UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN JOSE DIVISION

RJ,

Plaintiff,

v.

CIGNA BEHAVIORAL HEALTH, INC., et al.,

Defendants.

Case No. 5:20-cv-02255-EJD

ORDER GRANTING IN PART AND DENYING IN PART DEFENDANTS' MOTIONS TO DISMISS

Re: Dkt. Nos. 32, 33

In this putative class action suit, Plaintiff "RJ," as the representative of her beneficiary son, SJ, challenges Defendant Cigna Behavioral Health, Inc.'s ("Cigna") alleged failure to reimburse covered mental health provider claims at the usual, customary, and reasonable ("UCR") rates. Presently before the Court are two motions to dismiss; one brought by Cigna and a separate motion brought by Defendant Viant, Inc. ("Viant"). Dkt. Nos. 32-33, respectively. Plaintiff filed oppositions (Dkt. Nos. 40-41) and Defendant filed replies (Dkt. Nos. 42-43). The Court finds it appropriate to take the motions under submission for decision without oral argument pursuant to Civil Local Rule 7-1(b). For the reasons stated below, Defendants' motions will be granted in part and denied in part.

I. BACKGROUND[1]

SJ is a member of a Cigna-administered employee benefit plan ("Plan") of which he is a beneficiary. Compl. ¶ 32. The Plan is funded by Plaintiff's employer and is governed by the

[1] The Background is a brief summary of the allegations in the Class Action Complaint. *See* Dkt. No. 1.

Employee Retirement Income Security Act of 1974 ("ERISA"). *Id.* SJ sought treatment for behavioral health disorders, including for mental health and substance use disorders, from Summit Estate, Inc. ("Summit Estate"), a licensed and accredited treatment provider. *Id.* ¶ 173. The healthcare provider contacted Cigna to verify out-of-network ("OON") benefits and was told that benefits were paid at 70% of UCR rates until Plaintiff's out of pocket cost sharing responsibilities were met, and thereafter benefits were paid at UCR rates calculated according to the "MRC-1 methodology." *Id.* ¶¶ 34, 174. "[B]ased upon Summit Estate's prior dealings with Cigna and upon the representations made on the phone call and on the plain language of Plaintiff's employer benefit plan, it was understood by all parties that 100% of MRC-1 was equivalent to 100% of the billed charges of Summit Estate." *Id.* ¶ 175.[2] Based on Cigna's representations "and with an understanding of the plain terms of the employer benefit plan," SJ and his IOP provider contracted for SJ to receive treatment. *Id.* ¶¶ 37, 176. This contract obligated SJ to pay for any portion of the bills for services not paid by Cigna. *Id.* ¶ 35.

Notwithstanding Cigna's representations, Cigna sent every claim at issue in the case to Viant for repricing. *Id.* ¶ 42. Viant purported to offer payments at UCR rates, but in reality, the amount offered bore no relationship to UCR rates as that term is defined in SJ's Cigna policy. *Id.* ¶¶ 42-45. Viant offered essentially the same flat, lower rate that it offers across the entire country. *Id.* ¶ 46. This rate is the "product of a secret, proprietary, database and/or pricing method." *Id.* ¶ 52. For every dollar Viant "save[d]" Cigna, Viant received a kick-back. *Id.* ¶ 47.

Cigna never told Plaintiff, SJ or his IOP provider that claims were subject to third party repricing until after SJ and his IOP provider entered into a contract for treatment. *Id.* ¶ 51. SJ does not have any agreement with Viant that would permit Viant to negotiate with providers on his behalf. *Id.* ¶ 42. As a result of Cigna's and Viant's actions, Cigna allowed only $6,225.12 of the

[2] Plaintiff alleges generally that healthcare providers ask and are told by Cigna that no prior authorization was required prior to rendering intensive outpatient treatment ("IOP") services, and that claims for IOP services were not subject to third-party repricing by Viant. *Id.* ¶ 34. However, it is unclear whether Summit Estate specifically asked and received this information from Cigna.

$51,175.00 billed for IOP services (or 12% of billed charges). *Id.* ¶ 178. SJ was left responsible for the balance. *Id.* ¶ 179. SJ paid the amount owing on the balance bill directly to his provider. *Id.* ¶ 102. Cigna did not issue an "adverse benefit determination" in an Explanation of Benefits ("EOB") letter, and consequently SJ is unable to appeal the underpayment under ERISA. *Id.* ¶¶ 62-64.

Plaintiff asserts the following claims on behalf of SJ: (1) violations of RICO, 18 U.S.C. § 1962(c) against both Defendants; (2) underpayment of benefits in violation of ERISA § 502(a)(l)(B) against Cigna; (3) breach of plan provisions in violation of ERISA § 502(a)(1)(B) against Cigna; (4) failure to provide accurate materials and a request for declaratory and injunctive relief against Cigna in violation of ERISA § 502(c); (5) violation of fiduciary duties of loyalty and duty of care under ERISA § 502(a)(3) and a request for declaratory and injunctive relief against Cigna; (6) violation of fiduciary duty of full and fair review under ERISA § 502(a)(3) and a request for declaratory and injunctive relief against Cigna; (7) declaratory and injunctive relief pursuant to ERISA § 502(a)(3) against both Defendants; and for (8) "Other Appropriate Equitable Relief" against both Defendants under ERISA § 502(a)(3). *Id.* ¶¶ 193-295.

II. STANDARDS

Federal Rule of Civil Procedure 8(a) requires a plaintiff to plead each claim with sufficient specificity "to give the defendant fair notice of what the . . . claim is and the grounds upon which it rests." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (internal quotations omitted). A complaint which falls short of the Rule 8(a) standard may be dismissed if it fails to state a claim upon which relief can be granted. Fed. R. Civ. P. 12(b)(6).

To survive a Rule 12(b)(6) motion to dismiss, the complaint "must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp.*, 550 U.S. at 570). A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged. *Id.*

In evaluating the complaint, the court must generally accept as true all "well-pleaded factual allegations." *Iqbal*, 556 U.S. at 664. The court must also construe the alleged facts in the light most favorable to the plaintiff. *See Retail Prop. Trust v. United Bhd. Of Carpenters & Joiners of Am.*, 768 F.3d 938, 945 (9th Cir. 2014) (the court must "draw all reasonable inferences in favor of the nonmoving party" for a Rule 12(b)(6) motion). The court, however, "does not have to accept as true conclusory allegations in a complaint or legal claims asserted in the form of factual allegations." *In re Tracht Gut, LLC*, 836 F.3d 1146, 1150-51 (9th Cir. 2016) (citing *Bell Atl. Corp.*, 550 U.S. at 555-56); *see also Sprewell v. Golden State Warriors*, 266 F.3d 979, 988 (9th Cir. 2001) ("Nor is the court required to accept as true allegations that are merely conclusory, unwarranted deductions of fact, or unreasonable inferences.").

III. DISCUSSION

Cigna argues that the Complaint should be dismissed in its entirety. Specifically, Cigna contends that (1) as to the second claim for underpayment of benefits and third claim for breach of plan provisions, Plaintiff does not identify any terms in her ERISA Plan that required Cigna to pay Summit Estate's claim at 100% of the billed charges, and in fact, the Plan does not require Cigna to pay at that rate; (2) the fourth claim for failure to provide accurate materials cannot be maintained against Cigna because Cigna is not the plan administrator; (3) the fifth claim for violation for fiduciary duties is duplicative; (4) the sixth claim for violation of fiduciary duties is duplicative, cannot be asserted against Cigna because Cigna is not the Plan, and Plaintiff cannot show entitlement to 100% of the billed charges; (5) the seventh and eighth claims are duplicative; and (6) the RICO claim fails because Plaintiff does not plausibly allege an association-in-fact enterprise and predicate acts.

Viant seeks dismissal of the three claims pled against it, namely the RICO claim and the seventh and eighth claims for equitable relief. Viant contends that all three claims sound in fraud and are subject to dismissal for failure to plead fraud with the requisite particularity required under Federal Rule of Civil Procedure 9(b). As to the RICO claim, Viant argues that Plaintiff fails to

allege with particularity a pattern of racketeering activity and an association-in-fact enterprise.

A. ERISA CLAIMS

1. Second and Third Claims

In the second and third claims, Plaintiff seeks unpaid benefits pursuant to ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(l)(B) equal to 100% of billed charges. Compl. ¶¶ 174-5, 252, 261. To state a claim under Section 502(a)(1)(B), "a plaintiff must allege facts that establish the existence of an ERISA plan as well as the provisions of the plan that entitle it to benefits." *Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 99 F. Supp. 3d 1110, 1155 (C.D. Cal. 2015) (citation and internal quotation marks omitted).

Here, Plaintiff does not point to any particular provision or term in the Plan that requires Cigna to reimburse for IOP services at UCR rates or at 100% of billed charges. Accordingly, Cigna contends that the Plaintiff's second and third claims for benefits under the Plan are subject to dismissal. In *Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co.*, the court dismissed a claim for benefits because the plaintiff merely alleged it "believe[d]" most of its 106 patients had ERISA plans. 2019 WL 6329645, at *2 (C.D. Cal. Sept. 24, 2019); *see also Simi Surgery Ctr., Inc. v. Conn. Gen. Life Ins. Co.*, 2018 WL 6332285, at *3 (C.D. Cal. Jan. 4, 2018) (dismissing assignee's claim for benefits under 173 purported ERISA plans for, among other things, failure to identify "the plan terms that allegedly entitle [plaintiff] to benefits"). In *Glendale Outpatient Surgery Ctr. ("GOSC") v. United Healthcare Servs.*, the Ninth Circuit affirmed dismissal of plaintiff's ERISA claim because the complaint failed to identify "(i) any ERISA plan, apart from vague references to anonymous patients who allegedly assigned rights to GOSC; or (ii) any plan terms that specify benefits that the defendants were obligated to pay but failed to pay." 805 Fed. App'x 530, 2020 WL 2537317, at *1 (9th Cir. May 19, 2020). The Ninth Circuit also observed that the pleading deficiencies "[we]re exacerbated by GOSC's decision to lump 44 separate events — presumably involving distinct ERISA plans, coverage provisions, medical procedures, and insurer communications — into a single set of generalized allegations." *Id.*

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