THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

ANNA MOHR-LERCARA, Individually and on Behalf of All Others Similarly Situated, Plaintiff, vs. OXFORD HEALTH INSURANCE, INC., OPTUM, INC., and OPTUM RX, INC., Defendants.	Civil No. 7:18-cv-1427 Judge Vincent Briccetti

PLAINTIFF'S MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

Plaintiff was covered by annual medical benefits plans offered and underwritten by Oxford Health Insurance, Inc. (the "Plans"). Pl.'s R. 56.1(b) Resp. to Defs.' Stmt. of Material Facts ("SUF Resp.") ¶ 1.[1] From 2011 to 2013, the Plans provided that Plaintiff would not pay more than "the applicable Out-of-Pocket Expense." SUF Resp. ¶¶ 27, 37. From August 1, 2014, they provided that Plaintiff would not pay more than "[t]he applicable Cost-Sharing." *Id.* ¶ 58. The crux of the parties' dispute centers on the meaning of these terms. Plaintiff contends that the Plans defined "Out-of-Pocket Expense" and "Cost-Sharing" to limit Plaintiff's responsibility to the rates negotiated with Oxford's Network Pharmacies (the "Pharmacy Rate"). Based upon head-scratching distinctions between "Network Providers" and "Network Pharmacies" and false conflicts between plan terms, Defendants insist that these limitations do not apply. They are mistaken. Moreover, a reasonable jury could conclude that Defendants unlawfully conspired to claw back these excess payments for themselves. But first, Defendants attempt to avoid these issues altogether, arguing that Plaintiff failed to exhaust her administrative remedies. To the contrary, Defendants failed to follow the procedures required by the Plans and regulations. For these and other reasons set forth in detail below, Defendants' motion for summary judgment should be denied in its entirety.

STATEMENT OF FACTS

I. MOHR'S PLANS.

A. Mohr's 2011-2013 Plans.

From 2011 to 2013, the Plans' Outpatient Prescription Drug Rider ("Drug Rider") provided: "For Prescription Drug Products at a retail Network Pharmacy, you are responsible for

[1] The Plan renewed effective August 1 of each year. For example, the 2013 Plan was effective from August 1, 2013 to July 31, 2014. SUF Resp. ¶ 27. Plaintiff refers to each Plan by the year in which it became effective.

paying the lower of:

- the applicable Out-of-Pocket Expense; or
- the Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product."

Ex.[2] 2 at 00016080; Ex. 3 at 00019826; Ex. 4 at 00018513; SUF Resp. ¶ 37. The Drug Rider defined the term "Out of Pocket Expenses" as follows:

> You are responsible for paying the costs outlined in your Summary of Benefits when Covered Prescription Drug Products are obtained from the retail pharmacy or mail order supplier (if mail order coverage has been purchased). . . .
>
> You are responsible for paying the full cost (the amount the pharmacy charges you) for any non-Covered drug product and Our contracted rates (Our Prescription Drug Cost) will not be available to you.

Ex. 2 at 16080; Ex. 3 at 00019826; Ex. 4 at 00018513l SUF Resp. ¶ 34.

The Summary of Benefits in turn identified "In-Network" Copayment amounts for "Covered Services," such as "Outpatient Prescription Drugs." Ex. 2 at 00015958; Ex. 3 at 00019703; Ex. 4 at 00018381; SUF Resp. ¶¶ 47, 51. Regarding "Your Financial Responsibility for In-Network Benefits," the Member Handbook in relevant part provided: "We reimburse the Network Provider directly when you receive Covered Services and you will not be responsible for any amount billed in excess of the contracted fee for the Covered Service." Ex. 2 at 00016002; Ex. 3 at 00019745; Ex. 4 at 00018425; SUF Resp. ¶¶ 47, 50.

B. Mohr's 2014-2016 Plans.

From 2014 to 2016, the Plans' Certificate of Coverage ("COC") provided: "For Prescription Drugs purchased at a retail or mail order or designated Participating Pharmacy, You are responsible for paying the lower of:

[2] Numbered exhibits are attached the Declaration of Michelle S. Grant dated April 9, 2021. Lettered Exhibits are attached to the Declaration of Christopher M. Barrett, filed herewith.

- The applicable Cost-Sharing; or
- The Participating Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug."

SUF Resp. ¶ 58; Ex. 5 at 00017603; Ex. 6 at 00019463; Ex. 7 at 00019617. The COC defined the term "Cost-Sharing" as "[a]mounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance." Ex. 5 at 00017562; Ex. 6 at 00019412; Ex. 7 at 00019564; SUF Resp. ¶ 58. Regarding Copayments, in a section entitled "Cost-Sharing Expenses and Allowed Amount," the Certificate of Coverage in relevant part provided:

> **Copayments.** Except where stated otherwise, after You have satisfied the Deductible as described above,[3] You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Certificate for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount….
>
> **Allowed Amount.** "Allowed Amount" means the maximum amount we will pay for the services or supplies covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:
>
> The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider.

Ex. 5 at 0017573-74; Ex. 6 at 00019425-26; Ex. 7 at 00019579-80; SUF Resp. ¶ 58. The Schedule of Benefits, in turn, set forth the "Copayment" amounts for "Participating" Providers, stating that "Non-Participating Provider Services Are Not Covered and You Pay the Full Cost." Ex. 5 at 00017555; Ex. 6 at 00019403; Ex. 7 at 00019557; SUF Resp. ¶ 62.

II. DEFENDANTS' OVERCHARGES AND CLAWBACKS.

Until December 31, 2016, Defendants adjudicated outpatient prescription drug transactions at retail Network Pharmacies using "lesser-of-two" logic, meaning that the member paid the lesser of the Copayment or the Usual and Customary Charge ("U&C"), even if both exceeded the

[3] The description of the "Deductible" included a "Prescription Drug Deductible."

Pharmacy Rate. SUF Resp. ¶ 71. Defendants allowed pharmacies to keep these excess payments—rather than direct pharmacies not to overcharge Plan members—even though "[t]here was nothing in the pharmacy contract that gave the pharmacy the right to keep those dollars." Ex. F at 49:8-13; SUF Resp. ¶ 78. In mid-2014, Defendants began clawing back from the pharmacies the amounts that members paid in excess of the Pharmacy Rate. SUF Resp. ¶ 78. They hid these clawbacks, Ex. L at 4; SUF Resp. ¶ 74, and split the proceeds 50/50, Ex. 16 at 155:7-12; SUF Resp. ¶ 79.

On January 1, 2017, *without a contemporaneous change in Plan language*,[4] Defendants began adjudicating prescription drug transactions using "lesser-of-three" logic, meaning that Defendants limited Cost-Sharing to the Pharmacy Rate. SUF Resp. ¶ 80. Specifically, members paid the lower of the (1) fixed Copayment, (2) pharmacy's U&C, or (3) Pharmacy Rate. *Id*.

LEGAL STANDARD

Defendants bear "the burden of establishing that no genuine issue of material fact exists and that the undisputed facts establish her right to judgment as a matter of law." *Rodriguez v. City of N.Y.*, 72 F.3d 1051, 1060-61 (2d. Cir. 1995). "If . . . reasonable [people] might reach different conclusions, the motion should be denied and the case tried on its merits." *Empire Elecs. Co. v. United States*, 311 F.2d 175, 180 (2d Cir. 1962) (internal quotation marks omitted); *accord Nationwide Life Ins. Co. v. Bankers Leasing Ass'n*, 182 F.3d 157, 160-61 (2d Cir. 1999).

ARGUMENT

I. DEFENDANTS ARE NOT ENTITLED TO SUMMARY JUDGMENT ON MOHR'S ERISA CLAIM FOR BENEFITS (COUNT I).

A. Plaintiff is deemed to have exhausted all appeals.

Defendants must prove that they strictly complied with the Plan terms and DOL regulations

[4] *See, e.g.*, Ex. 7 at 00019525 (2016 Plan effective from August 1, 2016 through July 31, 2017); Barrett Decl. Ex. I at 00009608 (Oxford approved COC for small fully insured groups in New York for 2017).

that require them to implement reasonable claims and appeal procedures: (1) 29 C.F.R. § 2560.503-1 ("Reg. 503-1") and (2) 29 C.F.R. § 2590.715-2719 ("Reg. 715-2719") (collectively, the "Regulations").[5] *Halo v. Yale Health Plan, Dir. of Benefits & Records Yale Univ.*, 819 F.3d 42, 50 n.3 (2d Cir. 2016). Because Defendants violated the Plans and the Regulations, Plaintiff is deemed to have exhausted all administrative remedies.

1. Plaintiff filed a grievance concerning a pre-service claim.

In denying Defendants' motion to dismiss, the Court held that Plaintiff had plausibly alleged that she filed a "pre-service" claim because she had not received her prescription drugs when the pharmacy submitted the claim on her behalf. ECF 63 at 14-15. If these allegations were true, Defendants had to respond to Plaintiff's Grievance within 15 days, which Plaintiffs alleged Defendants failed to do. *Id*. The factual record confirms Plaintiff's allegations.

Under the 2014-2016 Plans, the Claim Determination Procedures apply to all claims that do not relate to medical necessity or experimental or investigational treatments, including Plaintiff's prescription drug claims. Ex. 6 at 00019479. They provide that a member does not submit a claim form for in-network claims because the network provider submits the claim on the member's behalf. *Id*. Finally, they provide that a pre-service claim is a request that a service or treatment be approved before it has been received.[6] *Id*. at 00019479-80.

Defendants' Rule 30(b)(6) testimony confirms that Plaintiff submitted a pre-service claim. *See* Ex. B at 102:5-104:15, 123:10-18; SUF Resp. ¶ 15. Likewise, Defendants *admitted* that in-

[5] "[Reg. 715-2719] sets forth requirements with respect to internal claims and appeals and external review processes for group health plans and health insurance issuers that are not grandfathered health plans under § 2590.715-1251." Reg. 715-2719(a)(1). Plaintiffs' plans are not grandfathered because, among other reasons, they do not "include a statement that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act." 29 C.F.R. § 2590.715-1251(a)(2)(i).

[6] The COC provides that a "post-service claim is a request for a service or treatment that You have already received." Ex. 6 at 00019480.

network pharmacy claims are pre-service claims in letters in the predecessor case, *In re: UnitedHealth Grp. PBM Litig*., 2017 WL 6512222, which described materially identical claims as "pre-service."[7] *See* Ex. Q. Accordingly, Plaintiff filed a Grievance relating to her pre-service claim. Ex. 6 at 00019479-81.

2. Defendants did not "strictly adhere" to the plan terms or regulations.

Although the Plans required Defendants to respond within 15 days, Ex. 6 at 00019481, Defendants did not do so. Contrary to their position in *UnitedHealth*, Oxford treated the Grievance as an initial post-service *claim* for benefits, to which it responded with a "Notice of Adverse Benefit Determination" ("Notice"). *See* SUF Resp. ¶ 17; Ex. 14. In doing so, Defendants did not "strictly adhere" to either the Plans or Regulations in at least five ways.

First, in issuing the Notice, Defendants treated Plaintiff's first-level Grievance appeal as an initial claim for benefits.[8] But, the initial claim was submitted by the pharmacy when Plaintiff purchased her drugs.[9] A Grievance is the first of two levels of appeals. Ex. 6 at 00019481. Accordingly, "[t]he [Minnesota District Court] held that plaintiff's claim under Section 502(a)(1)(B) of ERISA—Count I here—is subject to the requirement that plaintiff exhaust administrative remedies *by submitting a grievance* to defendants in accordance with the plans

[7] Defendants' counsel, Dorsey & Whitney LLP, also represents Defendants in the *UnitedHealth* action in Minnesota and served as the liaison for Plaintiff's administrative appeal.

[8] The Notice stated that "[w]e have received and reviewed *the pharmacy claim request for reimbursement* you have submitted on behalf of your client Anna Mohr. This notice is to inform you the *claim* is being denied." Ex. 14 at 00018648 (emphasis added). Defendants reiterated this point in response to a request for admission, asserting: "*Oxford denies that [the April 26, 2018 Grievance letter] was a 'Grievance'* under the terms of Plaintiff's Certificate of Coverage." *See* Ex. J at 39-40 (emphasis added); SUF Resp. ¶ 17.

[9] "[W]hether, and to what extent, the presentation of a prescription to a pharmacy which exercises no discretion on behalf of the plan will constitute a request for a plan benefit will be determined by reference to the plan's procedures for filing benefit claims." *See* Ex. K, Benefit Claims Procedure Regulation FAQ A-11, *available at* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/benefit-claims-procedure-regulation. Under the Plan procedures here, after the member presented the prescription to the in-network pharmacy, the in-network pharmacy filed the claim for benefits and made a request for benefits on Plaintiff's behalf. Ex. B at 123:15-18; SUF Resp. ¶ 15. In contrast, if Plaintiff went to an out-of-network pharmacy, she would have had to make a separate request for benefits on her own under the Plan procedures. *See, e.g.*, Ex. 7 at 00019617.

before filing suit." ECF 63 at 5 (emphasis added) (citing *UnitedHealth*, 2017 WL 6512222, at *6-7). Defendants are collaterally estopped from characterizing the Grievance as a post-service claim for benefits. *See* ECF 63 at 5.

By doing so, Defendants effectively contend that Plaintiff should have filed a second claim for benefits. But the 2014-2016 Plans and the Regulations require a member to file *either* a pre- *or* post-service claim. Ex. 5 at 00017619; Ex. 6 at 00019481; Ex. 7 at 19638. The 2011-2013 Plans are more explicit, providing that the Grievance and Appeal Procedure applies only *after* an initial Adverse Benefit Determination. Ex. 2 at 00015994; Ex. 3 at 00019737; Ex. 4 at 00018417. Because nothing in the Plans or the Regulations require a member to file two separate claims for benefits, Defendants violated both. *See* Reg. 503-1(e). At the least, Defendants violated Reg. 503-1(b)(3) by unduly inhibiting or hampering the claims process.

Defendants argue that Plaintiff "conflates a pre-service *claim* with a pre-service grievance." Mem. at 7. To the contrary, Defendants conflate "claims" and "grievances" about "claims." A "Post-Service Grievance" is "[a] *claim* for a service or a treatment that already has been provided." Ex. 7 at 00019639 (emphasis added); SUF Resp. ¶ 21. Because the pharmacy submitted a pre-service claim, Plaintiff's Grievance was not a "claim for a service or a treatment that already has been provided."[10]

Second, given that a Notice of Adverse Benefit Determination is not a response to an appeal (*compare*, Reg. 503-1(g) and Reg. 503-1(j)), by mischaracterizing the Grievance as a claim for benefits, Defendants violated the Plans and Reg. 503-1(j) by failing to respond to the appeal. ***Third***, by treating the Grievance as an initial claim for benefits rather than a "first-level appeal,"

[10] In their Motion, Defendants also reference for the first time the "Other Grievances" provisions in the 2014-2016 Plans. Mem. at 7. Defendants did not refer to this provision in the Notice. Moreover, the "Other Grievances" provision does not exist under the 2011-2013 Plans.

Defendants required Plaintiff to file two more appeals after filing the Grievance—meaning Plaintiff would have to file *three* appeals in total, in violation of Reg. 503-1(c)(2). ***Fourth***, Defendants misrepresented the appeal procedures by stating in the Notice that Plaintiff could file a *first-level appeal*, rather than a second-level appeal. *See* Ex. 14. This statement violated § 715-2719(b)(2)(ii)(E)(4), which requires a description and how to initiate a second-level appeal. Because the misrepresentation served to unduly inhibit or hamper the process, it also violated Reg. 503-1(b)(3). *See Novick v. Metro. Life Ins. Co*., 764 F. Supp. 2d 653 (S.D.N.Y. 2011) (violation because notice did not state the appropriate limitation period).

Fifth, the Notice was untimely because it was submitted more than two weeks after the 15-day deadline. SUF Resp. ¶ 16. "[P]lan participants will not be required to exhaust administrative remedies where they reasonably interpret the plan terms not to require exhaustion and do not exhaust their administrative remedies as a result." *Kirkendall v. Halliburton, Inc*., 707 F.3d 173, 181 (2d Cir. 2013). Here, Plaintiff's interpretation that the pre-service grievance procedure applied to her pre-service claims is reasonable and accordingly, she should not have been required to appeal Defendants' improper Notice of Adverse Benefit Determination.

3. Exhaustion would also be futile.

Although the Court ruled that Plaintiff was collaterally estopped from alleging futility, newly discovered facts demonstrate that exhaustion would have been futile. *See Kirkendall*, 707 F.3d at 179. Simply stated, Defendants' denial of her Grievance was a certainty. *See Cole v. Travelers Ins. Co*., 208 F. Supp. 2d 248, 262 (D. Conn. 2002).

First, as explained above, Defendants intentionally disregarded that Plaintiffs' April 26, 2018 letter was a Grievance and misstated the appeal process. These affirmative failures alone prove futility. *See Cole* at 262. ***Second***, the factual record demonstrates that the overcharges were not one-off errors done only to Plaintiff. To the contrary, Defendants used a lesser-of-two

adjudication method for all participants pursuant to an intentional, fixed company-wide policy, which establishes futility. *See, e.g.*, *Neufeld v. Cigna Health and Life Ins. Co.*, 2018 WL 4158377, at *10 (D. Conn. 2018); *Peck v. Aetna Life Ins. Co*., 2005 WL 1683491, at *3 (D. Conn. July 19, 2005). ***Third***, in its response to Plaintiff's Grievance, Oxford unsurprisingly concluded that Plaintiff was not overcharged—demonstrating that Oxford would not reverse its decision and compensate Plaintiff for her overcharges.

B. Oxford's interpretation of the Plans is not entitled to deference.

1. Because Defendants violated the plans and the regulations, this Court's review is *de novo*.

"[W]hen denying a claim for benefits, a plan's failure to comply with . . . [Reg.] 503-1, will result in that claim being reviewed *de novo* in federal court, unless the plan has otherwise established procedures in full conformity with the regulation and can show that its failure to comply with the regulation in the processing of a particular claim was inadvertent and harmless." *Halo*, 819 F.3d at 45. Moreover, § 715-2719(b)(2)(F)(1) provides that where the Regulations are not strictly adhered to, the claim or appeal will be "deemed denied on review without the exercise of discretion by an appropriate fiduciary."

Defendants "bear[] the burden of proof on this issue since the party claiming deferential review should prove the predicate that justifies it." *Halo*, 819 F.3d at 58 (quoting *Sharkey v. Ultramar Energy Ltd*., 70 F.3d 226, 230 (2d Cir. 1995)); *accord Schuman v. Aetna Life Ins. Co*., 2017 WL 1053853, at *12 (D. Conn. Mar. 20, 2017). Defendants not only violated their own Plans and the Regulations, but also failed to treat Plaintiff's April 26, 2018 letter as a first-level Grievance (rather than an initial claim for benefits). This was not inadvertent or harmless. *See supra* note 8; *see also* ECF 51 at 6 (representing in motion to dismiss brief that Plaintiff had "not yet appealed" initial "notice of adverse benefit determination"). Accordingly, this Court's

review should be *de novo*. *See Schuman v. Aetna Life Ins. Co*., 2019 WL 2991958, at *2 (D. Conn. July 9, 2019); *Satter v. Aetna Life Ins. Co*., 2019 WL 2896410, at *7 (D. Conn. Mar. 20, 2019).

2. Even if Oxford did not violate the Plan and Regulations, the 2014-2016 Plans did not delegate authority to interpret plan terms.

Oxford has not met its burden of showing that the 2014-2016 Plans delegate to it the authority to interpret the plan terms. Language delegating authority must be clear and unambiguous; any ambiguities are construed against the insurer. *Fay v. Oxford Health Plan*, 287 F.3d 96, 104 (2d. Cir. 2002) (emphasis added); *accord Kinstler v. First Reliance Standard Life Ins. Co*., 181 F.3d 243 (1999). For example, in *Krauss v. Oxford Health Plans, Inc*., 517 F.3d 614, 622 (2d Cir. 2008), the plan gave defendants the discretion to adopt "reasonable policies, procedures, rules and *interpretations* . . ." (emphasis added).[11] Although it leaves out the heading, Oxford quotes the following provision and argues that it grants it discretion to *interpret* plans:

> **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. . . . We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

Ex. 6 at 00019509. But, as the heading makes clear, this provision concerns guidelines and administrative rules, not discretion to interpret the COC.[12]

The case on which Oxford relies, *S.B. v. Oxford Health Ins., Inc*., 419 F. Supp. 3d 344 (D. Conn. 2019), involved Oxford's review of physicians' determinations about medical necessity

[11] *See, e.g.*, *Ganton Techs., Inc. v. Nat'l Indus. Grp. Pension Plan*, 76 F.3d 462, 466 (2d Cir.1996) (the plan explicitly provided that the trustees had authority to "resolve all disputes and ambiguities relating to the interpretation of the Plan"); *Deloach v. San Diego Gas & Elec. Co*., 2008 WL 4426010, at *7 (S.D. Cal. Sept. 24, 2008) ("[T]he Plan language adequately confers discretion on the then-Pension Committee as a named fiduciary with 'full discretion to administer and interpret the Plan.'").

[12] In contrast, the 2011-2013 Plans do grant Oxford discretion to interpret the Plans. As discussed above, however, the appeal is deemed denied on review without the exercise of discretion because Defendants violated the Plan and Regulations.

in a denial of benefits case. *Id*. at 354-56. The focus was not on the interpretation of the Plans, but rather their application to facts. *See id*. at 359 ("A Plan may confer discretionary authority on the administrator to make some decisions but not others."). This case, in contrast, does not concern the denial of benefits (Plaintiff received her prescription drugs and the pharmacy was paid in full) or a determination of medical necessity or eligibility. Rather, Plaintiff seeks to vindicate her rights under the Plan, and the dispute concerns the interpretation of plan terms. Because the language quoted by Oxford does not clearly and unambiguously delegate discretion to interpret plan terms, the wording should be resolved against Oxford.

C. Mohr should have been charged the Pharmacy Rate under the Plans.

A plan must be reviewed "as a whole, giving terms their plain meanings," *Fay*, 287 F.3d at 104, and interpreted "in an ordinary and popular sense as would a person of average intelligence and experience," *Pepe v. Newspaper & Mail Deliveries'-Publishers' Pension Fund*, 559 F.3d 140, 147 (2d Cir. 2009). If the wording has an unambiguous meaning, that controls. *Klimbach v. Spherion Corp.*, 175 F. App'x 412, 413 (2d Cir. 2006). If it is ambiguous, then the Court "must decide whether the party making the interpretation has discretion to interpret the terms." *Klimbach*, 175 F. App'x at 413. If a plan affords discretion, then the Court must "review the interpretation for arbitrariness and caprice."[13] *Id*. If the plan does not, then the standard of review is *de novo*, and ambiguities "are construed in favor of the plan beneficiary." *Fay*, 287 F.3d at 104. The standard of review here is *de novo*. *See supra* Part I.B.

1. Plaintiff's 2011-2013 Plans unambiguously provided that her "Out-of-Pocket Expense" would not exceed Oxford's "contracted fee" (i.e., the Pharmacy Rate) for in-network prescription drug purchases.

Plaintiff's 2011-2013 Drug Rider provided that, for drugs purchased from a "Network

[13] A denial of benefits is arbitrary and capricious "if the decision is without reason, unsupported by substantial evidence or erroneous as a matter of law." *Fay*, 287 F.3d at 104 (internal quotation marks omitted).

Pharmacy," members were "responsible for paying the lower of: [1] the applicable Out-of-Pocket Expense; or [2] the Network Pharmacy's Usual and Customary Charge [("U&C")] . . . ." Ex. 2 at 00016080; Ex. 3 at 00019826; Ex. 4 at 00018513; SUF Resp. ¶ 37. The Rider defined "Out-of-Pocket Expenses" as "the costs outlined in your Summary of Benefits." Ex. 2 at 00016080; Ex. 3 at 00019826; Ex. 4 at 00018513; SUF Resp. ¶ 34.

The Summary of Benefits listed in network "Outpatient Prescription Drugs" as a "Covered Service." Ex. 2 at 00015958; Ex. 3 at 00019703; Ex. 4 at 00018381; SUF Resp. ¶¶ 47, 51. The Member Handbook promised that, for in-network benefits, members "will not be responsible for any amount billed in excess of the contracted fee for the Covered Service." Ex. 2 at 00016002; Ex. 3 at 00019745; Ex. 4 at 00018425; SUF Resp. ¶¶ 47, 50. And, for out of network drugs, the Rider provided that Defendants' "contracted rates . . . will not be available" for "any non-Covered drug product." Ex. 2 at 00016080; Ex. 3 at 00019826; Ex. 4 at 00018513; SUF Resp. ¶ 34.

In summary, "Out-of-Pocket Expense" referred to the costs described in the Summary of Benefits; the Summary of Benefits identified in network "Outpatient Prescription Drugs" as a "Covered Service;" the Member Handbook promised that members would "not be responsible for any amount billed in excess of the contracted fee for the Covered Service," including in-network drugs; and the Rider confirmed "contracted rates . . . will not be available" for "any non-Covered drug product." Reading each Plan "as a whole," *Fay*, 287 F.3d at 104, and interpreting it "in an ordinary and popular sense as would a person of average intelligence and experience," *Pepe*, 559 F.3d at 147, the 2010-2013 Plans unambiguously provided that Out-of-Pocket Expenses for Covered Prescription Drug Products purchased at a retail Network Pharmacy would not exceed the contracted fee for that Covered Service. That is the Pharmacy Rate.

In response, Defendants first argue that the language of the Member Handbook—"[w]e

reimburse the Network Provider directly when you receive Covered Services and you will not be responsible for any amount billed in excess of the contracted fee for the Covered Service"—did not relate to pharmacy benefits because it "references 'Network Providers,' not 'Network Pharmacies'. . . ." Mem. at 9. To the contrary, a "Network Pharmacy" is a "Network Provider." Specifically, the COCs for the 2011-2013 Plans defined "Network Provider" as "[a] Physician, Certified Nurse Midwife, Hospital, Skilled Nursing Facility, Home Health Care Agency, or any other duly licensed or certified institution or health professional under contract with Us to provide Covered Services to Members." Ex. 2 at 00016051; Ex. 3 at 00019794; Ex. 4 at 00018474; SUF Resp. ¶ 53. A Network Pharmacy is a duly licensed or certified institution or health professional under contract with Oxford (through OptumRx) to provide Covered Services to Members. SUF Resp. ¶¶ 51, 53; Ex. 18 at 64:20-65:4; *see also* N.Y. Educ. Law § 6805 (licensing requirements for pharmacists). Consistent with treating a "Network Pharmacy" as a "Network Provider," the Certificate of Coverage defined "Copayment"—the term used in the Summary of Benefits for *Outpatient Prescription Drugs*, Ex. 2 at 00015958 (emphasis added); Ex. 3 at 00019703; Ex. 4 at 00018381—to mean "[t]he amount you are required to pay directly to a *Network Provider* at the time Covered Services are rendered," Ex. 2 at 00016050 (emphasis added); Ex. 3 at 00019793; Ex. 4 at 00018473; SUF Resp. ¶ 51.

Defendants next urge the Court ignore the Member Handbook, insisting that it was not a "Plan Document." Mem. at 9-10. But "multiple documents may collectively form an employee benefit plan, and those documents need not be formally labelled as comprising the plan." *Minerley v. Aetna, Inc.*, 801 F. App'x 861, 864 (3d Cir. 2020) (internal quotation marks omitted). Here, the Member Handbook referred to itself, the COC, and Summary of Benefits collectively as the "documents" that "describe" "plan coverage" and "Out-of-Pocket Expenses" "in detail." Ex. 2 at

00015970; Ex. 3 at 00019713; Ex. 4 at 00018393; SUF Resp. ¶ 46. And the Group Policy defined itself as "this Group Policy and Group Enrollment Agreement, the Group Application, the individual applications of Members, the Certificate of Coverage *and Member Handbook*, the Summary of Benefits and any applicable Amendments or Riders." Ex. 2 at 00015939 (emphasis added); Ex. 3 at 00019684; Ex. 4 at 00018364; SUF Resp. ¶ 28.

Finally, Defendants maintain that "even if the general language in the Member Handbook were a contractual term, the language in the Drug Rider is specific and would control." Mem. at 10. This argument rests upon a false conflict between the Member Handbook and the Drug Rider. *See id*. (discussing "irreconcilable contract terms"). These documents are not irreconcilable but rather must be read together, as shown above.

The argument also fails because the Drug Rider is not more specific. Although it includes the term "Out-of-Pocket Expenses," apart from referring to the Schedule of Benefits, the only relevant part of its definition provides that "for any non-Covered drug product and Our contracted rates (Our Prescription Drug Cost) will not be available to you." The way to interpret this language in "an ordinary and popular sense as would a person of average intelligence and experience," *Pepe*, 559 F.3d at 147, is that for any "Covered drug product," "Our contracted rates (Our Prescription Drug Cost)"—i.e., the Pharmacy Rate "will . . . be available to you."

2. Plaintiff's 2014-2016 Plans unambiguously provided that her "Cost-Sharing" would not exceed Oxford's "Allowed Amount" (i.e., the Pharmacy Rate) for in-network prescription drug purchases.

Plaintiff's 2014-2016 Plans included prescription drug coverage in the COC (not a separate rider). The COC for the 2014-2016 Plans provided that, for drugs purchased at a "retail or mail order or designated Participating Pharmacy," members were "responsible for paying the lower of: [1] [t]he applicable *Cost-Sharing*; or [2] [t]he Participating Pharmacy's [U&C]. . . ." Ex. 5 at 00017603 (emphasis added); Ex. 6 at 00019463; Ex. 7 at 00019617; SUF Resp. ¶ 58.

The COC's General Definitions section defined "Cost-Sharing" as "[a]mounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance." Ex. 5 at 00017562; Ex. 6 at 00019412; Ex. 7 at 00019564; SUF Resp. ¶ 58. Section IV—"Cost-Sharing Expenses and Allowed Amount"—provided that for a Copayment, "when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount." Ex. 5 at 00017573-74; Ex. 6 at 00019425-26; Ex. 7 at 00019579-80; SUF Resp. ¶ 58. "'Allowed Amount' means the maximum amount we will pay for the services or supplies covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted." *Id*. It is "the amount We have negotiated with the Participating Provider." Ex. 5 at 00017573-74; Ex. 6 at 00019425-26; Ex. 7 at 00019579-80; SUF Resp. ¶ 58.

In summary, members would not pay more than the applicable "Cost-Sharing;" "Cost-Sharing" includes "Copayments;" "Copayments" are limited to "the Allowed Amount;" and the Allowed Amount is the amount contracted with Network Providers. Plaintiff does not, as Defendants suggest, point to "vague, general language." Mem. at 11. To the contrary, she points to the only definitions of Cost Sharing and Copayment in the integrated COC. Reading each Plan "as a whole," *Fay*, 287 F.3d at 104, and interpreting it "in an ordinary and popular sense as would a person of average intelligence and experience," *Pepe*, 559 F.3d at 147, the 2014-2016 Plans provided that Copayments at a "Participating Pharmacy" would not exceed the Pharmacy Rate.

Defendants assert that "Allowed Amount" was not used in the Prescription Drug Coverage section of the COC. Mem. at 11. But, the term that *was* used in the Prescription Drug Coverage section—"Cost-Sharing"—was not defined in that section. Ex. 5 at 00017609; Ex. 6 at 00019470; Ex. 7 at 0019624; SUF Resp. ¶ 58. Instead, it was defined in COC section IV, which defined "Cost-Sharing" to include "Copayments" limited to the "Allowed Amount." Ex. 5 at 00017573-74; Ex. 6

at 00019425-26; Ex. 7 at 00019579-80; SUF Resp. ¶ 65.

Defendants argue that "'Allowed Amount' referenced the defined term 'Provider'—which includes Physicians, Health Care Professionals, and Facilities, all defined terms that do not include pharmacies . . . ." Mem. at 11-12. Defendants are wrong. Pharmacists are "Health Care Professionals." Ex. 5 at 00017564; Ex. 6 at 0001914; Ex. 7 at 00019566; SUF Resp. ¶¶ 59. Thus, "Participating Pharmacies" are "Participating Providers." SUF Resp. ¶ 66. Indeed, the Schedule of Benefits used the term "Provider" in conjunction with prescription drugs, explaining that "Non-*Participating Provider* Services Are Not Covered and You Pay the Full Cost." Ex. 5 at 00017555 (emphasis added); Ex. 6 at 00019403; Ex. 7 at 00019556; SUF Resp. ¶ 67. No "person of average intelligence and experience," *Pepe*, 559 F.3d at 147, would read the term "Provider" to exclude pharmacies.

Defendants next posit that "the specific language" of the Prescription Drug Coverage section controls over the Cost-Sharing Expenses and Allowed Amount section. Mem. at 12. As with the 2010-2013 Plans, however, this argument rests upon a false conflict—this time between two sections of the COC itself. As shown above, these sections are *not* irreconcilable; rather, the Prescription Drug Coverage section uses a term—"Cost-Sharing"—that is only defined in the section entitled "Cost-Sharing Expenses and Allowed Amount."

Finally, Defendants intimate in a footnote that Plaintiff was not entitled to the Pharmacy Rate because the Plans used the term "Prescription Drug Cost" concerning mail order but not retail drug purchases. Mem. at 4. n.3. The mail-order section has nothing to do with in network retail purchases, however, and no person of average intelligence and experience who was filling a prescription at a *retail* pharmacy would even read the page about *mail order coverage*, let alone expect it to alter the meaning of "Out-of-Pocket Expense" (in the 2011-2013 Plans) or "Cost-

Sharing" (in the 2014-2016 Plans).[14] SUF Resp. ¶¶ 38, 61.

3. Extrinsic evidence does not support Oxford's interpretation but rather demonstrates that it was arbitrary and capricious.

Because the Plans are not ambiguous, extrinsic evidence is not admissible. Even if they were ambiguous, the Plans did not afford discretion to interpret Plan terms. *See supra* Part I.B. Accordingly, any ambiguities must be "construed in favor of the plan beneficiary," *Fay*, 287 F.3d at 104, unless Defendants present "extrinsic evidence sufficient to remove the ambiguity and that evidence is not contradicted by opposing evidence," *McCutcheon v. Colgate-Palmolive Co.*, 481 F. Supp. 3d 252, 262 (S.D.N.Y. 2020). They have not done so.

Defendants ask the Court to consider evidence of how Oxford interpreted the Plans in the past, noting that before 2017, Oxford adjudicated prescription drug claims without "reference to the Pharmacy Rate." Mem. at 14. This tells us nothing about the meaning of the Plans, given that Defendants switched their adjudication logic on January 1, 2017—in the middle of the 2016 Plan year, *without any change in Plan language*—to limit "Copayments" to the Pharmacy Rate. Ex. G at 92:12-21; SUF Resp. ¶ 80. Although Oxford subsequently amended the Prescription Drug Coverage section, *see* Mem. at 14, its approved COC for 2017 contained the same language. Ex. I at 00009608; SUF Resp. ¶¶ 80-81. Thus, Defendants employed both lesser-of-two and lesser-of-three adjudication logic *under the identical plan terms*. Far from removing an ambiguity, *see McCutcheon*, 481 F. Supp. 3d at 262, Defendants' change in adjudication logic—without a contemporaneous change in Plan language—evidences their arbitrariness and caprice.

[14] Interpreting the Plans categorically to provide members with the benefit of the Pharmacy Rate for mail order drugs but not for retail pharmacy drugs would also foreclose Oxford from complying with New York law. Since 2012, New York has barred insurers from imposing higher cost-share amounts for drugs purchased from a retail pharmacy, rather than a mail-order supplier, when the retail pharmacy has agreed to the same reimbursement rate. *See* N.Y. Ins. Law § 3221(*l*)(18) (effective Jan. 11, 2012). Under Defendants' interpretation, the cost-share for retail drugs would *always* be higher than the cost-share for mail order (the Pharmacy Rate), even if the retail and mail-order pharmacies were paid the same amount for the drug.

Defendants also ask the Court to consider "'who drafted the contract terms,'" Mem. at 14 (quoting *I.V. Servs. of Am., Inc. v. Trustees of Am. Consulting Engineers Council Ins. Tr. Fund*, 136 F.3d 114, 120 (2d Cir. 1998)), noting that the Department of Financial Services ("DFS") approved the 2010-2013 Plans and supplied model language for the 2014-2016 Plans, *id.* at 15. But the Plans were not drafted by Plaintiff. *See I.V. Servs.*, 136 F.3d at 122 (applying rule of rule of *contra proferentem* to construe ambiguities against drafter). Evidence that DFS either drafted the Plans or blessed Oxford's interpretation is irrelevant.[15] Either way, under *Fay*, that interpretation must be construed against Oxford, not Plaintiff.

II. DEFENDANTS ARE NOT ENTITLED TO SUMMARY JUDGMENT ON MOHR'S ANCILLARY ERISA CLAIMS (COUNTS II-V).

Defendants next seek summary judgment on Counts II-V, which they erroneously term "ancillary ERISA claims." *See generally* Mem. at 15-20. Their arguments ignore the principles set forth in this Court's motion to dismiss ruling.

A. Defendants violated plan terms.

As set forth above, in Part I.C., Defendants wrongly argue that they followed the plan terms. Mem. at 16-17. Defendants also ignore that in ruling on Defendants' motion to dismiss, the Court found that Plaintiff properly alleged that Defendants exercised discretion over their compensation (specifically, by exercising discretionary authority over claim processing in a manner that allowed them to take clawback compensation in violation of the Plans). ECF 63 at 15-16. The Court also found that Plaintiff properly alleged that the Plans were Plan assets, and that Defendants breached their fiduciary duties when they exercised authority or control over those Plan assets to instruct pharmacies to charge excessive cost share amounts in violation of the Plan terms and took those excessive cost share payments as clawbacks. *Id.* at 16-17. Defendants do not

[15] The latter is also a disputed fact. See SUF Resp. ¶¶ 85-86.

address any aspects of these alleged claims or establish that there are related undisputed facts.[16]

B. Plaintiff does not seek duplicative remedies.

Defendants argue that Plaintiff's claims under ERISA § 502(a)(3) are barred on the grounds that the gravamen of that claim is "an improper denial of benefits" under Count I. Mem. at 18 (citing *Biomed Pharm., Inc. v. Oxford Health Plans (NY), Inc.*, 775 F. Supp. 2d 730, 738 (S.D.N.Y. 2011)). Because Plaintiff received her drugs and the pharmacy was paid in full, however, she does ***not*** assert a claim for benefits; she seeks to enforce her rights. ECF 47, Am. Compl. ¶ 140; SUF Resp. ¶ 15. Given that Defendants mischaracterize Count I, their argument that Counts II-V duplicate Count I logically fails. At a minimum, the conflict between Defendants' characterization of Count I and the express language of that Count—as well as Defendants' 30(b)(6) testimony that Plaintiff has received the benefits in full, Ex. B at 102:5-104:15, 123:10-18; SUF Resp. ¶ 15—weighs strongly against summary judgment. Unless and until the Court concludes that Counts II-V seek *identical* relief to Count I, and that the *full* scope of remedies sought under § 502(a)(3) in Counts II-V are available under Count I, judgment on Counts II-V is premature.

The Second Circuit has expressly *rejected* the argument that claims under § 502(a)(1)(B) to enforce the terms of a plan and under § 502(a)(3) for breach of fiduciary duty cannot both survive summary judgment. In doing so, the Second Circuit explained why Defendants' reliance, Mem. at 17, on *Varity Corp. v. Howe,* 516 U.S. 489 (1996), is misplaced: "the determination of 'appropriate equitable relief' rests with the district court *should plaintiffs succeed on both claims*." *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 89-90 (2d Cir. 2001) (emphasis added); *see also New York Psychiatric Ass'n, Inc. v. UnitedHealth Grp.*, 798 F.3d 125, 133-35 (2d Cir. 2015). *Devlin* specifically reversed summary judgment and instructed the district court to consider

[16] Defendants' knowing participation argument fails for the same reason. Mem. at 21.

remedies *only* if the plaintiffs ultimately prevailed on both claims.[17] The Court should not rule on this issue unless and until Plaintiff succeeds on Count I and Counts II, III and/or IV.[18]

C. Defendants' other arguments fail.

In a catchall section, Defendants raise two other arguments that they claim are "fatal" to Plaintiff's case. ***First***, they argue that this case is merely a claim that they violated the Plan terms while making a benefits determination. According to this Court's motion to dismiss ruling, however, Plaintiff properly alleged that Defendants instructed pharmacies to charge excessive cost shares and took those excessive cost share amounts in the form of clawbacks. *See* ECF 63 at 15-17. The alleged prohibited transaction is not the payment of benefits because Plaintiff received her prescription drugs and the pharmacy was paid. Instead, the alleged prohibited transactions were (1) the overcharges imposed on members when they received their drugs and (2) the separate transactions where Defendants took those overcharges from the pharmacies in the form of clawback compensation. *Id.* at 17; *see generally id.* at 15-17; *see also Negron v. CIGNA Health and Life Ins.*, 300 F. Supp. 3d 341, 359-60 (D. Conn. 2018) (discussing similar two-part prohibited transaction allegations). Defendants do not even address these transactions.

Second, Defendants contend that Plaintiff identifies no compensation that was improperly taken. But, as the Court noted, Plaintiff properly alleged that Defendants' Plans were Plan assets, over which Defendants exercised authority or control when they instructed pharmacies to charge excessive cost share amounts and took those overcharges (clawbacks) as excess compensation.

[17] Defendants ignore *Devlin*. Moreover, Defendants' cases provide no support because they concerned cases a denial of benefits. *See Whelehan v. Bank of Am. Pension Plan for Legacy Cos.*, 2014 WL 4285028, at *5 (W.D.N.Y. Aug. 29, 2014); *accord Easter v. Cayuga Med. Ctr. at Ithaca Prepaid Health Plan,* 217 F.3d 608, 636 (N.D.N.Y. 2016); *Elzabeth W. v. Empire Healthchoice Assurance, Inc.*, 2016 WL 5115496, at *17 (S.D.N.Y. Sept. 15, 2016).

[18] *Keir v. Unumprovident Corp.*, 2010 WL 3566878 (S.D.N.Y. Sept. 14, 2010), Mem. at 19, holds that "[b]ecause [p]laintiffs' request for re-evaluation of their claims and payment of any wrongfully-denied benefits is fully available under ERISA § 502(a)(1)(B), relief under § 502(a)(3) is inappropriate and unnecessary." *Id.* at *8. Since *Keir* only concerns a claim for "wrongly denied benefits" (and thus the first clause of § 502(a)(1)(B)), rather than enforcement of the terms of a plan (under the second clause), it does not apply.

ECF 63 at 15-17. And, as set forth above, Defendants violated the Plans by wrongfully taking clawbacks as compensation. *See* supra Part I.C. Accordingly, Defendants improperly took clawback compensation. *See, e.g.*, 29 C.F.R. § 2550.408b-2 ("Compensation is *anything* of monetary value (for example, money, gifts, awards, and trips) . . . ." (emphasis added)); *see also Lowen v. Tower Asset Mgmt., Inc*. 829 F.2d 1209 (2d Cir. 1987) ("fiduciaries . . . must either avoid the transactions described in Section 406(b) or cease serving in their capacity as fiduciaries, no matter how sincerely they may believe that such transactions will benefit the plan").[19]

Moreover, a fiduciary charged with a violation of § 406 "must prove by a preponderance of the evidence that the transaction . . . fell within an exemption or must prove by clear or convincing evidence that compensation it received was for services other than a transaction involving the assets of a plan."[20] *Lowen*, 829 F.2d at 1215. Defendants have not met this burden.[21]

III. DEFENDANTS ARE NOT ENTITLED TO SUMMARY JUDGMENT ON MOHR'S RICO CLAIMS (COUNTS VIII-IX).

As set forth above, the Plans unambiguously provided that Plaintiff's "Out-of-Pocket Expense" (2011-2013) and "Cost-Sharing" (2014-2016) for in-network prescription drug purchases would not exceed the Pharmacy Rate. A reasonable jury could conclude that Defendants violated RICO by conspiring surreptitiously to claw back those overcharges and split them 50/50.

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[19] *See also id*. ("Such protection of beneficiaries and notice to fiduciaries requires that Section 406(b) be broadly construed, and that liability be imposed even where there is 'no taint of scandal, no hint of self-dealing, no trace of bad faith,' . . . .").

[20] *Lockheed v. Spink*, 517 U.S. 882 (1996), concerned whether payment of early retirement benefits could be conditioned on a release and has nothing to do with this case. *Bush v. Liberty Life Assurance Co. of Boston,* 130 F. Supp. 3d 1320 (N.D. Cal. 2015), is equally irrelevant because it concerned the set off of disability benefits.

[21] *Alves v. Harvard Pilgrim Health Care, Inc.*, 204 F. Supp. 2d 198 (D. Mass. 2002), does not apply. In that case, the plans required members to pay a fixed copayment amount without regard to the amount paid to the pharmacy. Accordingly, the provider did not breach the plans or improperly use copayments for personal gain by receiving excessive copayment amounts back from the pharmacies. *Id.* at 207-209, 215. Here, Oxford violated the Plans and used them for personal gain in the form of improper clawback compensation. Similarly, vague notions of controlling costs under *Pegram v. Herdrich,* 530 U.S. 211 (2000), or taking rebates under *Doe 1 v. Express Scripts, Inc*., 837 Fed. App'x 44 (2d Cir. 2020), are irrelevant here where Defendants violated the Plans.

A. A reasonable jury could find that Defendants obtained clawbacks by means of materially false or fraudulent pretenses or representations.

Optum's claim that there is no evidence of its RICO *mens rea* is wrong. Mem. at 22. Optum prepared a PowerPoint entitled "OptumRx Overview – E&I Claw back." Ex. L; SUF Resp. ¶ 74. . Ex. L at 2; SUF Resp. ¶ 74. Ex. L at 4; Ex. H [Answer to Interrog. 20]; SUF Resp. ¶ 74. Ex. M at 00043894; SUF Resp. ¶ 74. Optum admitted that Ex. L at 3; SUF Resp. ¶ 74. A reasonable jury could conclude that Optum made this misrepresentation because the Plans entitled members to the Pharmacy Rate and Optum knew that including the clawback amount on "member facing applications" would reveal that members were being overcharged.

B. A reasonable jury could conclude that Optum exercised untoward control over its network pharmacies.

Plaintiff contends that each pharmacy in its network is a separate "legal entity" enterprise and that Optum controlled each enterprise to carry out and conceal its overcharge scheme. ECF 47, Am. Compl. ¶ 261. "When a plaintiff identifies a legitimate business or organization as the relevant enterprise, the need to allege and prove the existence of enterprise structure can be met without great difficulty, since all aspects of the enterprise element, including the structure aspect, are satisfied by the mere proof that the entity does in fact have a legal existence." *In re Ins. Brokerage Antitrust Litig*., 2007 WL 2892700, at *9 (D.N.J. Sept. 27, 2007). There is no dispute that Optum's network consists of legitimate pharmacy businesses. The existence of those pharmacies as

"legitimate business[es]" is all that is required to prove the separate "legal entity" enterprises.[22]

Optum argues that "Mohr does not have any evidence of control" over the pharmacy enterprises. Mem. at 23. But Plaintiff need not prove that Optum controlled every aspect of its network pharmacies; all that is required is that the Optum "'played *some* part in directing [the enterprise's] affairs.'" *Baisch v. Gallina*, 346 F.3d 366, 376 (2d Cir. 2003) (emphasis added) (quoting *Reves v. Ersnt & Young*, 507 U.S. 170, 179 (1993)). Just as Optum was "MIS-REPRESNTING" [*sic*] the clawbacks through its "masking" process on its "member facing applications," *see supra* Part III.A., Optum concomitantly controlled the information flow through its network pharmacies to conceal the scheme. For instance, Optum controlled its network pharmacies through its Provider Manual, through which Optum required network pharmacies to collect the cost-sharing overcharges that Optum dictated, including the portion it clawed back. Ex. N at 00016302; SUF Resp. ¶ 76. Optum prohibited its pharmacies from charging any amount other than the amount that it dictated and that included the clawbacks. Ex. F at 87:25-88:6; SUF Resp. ¶ 76. Optum also prohibited the network pharmacies from disclosing the overcharges and clawbacks. Ex. N at 00016345, 59; SUF Resp. ¶ 76. If a pharmacy did not adhere to Optum's controls, Optum could fine the pharmacy $5,000 and kick the pharmacy out of Optum's network. *Id*. at 00016344.SUF Resp. ¶ 76.

Further, Optum unilaterally decided when, or when not, to impose clawbacks on its members. Ex. 16 at 45:16-24; Ex. G at 14:24-15:5; Ex. F at 33:1-11; SUF Resp. ¶ 77. By deciding when pharmacies had to collect and pay clawbacks to Oxford, Optum exercised untoward control over the pharmacies.

[22] Contrary to Defendants' argument, Mem. at 23, Plaintiff is not alleging that Optum ***and*** each pharmacy constitute a "legal entity." Plaintiff will prove, and Defendant's do not contest, that each network pharmacy is a separate "legal entity" enterprise.

Ex. P at 00045079; SUF Resp. ¶ 77.

Optum argues that these controls were "garden-variety" contractual provisions. Mem. at 24. While they may be "garden-variety" in the abstract, they are not when Optum's own documents show

Ex. M at 00043894; SUF Resp. ¶ 74. Without Optum's controls over the pharmacy enterprises, the clawback scheme would have been revealed. Accordingly, as an essential aspect to carrying out its scheme, Optum played *some* part in directing the enterprise's affairs by requiring the pharmacy enterprises to overcharge the members, pay the excess payment to Optum as a clawback and keep the entire scheme quiet. *Baisch*, 346 F.3d at 376.

C. A reasonable jury could conclude that Defendants agreed to facilitate a scheme to overcharge insureds.

Defendants argue that there is no evidence of any agreement between them "to participate in the purported conspiracy." Mem. at 25. But, among other evidence, in an email chain

Ex. O at 00044149; SUF Resp. ¶ 78. The clawback scheme *is* "the purported conspiracy." From this email alone, a jury could conclude that Optum and Oxford conspired to carry out the clawback scheme. Further, Oxford's 30(b)(6) witness testified that "the full value for all of the Oxford New York membership, when the clawback program was implemented, was booked directly to that regulated entity." Ex. B at 156:21-24; SUF Resp. ¶ 79. Because all of the New York clawbacks were credited to Oxford, a jury could readily conclude that Optum and Oxford agreed to engage in the clawback scheme.

CONCLUSION

For all of these reasons, the Court should deny Defendants' motion for summary judgment in its entirety.

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