17-1744

United States Court of Appeals
for the
Eighth Circuit

LOUIS J. PETERSON, D.C., on behalf of Patients E, I, K, L, N, P, Q and R, and on behalf of all others similarly situated,

Plaintiff-Appellee,

LUTZ SURGICAL PARTNERS, PLLC; NEW LIFE CHIROPRACTIC, PC,

Plaintiffs,

– v. –

UNITEDHEALTH GROUP INC.; UNITED HEALTHCARE SERVICES, INC.; UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTHCARE SERVICE LLC,

Defendants-Appellants.

(For Continuation of Caption See Reverse Side of Cover)

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA (MINNEAPOLIS)

MOTION TO STAY MANDATE

ANTON METLITSKY
JENNIFER B. SOKOLER
O'MELVENY & MYERS LLP
Times Square Tower
7 Times Square
New York, New York 10036
(212) 326-2000

BRIAN D. BOYLE
JONATHAN D. HACKER
GREGORY F. JACOB
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, DC 20006
(202) 383-5300

Attorneys for Defendants-Appellants UnitedHealth Group Inc., United Healthcare Services, Inc., United Healthcare Insurance Company, United Healthcare Service LLC and Optum, Inc.

RIVERVIEW HEALTH INSTITUTE, on its own behalf and on behalf of all others similarly situated,

Plaintiff-Appellee,

– v. –

UNITEDHEALTH GROUP INC.; UNITED HEALTHCARE SERVICES, INC.; UNITED HEALTHCARE INSURANCE COMPANY; OPTUM, INC.,

Defendants-Appellants.

SECRETARY OF LABOR,

Amicus on Behalf of Appellee(s).

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

TABLE OF AUTHORITIES
(continued)

Page(s)

Rules

Treatises

Regulations

United[1] respectfully moves this Court under Federal Rules of Appellate Procedure 27 and 41 for a stay of this Court's mandate pending the filing and disposition of United's forthcoming petition for a writ of certiorari. A stay of the mandate is warranted because United's petition will "present a substantial question" and "there is good cause for a stay." Fed. R. App. P. 41(d)(1).

INTRODUCTION

United is the nation's leading health and well-being company. One of United's core services is administering health benefit plans (the "United Plans") nationwide. This case concerns a system that United and other leading insurers have developed and implemented over the past decade to efficiently recoup overpayments to out-of-network healthcare providers, thus conserving the assets of all United Plans.

United's administrative services include paying the medical professionals who provide care to Plan members. United is committed to paying these claims quickly. But this rapid payment approach does not allow United to audit most claims until after they have been paid. Thus, United occasionally discovers that it has *overpaid* providers, whether because of United's error or the provider's. When overpayments occur, United requests refunds, considers any appeals, then recoups

[1] "United" refers collectively to all Defendants.

overpayments from payments otherwise due. All agree the terms of the pertinent plans entitle United to use offsets to recover overpayments if (1) the provider has contractually agreed to offsetting by joining United's network or (2) the provider is out-of-network and both the overpayment and the payment due pertain to the same Plan. Plaintiffs assert, however—and the Court agreed—that the Plans are powerless to instruct United to jointly recoup overpayments from each other's payments.

This proposed "intra-plan" limitation significantly impedes the effectiveness of offsetting, because benefit payments are usually routed to providers rather than to patients, and each provider sees members of many different United Plans; a single provider may not see two members of the same Plan for months or years, if ever. When such providers refuse to refund even undisputed overpayments, they unjustly enrich themselves at the Plans' expense, retaining Plan assets to which they are not entitled. To address that problem, United developed a payment system that allows United (after provider appeals) to offset overpayments from payments due under any United-administered Plan. This practice, which Plaintiffs call "cross-plan offsetting," has undisputedly saved substantial plan assets over the past decade.

As this Court and the district court expressly recognized, the Fifth Circuit has construed materially identical plans to authorize cross-plan offsetting. *See*

Quality Infusion Care, Inc. v. Health Care Service Corp. ("*QIC*"), 628 F.3d 725 (5th Cir. 2010). This Court, however, rejected that view, concluding that United's construction of the United Plans to authorize cross-plan offsetting is unreasonable. United expects to petition the Supreme Court for a writ of certiorari to review that decision. A stay of this Court's mandate is warranted pending the filing and resolution of that petition under the governing standard, for several reasons.

First, there is a "reasonable probability," *John Doe I v. Miller*, 418 F.3d 950, 951 (8th Cir. 2005), that the Supreme Court will grant certiorari to resolve the decisional conflict over the question of national importance to be presented by United's petition—i.e., whether health benefit plans that grant plan fiduciaries broad interpretive and remedial authority are reasonably construed to allow for cross-plan offsetting when they neither expressly authorize nor preclude the practice. *See* Sup. Ct. R. 10 (decisional conflict warrants certiorari). *Second*, there is a "fair prospect," *Miller*, 418 F.3d at 951, that the Supreme Court will reverse this Court's decision in light of the highly deferential standard of judicial review of a claim administrator's plan construction required by Supreme Court precedent. *Third*, United will be irreparably harmed by issuance of the mandate, *id.*, because if this Court's decision goes into effect, United will be forced to substantially alter its entire system of provider reimbursement, not only in this Circuit but nationwide—a process the district court recognized would be "extremely

expensive and disruptive." SAPX-393. *Fourth*, the balance of equities and public interest, *Miller*, 418 F.3d at 951, warrant a stay—the Court's decision affects not only United but other national healthcare providers that have adopted cross-plan offsetting, and plaintiffs will not be prejudiced by a short stay of this Court's mandate to allow the Supreme Court to definitively resolve the circuit conflict over this important question.

The motion for a stay of the mandate pending the filing and disposition of a petition for certiorari should be granted.

FACTUAL BACKGROUND

A. History Of United's Payment And Recovery Process

1. United administers hundreds of thousands of ERISA-governed health plans across the country. Consequently, healthcare providers like Plaintiffs routinely see patients covered by different United-administered plans. When providers bill United, their claims are paid quickly, sometimes under the direction of state "prompt pay" laws, e.g., N.Y. Ins. Law § 3224-a, and otherwise for the convenience of members and providers alike. This system, however, necessarily results in overpayments, which United identifies through audits conducted *after* providers have been paid. *See Premier Health Ctr., P.C. v. UnitedHealth Grp.*, 292 F.R.D. 204, 210 (D.N.J. 2013). Both United's audits and the ability to recoup later-discovered overpayments are essential for United to be able to pay claims

promptly. *Id.* If United determines that a provider has been overpaid, and the provider neither remits the overpayment nor appeals through United's administrative review procedures, United compensates the provider for a new claim by extinguishing the provider's outstanding debt and paying any additional amount owed in cash.[2]

2. More than a decade ago, United offered plan sponsors an innovative payment system that provided numerous benefits to United Plans, including the ability to aggregate an unlimited number of claims from multiple plans into a single check to providers. SAPX-470. In addition to reducing the costs associated with issuing thousands of checks, United's multi-claim "summarized" payment system allows Plans to cooperatively recoup overpayments by *netting* offsets into summarized payments, regardless of whether the outgoing payments are on behalf of the same Plans that are owed outstanding overpayments. SAPX-112-15. In other words, if United overpays a provider for services to a participant of one Plan, United may "offset" the amount of that overpayment against a future payment to the same provider for services to a participant of a different Plan. As a result, all

---

[2] Plans that overpaid providers effectively *assign* that debt to other plans that receive claims from the same providers. The plan-assignees are then authorized under the common law to pay providers by offsetting the debts that they have been validly assigned. *See, e.g.*, *In re U.S. Aeroteam, Inc.*, 327 B.R. 852, 864 (Bankr. S.D. Ohio 2005).

providers and Plans end up in a financial position consistent with their obligations and entitlements.

3. The undisputed record demonstrates that United's summarized payment-and-recovery process benefits all Plans. By combining payments and recoveries into a single payment instrument, Plans save significant amounts on checks and postage. Additionally, because Plans no longer need to wait for one of their members to visit a provider the Plan overpaid before the Plan can recover, the summarized system greatly enhances the rate at which Plans recoup overpayments. *See* SAPX-112.

These benefits are not merely theoretical: In the proceedings below, United produced undisputed data showing that, on average, Plans recovered nearly 25% more through aggregate recoveries than they could have recouped through only same-plan offsets—an average of more than $290,000 recovered per plan. *See* SAPX-529. The savings across all United Plans is indisputably enormous.

4. It is undisputed that each Plan grants broad discretion to interpret the Plan, which means that judicial review of plan construction is highly deferential. Panel Opinion ("Op.") 9 (Ex. A). The question in this appeal is thus whether the Plans can be reasonably construed to authorize the "cross-plan offsetting" just described.

Here, each Plan grants United broad authority to administer benefits. *E.g.*, SAPX-89 (delegating authority to "[d]ecide the amount, form and timing of benefits"). In addition, almost all United Plans provide their administrators with an express grant of overpayment recovery authority. SAPX-372. The language among the Plans varies, SAPX-373-74, but these provisions generally authorize plans to recover overpayments, including through offsets, without limiting the specific recovery methods that may be employed. For example, many Plans explicitly reserve to the plan or its administrator non-enumerated recovery authority. *See* SAPX-93-94, 96-98, 107 (providing the plan "may have other rights in addition to the rights to reduce future Benefits," or materially similar language); *see also* SAPX-105 (Exemplar O (providing that "[i]f the Plan overpays a health care provider, [United] *reserves* the right to recover the excess amount" (emphasis added))). Other Plans similarly describe offset powers in purely illustrative terms, *e.g.*, by citing recovery authority that "includ[es]" the power to offset, or by "reserv[ing]" the right to offset without forbearing other powers, *see* SAPX-102, 108 (Exemplars L & R).

B. Procedural History

Plaintiffs Louis Peterson and Riverview Health Institute are out-of-network healthcare providers who treat United Plan members. SAPX-49, 441, 443. They allege that United paid various benefits that United determined should be paid

under the applicable Plan terms by canceling overpayment debts that Plaintiffs owed to *other* United-administered Plans.

Plaintiffs offered no evidence challenging the *fact* that they were overpaid by the amounts United recouped through cross-plan offsetting. Plaintiffs also repeatedly conceded that ERISA permits cross-plan offsetting. *See, e.g.,* Dkt. No. 60 at 35 ("[I]f the defendants[] wanted this right, this cross-plan offset[] right, they can put it in the plan."); *accord* SAPX-134-3; Dkt. No. 168 at 53. But Plaintiffs argued the Plans' text could not reasonably be construed to authorize the practice. Op. 3. On that basis alone, Plaintiffs sought payment of benefits allegedly owed under ERISA § 502(a)(1)(B), and injunctive relief prohibiting "cross-plan offsets" under ERISA § 502(a)(3).

1. *District Court Order*

Recognizing that Plaintiffs' claims would fail if the United Plans are reasonably construed to allow cross-plan offsetting, the district court called for "Phase I" of the litigation to be limited to "whether the applicable plans of the [relevant] patients authorize or prohibit" the practice. Dkt. No. 65.

At summary judgment on Phase I, the district court acknowledged that an administrator's plan "interpretation is … reviewed for abuse of discretion." SAPX-375. The district court also expressly acknowledged that the question whether cross-plan offsetting might violate ERISA was not before it. SAPX-381.

Still, the court held that absent "*explicit* language" authorizing cross-plan offsetting, the Plans could not reasonably be construed to allow the practice. SAPX-384 (emphasis added).

2. *This Court's Decision*

After an appeal under 28 U.S.C. § 1292(b), this Court affirmed the district court's decision. The Court acknowledged that courts review "administrators' plan interpretations" to determine whether a plan interpretation is "reasonable." Op. 9. But despite this deferential standard, and despite United's undisputedly "broad authority to administer the plan," *id.* at 10, the Court held the plans could not reasonably be construed to authorize cross-plan offsetting because "not one of th[e] plans *explicitly* authorizes cross-plan offsetting," *id*. at 9 (quotations omitted; emphasis added). The Court did not decide that cross-plan offsetting "necessarily violates ERISA," *id*. at 10, but held that *explicit* authorization was required for cross-plan offsetting because "it approaches the line of what is permissible," *id.*

ARGUMENT

Appellate Rule 41 authorizes a stay of this Court's mandate pending the filing and resolution of a petition for certiorari when the petition will raise a "substantial question" and there is "good cause for a stay." Fed. R. App. P. 41(d)(1). In applying that standard, this Court considers "whether there is a reasonable probability that the Supreme Court will grant certiorari, whether there is

a fair prospect that the movants will prevail on the merits, whether the movants are likely to suffer irreparable harm in the absence of a stay, and the balance of the equities, including the public interest." *Miller*, 418 F.3d at 951. The governing standard is readily satisfied here.

A. There Is A Reasonable Probability That The Supreme Court Will Grant Certiorari To Review This Court's Decision

Certiorari is warranted when "a United States court of appeals has entered a decision in conflict with the decision of another United States court of appeals on the same important matter." Sup. Ct. R. 10(a). There is a reasonable probability that the Supreme Court will grant certiorari here because this Court's decision directly conflicts with the Fifth Circuit's decision in *QIC* on a question of national importance.

1. *QIC* held that plans materially identical to the United Plans permitted aggregate recoupments of overpayments. *QIC*, 628 F.3d at 725. None of the plans in that case contained provisions expressly authorizing offsets from benefit payments involving other plans. Still, the court construed each plan, and concluded that plans that said nothing about cross-plan offsets—and in one case, a plan limiting its express remedies to same-plan offsets—were not only reasonably but *correctly* construed to allow cross-plan offsetting because each plan granted its administrator broad remedial authority. *See id.* at 728-30.

The Court here created a clear split of authority by concluding that materially similar language cannot be reasonably construed in a similar manner. The fact that *QIC* did not apply ERISA's deferential standard of review, Op. 10 n.5, only enhances the conflict—the panel holds that plan language cannot even *reasonably* be construed the way the Fifth Circuit construed it de novo. *See also* SAPX-393 (district court explaining that "the sole extra-circuit authority to address the practice [of cross-plan offsetting] found that it was permissible").

2. Not only does the Court's decision create a decisional conflict with the Fifth Circuit, but the practical impact of that decision will be to require United (and other insurers, *see infra* at 12) to significantly alter the manner in which they process provider payments nationwide, which (as the district court recognized) will impose "extreme[] … disrupt[ion]," SAPX-393, on the nation's largest health insurers. As the district court correctly understood, its order (and now the Court's decision) upends a procedure that United—the largest insurer in the nation—has been utilizing for a decade to administer health plans. SAPX-393-94. The "legal limbo" (*id.*) perpetuated by the Court's decision—which creates an intercircuit conflict on this crucial question of ERISA law, and thus undermines ERISA's goal "of uniformity with respect to interstate plans," *Wilson v. Zoellner*, 114 F.3d 713, 715-16 (8th Cir. 1997) (quotation omitted)—can now only be resolved by the Supreme Court.

Nor is the problem limited to United: at least Blue-Cross/Blue-Shield, *QIC*, 628 F.3d at 725, Aetna,[3] and Cigna[4] also engage in cross-plan offsetting and have been put on notice by the panel decision that their established practices are in legal jeopardy. The question presented, in other words, is one of obvious national importance over which the courts of appeals are in conflict—precisely the type of question with at least a "reasonable probability" of resulting in a grant of certiorari.

B. There Is At Least A "Fair Prospect" That United Will Prevail On The Merits

There is at least a "fair prospect" that United will prevail on the merits before the Supreme Court because this Court's decision is in substantial tension with the highly deferential standard the Supreme Court has adopted for review of an administrator's plan construction.

The Supreme Court has repeatedly set forth "a broad standard of deference" to plan fiduciaries authorized to construe and administer ERISA plans. *Conkright v. Frommert*, 559 U.S. 506, 513 (2010); *see also Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115-19 (2008); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989). That deferential standard promotes ERISA's overriding purposes: It "promotes efficiency by encouraging resolution of benefits disputes through

---

[3] *See Mayer v. Aetna Inc.*, No. 15-cv-02595 (C.D. Cal.).

[4] *See Rojas v. Cigna Health & Life Ins. Co.*, No. 14-cv-06368 (S.D.N.Y.).

internal administrative proceedings rather than costly litigation." *Conkright*, 559 U.S. at 517. "It also promotes predictability, as an employer can rely on the expertise of the plan administrator rather than worry about unexpected and inaccurate plan interpretations that might result from de novo judicial review." *Id*. And it "serves the interest of uniformity, helping to avoid a patchwork of different interpretations of a plan, like the one here, that covers employees in different jurisdictions." *Id.*

The Court's decision here is in significant tension with the deferential standard the Supreme Court's precedents require. The Court acknowledged that the Plans all contain broad grants of authority to interpret and implement the plan, so "courts must apply a deferential abuse-of-discretion standard of review." Op. 9 (quotations omitted). Nor did the Court dispute that the Plans grant United broad power to "[d]ecide the amount, form and timing of benefits," SAPX-89, while also noting that any remedial authority set forth in the Plans is non-exclusive, *see supra* at 6-7. Nevertheless, the Court held that because "not one of th[e] plans *explicitly* authorizes cross-plan offsetting," Op. 9 (quotations omitted; emphasis added), the plans could not reasonably be construed to allow such offsetting. "[A]dopt[ing] United's argument," the Court held, "would be akin to adopting a rule that anything not forbidden by the plan is permissible." *Id*. at 10.

This "*expressio unius*" approach to ERISA plan construction is inconsistent with the deferential standard of review afforded ERISA plan fiduciaries. After all, ERISA plans delegate discretion to plan fiduciaries in large part to allow them to handle unforeseen challenges and to take advantage of innovations that would improve the plans' operations and finances. Yet limiting a plan's remedial authorities based on negative inferences from expressly provided powers would hurt plan participants by weakening the plan's fiscal integrity. Moreover, the effect of the panel's decision will be to require plans to add express authorization every time they or their claim administrators recognize problems requiring solutions. That rule not only serves no purpose, but is exactly backwards: the whole point of delegating plan fiduciaries broad administrative and remedial authority is to allow them to take needed actions *without* express enumeration.

Similarly inconsistent with the applicable standard of deferential review is the Court's view that United's plan construction should be viewed skeptically because it "approaches the line of what is permissible" under ERISA. Op. 10. That is wrong on the merits,[5] but it is also irrelevant for the only question at issue

---

[5] The panel held that cross-plan offsetting is in "tension" with ERISA because it amounts to "failing to pay a benefit owed to a beneficiary under one plan in order to recover money for the benefit of another plan." Op. 10-11. But if that were so, then cross-plan offsetting for *in*-network providers would also violate ERISA—a position that the Department of Labor has expressly disclaimed. *See* Br. of Sec'y of Labor as Amicus Curiae in Support of Plaintiffs-Appellees 15 n.3.

here: was United's construction an abuse of discretion? No authority has ever held that an ERISA fiduciary with broad interpretive authority cannot adopt an otherwise reasonable plan construction if it "approaches"—but does not cross—a statutory limit, or that more express plan language is required in these circumstances. Such an unprecedented clear-statement rule would absurdly preclude plan construction that is admittedly reasonable *and* lawful, thus turning the abuse-of-discretion standard on its head.

Indeed, the Court's view that deference to an otherwise reasonable interpretation is unwarranted when the interpretation is lawful but "approaches the line" established by ERISA conflicts with the Supreme Court's repeated "refus[al] to create … exception[s] to *Firestone* deference." *Conkright*, 559 U.S. at 513

And there is no support for the proposition that cross-plan offsetting pushes ERISA's boundaries. As an initial matter, each United Plan participates in United's aggregate recovery process for its own benefit in the form of mutual reductions in overpayment losses. Common law trust principles recognize that trusts may engage in such mutually beneficial transactions. See Restatement (Third) of Trusts § 78 cmt. (c)(7) (2007). It is true that participating plans also benefit from other plans' decision to participate in cross-plan offsetting. But ERISA does not prohibit plan sponsors from acting to benefit their own plans just because other plans also incidentally benefit. *Cf. Bussian v. RJR Nabisco, Inc.*, 223 F.3d 286, 302 (5th Cir. 2000). Indeed, DOL advisory opinions establish that plans may share costs cooperatively, so long as there is a reasonable method for determining each plan's contribution and relative benefit. See DOL Adv. Op. 1993-06A (plans can share the cost of compensating several full-time employees who can assist with their administration); DOL Adv. Op. 1989-09A (same). Here, it is undisputed that United provides a reasonable method for determining each United Plan's contributions to and benefits from aggregate payment transactions.

(citing *Glenn*, 554 U.S. at 116). Obviously, a plan ambiguity cannot reasonably be construed to allow what is unlawful. But precluding a plan fiduciary from adopting an ultimately *legal* construction is just another way of saying that a court should not defer to a reasonable plan interpretation in these circumstances. That is precisely the type of exception to deferential review that the Supreme Court has expressly rejected.

C. United Will Suffer Irreparable Harm In The Absence Of A Stay

The harm to United if this Court's decision goes into effect is obvious, and obviously irreparable. As the district court explained in staying its proceedings and certifying this case for interlocutory appeal:

> [T]his is an exceptional case. United is, by far, the largest health insurer in the United States, and it is one of a handful of the largest health insurers in the world. United has engaged in cross-plan offsetting for the past decade. If United is ultimately enjoined from engaging in the practice, United will have to undertake the extremely expensive and disruptive process of unwinding its cross-plan offsetting practice. Having lost its initial (and, it appears to the Court, strongest) argument in favor of cross-plan offsetting, United now faces a lengthy period of uncertainty concerning a major component of its business.

SAPX-393-94. If this Court's decision goes into effect, United will have to undertake precisely "the extremely expensive and disruptive process" that the district court identified. And because the practical effect of the Court's ruling cannot be limited to geographic bounds of this Circuit, this "extremely expensive and disruptive process" will have to proceed nationwide. Allowing the Supreme

Court the opportunity to resolve the circuit conflict created by the Court's decision before imposing these substantial harms on United—and, indirectly, on its customers and patients covered by its Plans—strongly favors a stay of the mandate.

D. The Balance Of Equities Strongly Favor A Stay

Finally, the balance of equities strongly favors a stay. As explained earlier, the Court's decision limiting cross-plan offsetting not only affects United but also several of the other largest health insurers in the nation. *See supra* at 12. Thus, the "expensive and disruptive process" just described will not be limited to United. Moreover, cross-plan offsetting is unambiguously beneficial to the Plans to which it applies, saving those plans substantial administrative costs and ensuring speedy recovery of overpayments. *See supra* at 6. There is no equity or public interest in halting these benefits while awaiting Supreme Court review.

Plaintiffs, meanwhile, will suffer no prejudice from the relatively short delay required to allow the Supreme Court to consider a petition for certiorari. Such a petition must be filed 90 days from the date this Court denied en banc review, Sup. Ct. R. 13.1, which means that the Supreme Court will decide whether to grant certiorari in a matter of months. That modest incremental delay will not prejudice plaintiffs in any material respect, particularly because—as the district court and this Court concluded in certifying and accepting this interlocutory appeal—a final resolution of this question now "may materially advance the ultimate termination

of the litigation." 28 U.S.C. § 1292(b); *see also* SAPX-392. Certainly, any prejudice to plaintiffs stemming from a few additional months of delay pales in comparison to the harm that United would suffer if required to substantially alter its nationwide cross-plan offsetting practice immediately.

CONCLUSION

For the foregoing reasons, a stay of the mandate pending the filing and resolution of a petition for certiorari should be granted.

Respectfully submitted,

/s/ Brian D. Boyle

ANTON METLITSKY
JENNIFER B. SOKOLER
O'MELVENY & MYERS LLP
Times Square Tower
7 Times Square
New York, N.Y. 10036
(212) 326-2000

BRIAN D. BOYLE
JONATHAN D. HACKER
GREGORY F. JACOB
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006
(202) 383-5300

CERTIFICATE OF COMPLIANCE

I hereby certify that the above Motion to Stay Mandate:

1. Complies with the type-volume limitation of Fed. R. App. P. 27(d)(2)(A) because it contains 4,003 words, excluding the parts of the Motion exempted by Fed. R. App. P. 32(f); and

2. Complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirement of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word and size 14-point font.

Dated: March 5, 2019

/s/Brian D. Boyle

ANTON METLITSKY
JENNIFER B. SOKOLER
O'MELVENY & MYERS LLP
Times Square Tower
7 Times Square
New York, N.Y. 10036
(212) 326-2000

BRIAN D. BOYLE
JONATHAN D. HACKER
GREGORY F. JACOB
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006
(202) 383-5300

CERTIFICATE OF SERVICE

I hereby certify that on March 5, 2019, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system, which will send a notice of electronic filing to counsel of record receiving electronic notification.

I certify that all participants in the case are registered as CM/ECF users and that service will be accomplished by the CM/ECF system.

Dated: March 5, 2019

/s/Brian D. Boyle

ANTON METLITSKY
JENNIFER B. SOKOLER
O'MELVENY & MYERS LLP
Times Square Tower
7 Times Square
New York, N.Y. 10036
(212) 326-2000

BRIAN D. BOYLE
JONATHAN D. HACKER
GREGORY F. JACOB
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006
(202) 383-5300