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

DEFENDANTS' REPLY MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

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Mohr agrees this is a dispute over plan terms. But she ignores the clear and unambiguous terms of her prescription drug benefits and instead asks this Court to bless the linguistic acrobatics she employs to try to save her claims. Mohr's interpretation of the contract is neither convincing nor supportable, and fails to raise any genuine issues of material fact. All of her claims should be dismissed.

ARGUMENT

I. MOHR HAS FAILED TO EXHAUST HER ADMINISTRATIVE REMEDIES

Mohr admits that she did not exhaust her administrative remedies, but insists she should be deemed to have exhausted them because she claims Defendants did not "strictly adhere" to plan regulations in responding to her "pre-service" grievance within 15 days. Dkt. 130 ("Opp'n") at 6. Mohr's grievance was filed more than *two years* after the last prescription drug claim was filled, and nearly twenty months after Mohr ceased being a member of the plan. The evidence adduced in discovery and laid out in Defendants' initial brief makes clear that hers was a *post-service* grievance (*i.e.*, a grievance filed after the service was provided), to which Defendants timely responded within 30 days. Because all of Mohr's arguments are rooted in the incorrect assumption that her grievance was pre-service, they all fail.[1] Mohr further suggests that "newly discovered facts" should entitle her to argue futility, though this Court already ruled she was collaterally estopped from doing so. Dkt. 63 at 10. None of the three "facts" she cites are newly discovered. The Court's previous ruling on this point should not be disturbed.

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[1] That Defendants considered Mohr's letter requesting reimbursement for prior copayments as an initial claim for benefits was not a violation of the DOL regulations. As Mohr concedes, the regulations recognize that presenting a prescription to a pharmacy is not always a request for a plan benefit. Dkt. 130 at n.9. Mohr does not claim she was denied prescription drug coverage at the pharmacy, but that she was entitled to reimbursement of prior copayments. Consistent with Defendants' position in *UnitedHealth,* Mohr was required to file a post-service claim and then exhaust the administrative appeal process. Grant. Suppl. Decl., Ex. 29 at 5.

II. MOHR IS NOT ENTILTED TO ADDITIONAL BENEFITS

A. Mohr's 2011–2013 Plans Did Not Entitle Her to the Pharmacy Rate

As Mohr recognizes, the 2011–2013 Prescription Drug Rider specifically and unambiguously provided that Mohr was "responsible for paying the lower of: [1] the applicable Out-of-Pocket Expense; or [2] the Network Pharmacy's [U&C]" for drugs purchased from a "Network Pharmacy." SUF ¶ 37; Ex. 1 at 00053252; Ex. 2 at 00016080; Ex. 3 at 00019826; Ex. 4 at 00018513. The Drug Rider specifically did ***not*** limit Mohr's payment to the "Prescription Drug Cost," which is defined as "the rate We have agreed to pay Our Network Pharmacies…." SUF ¶ 39; Ex. 1 at 00053257; Ex. 2 at 00016085; Ex. 3 at 00019831; Ex. 4 at 00018518. Mohr suggests that the use of "Prescription Drug Cost" with respect to certain mail order drugs is irrelevant; to the contrary, it proves Defendants' point. It shows Oxford chose when to use that term, and by implication when it chose not to. SUF ¶ 38.[2] *See Roche Diagnostics GmbH v. Enzo Biochem, Inc.*, 992 F. Supp. 2d 213, 219 (S.D.N.Y. 2013) ("Had the parties sought to [apply] a similar restriction . . . they certainly knew how to draft it, but they obviously declined to do so.").

Despite this, Mohr argues that Out-of-Pocket Expenses should not exceed the Pharmacy Rate because of language in the Member Handbook relating to "Network Providers." Mohr is incorrect. The Handbook language makes no reference to any limit on Out-of-Pocket Expenses or copayments. And a "Network Pharmacy." "Network Pharmacy is a defined term in the Drug Rider; equating it to "Network Provider" would render the use and definition of "Network

[2] Contrary to Mohr's argument (Opp'n at n.14), this does not violate a New York Law forbidding different cost shares for prescription drugs at a "network participating non-mail order retail pharmacy" and a "network participating mail order pharmacy." N.Y. Ins. Law § 3221(l)(18). Mohr's policy properly provides the same copayments for mail-order and non-mail-order *network* pharmacies. *See, e.g.*, Ex. 4 at 00018513 & 17 ("Network Pharmacy" can be either a retail or home delivery pharmacy). By contrast, it has a different provision for mail order drugs from Oxford's *own* mail order supplier (not a network pharmacy). *Id.* at 18515 (para. 7). New York's model language, implemented in 2014, continued to recognize this distinction by providing different provisions for cost-shares through the insurer's own mail order supplier versus a network retail or mail-order pharmacy. Ex. 5 at 00017603-05. Surely DFS's model language would not be written to violate the New York statute.

Pharmacy" superfluous. *Galli v. Metz*, 973 F.2d 145, 149 (2d Cir. 1992) (clauses should not be interpreted as meaningless). Indeed, "Network Provider" is a defined term from the COC, which *excludes* coverage for prescription drugs. Ex. 2 at 00016002; Ex. 3 at 00019745; Ex. 4 at 00018425.

Mohr next argues that the Handbook language should control because the Handbook is defined as part of the Group Policy. But the Group Policy specifically states that terms, conditions, limitations, and exclusions are set forth in the COC, Schedule of Benefits, and any Rider—not the Member Handbook. SUF ¶ 28; Ex. 2 at 0001590; Ex. 3 at 00019685; Ex. 4 at 00018365. Nowhere does the Group Policy identify the Member Handbook as a source of benefits.

Finally, Mohr contends that the language in the Drug Rider and that of the Member Handbook are not "irreconcilable," but instead must be read together. Setting aside that reading them as Mohr suggests would cause a result irreconcilable with the plain meaning of the language in the Drug Rider, the law does not in fact require language to be in "true conflict" for a more specific provision to govern over a more general one. *See., e.g., Aramony v. United Way of Am.*, 254 F.3d 403, 413–14 (2d Cir. 2001) ("Even when there is no 'true conflict' between two provisions, specific words will limit the meaning of general words if it appears from the whole agreement that the parties' purpose was directed solely toward the matter to which the specific words or clause relate.") (internal citations omitted). Here, the Drug Rider "provides benefits for outpatient Prescription Drug Products" and includes the specific terms and conditions for those benefits. Under the heading of "Network Pharmacies," the Drug Rider unambiguously states that Mohr's cost-share was the lower of the Out-of-Pocket Expense (the fixed copayment set forth in the Summary of Benefits) or the Network Pharmacy's U&C, with no reference to the Prescription Drug Cost (the Pharmacy Rate). This prescription-drug-specific reference controls.

B. Mohr's Cost-Share in 2014–2016 Was Not Limited to the Pharmacy Rate

Mohr similarly ignores the specific and unambiguous "lower of" provision for prescription drugs purchases in her 2014–2016 plans. Again, "Prescription Drug Cost" is specifically *not* included among the options for member payment for prescriptions at retail "Participating Pharmacies" (as defined in the COC). SUF ¶¶ 58–61; Ex. 5 at 00017603 & 17610; Ex. 6 at 00019463 & 19471; Ex. 7 at 00019617 & 19625.

Despite this, Mohr argues that her cost-share should have been limited to the Pharmacy Rate because another section provides that "when the Allowed Amount for a service is less than the Copayment, You [the plan member] are responsible for the lesser amount." Opp'n at 15. The term "Allowed Amount" is defined as the "maximum amount we will pay to a Provider." SUF ¶¶ 63–64. Mohr argues that "Participating Pharmacies" are "Providers" because the definition of "Provider" includes a "Health Care Professional." Opp'n at 16. But a pharmacist differs from a pharmacy just like a physician differs from a hospital. Here, the contracting entity is the pharmacy, *not* the pharmacist.[3]

C. Oxford's Interpretation of Plan Language Is Entitled to Deference

Oxford did not violate plan terms or DOL regulations in responding to Mohr's claim and/or Grievance. But even if Mohr was right that her April 26, 2018 letter as a grievance and Defendants should have responded in 15 rather than 29 days, this does not mean *de novo* review applies. Where the plan has established procedures in full conformity with the regulation and any

[3] Mohr raises hearsay objections to Defendants' interrogatory answer regarding communications with DFS. SUF Resp. ¶¶ 84-86. However, "material relied on at summary judgment need not be admissible in the form presented to the district court." *Rapaport v. Barstool Sports, Inc.*, 2021 U.S. Dist. LEXIS 59797, at *10 (S.D.N.Y. Mar. 29, 2021) (quotation omitted). Knowledgeable witnesses, including Mr. Harvey, could testify at trial regarding the communications with DFS.

deviation from "the claims-procedure regulation in the processing of a particular claim was inadvertent *and* harmless," deference should still be given to the insurer. *Halo v. Yale Health Plan*, 819 F.3d 42, 58 (2d Cir. 2016). There is no evidence that Defendants' processing of Mohr's letter was a deliberate violation (if it was a violation at all), nor did it prejudice Mohr in any way. Mohr's cases (Opp'n at 9-10) are inapposite. In *Schuman*, the plan acted intentionally and its conduct was prejudicial. The plan ignored evidence on appeal, failed to give appropriate weight to an expert's opinion, and failed to provide the claimant with the internal guidelines. *Schuman v. Aetna Life Ins. Co.*, 2019 U.S. Dist. LEXIS 113375, at *6 (D. Conn. July 9, 2019). In *Satter*, the plan did not identify any "special circumstances" allowing an extension as specifically required by the DOL regulations. *Satter v. Aetna Life Ins. Co.*, 2019 U.S. Dist. LEXIS 112734, at *17–18 (D. Conn. Mar. 20, 2019). Here, Defendants considered Mohr's letter a post-service claim and accordingly provided a response in 29 days. Responding to the letter 14 days earlier would not have made any meaningful difference. Unlike in *Satter* and *Schuman*, the alleged delay here caused no discernible injury or prejudice to Mohr as she had already received the prescription drugs. Even if the letter had been considered a pre-service grievance, Mohr still would have been required to file a second-level appeal under her plan; Defendants' response even explained how to do so. Even if Oxford owed a response within 15 days, then (which it did not), Oxford is still entitled to deferential review. *Wilson v. Aetna Life Ins. Co.*, 2016 U.S. Dist. LEXIS 135396, at *23 (N.D.N.Y. Sept. 30, 2016) (applying deferential review even where plan provided an untimely denial of a claim).

Mohr concedes that the 2011–2013 plans granted Oxford discretionary authority to interpret plan terms. Opp'n at n.12. So, too, do her 2014-2016 plans, despite Mohr's contentions to the contrary. Oxford reserved its right to develop and adopt standards for determinations as to when it will or will not make payments under the COC. SUF ¶ 69. Further, Oxford reserved all powers necessary and appropriate to administer the plan. Interpretation of the plan is necessary to create any guidelines or standards. Like the language considered in *Krauss v. Oxford Health Plans, Inc.*, 517 F.3d 614, 622–23 (2d Cir. 2008) ("adopt reasonable policies, procedures, rules and interpretations"), the language in this COC is "akin to authority to 'resolve all disputes and ambiguities relating to the interpretation' of a benefits plan." (internal quotation marks omitted).[4]

III. THE OPPOSITION CONFIRMS THAT SUMMARY JUDGMENT IS WARRANTED ON MOHR'S ADDITIONAL ERISA CLAIMS (COUNTS II–VI)

Mohr admits the "crux of the parties' dispute centers on the meaning of [plan] terms" and admits the dispute is properly resolved under ERISA Section 502(a)(1)(B) (Count I). Opp'n at 19. Mohr's opposition also makes clear that her prohibited transaction and fiduciary duty claims (Counts II–VI) raise the same plan interpretation questions and seek the same relief. *Id.* at 18–19 ("Defendants breached their fiduciary duties . . . in violation of the Plan terms"). These admissions are fatal to Mohr's ancillary ERISA claims for two reasons.

First, Mohr admits all of her ancillary claims are premised on an alleged "violation of the Plan terms" (*id.*), but as described above, there is no genuine dispute of fact that Defendants *followed* the plan terms. That sinks all the ancillary ERISA claims. *Harris Tr. & Sav. Bank v. John Hancock Mut. Life Ins. Co.*, 302 F.3d 18, 29 (2d Cir. 2002). Moreover, Mohr has not identified any evidence suggesting Defendants did anything other than interpret the plan in good faith (*see* Opp'n at 18–20). Good faith disputes about the meaning of plan terms do not give rise to fiduciary duty or prohibited transactions claims. *See* Defs.' Mem. at 16–17 (collecting cases).

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[4] Oxford's decision to provide lesser-of-three benefits beginning in 2017 was not "arbitrary and capricious," as Mohr suggests. In mid-2016, United made the decision to change its plan benefit design across all platforms, including Oxford. SUF ¶ 80; Ex. 11 at 2-4, 8. Given the time required for COC approval, Ex. 22 at 21:15-20, it did so for all fully insured plans effective as of January 1, and language was added as states permitted. Ex. 11 at 4.

Mohr cannot avoid dismissal of these claims by vaguely referencing theories about Defendants' "compensation," control of "plan assets," and other "transactions." Opp'n at 18, 20. As the Court recognized—and Mohr concedes—the fundamental premise of all those theories is the same alleged "violation of the plans' terms" by "overcharging" for prescription drugs. Dkt. 63 at 4, 15–16 & n.4; *see also* Opp'n at 18. Mohr does not and cannot dispute that if Defendants' interpretation of the plan terms was correct or made in good faith, all of her additional ERISA claims fail as well.

Second, settled laws bars Mohr from pursuing these duplicative plan interpretation-based claims under ERISA Section 502(a)(3) when she has a remedy available under Section 502(a)(1)(B). As the Supreme Court has explained, Section 502(a)(1)(B) "specifically provides a remedy for breaches of fiduciary duty *with respect to the interpretation of plan documents.*" *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996) (emphasis added). Section 502(a)(3) is the remedy for "*other* breaches of *other* sorts of fiduciary obligation." *Id.* Here, Mohr admits the relief she seeks—"to enforce her rights" under the plan—is available under Count I.[5] Opp'n at 19. And Mohr identifies no distinct conduct or remedy that could warrant a claim under Section 502(a)(3). *See id.* Mohr's duplicative Section 502(a)(3) claims are therefore barred. *Varity*, 516 U.S. at 512where; *Whelehan v. Bank of Am. Pension Plan for Legacy Cos.-Fleet-Traditional Benefit*, 621 F. App'x 70, 72 (2d Cir. 2015).

Mohr cannot avoid dismissal of her ancillary ERISA claims by arguing that Count I is a claim under "the second clause" of Section 502(a)(1)(B)—"enforcement of the terms of a plan"—rather than "the first clause" for "wrongly denied benefits." Opp'n at 20 n.18; *see also id.* at 19 (same). Any such distinction is irrelevant. Mohr concedes this is a dispute over "terms of a

[5] That Mohr's claim under Section 502(a)(1)(B) itself is fatally flawed does not permit her to repackage the same claim under Section 502(a)(3). *See, e.g.*, *Halberg v. United Behavioral Health*, 408 F. Supp. 3d 118, 130, 145 (E.D.N.Y. 2019) (granting summary judgment on "duplicative" Section 502(a)(3) claims).

plan" for which relief is available under Section 502(a)(1)(B)—which bars her claims under Section 502(a)(3). "ERISA § 502(a)(3) . . . may not be relied on by a claimant to pursue relief . . . available under a separate ERISA provision." *Whelehan*, 621 F. App'x at 72.

Likewise, Mohr wrongly suggests the Court must wait until after a trial to dismiss her duplicative Section 502(a)(3) claims. Opp'n at 19–20. The Second Circuit rejected such a rule in *Whelehan*, 621 F. App'x at 72, and courts in this Circuit refuse to allow duplicative Section 502(a)(3) claims to survive summary judgment. *See, e.g.*, *Easter v. Cayuga Med. Ctr. at Ithaca Prepaid Health Plan*, 217 F. Supp. 3d 608, 636 (N.D.N.Y. 2016). Mohr does not even acknowledge *Whelehan*, nor does she identify any case allowing a facially duplicative Section 502(a)(3) claim to survive past summary judgment.[6]

Finally, Mohr cannot avoid summary judgment by invoking claims and theories already dismissed by this Court. Specifically, Mohr vaguely suggests she is challenging Defendants' dealings with "pharmacies" (Opp'n at 20), but the Court already dismissed that claim and held that Mohr is "collaterally estopped from arguing" Defendants "acted in a fiduciary capacity in their dealings with pharmacies." Dkt. 63 at 11–13. For all these reasons, Mohr's prohibited transaction and fiduciary duty claims fail and should be dismissed.[7]

IV. MOHR'S RICO CLAIMS FAIL AS A MATTER OF LAW

A. Mohr Offers No Evidence that Optum Intended to Defraud

Mohr fails to offer any evidence that Optum knowingly and fraudulently violated her plan terms by "overcharging patients for" their prescription drugs. To establish the existence of a

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[6] The two cases Mohr cites are inapposite as they address "the motion-to-dismiss stage" or a situation, not present here, where the plaintiff "has no remedy under another section of ERISA." *See N.Y. State Psychiatric Ass'n v. UnitedHealth Grp.*, 798 F.3d 125, 134 (2d Cir. 2015); *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 89 (2d Cir. 2001).

[7] Mohr does not dispute that the absence of any underlying breach of fiduciary duty is fatal to any claim for "knowing participation" in ERISA fiduciary breaches (Count VI). *Compare* Defs.' Mem. at 21, *with* Opp'n at 19 n.16.

scheme to defraud, Mohr must present proof that Optum "possessed a fraudulent intent." *United States v. Starr,* 816 F.2d 94, 98 (2d Cir. 1987); *United States v. Guadagna*, 183 F.3d 122, 129 (2d Cir. 1999) ("the proof must demonstrate that the defendant had a 'conscious knowing intent to defraud'") (citation omitted). "Acts done inadvertently, mistakenly, or in good faith without an intent to defraud do not satisfy the requirements of [mail and wire fraud] statute[s]." *O'Malley v. N.Y.C. Transit Auth.,* 896 F.2d 704, 706 (2d Cir. 1990) (citations omitted), *superseded on other grounds by statute*; *see also Costello v. Norton*, 1998 U.S. Dist. LEXIS 16755, at *47 (N.D.N.Y. Oct. 21, 1998) (granting summary judgment when defendant had a good faith belief of her entitlement to the funds and, therefore, no intent to defraud).

Here, the evidence shows Optum understood Mohr's plan terms to provide for lesser-of-two adjudication. SUF ¶ 74; Ex. 20 at 22:3–7, 68:15–69:13; Ex. 19 at 29:6–31:1. Mohr does not dispute this.[8] Mohr's reliance on the alleged "masking" of the clawbacks is insufficient to show that Optum had any fraudulent intent. Opp'n at 22. It provides *no* basis for Mohr's claim that Optum *knew* her plan entitled her to the Pharmacy Rate and *intended* to fraudulently deny her that benefit as Mohr alleged. Am. Compl. ¶¶ 272–273. Indeed, the evidence suggests Optum was seeking to avoid member confusion (Ex. 30 at 65:20-66:15); that is not the same as knowingly violating plan terms, as Mohr has alleged (and that allowed her RICO claims to get past the pleading stage). Without evidence of the alleged predicate offense, Mohr's RICO claim fails.

B. Mohr Offers No Evidence that Optum Controlled the Pharmacies

Mohr also has not presented any evidence that Optum controlled the pharmacies. She relies on the Provider Manual and the agreements between Optum and the pharmacies for her contention that Optum "played *some* part in directing the [enterprise's] affairs." Opp'n at 23. But

[8] Mohr's complains that OptumRx did not have any policies or procedures to verify the adjudication information provided by Oxford, SUF Resp. ¶ 74, but that does not equate to fraudulent intent.

the Provider Manual is merely a guide to payments and pricing, the information that should be collected from consumers, and the like. And the existence of a contractual relationship does not amount to control. *See* Defs.' Mem. at 23-24 (collecting cases).[9] The pharmacies in Optum's network, many of which are part of large national chains, are sophisticated parties that freely negotiated the contracts. "Absent some violation of law or transgression of a strong public policy, the parties to a contract are basically free to make whatever agreement they wish." *Rowe v. Great Atl. & Pac. Tea Co.,* 46 N.Y.2d 62, 67-68 (1978). Mohr's substantive RICO claim fails for this reason, as well.

C. Mohr Fails to Provide Evidence that Optum and Oxford Conspired

Mohr's RICO conspiracy claim also fails as a matter of law. Mohr asserts in her Opposition that, "[t]he clawback scheme *is* 'the purported conspiracy'" (Opp'n at 24), but the scheme alleged in the complaint was that Optum and Oxford agreed to instruct the pharmacies to charge Mohr amounts higher than allowed under her plans. Am. Compl. ¶¶ 13, 271-–273, 280, 287, 291–293. Mohr points to *no* evidence that Defendants *knew* Mohr's plans entitled her to the Pharmacy Rate, much less that there was any agreement between Optum and Oxford to conspire to charge some greater amount. That Optum and Oxford agreed to implement clawbacks—which had no impact on Mohr's cost-share (SUF Resp. ¶ 78)—is not the same as agreeing to intentionally overcharge members in violation of the plan. Mohr's RICO claims must be dismissed.

CONCLUSION

For all these reasons, the Court should grant Defendants' motion for summary judgment.

[9] Mohr references a general fine and termination provision for any violation of the contract, SUF Resp. ¶ 76, but cites no evidence that OptumRx took any disciplinary action against any pharmacies for disclosing clawbacks because such a disclosure is not a breach of the agreement. Ex. 19 at 84:2-8.

Dated: June 4, 2021

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