **ERISA Governs an Insurer's Effort to Recover an <u>Overpayment of Prior Benefits from a Subscriber or Provider</u>**

As the entities that assume responsibility for administering their health care plans, including making coverage decisions, Defendants are clearly ERISA fiduciaries. FAC ¶ 79. *See Smith v. Med. Benefit Admin. Group, Inc.*, 2011 U.S. App. LEXIS 5099, at *8-*9 (7th Cir. Mar. 15, 2011) ("As a claims administrator with the power to grant or deny a participant's claim for health insurance benefits, Auxiant is an ERISA fiduciary."); *Mondry v. American Family Mut. Ins. Co.*, 557 F.3d 781, 803 (7th Cir.) (2009); *see also Health Care Serv. Corp. v. Tap Pharm.*

Prods., 274 F. Supp. 2d 807, 812 (E.D. Tex. 2003) (finding that Defendant HCSC "is an ERISA fiduciary within the meaning of 29 U.S.C. § 1002(21)(A)").

In *Sereboff v. Mid Atl. Med. Servs.*, 547 U.S. 356, 361 (2006), the Supreme Court held that ERISA governs efforts to seek repayment of previously paid benefits by ERISA fiduciaries, finding that this was "a proper use" of ERISA. Holding that "[t]here is no dispute that" Mid Atlantic Medical Services, Inc., which "administered" an employer sponsored health insurance plan, "is a fiduciary under ERISA," the Supreme Court concluded that it could therefore bring claims under Section 502(a)(3) "to enjoin" actions that violate the terms of its plans or "to obtain other equitable relief," such as seeking to obtain repayment of overpaid benefits. *Id.* at 359, 361. *Sereboff* has been followed by numerous courts which have applied ERISA to repayment demands, with ERISA having been recognized as the "exclusive remedy" by which an insurer can pursue repayments of previously paid benefits. *See Aetna Life Ins. Co. v. DFW Sleep Diagnostics Ctr.*, 2004 U.S. Dist. LEXIS 17141, at *1-*15 (E.D. La. Aug. 25, 2004), *aff'd,* 2006 Fed. Appx. 309 (5th Cir. 2006).

Significantly, the application of ERISA does not relate solely to subscribers. Courts have universally held that ERISA also governs an insurer's effort to recover overpaid benefits from ***providers*** – including both hospitals or facilities and individuals. In *Central States, Southeast & Southwest Areas Health & Welfare Fund v. Neurobehavioral Assocs., P.A.,* 53 F.3d 172, 174 (7th Cir. 1995), the 7th Circuit considered an ERISA action brought by a health care plan ("Central States") against a health care provider group, Neurobehavioral Associates ("NBA"), to recover an alleged overpayment of benefits – due to a clerical error – for services provided to one of the plan's subscribers. Reversing the district court dismissal, the 7th Circuit ruled that "a federal

court has jurisdiction over an action seeking restitution of wrongfully-paid ERISA benefits under section 502(a)(3)." Explaining its ruling, the Court stated:

> Central States' lawsuit falls easily within the language of [ERISA § 502(a)(3)(B).] That it is brought by an ERISA fiduciary is undisputed, and it is an action seeking equitable relief (restitution) which seeks both to redress a violation of the plan and to enforce the recovery of the overpayments portion of the plan. Additionally, the court's characterization of Neurobehavioral as a third party is misleading. ERISA defines the term beneficiary as "a person designated by a participant . . . who is or may become entitled to a benefit" under a plan. 29 U.S.C. § 1002(8). A medical care provider who receives benefits from the fund at the behest of a participant is a beneficiary. *Kennedy v. Connecticut General Life Ins. Co.*, 924 F.2d 698, 700 (7th Cir. 1991). Hence, according to the terms of the statute, this dispute is between a fiduciary and a beneficiary; a relationship which is of primary concern under ERISA.

Id. at 173-74.

The Seventh Circuit relied on *Central States* on *Trustmark Life Ins. Co. v. University of Chicago Hosps.*, 207 F.3d 876, 880 (7th Cir. 2000), where a health insurer, Trustmark, brought an action against a hospital, the University of Chicago Hospitals ("UCH"), to recover over $350,000 in benefits that Trustmark allegedly overpaid for services provided to its insured. Relying on *Central States*, the 7th Circuit confirmed that ERISA governed the dispute. Noting that "UCH is a medical care provider who received benefits from a welfare fund at the behest of a Plan participant . . . and is therefore recognized as a beneficiary," the Circuit Court held that "Trustmark's action for recovery of ERISA benefits should be resolved in a federal forum." *Trustmark*, 207 F.3d at 880-81.

The holdings by the Circuit in *Central States* and in *Trustmark* conclusively demonstrate that an insurer's effort to recover previously paid ERISA benefits, whether against a subscriber or provider, must arise under ERISA. *See also Blue Cross & Blue Shield of Alabama v. Weitz*, 913 F.2d 1544, 1549 (11th Cir. 1990) (upholding district court's finding that "'an equitable action to recover benefits erroneously paid'" to a doctor for services actually provided by a licensed

social worker "'falls within the clear grant of jurisdiction contained in 29 U.S.C. § 1132(a)(3)'"); *Aetna Life Ins. Co. v. DFW Sleep Diagnostics Ctr.*, 2004 U.S. Dist. LEXIS 12780, at *15-*16 (E.D. La. July 8, 2004) (finding Aetna to be "a fiduciary as administrator of the various ERISA plans," and holding that "[a] suit by a fiduciary against a medical care provider to recover mistaken overpayments made to the medical care provider for the medical treatment of a plan member is of primary concern under ERISA and, as such, is an action to redress a violation of ERISA"); *Nationwide Children's Hosp., Inc. v. D.W. Dickey & Sons, Inc.*, No. 2:08-cv-1140, 2010 U.S. Dist. LEXIS 21077, at *10-*11 (S.D. Ohio Jan. 27, 2010) (repayment demand against hospital treated as an Adverse Benefit Determination, with the hospital given full ERISA appeal rights and both parties seeking relief under ERISA).

Significantly, WellPoint, Inc.'s own subsidiary, Anthem Health Plans of Kentucky, successfully argued for the application of ERISA to a recoupment dispute in *Porter v. Anthem Health Plans of Ky., Inc.*, Civ. A. No. 10-8-HRW, 2010 U.S. Dist. LEXIS 25791 (E.D. Ky. Mar. 18, 2010). In that case, a chiropractor sued Anthem in state court for its improper recoupment of previously paid benefits, after which Anthem successfully removed the case to federal court based on ERISA preemption. In denying Porter's motion to remand, the court explicitly found that the provider's claims arose under ERISA, stating:

> First, Plaintiffs are, indeed, 'beneficiaries" who have standing to sue under ERISA. Although not plan subscribers, by submitting claims for payments, Plaintiffs have taken assignments of benefits under ERISA based benefits plans. Thus, Plaintiffs have standing to bring an ERISA claim. *See e.g., Cromwell v. Equicor-Equitable HCA Corp.,* 944 F.2d 1272 (6th Cir. 1991); *Kennedy v. Connecticut General Life Insurance Company*, 924 F.2d 698 (7th Cir. 1991).
>
> In addition, Plaintiffs' claim sounds in ERISA. *Absent ERISA, there would be no obligation between the parties*. Of note in this regard is United States Supreme Court decision in which participants in an ERISA plan sued the plan administrators in tort, alleging injury arising from the administrators' decisions to deny coverage for certain treatments. *Aetna Health Inc. v. Davila,* 542 U.S. 200, . . . (2004). The Supreme Court rejected the Plaintiffs' argument that the action

> sounded in state tort law, finding that liability only existed because of the ERISA plans that bound the parties. *Id.*

Id., at *4-*5 (emphasis added). The court also rejected Porter's argument that the in-network ("INET") Provider Agreement governed, rather than ERISA, stating: "What is payable, and, more importantly, what is not [payable,] is defined by the terms of the benefit plans and, thus, governed by ERISA." *Id.* at *5. Moreover, the court found that there was no dispute over an assignment, given that Anthem had paid the provider directly for the services. *Id.*, at *7 ("As discussed by the Court in *Davila*, an actual payment to the provider creates an assignment of benefits, thereby endowing the provider with standing to bring an ERISA claim.").[9]

Notably, the application of ERISA to the underlying dispute has already been resolved with regard to Defendant BCBSRI and two of the Individual Provider Plaintiffs, Korsen and Barlow. *See Blue Cross & Blue Shield of R.I. v. Korsen,* C.A. No. 09-317L, 2010 U.S. Dist. LEXIS 116175, at *11 (D.R.I. Oct. 27, 2010), *mot. for recon. or to certify for immed. app. denied*, 2011 U.S. Dist. LEXIS 4899 (D.R.I. Jan. 19, 2011). In that case, BCBSRI sued Korsen and Barlow in state court, alleging fraud and breach of contract in support of its effort to recoup more than $400,000 in alleged overpayments, one of the same repayment demands at issue

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9 Anthem itself argued vociferously in *Porter* that ERISA does, in fact, preempt and govern any dispute over repayment demands and recoupments. Indeed, in its opening substantive paragraph in its Remand Brief it stated that the provider's claim was, "at its core, an action by beneficiaries for benefits under an ERISA plan," and that because the action could "be stated as a 29 U.S.C. §1132(a)(1)(B) claim, . . . the doctrine of "complete preemption" under ERISA applies. Anthem's Response to Motion to Remand ("Remand Brief") (Hufford Decl., Ex. 23), at 1-2. Anthem further argued in its Porter brief that, by filing claims directly pursuant to assignments from their patients, the providers "became beneficiaries of the plan," and that what the providers seek "are the benefits payments under the health plans which Anthem recouped and which plaintiffs contend were properly payable. Id. at 8-9. Finally, Anthem explained that the plaintiff provider's INET provider agreement did not create an independent legal duty that arose outside ERISA. Id. at 9-10 ("Consistent with *Davila*, Porter's claim could have been brought under 29 U.S.C. §1132(a)(1)(B) and there is no independent legal duty.").

here.[10] Korsen and Barlow removed the case, alleging that the claims were preempted by ERISA. In denying BCBSRI's motion to remand, the court expressly concluded that ERISA governed BCBSRI's repayment demand since, while the defendant "alleges that [the providers] breached their Provider Agreements by their willful failure to use proper coding.. . ., it is undeniable that what constitutes proper coding derives from [the insurer's] right to pay only for services covered by the ERISA Plans." *Korsen*, 2010 U.S. Dist. LEXIS 116175, at *15. The court reached its decision notwithstanding BCBSRI's fraud allegations, based on its finding that the fraud and breach of contract claims "are completely preempted by ERISA." *Id.*, at *16.

This decision is particularly significant because it not only was against one of the BCBS Defendants and in favor of two of the Individual Provider Plaintiffs, but the identical claims of Korsen and Barlow are asserted here against virtually all of the Defendants, since BCBSRI was acting on their behalf through the BlueCard program in issuing its repayment demand. *See* FAC, ¶ 157; Chart attached to BCBSRI Response to Interrogatories, dated December 30, 2010.[11] This case and the others cited herein clearly establish that ERISA governs any dispute over Defendants' repayment demands, as Plaintiffs have alleged. For purposes of the present motion, this is a common issue of law.

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10 This Court denied BCBSRI's motion to dismiss or stay this action pending resolution of the Rhode Island case, finding this case to be the "superior vehicle" for resolving the underlying claims. *PCA v. BCBSA*, 2010 U.S. Dist. LEXIS 132527, at *11-*13 (N.D. Ill. Dec. 15, 2010).

11 As reflected in BCBSRI's interrogatory responses, when it demanded repayment of $400,000 in previously paid benefits from Plaintiffs Korsen and Barlow, and then began recouping those payments, it did so on behalf of not only itself, but also on behalf of Defendants WellPoint (including through Defendants Anthem CT, Empire, BCBSGA, Anthem OH and BCCA), HCSC (though its divisions BCBS of both Illinois and Texas), BCBSMA, BS CA, CareFirst, Horizon, Highmark, Wellmark, BCBSSC, BCBSNC, Regence, BCBSAL, BCBSKS, BCBSTN, BCBSKC, BCBSF, BCBSMN and IBC. Hufford Decl., Ex. 15.

b. **Whether Defendants' Efforts to Compel Repayment of Previously Paid Benefits Were in Violation of ERISA Is a Common Issue**

Once the Court determines that ERISA applies to Defendants' repayment demands, it then can determine on a classwide basis whether Defendants' common practices in pursing such repayments and recouping benefits violate ERISA. That, too, is a common issue in this case.

When a BCBS Defendant makes an Adverse Benefit Determination, it must comply with strict ERISA requirements, including providing notification of the denial, with "[t]he specific reason or reasons for the adverse determination," "[r]eference to the specific plan provisions on which the determination is based," "[a] description of any additional material or information necessary for the claimant to perfect the claim," and "[a] description of the plan's review procedures . . ., including a statement of the claimant's right to bring a civil action under section 502(a) of the Act," and making available any "internal rule, guideline, protocol, or other similar criterion . . . relied upon in making the adverse benefit determination." 29 C.F.R. § 2560.503-1(g). Most importantly, ERISA regulations require that employee benefit plans provide a "full and fair review of the claim and the adverse benefit determination." 29 C.F.R. § 2560.503-1(h). A "full and fair review" under ERISA requires "knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering a decision." *Brown v. Ret. Comm. of Briggs & Stratton*, 797 F.2d 521, 534 (7th Cir. 1986); *Holmstrom v. Metro. Life Ins. Co.*, 615 F.3d 758, 774 (7th Cir. 2010) (noting that "ERISA requires plan administrators to provide claimants a reasonable opportunity for 'a full and fair review' of the denial decision," and reversing denial of disability benefits after finding that "MetLife's rejection" of certain evidence presented by insured "to be arbitrary and capricious, failing to provide a full and fair review"); *Leger v. Tribune Co. Long Term Disability Benefit*

Plan, 557 F.3d 823, 832 (7th Cir. 2009) ("when determining whether a decision to terminate benefits was arbitrary and capricious, we look to . . . whether 'the claimant [was] afforded an opportunity for 'full and fair review'"); *Majeski v. Metro. Life Ins. Co.*, 590 F.3d 478, 484 (7th Cir. 2009) ("By ignoring Majeski's key medical evidence, MetLife can hardly be said to have afforded her an opportunity for full and fair review, and its failure to address that evidence in its determination surely constitutes an absence of reasoning.").

There can be no dispute in this case that all of the Defendants engage in post-payment audits or reviews of providers, whereby they evaluate whether there have been overpayments of benefits. *See* Hufford Decl., Exs. 5-15, 17-21. This is done both through formal "fraud" investigations, undertaken by the Special Investigation Unit ("SIU") or similar department of each Defendant, as well as through collection units that address overpayments that are not considered fraudulent. *Id.*. When Defendants determine that there have been such overpayments, Defendants make repayment demands or apply offsets against new and unrelated claims to recoup the alleged overpayments, even without making formal demands for repayment. *Id.*; Exs. 24; 25-71.

While there may be minor variations in how each Defendant structures its SIU and collection units that pursue overpayments, the common unifying factor is that *none* of the Defendants follows ERISA when doing so. Rather, they all hold that ERISA does not apply to efforts to obtain repayments of previously paid benefits. *See* Hufford Decl., Ex. 24; 25-71. Any variations in how Defendants engage in post-payment audits leading to repayment demands are therefore irrelevant to the common issues of whether Defendants' policies comply with ERISA, and whether Defendants' recoupments and offsets represent Adverse Benefit Determinations.

Because none of the Defendants accept that ERISA even applies to their repayment demands or recoupments of previously paid benefits, they similarly do not – and cannot – assert that they complied with these ERISA requirements. For example, notwithstanding the central ERISA requirement that insurers provide a "full and fair review" of any Adverse Benefit Determination, eleven of the sixteen Individual Plaintiffs were given ***no*** rights to appeal the retroactive benefit denials whatsoever (much less rights under ERISA), but were simply told that they owed the funds and, if they refused to pay, the BCBS Defendant forcibly recouped them by withholding payments owed for new claims submitted for unrelated BCBS Insureds:

• Plaintiffs Korsen and Barlow, FAC ¶¶ 122-23, 153 (Defendant BCBSRI making repayment demand and taking recoupments without offering any right to appeal, while acting on its own behalf and, through BlueCard, on behalf of Defendants WellPoint (including through Defendants Anthem CT, Empire, BCBSGA, Anthem OH and BCCA), HCSC (through its operating divisions BCBSIL and BCBSTX), BCBSMA, CareFirst, Horizon, Highmark, BCBSAR, Wellmark, BCBSSC, BCBSNC, Regence, BCBSAL, BCBSKS, BCBSTN, BCBSKC, BCBSF, BCBSMN and IBC);

• Plaintiff Barnard, FAC ¶¶ 270-74 (Defendant IBC taking offsets from new claims as recoupments against alleged overpayments, without providing any appeal rights);[12]

• Plaintiff Wahner, FAC ¶¶ 279-80 (Defendant IBC making repayment demand and taking offsets from new claims, without providing any appeal rights);

• Plaintiff Fava, FAC ¶¶ 301-05 (Defendant Horizon taking offsets from new claims as recoupments against alleged overpayments, without providing any appeal rights);

• Plaintiff Miggins, FAC ¶¶ 312-16 (Defendant Premera making repayment demand without providing any appeal rights), ¶ 317 (Defendant Regence taking offsets from new claims as recoupments against alleged overpayments, without providing any appeal rights);

• Plaintiff Reno, FAC ¶¶ 325-26, 336-37 (Defendant Wellpoint, operating through Defendant Anthem-VA, making repayment demand and coercing settlement without offering any appeal rights);

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12 While IBC offered no appeal rights to Plaintiff Wahner, he nevertheless filed formal appeals to the repayment demands. These were denied by IBC. FAC ¶¶ 290-93. In doing so, IBC failed to comply with ERISA requirements concerning how such appeals must be processed. *Id.* ¶ 294. Moreover, IBC explicitly concluded that as a provider, Dr. Wahner had no right to participate in any appeal. *Id.* ¶ 295.

- Plaintiff Dwyer, FAC ¶¶ 343-44 (Defendant BCBSF making repayment demands and taking offsets from new claims as recoupments against alleged overpayments, without providing any appeal rights, while acting through BlueCard on behalf of Defendants IBC, Highmark, WellPoint (though Defendant Empire), BCBSAL, and HCSC (through its operating division, BCBSIL).[13]

- Plaintiff Transitions, FAC ¶¶ 399-400, 412-13 (Defendant Horizon making repayment demand and filing suit to recover alleged overpayment without offering right to internal appeal), ¶¶ 422-23 (Defendant BCBSF applying offsets of pending claims to recoup alleged overpayments, without offering any appeal rights, while acting through BlueCard on behalf of Defendants IBC, Horizon, BCBSMN, WellPoint (including through Defendants Empire and BCCA), Excellus, BCBSTN, BCBSKS and CareFirst);

- Plaintiff Hopkins, FAC ¶¶ 429-31, 434 (Defendant WellPoint, through Defendant CIC, took offsets from Miami Valley Hospital in order to recoup alleged overpayments for benefits paid on behalf of Ms. Hopkins, without making any disclosure to Ms. Hopkins in advance or providing any appeal rights).

- Intervenor Plaintiff Tri3, Intervenor Cpt. ¶¶ 15-16, 20, 27 (Defendant WellPoint, through Anthem, taking offsets of pending claims to recoup alleged overpayments, without offering any appeal rights).

Notably, these examples from the Individual Plaintiffs include repayment demands and recoupments taken by or on behalf of ***every single Defendant***.[14]

While the remaining five Individual Plaintiffs were offered at least some form of appeal, each was effectively a sham and failed to comply with explicit ERISA requirements, leading thereafter to the same improper forced restitution of unrelated benefit payments:

- Plaintiff Kuhlman, FAC ¶¶ 100-05 (while Defendant HCSC purported to offer appeal rights relating to its repayment demands, it subsequently ignored repeated letters from Dr. Kuhlman's counsel seeking to appeal and requesting back-up information, and then proceeded to offset more than $10,000 in new claims as a means to recoup the alleged overpayments).

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13 While BCBSF did not offer Dr. Dwyer any appeal rights with regard to the repayment demands and recoupments taken on behalf of these identified Defendants, it did purport to offer certain appeal rights with regard to Defendant BCBSMI. In doing so, however, BCBSF failed to provide her any of the underlying information required under ERISA. FAC ¶ 117. Moreover, after Dr. Dwyer submitted formal appeals, and demanded the necessary back-up information to allow her to appeal effectively, they were ignored, and BCBSF took offsets of new claims as a means to recoup the alleged overpayments. *Id.* ¶¶ 351-64.

14 As explained below, Defendants HCSC, Highmark and Regence purported to offer certain limited appeal rights with regard to certain Plaintiffs, but each of them also had recoupments taken on their behalf, through the BlueCard program, by other Defendants with no appeal rights provided.

• Plaintiffs Leri, FAC ¶¶ 177-78, 196 Askar, FAC ¶¶ 217-22, 235, and Tomanek, FAC ¶¶ 243, 246-50, 261 (each of these Plaintiffs was subjected to repayment demands by Defendant Highmark, which forced them to go through its Medical Review Committee ("MRC"), established under state law, while expressly denying the right to pursue ERISA appeals; no ERISA appeal rights were provided, leading to Dr. Leri being coerced into a settlement and Drs. Askar and Tomanek being subjected to offsets of new claims as a means to recoup the alleged overpayments).[15]

• Plaintiff Wood, FAC ¶¶ 278-79, 384-88 (while Regence purported to offer appeal rights with respect to its repayment demand, it upheld its determination without considering her appeal, including by acting without obtaining additional information offered by Wood or otherwise complying with ERISA, and sent its claim to a collections agency to recover the alleged overpayments).

These facts in and of themselves demonstrate the common issue applicable to each Defendant – whether Defendants must comply with ERISA prior to making repayment demands and recoupment benefits, including by providing a "full and fair review" of the underlying basis for Defendants' determination that they had overpaid benefits to Plaintiffs.

This conclusion is reinforced by the Court's prior decision on the motion to dismiss in which it has already found that ERISA will preempt state laws that might otherwise govern appeal rights relating to repayment demands. In rejecting Highmark's assertion that it complied with state law with regard to its appeal process under the MRC, for example, the Court stated:

> The plaintiffs' ERISA claims arise from their allegation that defendants failed to comply with the statutory provisions under ERISA that require a full and fair review of adverse benefits determinations. This amounts to a claim to enforce ERISA's statutory provisions, for which the civil enforcement scheme described in section 502(a) provides the exclusive remedy. *Pilot Life Ins.* [v. *Dedeaux,* 481 U.S. 41, 45 (1987)]. Therefore, to the extent that Highpoint argues that Section 6324(c) of the Pennsylvania statute precludes federal court review of plaintiffs' ERISA claims, that argument fails.
>
> Having found that the plaintiffs have alleged sufficient facts to allow their ERISA claims to proceed, and because section 502 provides the exclusive means

15 In response to the efforts by Drs. Askar and Tomanek to pursue ERISA appeals, Highmark expressly stated in writing that it deemed ERISA to be inapplicable and refused to comply with the ERISA rules and regulations with regard to its repayment demands. FAC ¶¶ 222 (letter to Askar denying the application of ERISA); *id*. ¶¶ 247, 252, 255 (letters to Tomanek denying the application of ERISA).

> for resolving disputes under ERISA to the preclusion of any state laws, the Court denies Highmark's motion to dismiss the claims of Levi and Askar.

2010 U.S. Dist. LEXIS 49151, at *71-*72. Thus, a determination as to whether Defendants violated ERISA by failing to provide a "full and fair review" of their retroactive Adverse Benefit Determinations constitutes a common issue for the ERISA Classes.

c. **The Appropriate Remedy for Defendants' ERISA Violations is a Common Issue for All Class Members**

Defendants may assert many different reasons for seeking repayments of previously paid benefits from Class Members. The Court need not adjudicate the validity of those retroactive Adverse Benefit Determinations, however. As demonstrated above, Plaintiffs seek a finding that (1) ERISA governs Defendants' efforts to recover previously paid ERISA benefits, and (2) Defendants violated ERISA by making repayment demands and recouping benefits without complying with ERISA, including by failing to comply with ERISA's requirements for a full and fair review. Once the ERISA violations have been established, the Court will not be required to review the underlying repayment demands. Instead, the proper remedy will be to void the violative repayment demands and remand to Defendants, where they can reconsider the payments and, if they elect to pursue repayment, do so in compliance with ERISA. The remedy sought by Plaintiffs is therefore injunctive. *See Chionis v. Group Long Term Disability Plan*, No. 04C4120, 2006 U.S. Dist. LEXIS 49221, at *19 (N.D. Ill. July 7, 2006) ("The Seventh Circuit has stated that the proper remedy for the failure to provide a full and fair review [under ERISA] is to maintain the *status quo* and remand the case to the plan administrator for further administrative proceedings that comply with ERISA.") (citation omitted).

In this context, where Defendants had previously authorized and paid benefits, before the ERISA violation occurred, the "status quo" is before the subsequent repayment demand had been made or the recoupment taken. *See Hackett v. Xerox Corp.*, 315 F.3d 771, 776 (7th Cir. 2003)

("[W]here the plan administrator terminated benefits under defective procedures . . . the *status quo* prior to the defective procedure was the continuation of benefits. Remedying the defective procedures requires a reinstatement of benefits."). This analysis of a proper remedy under ERISA was recently discussed by the Seventh Circuit in *Holmstrom*, where an ERISA insured challenged a decision by MetLife to terminate ongoing disability benefits. After finding that the defendant's "denial decision" was arbitrary and capricious because it had "fail[ed]" to provide the plaintiff "a reasonable opportunity for 'a full and fair review'" under ERISA, 615 F.3d at 774, it turned to the remedy. While the court noted that "the most common remedy" when an insurer is found to have violated ERISA "is a remand for a fresh administrative decision rather than an outright award of benefits," it added that "[t]he claimant's benefit status prior to the denial informs our determination," since "'[i]n fashioning relief for a plaintiff who has sued to enforce her rights under ERISA . . . we have focused on what is required in each case to fully remedy the defective procedures given the *status quo* prior to the denial or termination of benefits.'" *Id.* at 778 (quoting *Schneider v. Sentry Group Long Term Disability Plan*, 422 F.3d 621, 629 (7th Cir. 2005)," and *Hackett*, 315 F.3d at 776. The court then described the "key distinction between an initial denial of benefits and a termination of benefits that were being received," as stated in *Schneider*:

> Because of our emphasis on restoring the *status quo* prior to the defective procedures, we have distinguished between "a case dealing with a plan administrator's initial denial of benefits and a case where the plan administrator terminated benefits to which the administrator had previously determined the claimant was entitled. Compare *Wolfe v. J.C. Penney Co., Inc.*, 710 F.2d 388, 393-94 (7th Cir. 1983) (remanding to the administrator for new hearing where initial denial of benefits was not procedurally accurate) with *Halpin* [*v. W.W. Grainger, Inc.*, 962 F.2d 685, 697 (7th Cir. 1992)] (affirming district court's reinstatement of benefits where termination was not procedurally adequate)."

Id.; Schneider, 422 F.3d at 629; *Hackett*, 315 F.3d at 776. The *Holmstrom* court therefore ordered the district court "to reinstate long-term benefits retroactively." 615 F.3d at 779.

The common relief sought in the present action is the identical return to the *status quo* prior to the violation of ERISA and classwide injunctive relief requiring Defendants to comply with ERISA – including by providing a full and fair review of any overpayment determination – should they elect to pursue further post-payment audits and repayment demands going forward.[16]

3. **Typicality**

Under Rule 23(a)(3), the Court "must determine whether 'the claims or defenses of the representative parties are typical of the claims and defenses of the class.'" *Brieger*, 245 F.R.D. at 350. In applying this standing in *Brieger*, this Court explained:

> Under Rule 23(a)(3), the Court must determine whether the "claims or defenses of the representative parties are typical of the claims or defenses of the class." *FED. R. CIV. P. 23(a)(3)*. A "'plaintiff's claim is typical if it arises from the same event or practice or course of conduct that gives rise to the claims of other class members and his or her claims are based on the same legal theory.'" *Keele* [*v. Wexler,* 149 F.3d 589, 595 (7th Cir. 1998)] (quoting *De La Fuente v. Stokely-Van Camp, Inc*., 713 F.2d 225, 232 (7th Cir. 1983)). Courts have cautioned, however, that "[t]ypical does not mean identical, and the typicality requirement is liberally construed." *Gaspar v. Linvatec Corp.,* 167 F.R.D. 51, 57 (N.D. Ill. 1996) (citing *Scholes v. Stone, McGuire & Benjamin,* 143 F.R.D. 181, 185 (N.D. Ill. 1992)). In deciding whether a plaintiff has met the typicality requirement, courts focus on the conduct of the defendant and determine whether the putative class representative and the members of the putative class claim similar injuries due to the defendant's alleged actions. *See Rosario,* 963 F.2d at 1018.

Id. See also George, 270 F.R.D. at 266 (the typicality requirement "directs the district court to focus on whether the named representatives' claims have the same essential characteristics as the claims of the class at large"); *Muro v. Target Corp.,* 580 F.3d 485, 492 (7th Cir. 2009); *Retired*

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[16] *See Smith*, 2011 U.S. App. LEXIS 5099, at *16 ("Restitution, it is true, may in appropriate circumstances be deemed equitable rather than legal relief, as when a fiduciary is wrongfully holding money that belongs to plaintiff. *Keneseth*, 610 F.3d at 482; *cf. Mondry*, 557 F.3d at 806-07 (self-funded insurance plan, by delaying reimbursement to plaintiff for covered services, arguably benefited from delay while depriving plaintiff the time value of her money; restitution therefore equitable in sense it would serve to disgorge plan of ill-gotten gain.")).

Chicago Police, 7 F.3d at 596. Rather than focusing on "the particularized defenses the defendant may have against certain class members," the Court should focus "on the defendant's conduct and the plaintiff's legal theory" in determining whether typicality has been satisfied. *Id.*; *Wagner v. NutraSweet Co.,* 95 F.3d 527, 534 (7th Cir. 1996)). *See Kaufman v. Am. Express Travel Related Servs. Co.,* 264 F.R.D. 438, 442 (N.D. Ill. 2009) ("The *Kaufman* plaintiffs' claims arise from similar events and the same alleged conduct by American Express, give rise to similar claims as those of other members of the Class, and thereby satisfy the typicality requirement."); *FedEx*, 2007 U.S. Dist. LEXIS 76798, at *34 ("A plaintiff's claims is typical if it arises from the same event or practice or course of conduct that gives rise to the claims of other class members and his or her claims are based on the same legal theory.").

In *George*, the court certified an ERISA class, finding that "the relevant conduct – allegedly imprudent decisions involving the Funds – and legal theory – breach of fiduciary duty under ERISA – are the same for Plaintiffs and other members of their proposed class," and "[n]othing more is required to satisfy Rule 23." 270 F.R.D. at 367. Here, too, the "relevant conduct" of Defendants – making repayment demands and taking recoupments without providing the full and fair review required under ERISA – and "legal theory" – that ERISA governs and insurer's effort to recover overpaid benefits – "are the same for Plaintiffs and other members of their proposed class." Typicality is therefore satisfied. Just as this Court granted class certification in *Brieger*, after noting that "plaintiffs' claims on behalf of the Plan [were not] affected by individual investment patterns," 245 F.R.D. at 353, certification is similarly appropriate here, where the individual bases for Defendants' repayment demands do not affect Plaintiffs' claims with regard to the proper process by which such demands should be pursued.

In *Paldo Sign and Display Co. v. Topsail Sportswear Inc.*, 2010 U.S. Dist. LEXIS 125842 (N.D. Ill. Nov. 29, 2010) (Kennelly, J.), the Court found typicality and granted certification of a class under 23(b)(3), for reasons applicable to this case, stating:

> The typicality requirement focuses on "whether the named representatives' claims have the same essential characteristics as the claims of the class at large." *De La Fuente v. Stokely-Van Camp, Inc.*, 713 F.2d 225, 232 (7th Cir. 1983); *see, e.g., Muro v. Target Corp.*, 580 F.3d 485, 492 (7th Cir. 2009). The proposed class representative's claim is typical if it "arises from the same event or practice or course of conduct that gives rise the claims of the other class members and [their] claims are based on the same legal theory." *De La Fuente*, 713 F.2d at 232.
>
> That is the case here. The claims of each class member arise from a common alleged course of conduct on the part of Topsail. There are unlikely to be any factual differences (at least not any significant ones) relating to each class member's receipt of a faxed advertisement.

Id., at *5. The same reasoning applies here with the "common alleged course of conduct on the part of [Defendants]" being their violations of ERISA. As Plaintiffs demonstrate, there are no significant factual differences between the experiences of Class Members in being subjected to Defendants' improper payment demands and recoupments.

The Provider ERISA Class is defined to include all types of health care providers, including chiropractors, social workers, physicians, facilities, hospitals, and any other provider type.[17] Including all providers does not defeat typicality. They all have the identical claim as any other health care provider of whether ERISA governs repayment demands and recoupments. Discovery has demonstrated that Defendants' post-payment audit and recoupment practices do not differ based on provider type. Nor do Defendants' failure to comply with ERISA differ based

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[17] The defined class includes physicians. To avoid conflicts with certain other cases that have settled with broad releases that could be interpreted to have released recoupment-related claims, Plaintiffs have defined the Provider ERISA Class to exclude all Class Members in such other cases, except with respect to repayment demands or recoupments "arising from health care services and supplies for which benefits were originally paid after the Effective Date of the respective Settlement Agreements of these other class actions." FAC ¶ 495. That way, the claims incorporated in this action have not been released as they had not arisen as of the Effective Dates for the various settlements.

on the type of provider. Each Defendant testified that there is absolutely no difference in the procedure for recoupments based on variations among providers. *See* excerpts from Defendants' 30(b)(6) depositions attached to the Hufford Decl., Ex. 76.

Case law also shows that the same issues apply to providers across the board. *Trustmark* and *Nationwide* both involved efforts to recover overpayments from hospitals, *Central States* involved a physician group, *DFW* concerned a diagnostics center, *Weitz* involved a medical doctor and social worker, *Porter* concerned a chiropractor, and *Korsen* involved a chiropractor and occupational therapist. In each case the court found that ERISA governs efforts to recover previously paid benefits. The fact that the proposed Provider Class Representatives including two facilities (Transitions and Tri 3), a social worker (Wood), an occupational therapist (Barlow) and a chiropractor whose recoupments were based on services provided by a physician,[18] as well as various chiropractors, ensures that the interests of all provider types will be protected in the action. Similarly, Plaintiff Hopkins' claims are typical to those of the Subscriber ERISA Class who were subjected to balance bills from recouped providers. Each has "the same essential characteristics" arising from Defendants' obligations under ERISA.

The Court recognized in its December 15, 2010 Order retaining jurisdiction of the Transitions claims that, regardless of the type of provider, all Plaintiffs assert similar claims:

> . . . [I]n the present case, Transitions is joined by numerous other plaintiffs who assert similar claims, and they have sued Blue Cross-related entities . . . on the ground that some of the patients for whom they performed services were covered by other Blue Cross plans that allegedly were involved in the decisions to retroactively deny coverage. . . . This case is, at present a "superior vehicle" for resolution of the full range of disputes between Transitions and the defendants.

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18 As explained above, recoupments taken by Defendant HCSC against Plaintiff Kuhlman, a chiropractor who owns a business with non-chiropractic employees, further highlights why the case is not limited to chiropractic services, in that the relevant recoupments at issue in the case were taken with regard to medical services provided by an employed medical doctor, not chiropractic services. Hufford Decl., Ex. 71 (Kuhlman Dep. Tr. at 18:19-19:23; 168:20-169:11.

PCA v. BCBSA, slip op. at 2 (N.D. Ill. Dec. 15, 2010).(DE 331) Accordingly, typicality is satisfied here.

4. **Adequacy**

The final requirement under Rule 23(a) is adequacy, whereby the class representatives must be able to "fairly and adequately protect the interests of the class." To determine if adequacy is satisfied, "the Court must ask whether the individual: '(1) has antagonistic or conflicting claims with other members of the class; (2) has sufficient interest in the outcome of the case to ensure vigorous advocacy; and (3) has counsel that is competent, qualified, experienced and able to vigorously conduct the litigation.'" *George*, 270 F.R.D. at 368 (quoting *Wahl v. Midland Credit Mgmt.,* 243 F.R.D. 291, 298 (N.D. Ill. 2007)). Courts have recognize that this burden is "not difficult" to meet, *id.*, but the Plaintiffs simply must show that the "interests" of the Class Representatives "are aligned with the rest of the class." *Wallace v. Chi. Hous. Auth.*, 224 F.R.D. 420, 430 (N.D. Ill. 2004). *See Brieger*, 245 F.R.D. at 355 ("Courts do not deny class certification on speculative or hypothetical conflicts.").

None of the proposed Class Representatives have claims that are "antagonistic or conflict" with those of the remainder of the class, as they all have been subject to Defendants' repayment demands and recoupments and the legal argument that ERISA applies governs all such claims. Moreover, given the specific examples of the repayments demanded of, and recoupments taken from, each proposed Class Representatives, it is also clear that they have "sufficient interest in the outcome of the case to ensure vigorous advocacy." *See* Hufford Decl., Exs. 5-15; 17-21; *see also George*, 270 F.R.D. at 368 ("The Court cannot identify any conflict between Plaintiffs' claims and those of unnamed class representatives. In addition, the Court finds that Plaintiffs have a sufficient interest in this litigation, and thus will vigorously advocate

their positions."). To the extent any conflicts arise during the course of the litigation, the Court can address it then, including by creating subclasses, if necessary. *See Brieger*, 245 F.R.D. at 356 ("the Court is prepared to monitor conflicts that may arise within the class it certifies today and to consider the corresponding need for subclasses as the case develops").

The burden on Defendants to show a "conflict" between class members sufficiently high to defeat certification is a difficult one. *See In re Ins. Brokerage Antitrust Litig.*, No. 04-5184 (FSH), 2009 U.S. Dist. LEXIS 17754, at *69 (D.N.J. Feb. 17, 2009) (antagonism between named plaintiffs and class must rise to the level of being "a legally cognizable conflict of interest between the two groups") (citation and internal quotation marks omitted), *aff'd*, 374 Fed. Appx. 263 (3d Cir. 2010). As the court explained in *In re Bulk [Extruded] Graphite Prods. Antitrust Litig.*, No. 02-6030 (WHW), 2006 U.S. Dist. LEXIS 16619, at *24 (D.N.J. Apr. 4, 2006): "[C]ourts are generally skeptical of defenses to class certification based on conflicts between the proposed class members. The mere fact that a representative plaintiff stands in a different factual posture is not sufficient to refuse certification . . . . The atypicality or conflict must be clear and must be such that the interests of the class are placed in significant jeopardy. Courts have generally declined to consider conflicts, particularly as they regard damages, sufficient to defeat class action status at the outset unless the conflict is apparent, imminent, and on an issue at the very heart of the suit." (citations omitted). Defendants cannot meet that burden here.

Finally, Plaintiffs' counsel have shown by their vigorous advocacy throughout this litigation that they are "competent, qualified, experienced and able to vigorously conduct the litigation.'" *George*, 270 F.R.D. at 368. Moreover, the firms are highly qualified in litigation concerning ERISA and health care, both on behalf of classes and individuals, as reflected in the firm resumes of Pomerantz Haudek Grossman & Gross LLP and Buttaci & Leardi LLP, the two

firms serving as co-lead counsel in the litigation. *See* Hufford Decl., Exs. 74-75. Pomerantz has been a leader in the health care class action field on behalf of providers and subscribers. In *AMA v. United Healthcare Corp.*, No. 00 Civ. 2800 (LMM), 2009 U.S. Dist. LEXIS 112634, at *32 (S.D.N.Y. Nov. 17, 2009), Pomerantz was appointed co-lead counsel and subsequently as "lead counsel for settlement purposes" in representing a class of health care subscribers and providers (as well as the American Medical Association, among other health care associations), asserting, *inter alia*, claims under ERISA for improper reductions in health care benefits. On September 20, 2010, the court entered final approval of a $350 million settlement in that case, the largest such settlement ever achieved in an ERISA class action. Pomerantz was also appointed co-lead and class counsel in *McCoy v. Health Net*, *Inc.*, 569 F. Supp. 2d 448, 463 (D.N.J. 2008), where the court granted final approval of a $249 million ERISA settlement on behalf of a class of health care subscribers, the largest such ERISA settlement until it was exceeded in *AMA*. Thereafter, Pomerantz was appointed as Chair of the Plaintiffs' Executive Committee in *In re Aetna UCR Litig.*, MDL No. 2020, 2009 U.S. Dist. LEXIS 66853, at *8 (D.N.J. July 31, 2009), based in part on its success in the *Health Net* litigation.[19]

With the Representative Plaintiffs' lack of conflicts with the proposed Classes and their interest in the outcome of the litigation, combined with the experience and qualifications of Plaintiffs' counsel, Plaintiffs clearly satisfy the adequacy requirements under Rule 23(a).

19 In appointing Pomerantz to this position, the court stated that it "similarly appointed Pomerantz to be Plaintiffs' spokesman to the Court in the Health Net litigation because the Court found D. Brian Hufford, Esq. to be the attorney most capable of presenting Plaintiffs' positions in a clear and concise manner." *Aetna UCR Litig.*, 2009 U.S. Dist. LEXIS 66853, at *8 n.4. Mr. Hufford is one of the attorneys with primary responsibility for this litigation.

C. **The ERISA Plaintiffs Satisfy the Requirements under Rule 23(b)**

Upon showing that they have satisfied the requirements of Rule 23(a), Plaintiffs must further demonstrate that they satisfy the requirements of Rule 23(b) to warrant class certification. Plaintiffs easily do so.

1. **Plaintiffs Satisfy the Requirements of Rule 23(b)(1) and (b)(2)**

This action is a paradigmatic case for certification under either Rule 23(b)(1) or (b)(2). *See Calkins v. Blum*, 511 F. Supp. 1073, 1089 (N.D.N.Y. 1981), *aff'd*, 675 F.2d 44 (2d Cir. 1982) (actions that "seek classwide structural relief that would redound equally to the benefit of each class member" can be "regarded as the 'paradigmatic 23(b)(2) class suits'"). *See Neil*, 2011 U.S. Dist. LEXIS 22038, at *33 ("ERISA class actions are commonly certified under either or both subsections of 23(b)(1)"); *Rogers*, 2006 U.S. Dist. LEXIS 12926, at *31 ("The propriety of Rule 23(b)(1) certification is confirmed by the vast number of cases which have certified ERISA classes pursuant either to Rule 23(b)(1)(A) or Rule 23(b)(1)(B), or both."); *In re Williams Cos. ERISA Litig.,* 231 F.R.D. 416, 425 (N.D. Okla. 2005) (certifying ERISA class under Rule 23(b)(1)(A) and (B) and 23(b)(2)); *In re CMS Energy ERISA Litig.,* 225 F.R.D. 539, 546 (E.D. Mich. 2004) (certification under Rule 23(b)(1)(A) and 23(b)(1)(B)); *In re Ikon Office Solutions, Inc. Sec. Litig.,* 191 F.R.D. 457, 467 (E.D. Pa. 2000) (certification under 23(b)(1)).

a. **Rule 23(b)(1)(A)**

Rule 23(b)(1)(A) is satisfied if pursuing individual instead of class claims would create the risk of "inconsistent or varying adjudications with respect to individual class members that would establish incompatible standards of conduct for the party opposing the class." This Rule 23 standard has been describes as follows:

> Subdivision (b)(1)(A) is used to 'obviate the actual or virtual dilemma which would . . . confront the party opposing the class' if separate lawsuits resulted in 'incompatible standards' for that opposing party. Basically the phrase

> 'incompatible standards of conduct' is deemed to refer to the situation in which different results in separate actions would impair the opposing party's ability to pursue a uniform continuing course of conduct. That section requires that the varying adjudications 'would establish incompatible standards of conduct for the party opposing the class.' In that case, the Court determined that '[t]his language does not require that the varying adjudications would establish incompatible standards as the exclusive or even primary remedy. It only requires that varying adjudications would establish incompatible standards . . .'

In re Schering-Plough/Merck Merger Litig., 2010 U.S. Dist. LEXIS 29121, at *24-*25 (D.N.J. Mar. 25, 2010) (internal citations omitted). *See also George,* 270 F.R.D. at 369 (under Rule 23(b)(1), "[t]he shared character of rights claimed or relief awarded entails that any individual adjudication by a class member disposes of, or substantially affects, the interests of absent class members." 270 F.R.D. at 369.

Plaintiffs' claims easily satisfy this requirement. The Complaint challenges a process of review that is applied equally to all class members, not individualized benefit determinations. Therefore, exposing Defendants to multiple lawsuits for uniform misconduct will undoubtedly result in varying and inconsistent adjudications and require incompatible standards of conduct. If this case were not to proceed on a class basis, it could mean that, as a result of differing determinations by various courts, Defendants would be required to follow one set of procedures with regard to certain providers or subscribers, and another set for others. For example, if Plaintiffs Leri, Askar and Tomanek were to be successful in an *individual* action against Defendant Highmark, Highmark would be precluded from using its MRC procedure under state law to handle repayment demands, as such procedures will be preempted by ERISA, while all other providers would continue to be wrongly processed under the MRC. Similarly, if Plaintiffs succeed in requiring a "full and fair review" under ERISA, but only on an individual basis, then Defendants will have different standards applicable to different providers and subscribers, depending on what different courts rule.

b. **Rule 23(b)(2)**

Similarly, given that Plaintiffs primarily seek injunctive and declaratory relief as alleged in the Complaint, Plaintiffs also allege a Rule 23(b)(2) class, in which “[a] class action is maintainable . . . when ‘the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole’," *Barnes v. American Tobacco Co.*, 161 F.3d 127, 142 (3d Cir. 1998)(quoting Fed. R. Civ. P. 23(b)(2)). These claims are "limited to those class actions seeking primarily injunctive or corresponding declaratory relief." *Id.*; *see* 1 NEWBERG ON CLASS ACTIONS § 4.11, at 4-39; *Cox v. Keystone Carbon Co.*, 894 F.2d 647, 649-50 (3d Cir. 1990) (a § 502(a)(1)(B) claim for recovery of benefits is equitable in nature); *Sereboff*, 547 U.S. at 361 (recognizing that only equitable relief is available under § 502(a)(3)). Additionally, subsection (b)(2) imposes a cohesion requirement, *Barnes*, 161 F.3d at 143 that Plaintiffs easily meet.

In *FedEx,* Chief Judge Miller certified a national ERISA class of FedEx drivers, where plaintiffs were seeking “both declaratory relief regarding the putative class members’ participant status and entitlement to benefits under FedEx Ground’s ERISA plan, as well as payment of benefits to which they are entitled, but were improperly denied as a result of their misclassification.” 2007 U.S. Dist. LEXIS 76978, at *3. In explaining why certification under Rule 23(b)(2) was appropriate, notwithstanding a claim for benefits, the court stated:

> Fed Ex's treatment of the package and delivery drivers as independent contractors and denial of benefits on those grounds can fairly be characterized as a course of conduct that is "generally applicable" to the proposed class. *See, e.g., Breedlove v. Tele-Trip Co. Inc.,* No. 91-C5702, 1993 U.S. Dist. LEXIS 10278, 1993 WL 284327, at *9 (N.D. Ill. July 27, 1993). And because the named plaintiffs seek benefits that were not paid as a result of their alleged uniform improper classification, the requested monetary relief is incidental to the declaratory relief with respect to the class members' rights under the subject plans. *Bublitz v. E.I. du Pont de Nemours & Co.,* 202 F.R.D. 251, 259 (S.D. Iowa 2001); *Fuller v.*

> *Fruehauf Trailer Corp.,* 168 F.R.D. 588, 603 (E.D. Mich. 1996); *Jansen v. Greyhound Corp.,* 692 F. Supp. 1022, 1028 (N.D. Iowa 1986). Certification under Rule 23(b)(2) is therefore appropriate.

Id. at *73.[20] *See Pella Corp. v. Saltzman*, 606 F.3d 391, 395 (7th Cir. 2010) (affirming certification of (b)(2) class); *Berger v. Xerox Corp. Ret. Income Guar. Plan*, 338 F.3d 755, 764 (7th Cir. 2003) (affirming certification of a Rule 23(b)(2) ERISA class).

The application of Rule 23(b)(2) to this case is particularly appropriate given that the recovery of benefits in an ERISA action has long been considered to be equitable relief, not damages at law. *Hunt v. Hawthorne Assocs.*, 119 F.3d 888, 907 (11th Cir. 1997) ("[T]he relief provided in an action to recover benefits under ERISA is equitable, not legal[.]"); *see Millar v. Lakin Law Firm PC*, No. 09-cv-101-JPG, 2009 U.S. Dist. LEXIS 52845, at *9 (S.D. Ill. June 23, 2009); *Mehling v. New York Life Ins. Co.*, 246 F.R.D. 467, 476 (E.D. Pa. 2007); *In re Citigroup Pension Plan ERISA Litig.*, 241 F.R.D. 172, 181 n.69 (S.D.N.Y. 2006) ("[I]t is not uncommon, for purposes of (b)(2) certification, for courts to treat injunctions requiring the payment of monies unlawfully withheld as *injunctive* – rather than monetary – relief.")(citations omitted).

In *Serio v. Wachovia Securities, LLC,* Civ. A. No. 06-4681 (MF), 2009 U.S. Dist. LEXIS 27992, at *13-*14 (D.N.J. Mar. 31, 2009), the court certified a Rule 23(b)(2) ERISA class, as part of its approval of a settlement, stating:

> Federal Rule of Civil Procedure 23(b)(2) allows a court to certify a class, barring opt-outs, where the defendant has acted or refused to act in a way that is applicable to the entire class, making equitable and/or declaratory relief for the class as a whole appropriate. *See, e.g., Stoetzner v. U.S. Steel Corp.,* 897 F.2d 115, 119 (3d Cir. 1990) (finding Rule 23(b)(2) certification appropriate where several key factual questions were dispositive as to all class members) . . . Rule 23(b) certification is proper here because the basis for the suit is Wachovia's alleged

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20 The court in *FedEx* ultimately concluded that the ERISA class "can be appropriately certified under both Rule 23(b)(2) and Rule 23(b)(3)," and decided to maintain the class under Rule 23(b)(3), because it "is more suited to claims for monetary damages and contains a provision requiring notification to class members of their opt-out option." 2007 U.S. Dist. LEXIS 76798, at *77.

> failure to return certain deferred compensation plan contributions – a practice applicable to all Class members. In addition, for purposes of Rule 23(b)(2) certification, courts routinely characterize injunctions requiring the payment of monies unlawfully withheld as injunctive, rather than monetary, relief - particularly in ERISA cases such as this one. *See, e.g., In re Citigroup Pension Plan ERISA Litig.,* 241 F.R.D. 172, n. 69 (S.D.N.Y. 2006).

See also Mulder, 216 F.R.D. at 319 (monetary relief would "flow directly from liability to the class as a whole on the claims forming the basis [for] the injunctive or declaratory relief"). As these cases reflect, classes are routinely certified under Rule 23(b)(2) where the ERISA claims involve challenges to plan-wide policies or practices, including where the plaintiffs sought payment of additional benefits. *See Thomas v. SmithKline Beecham Corp.*, 201 F.R.D. 386, 397 (E.D. Pa. 2001). A Rule 23(b)(2) class is appropriate here where Plaintiffs seek the equitable relief of restitution. *See Haddock v. Nationwide Fin. Servs., Inc.*, 262 F.R.D. 97 (D. Conn. 2009).

2. **Plaintiffs Also Satisfy the Requirements of Rule 23(b)(3)**

As an alternative to Rule 23(b)(1) and (2), Plaintiffs also satisfy the predominance and superiority requirements imposed by Rule 23(b)(3). The Court must find under this provision "'that questions of law or fact common to the members of the **class** predominate over any questions affecting only individual members,' and that a **class** action 'is superior to other available methods for fairly and efficiently adjudicating the controversy.'" *CE Design Ltd. v. Cy's Crabhouse North, Inc.*, 259 F.R.D. 135, 138 (N.D. Ill. July 27, 2009) (Kennelly, J.)

Plaintiffs allege that Defendants apply uniform policies in making repayment demands against Plaintiffs and the Class in violation of ERISA. The common question of whether ERISA precludes Defendants' conduct clearly predominates over individual issues -- particularly when the Court need not adjudicate the underlying basis for the repayment demands -- and makes pursuit of these claims through a class action a superior means of adjudication. Even so, common questions of law or fact "need not be exclusive." *Tatz v. Nanophase Techs. Corp.*, 2003 U.S.

Dist. LEXIS 9982, at *26 (N.D. Ill. June 12, 2003)(finding predominance in case where "the many common issues will unquestionably dominate this Court's attention" in that central to the complaint were "defendants' alleged misstatements and omissions of material fact to members of the class" and "[t]he issues of law and fact that flow from the[m] predominate over any individual issue."; *Abrams v. Van Kampen Funds, Inc.*, 2002 U.S. Dist. LEXIS 16022, at *13 (N.D. Ill. Aug. 26, 2002)(N.D. Ill. Aug. 27, 2002) (finding predominance of common issues notwithstanding variance in material information). "When determining if plaintiffs have met the predominance requirement, district courts focus on questions of liability, not damages." *Fletcher v. ZLB Behring LLC*, 245 F.R.D. 328, 332 (N.D. Ill. 2006); *see also Beale v. Edgemark Fin. Corp.,* 164 F.R.D. 649, 658 (N.D. Ill. 1995).

The existence of individual questions simply does not preclude a finding of predominance. *Wachtel v. Guardian Life Ins.*, 223 F.R.D. 196, 213 (D.N.J. 2004), *vacated on other grounds*, 453 F.3d 179 (3d Cir. 2006).[21] "A single common issue may be the overriding one in the litigation, despite the fact that the suit also entails numerous remaining individual questions." *Chavez v. Don Stoltzner Mason Cont., Inc.*, No. 10C 264, 2011 U.S. Dist. LEXIS 20073, at *11 (N.D. Ill. Feb. 28, 2011) (Kennelly, J.); *Mercedes-Benz Antitrust Litig.*, 213 F.R.D. 180, 186 (D.N.J. Feb. 19, 2003)(a small number of common issues can satisfy predominance if the resolution of those issues will "significantly advance the litigation"). This is especially true "when the focus is on the defendant's conduct and not on the conduct of the individual class members." *Id.* at 187 (citing *In re Flat Glass Antitrust Litig*., 191 F.R.D. 472, 484 (W.D. Pa. 1999)). As outlined below, an analysis of the applicable law demonstrates that Plaintiffs' claims

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21 While the Third Circuit remanded this class certification decision to identify the specific claims and issues that were being certified under Rule 23, the district court subsequently reissued the class decision. See *McCoy*, 569 F. Supp. at 463.

can be proved by resolution of common questions that significantly advance this litigation.

Rule 23(b)(3) also requires that a class action be "superior to other available methods for the fair and efficient adjudication of the controversy." The superiority inquiry requires a court to "consider[] the alternatives to a class action." *Wachtel*, 223 F.R.D. at 209; *see* 7A CHARLES ALAN WRIGHT, ARTHUR R. MILLER & MARY KAY KANE, FEDERAL PRACTICE AND PROCEDURE § 1777 at 518-19 ("[T]he predominance test really involves an attempt to achieve a balance between the value of allowing individual actions to be instituted so that each person can protect his own interests and the economy that can be achieved by allowing a multiple party dispute to be resolved on a class action basis.").

In fact, not only is a class action a superior method of adjudicating this controversy, it is the only viable means for class members. As the court recognized in *Cotton*, 2008 U.S. Dist. LEXIS 49042, at *17-*18:

> "Rule 23(b)(3) was designed for situations . . . in which the potential recovery is too slight to support individual suits, but injury is substantial in the aggregate.". . . (quoting *Murray v. GMAC Mort. Corp.*, 434 F.3d 948, 953 (7th Cir. 2006))
>
> . . . . The Court's conclusion that a class action is superior to individual lawsuits under the circumstances is also supported by "the policy at the very core of the class action mechanism," which is to overcome the problem that small recoveries do not provide the incentive for any individual to bring a solo action prosecuting his or her rights."

Id. (*quoting Mace v. Van Ru Credit Corp.*, 109 F.3d 338, 344 (7th Cir. 1997); *Rand v. Monsanto Co.*, 926 F.2d 596, 599 (7th Cir. 1991).

Manageability cannot be evaluated in a vacuum because a court is not to "assess[] whether this class action will create significant management problems, but instead *determin[e] whether it will create relatively more management problems than any of the alternatives* . . . . [W]here a court has already made a finding that common issues predominate over individualized issues, we would be hard pressed to conclude that a class action is less manageable than

individual actions." *Klay v. Humana*, *Inc.*, 382 F.3d 1241, 1273 (11th Cir. 2004)(emphasis added; citations omitted); *see Williams v. Mohawk Indus*, 568 F.3d 1350, 1358 (11th Cir. ("If a district court determines that issues common to all class members predominate over individual issues, then a class action will likely be more manageable than and superior to individual actions."); *cert. denied*, 130 S. Ct. 500 (2009); *Schoenbaum v. E.I. Dupont De Nemours and Co.*, No. 4:05-CV-01108-ERW, 2009 U.S. Dist. LEXIS 114080, at *30 (E.D. Mo. Dec. 8, 2009) (superiority analysis is "ultimately dependent on the predominance issue")(citing *Klay*, 382 F.3d at 1269). Thus, Defendants must put forth evidence that a class action would be relatively more unmanageable than many thousands of individual trials, a burden they have plainly cannot carry.

The factors that determine whether class treatment is superior to other methods of adjudication include (a) the interest of class members in individually controlling the prosecution of separate actions; (b) the extent and nature of any litigation concerning the controversy already commenced by class members; (c) the desirability of concentrating the litigation of the claims in the particular forum; and (d) the difficulties likely to be encountered in managing a class action. Fed. R. Civ. P. 23(b)(3)(A)-(D). Here, each of these factors favors certification.

As explained above, there are common issues in this case that allow for findings of liability against Defendants under ERISA and application of a common remedy – injunctive relief to require compliance with ERISA and a return of the improperly recouped funds – without regard to any individualized issues relating to the validity of the underlying repayment demands. Plaintiffs' expert, Dr. Foreman, opined in his expert report and his deposition how equitable restitution under ERISA can be calculated on a classwide basis:

> The calculation of damages [equitable restitution] in this case will be possible, tractable and ascertainable on a class-wide basis.
>
> In the first instance, if all of the recoupments are found to be improper it would be relatively easy to identify all of the amounts recouped and provide for their

> refunding to plaintiffs. To the extent the recoupments had been taken as an offset from a new and unrelated benefit payment, the damages in effect constitute payment of the appropriate benefits. Indeed, as part of their interrogatory responses many of the defendants have already identified many of their recoupments for chiropractic services. While plaintiffs seek to represent all providers (including both providers and facilities) it should be a simple matter for defendants to identify all the recoupments they took (whether through offsets, coerced settlements with providers, or otherwise), which will then allow for total damages to be calculated and the class members who are entitled to recoveries to be identified. Upon defendants' completion of all interrogatory responses and other discovery, calculation of damages based on refunding all recoupments can be made.
>
> Aside from the damages, based on a return of improperly recouped funds, the Court can also determine other appropriate equitable relief, including an injunction to require defendants to comply with ERISA and apply proper due process protections when engaging in retroactive audits.

Foreman Expert Report, at 28-29.[22] Dr. Foreman further explained in his deposition how equitable restitution may be calculated on a class-wide basis:

> [O]n a class-wide basis it would be possible from defendants' records . . . to ascertain the total amount of those offsets and that compilation and calculation would be done on a class-wide basis.
>
> Q. Could you take us through a little bit about how that would be done on a class wide basis?
>
> A. All of the defendants maintain claims records and when a claim comes in . . . they would have the option to pay the claim and deny the claim. When the claim is denied, there is a reason code that would appear in a flag field. . . . So you should be able to do a data run for each of the defendants and pull out the offsets. . . .
>
> Q. Where there are recoupments done through the Blue Card program, would you also be able to capture that information and add that to the amount of the equitable restitution [] that you've testified can be calculated on a class-wide basis?
>
> A. Yes, and in fact there are reports that are provided through the Blue Card program by each of the plans that does recoupments. Those reports, as I understand it, go to the national association [Blue Cross Blue Shield Association]. The national guidelines and rules . . . set forth the rules on how those monies are paid back to the home plan from the host plan when they recoup . . . and you could . . . use those reports as a basis . . . and I'm

[22] Dr. Foreman clarified at his deposition that he was using the term "damages" generically and understood the word to mean equitable restitution in the context of this ERISA case. Foreman Dep. 395:14-20

> also certain that . . . claim line recoupment information information exists in the data repositories of the firms.

Foreman Dep. 388:22-391:20.

The common issues present here clearly predominate over any individual ones. When certifying an ERISA class in *Wachtel*, the court concluded: "Class action is the superior form of litigation in this case because it ensures that potentially meritorious claims will be addressed efficiently and without waste of judicial resources." *Wachtel*, 223 F.R.D. at 217. Just as in *Wachtel*, where Defendants are found liable to the classes, it can readily "recalculate its reimbursements for each class member whose benefits were determined based on improper methods," in this case simply by returning the improperly recouped benefits. *Id.*

D. The Florida Chiropractor Discrimination Class Satisfies the Requirements for Certification under Rule 23

1. Background

In March 2008, Blue Cross Blue Shield Florida (BCBSF), instituted a new Chiropractic billing guideline as part of its larger project called the Chiropractic Program Redesign. Deposition of Craig Menkhus at 17:11-24. Hufford Decl., Ex. 29. The Chiropractic Program Redesign "was a program that was developed ... to standardize our approach to our chiropractic network . . . .with regard to the types of contracts, the types of policies and procedures around them." *Id.* at 12:15-13:3. Aside from establishing one standardized fee schedule throughout the state of Florida (*id.* at 19:13-15), wherein most geographic areas received a reduction in reimbursements to Chiropractic Physicians (*id.* at 20:9-12), BCBSF also instituted a significant reimbursement change known at BCBSF as the "Single Modality Project." *Id.* at 39:8-14. The Single Modality Project resulted in limiting payment "to one clinically indicated and medically necessary physical medicine modality or procedure code per patient per date of service." *Id.* at 96:2-14.

The Single Modality Project resulted in a significant reduction in reimbursements to Chiropractors, as this class of providers was now only allowed reimbursement for one physical therapy modality when performed on the same day as chiropractic manipulation. *Id.* at 52:19-53:6. BCBSF applied this "Chiropractic" Billing Guideline to all network providers in the State of Florida who perform CMT.

2. **The Florida Discrimination Class**

This Court succinctly described Plaintiffs' Peri Dwyer, D.C. (Dwyer) and Florida Chiropractic Association's (FCA) discrimination count in its Memorandum Opinion and Order (Doc. 169) on Defendants' Motion to Dismiss Plaintiff's Complaint:

> Plaintiffs Dwyer and FCA allege that Blue Cross and Blue Shield of Florida (BCBSF) violated Section 627.419 of the Florida Insurance Equality Laws. BCBSF policies limit coverage for certain chiropractic services by covering only a single physical medical modality or procedure code per patient per day and limiting the number of spinal manipulations that are covered in a calendar year.
>
> Florida Statute section 627.419(4) states:
>
>> Notwithstanding any other provision of law, when any health insurance policy, health care services plan, or other contract provides for the payment for medical expense benefits or procedures, such policy, plan, or contract shall be construed to include payment to a chiropractic physician who provides the medical service benefits or procedures which are within the scope of a chiropractic physician's license. *Any limitation or condition placed upon payment to, or upon services, diagnosis, or treatment by, any licensed physician shall apply equally to all licensed physicians, without unfair discrimination to the usual and customary treatment procedures of any class of physicians.*

(emphasis added). Plaintiffs allege that the BCBSF policies and reimbursement practices 'discriminate against policyholders who choose chiropractic treatments, by unfairly limiting payments for the treatments usually and customarily afforded by chiropractors.' FAC ¶ 485.

3. **<u>23(a) Requirements</u>**

In order to avoid duplication, Plaintiffs incorporate by reference the earlier portions of this Memorandum discussing class certification requirements under Fed. R. Civ. P. 23(a). Plaintiffs' discrimination class meets the Rule 23(a) requirements, allowing this Court to likewise certify the Florida discrimination class.

a. **Numerosity**

The evidence clearly demonstrates that the BCBSF Chiropractic billing guideline change resulted in a systematic denial of more than one physical medicine modality when performed with chiropractic manipulative treatment (CMT) on the same date of service. Ex. 29 at 95:8-14. The evidence reveals that this one systematic change to Chiropractic reimbursements resulted in a medical cost savings to BCBSF of a minimum of $3-8.5 million annually *Id.* 79:13-17; 82:14-18). Considering the average amount of physical medicine modality charges ($50 - $75), common sense dictates that thousands of Chiropractic Physicians on a regular basis are affected by this state-wide reimbursement change. Physical therapy modalities performed in conjunction with CMT are part of a chiropractor's customary treatment plan.

b. **Commonality**

Rule 23(a)(2)'s commonality element is easily satisfied in the Florida discrimination count. The facts are not in dispute. Each time the BCBSF system recognizes the code for CMT, the system automatically looks for and denies any physical medicine code beyond one. In addition, BCBSF policies are consistent in allowing a maximum of 26 spinal manipulations in a calendar year. *Id.* 99:13-21. There is one specific question of law common to the entire discrimination class: Did BCBSF discriminate against a class of physicians, namely Chiropractic Physicians, in violation of Section 627.419, Florida Statutes, when it (a) changed its billing practices to deny more than one physical therapy modality when performed on the same day as

CMT and/or (b) when BCBSF limited insureds to 26 CMTs per year? These issues are clearly common ones that are applicable on a classwide basis. Moreover, if the answer to the legal questions are in the affirmative, then the Court can decide, on a classwide basis, what is the appropriate remedy. As a result, of these common legal and factual issues, Plaintiffs easily satisfy the commonality requirement of Rule 23(a).

c. **Typicality**

Dr. Dwyer's claims are typical of the claims and defenses of the discrimination class. Dr. Dwyer testified to treating patients for more than 26 visits and to having been denied payment for the visits past 26. *See* Deposition of Dr. Peri Dwyer, D.C., Hufford Decl., Ex. 72 at 108:2-14. In addition, Dr. Dwyer has seen patients for which she has provided more than one physical therapy modality and not received payment, resulting in a financial loss. *Id.* at 112:10-24.

Approximately 94% of Physicians who perform Chiropractic Manipulation are Chiropractors. *See* Deposition of Debra Brown, Hufford Decl., Ex. 73 at 116:2-13. BCBSF systematically instituted the Single Modality Project so that Dr. Dwyer and *all other* in-network chiropractors are denied reimbursement when billing for more than one physical medicine treatment when performed on the same date of service. Because Dr. Dwyer's denials arise out of the same reason as others in the Florida discrimination class, she satisfies the typicality requirement.

d. **Adequacy**

The final requirement under Rule 23(a) is adequacy, whereby the class representatives must be able to "fairly and adequately protect the interests of the class." Dr. Dwyer exhibited a firm understanding of the Florida Statute at issue, Ex. 72 at 94:3-13,[23] and her claims are not

[23] Q What is your understanding of the claim that you are asserting both on your behalf and on behalf of Florida chiropractors as part of the discrimination class that's in this lawsuit?

"antagonistic or conflict" with those of the class, as they all have been subject to Defendants' denials due to the Single Modality Project. The legal argument that BCBSF violated Florida law governs all such claims. The adequacy of class counsel is discussed above.

4. **The Discrimination Plaintiffs Satisfy the Requirements under Rule 23(b)**

While Florida's discrimination class can satisfy all Rule 23(b) requirements, Plaintiff must only satisfy ***one*** of the requirements after meeting the 23(a) requirements, in order to satisfy the burden for class certification.

a. **Plaintiffs Satisfy the Requirements of Rule 23(b)(1) and (b)(2)**

Should certification of the Florida discrimination class be denied, each provider who has been harmed by BCBSF's denial of the physical modality codes when performed with CMT will be forced to file an individual lawsuit over a relatively small amount of money, or forego relief entirely. Likewise, should each provider be forced to court on the same legal issue of whether or not BCBSF violated Section 627.419, Florida Statutes, there would be inconsistent or varying adjudications that would provide no guidance to BCBSF on whether to continue with the same reimbursement practices. Accordingly, Plaintiffs satisfy the requirements of Rule 23(b)(1).

The discrimination class Plaintiffs likewise satisfy Rule 23(b)(2) in that final injunctive declaratory relief is appropriate for the class as a whole. Similar to this case, in *Weiss v. York Hospital*, 745 F.2d 786 (3d Cir. 1984), a class of osteopaths alleged discriminatory practices against allopaths (medical doctors or M.D.s) when they were denied staff privileges at York

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A. Are you talking about the Florida specific discrimination class relating to 627.419?
Q Yes.
A My understanding of the discrimination is that the Florida Insurance Equality Law prohibits an insurer from applying different rules for payment to – of services to one class of physicians, in this case chiropractors, that is not similarly applied to other classes of physicians.
Q. Were there any particular services for which you believe the Blue Cross/Blue Shield of Florida has discriminated?
A Yes.
Q Which ones?
A. Physical therapy modalities.

Hospital solely because of their status as a D.O. and not an M.D. The Third Circuit granted class certification under Rule 23(b)(2), based on common claims that the defendant had engaged in discriminatory practices in violation of the Sherman Antitrust Act. Ex. 72 at 66. In doing so, the court stated: ”We simply note that the class in this case is a classic (b)(2) class in that the defendants have ‘acted or refused to act on grounds generally applicable to the class’ and the primary relief sought is an injunction against future discrimination. When a suit seeks to define the relationship between the (defendants) and the world at large, as in this case, (b)(2) certification is appropriate.” *Id.* The Florida discrimination class is no different: it is seeking to establish that BCBSF is discriminating against one type of provider class in violation of Florida Statutes. Likewise, this class should proceed under 23(b)(1) or 23(b)(2).

E. **<u>The Court Should Appoint Lead Counsel as Class Counsel</u>**

Rule 23(g) provides that “[u]nless a statute provides otherwise, a court that certifies a class must appoint class counsel.” As discussed above, Pomerantz Haudek Grossman & Gross LLP and Buttaci & Leardi LLC should be appointed as lead class counsel. These firms are well qualified to act as class counsel, as demonstrated by their firm resumes. Hufford Decl., Exs. 74-75; *see Lutz v. International Ass’n of Machinists & Aero. Workers*, 196 F.R.D. 447, 453 n.6 (E.D. Va. 2000) (when “attorneys have been found to be adequate in the past, it is persuasive evidence that they will be adequate again”) (quoting *Gomez v. Illinois State Bd. Of Education*, 117 F.R.D. 394, 401 (N.D. Ill. 1987)).

CONCLUSION

For the foregoing reasons, the Court should certify the Classes, appoint the moving Plaintiffs as Class representatives, and appoint their counsel as Class Counsel pursuant to Fed. R. Civ. P. 23(g)(1).

Dated: March 17, 2011

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