UNITED STATES DISTRICT COURT
FOR THE 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.	No. 7:18-cv-1427-VB-PD

PLAINTIFF'S MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS THE AMENDED COMPLAINT

−ORAL ARGUMENT REQUESTED −

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"Spread"	The term "Spread" is the amount of an overcharge when a participant pays a copayment or deductible payment. Specifically, Spread is the amount by which (a) the amount paid by the participant exceeds (b) the amount the pharmacy agreed to accept. For example, when a participant pays a $10 copayment, but the pharmacy has agreed to accept $6, there is a $4 Spread. Amended Complaint ¶ 8.
"Clawback"	"Clawback" is the amount of Spread transferred or credited to Defendants. Amended Complaint ¶ 10.
"Overcharges"	The term "Overcharges" is broader than the term "Spread" because it also includes an overcharge when a participant pays a coinsurance payment. Specifically, "Overcharges" are (a) Spread and also (b) with respect to coinsurance plans, the amount by which (i) the cost-share paid by the participant exceeds (ii) the applicable coinsurance percentage rate times the amount the pharmacy agreed to accept. For example, when the plan dictates that the participant should pay 20% coinsurance and a participant pays a $2 coinsurance payment when the pharmacy has agreed to accept $5, there is a $1 Overcharge. Amended Complaint ¶ 6; *id*. ¶ 8 n.3.

I. INTRODUCTION

Plaintiff's claims are simple and straightforward. Plaintiff Mohr is a participant in a prescription drug plan administered by Defendants. Defendants charged Plaintiff excessive cost-sharing payments in violation of ERISA and RICO. Rather than focus primarily on these allegations, Defendants wrongly claim that this action is an attempted "end-run around [a] Minnesota court's decision." Defs.' Mem. of Law (ECF 51) at 1 ("MTD"). But Plaintiff has no reason to do an "end-run." The court in *UnitedHealth Group Litigation,* 2017 WL 6512222 (Dec. 19, 2017 D. Minn.) ("*UnitedHealth*"), assumed that Mohr was entitled to the benefit of the discounted rate for prescription drugs that Defendants negotiated with their in-network pharmacies. *Id*. at *3-4. This Court should reach the same conclusion.

Plaintiff is not forum shopping. *See* MTD at 1. Her claims were initially brought in Minnesota because they were joined with the claims of several other plaintiffs whose plans—unlike hers—did not contain a New York venue provision. The Minnesota court observed that Mohr's plan "designate[s] courts located in New York as the forum for legal disputes related to the plan," *id*. at *6, and the court dismissed her claims ***without prejudice*** to refiling, *id*. at *17. Mohr substantially revised her allegations and filed what is, in effect, an "amended complaint" in this District. She dropped UnitedHealth Group Inc. as a Defendant and filed this ***new and substantively revised*** complaint in New York, as dictated by her Plan. Far from an "end-run" from the *UnitedHealth* decision, this is the action the Minnesota court contemplated.

II. PLAINTIFF'S CLAIMS ARE NOT PRECLUDED

Defendants argue that Plaintiff's claims should be precluded, but the Second Circuit has held that "a dismissal without prejudice permits a new action . . . without regard to Res judicata principles." *Elfenbein v. Gulf & W. Indus., Inc.*, 590 F.2d 445, 449 (2d Cir. 1978) (citation

omitted).[1] The cases cited by Oxford are either not on point or actually support Plaintiff.[2] For example, in *Deutsch v. Flannery*, 823 F.2d 1361 (9th Cir. 1987), the Ninth Circuit reversed, in part, the district court's dismissal based on issue preclusion, explaining that "[i]nsofar as [plaintiff]'s additional allegations are colorably responsive to the deficiencies noted by [the first court], . . . we must agree with [plaintiff]" that his claims are not precluded. *Id*. at 1364. The same reasoning supports Plaintiff.[3]

Moreover, Defendants have not met their burden of establishing either that the issues here are identical to those in *UnitedHealth* or that they were necessarily decided. *Proctor v. LeClaire*, 715 F.3d 402, 414 (2d Cir. 2013). In particular, Defendants cannot show that "the matter raised in the second suit is identical in all respects with that decided in the first proceeding" and that "the controlling facts … remain unchanged." *Faulkner v. National Geographic Enterprises, Inc.*, 409

[1] *Accord Tosado v. Klein*, 1991 WL 218547, at *3 (D. Conn. Aug. 20, 1991); *Hannon v. U.S. Postal Serv*., 701 F. Supp. 386, 387 (E.D.N.Y. 1988); *see also Gaddy v. U.S. Dept. of Educ*., 2010 WL 1049576, at *3 (E.D.N.Y. Mar. 22, 2010) ("[A] dismissal of an action without prejudice is an indication that the judgment is not on the merits and will therefore have no preclusive effect."); *id*. at *3 n.4 ("In layman's terms, dismissal of an action without prejudice means that the [party] was free to bring the action again, presumably after correcting some minor defect in the original complaint."). The term "res judicata embraces two concepts: issue preclusion and claim preclusion." *Murphy v. Gallagher*, 761 F.2d 878, 879 (2d Cir. 1985); a*ccord Marcel Fashions Group, Inc. v. Lucky Brand Dungarees, Inc*., 779 F.3d 102, 107 (2d Cir. 2015); *Wyly v. Weiss*, 697 F.3d 131, 140 (2d Cir. 2012); *Nestor v. Pratt & Whitney*, 466 F.3d 65, 70 n.5 (2d Cir. 2006).

[2] *Lia v. Saporito*, 542 F. App'x 71 73-74 (2d Cir. 2013) (summary order), does not concern a dismissal without prejudice. In *Miller v. Norris*, 247 F.3d 736, 740 (8th Cir.), the court ultimately concluded that plaintiff was not precluded, and that he complied with the exhaustion requirement. The language from *Washington v. Sheinberg*, 1996 WL 118557 (E.D.N.Y. Mar. 5, 1996), cited by Oxford is actually the court's recitation of the defendant's argument, and the court quoted *Deutsch v. Flannery* which (as explained in the text above) supports Plaintiff on this issue. The *Washington* court held that the earlier action did *not* preclude the plaintiff's claim. In *Gashi v. City of Westchester*, 2005 WL 195517 (S.D.N.Y. Jan. 27, 2005), the court held that plaintiff's claims were not precluded. Although the court suggested that "collateral estoppel" could be applied to a claim dismissed without prejudice, the court did not cite to any authority and appeared to assume that the Second Circuit's mandate only applied to claim preclusion. But there is no compelling reason to treat issue preclusion differently than claim preclusion. To do so would allow a dismissal "without prejudice" to prejudice the Plaintiff, contravening Second Circuit law.

[3] Notably, the *UnitedHealth* court dismissed some counts with prejudice, further supporting the conclusion that its dismissal of the other counts was not intended to have a preclusive effect. *See Raine v. Paramount Pictures Corp.,* 1998 WL 655545, at *8 (S.D.N.Y. Sept. 24, 1998) ("[T]hat a court explicitly dismisses an action 'without prejudice'—or, as in this case, explicitly declines to dismiss it 'with prejudice'— surely indicates a refusal to rule upon the merits of those causes of action . . . ."); *id*. at *9 ("In sum, the 'without prejudice' dismissal of the [first action] has ***no preclusive effect*** on [plaintiff]'s present lawsuit." (emphasis added)).

F.3d 26, 37 (2d Cir. 2005) (quoting *Commissioner v. Sunnen*, 333 U.S. 591, 599-600 (1948)); *see also Indagro, S.A. v. Bauche, S.A.,* 652 F. Supp. 2d 482, 486-87 (S.D.N.Y 2009) (the actions must "present the same material facts."). Because the numerous new alleged material facts and legal theories against a different set of defendants cure the deficiencies discussed in *UnitedHealth*, there is no issue preclusion.

III. PLAINTIFF'S CONTROLLING PLAN LANGUAGE

This case raises a single issue of Plan interpretation: can Plaintiff's cost-share (*i.e.*, copayment) for a prescription drug exceed the amount the pharmacy agreed to accept? Defendants argue that it can, and that they are allowed to pocket the excess amount. Mohr contends that her cost-share for prescription drugs cannot exceed the amount the pharmacy agreed to accept. ¶¶ 52–61.[4] Mohr's 2011-13 Plans provide that Mohr "will not be responsible for any amount billed in excess of the contracted fee for the Covered Service" (*i.e.*, the amount the pharmacy agreed to accept)[5]; and her 2014-16 Plans provide that "when the Allowed Amount for a service (*i.e.*, the amount the pharmacy agreed to accept) is less than the Copayment, you are responsible for the lesser amount." These unambiguous Plan provisions (among others) led the Minnesota court to assume that Mohr's interpretation of the relevant plan language is correct.[6]

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[4] Paragraphs in the Amended Complaint (ECF 47) ("Complaint") are cited as "¶ __."

[5] Although UnitedHealth and Oxford use the term "discounted rate" as a short-hand term, in fact, Plaintiff alleges that she is entitled to the rate provided for by her Plans. The Plans do not refer to any "discounts."

[6] ERISA "Plans" consist at a minimum of Mohr's Certificate of Coverage, the Member Handbook, the Summary of Benefits and the applicable riders. "[T]he relevant ERISA provisions do not restrict the number or the kinds of documents that can constitute a written plan." *Palmiotti v. Metlife,* 423 F. Supp. 2d 288, 299 (S.D.N.Y. 2006) (citations omitted); *see also Silverman v. Teamsters Loc. 210 Aff. Health and Ins. Fund*, 761 F.3d 277, 286 (2d Cir. 2014) ("ERISA itself does not make plain where one looks to find the 'terms' of an ERISA plan, other than to mandate that '[e]very employee benefit plan shall be established and maintained pursuant to a written instrument.'"). A recent case against Oxford similarly held that "[t]he documents referred to as 'the Plan' include the Member Handbook and . . . Certificate of Coverage, which provide the details of Plaintiff's coverage." *S.M. v. Oxford Health Plans (N.Y.), Inc.*, 94 F. Supp. 3d 481, 490 (S.D.N.Y. 2015), *aff'd* 644 F. App'x 81 (2d Cir. 2016). Indeed, the Plans' "Welcome!" refer participants to all of those documents to "help you understand your coverage, your rights as a Member, and your responsibilities." MTD Ex. 1 at 24*; see also* MTD Ex. 4 at 3 (referencing Certificate of Coverage and Summary of Benefits) and 121 (referencing Handbook). **Note:** citations to specific pages in Defendants' Exhibits ("MTD Ex. __") use the bolded pages numbers found at the bottom right each page.

Specifically, the Minnesota court refrained from deciding the meaning of Mohr's plan language, stating, "the Court will assume, without deciding, that [Mohr] may be entitled to the discounted rate under the terms of her plans for 2011 to 2013," and "[f]or present purposes, the Court assumes that Mohr's 2014 plan entitled her to the discounted rate if it was less than the listed copayment amounts," *UnitedHealth,* 2017 WL 6512222 at *3, 4. *See also id.* at *8 n.10 ("Having decided that exhaustion by . . . Mohr . . . is required, ***the Court need not address the other arguments raised with respect to Count I***." (emphasis added)). Because the court "assumed" its conclusion rather than "deciding" it, the issue of whether Mohr's plan language entitles her to a discounted rate is not precluded. *See Ball v. A.O. Smith Corp*., 451 F.3d 66, 69 (2d Cir. 2006).

The Complaint alleges that Mohr is entitled to the rate Defendants negotiated with their network pharmacies. ¶¶ 52-61. Under her 2011-13 Plans, Mohr pays "the costs outlined in [her] Summary of Benefits." ¶ 53. Specifically, she pays the "Out-of-Pocket Expense" for outpatient prescription drugs (the "applicable Copayment, Deductibles and Coinsurance") and is specifically directed to "see your Summary of Benefits for the Out-of-Pocket Expenses required." ¶¶ 52-54; MTD Ex. 1 at 134[7]; *see also* "How Covered Services Are Reimbursed," MTD Ex. 1 at 55. The "Summary of Benefits" expressly lists "Outpatient Prescription Drugs" as "Covered Services" and lists maximum fixed-dollar "Copayments." ¶ 55; MTD Ex. 1 at 12. Plaintiff's responsibility to pay for any "In-Network" "Covered Services," including "Outpatient Prescription Drugs," is expressly limited to Defendants' contracted fee with the Network Provider, here the in-network pharmacy. Thus Plaintiff's cost-share cannot exceed that contracted fee.

[7] The Prescription Drug Rider specifically directs Plan participants to refer to other sections of the Plan for the definitions of capitalized words. MTD Ex. 1 at 134.

> **Your Financial Responsibility For In-Network Benefits**
>
> In-Network benefits are typically provided through arrangements with Network Providers. Network Providers have agreed to accept our contracted fees as payment in full for Covered Services. 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.

Id. at ¶¶ 56-57 (highlighting added); MTD Ex. 1 at 56. *See UnitedHealth*, 2017 WL 6512222 at *3-4 (citing this Member Handbook language as ECF 98-7 at 55).

Defendants' claim that Mohr is not entitled to the contracted fee because the '[t]he definition of 'Network Providers' does ***not*** include pharmacies." MTD at 3 n.4 (emphasis in original). They are wrong because the Plan defines a "Network Provider" as follows:

> **Network Provider:** 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. A list of Network Providers and their locations is available to you upon enrollment or upon request. The list will be revised from time to time by Us.

MTD Ex. 1 at 105 (highlighting added). Pharmacists are licensed in New York and New York law governs the Plan. N.Y. Educ. Law §§ 6501, 6800 *et seq*. (McKinney); MTD Ex. 1 at 103. Moreover, the Plan "Overview of ***Provider*** Reimbursement Methodologies," MTD Ex. 1 at 124-25 (emphasis added), contradicts Defendants' argument. That section states that "Oxford pays ***Network Providers*** on a fee-for-service basis" and then lists the types of "providers" that it reimburses, including physicians, hospitals and other facilities, labs, radiologists ***and pharmacies***. *Id.* (emphasis added). Accordingly, Defendants cannot reasonably claim that pharmacies are not "Network Providers."

The 2014-16 Plans likewise limit Mohr's cost-sharing to the contracted rate with the pharmacy. The capitalized term "Cost-Sharing" is used but not defined in the Plan's "Covered Services" section, which includes pharmacy benefits. ¶¶ 58-61; *see, e.g.,* MTD Ex. 4 at 42, 65-74. "Cost-sharing" is defined in the "Cost-Sharing" section, which provides for "Copayments" as "Cost-Sharing." ¶ 59; *see, e.g.*, MTD Ex. 4 at 26, 19. The Plan expressly limits "Copayments" to

the "Allowed Amount." *See, e.g.*, MTD Ex. 4 at 26, 19, 37. "Allowed Amount" is defined as the "maximum amount we will pay to a provider for the services or supplies covered under this Certificate," and it is "the amount [Defendants] negotiated with the Participating Provider." ¶ 59-60; *see, e.g.*, MTD Ex. 4 at 37-38. The Plan further states that "when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount." ¶ 59; *see, e.g.*, MTD Ex. 4 at 37. The *UnitedHealth* court relied on this unambiguous language in assuming that Mohr was entitled to the "discounted rate." *UnitedHealth,* 2017 WL 6512222 at *3-4.

Defendants wrongly claim that "the term 'Allowed Amount' is used for medical benefits and in reference to the defined term 'Provider,' which does not include a pharmacy." MTD at 3-4 n. 5. But "Allowed Amount" is not restricted to "medical benefits." *See, e.g.*, MTD Ex. 4 at 26. To the contrary, "Allowed Amount" expressly applies to all "services or supplies covered under this Certificate [of Coverage]," which obviously includes prescription drugs under the Plans. *See, e.g.*, *id*. at 22, 24, 42 and 65-74. Additionally, contrary to Defendants' argument that "the defined term 'Provider' . . . does not include a pharmacy," a "Provider" includes any "Health Care Professional," which, in turn, specifically incorporates the licensed professions in "Title 8 of the Education Law" of New York and ***includes pharmacies***. MTD Ex. 4 at 31, 28; N.Y. Educ. Law §§ 6501, 6800 *et seq*. Moreover, like the 2011-13 Plans, the 2014-16 Plans define "Network Provider" to specifically include a "Pharmacy." MTD Ex. 4 at 120-21.

Finally, the interpretation that in-network pharmacies are "Network Providers" and "Providers" is further bolstered by (1) the Plans' "Summary of Benefits" sections, which describe pharmacies as "In-Network" and "Participating" with regard to the "Covered Services" of "Prescription Drugs" and (2) the fact that the Plans do not provide ***any*** coverage for prescriptions obtained from a non-network pharmacy. *See, e.g.*, MTD Ex. 1 at 12 and Ex. 4 at 19.

Both sets of Plans provide that when a participant goes to a ***non-***network pharmacy:

> 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.

See, e.g., MTD Ex. 1 at 134 and Ex. 4 at 67. The necessary corollary is that if a covered prescription drug is obtained from an in-network pharmacy, Defendants' "contracted rates" will be available. If that were not the case, the exclusion of "Our contracted rates (Our Prescription Drug Cost)" for non-network purchases would be irrelevant.

IV. PLAINTIFF HAS STATED ERISA CLAIMS (COUNTS I-VI)

A. Defendants cannot meet their burden of proving failure to exhaust (Count I).[8]

Defendants argue that the issue of whether Plaintiff must exhaust Count I is precluded. MTD at 6–7. But controlling facts have changed because Plaintiff has alleged a substantial number of new material facts that were not alleged in *UnitedHealth* concerning Defendants' failure to follow reasonable claim procedures and the systematic denials of claims and grievances. Compare ¶¶ 140-164 with *UnitedHealth* Complaint ¶¶ 192-200. Since the *UnitedHealth* ruling, Plaintiff filed a grievance and Defendants failed to properly and timely respond pursuant to their own procedures. *See Criales v. Am. Airlines, Inc.*, 105 F.3d 93, 95 (2d Cir. 1997).

In analyzing these new facts, the Court should consider three overriding principles. First, a participant must exhaust "only those administrative appeals provided for in the relevant plan or policy." *Kirkendall v. Halliburton, Inc.*, 707 F.3d 173, 179 (2d Cir. 2013) (citing *Kennedy v. Empire Blue Cross & Blue Shield*, 989 F.2d 588, 594 (2d Cir. 1993)). Second, plan 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."

[8] As admitted by Oxford, the issue of exhaustion applies only to Count I. See MTD at 13.

Kirkendall, 707 F.3d at 181; *Negron v. Cigna Health and Life Ins.,* 300 F. Supp. 3d 341, 352 (D. Conn. 2018) ("'ERISA seeks to avoid saddling plaintiffs in such circumstances with the burdens and procedural delays imposed by inartfully drafted plan terms.'" (quoting *Kirkendall*, 707 F.3d at 181)). Third, exhaustion is an affirmative defense and Defendants have the burden of proof. *See Halo v. Yale Health Plan, Director of Benefits & Records Yale Univ.*, 819 F.3d 42, 57 (2016); *Negron*, 300 F. Supp. 3d at 352.

1. Mohr is "deemed to have exhausted her administrative remedies"

Based on the new facts alleged in the Complaint, Plaintiff is deemed to have exhausted because Defendants have not met their burden of proving that they established and followed reasonable claim procedures under governing Department of Labor ("DOL") Regulations and the Plans. Complaint ¶¶ 154-160. DOL Rule 503-1 sets forth the minimum requirements for claims for benefits, which it defines broadly as any "request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims." 29 C.F.R. § 2560.503-1(e) ("Rule 503-1"). A claim for benefits includes both pre-service and post-service claims. *Id*. If a plan fails "to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim." Rule 503-1(l)(1). Here, Defendants failed to comply with these Regulations in at least three ways.

First, Defendants failed to provide any, much less a detailed, notice of any denial of a claim as required by Rule 503-1(g). Plaintiff's claim for benefits was filed by the network pharmacy when she received her prescription drugs. ¶¶ 41, 70, 145. Assuming there was a denial of benefits, which, as discussed below, there was not, Rule 503-1(g) requires notice of (1) specific

facts concerning the reason for the denial, (2) reference to the plan provisions on which the determination was based, and (3) a description of the review procedures and the rules relied upon in making the determination. Rule 503-1(g). *See Halo,* 819 F.3d at 46. The most Plaintiff received when she received her prescription drugs was a piece of paper stapled to a pharmacy bag that stated only the amount of the cost share (but concealed the fact that there was an Overcharge). ¶ 158. That "notice" does not meet any of the requirements of the Regulation and it renders the exhaustion defense invalid. *Burke v. Kodak Ret. Income Plan*, 336 F.3d 103, 107-08 (2d Cir. 2003).[9] "[A]t a minimum, plaintiffs have plausibly alleged that they did not receive notice of an adverse benefit determination that complies with the DOL regulation" and "Defendants have failed to prove as a matter of law that plaintiffs' claims are barred due to failure to satisfy their administrative remedies." *Negron*, 300 F. Supp. 3d at 355. Accordingly, Plaintiff is deemed to have exhausted at the time she received her prescription drugs. *Id.*

Second, Plaintiff is deemed to have exhausted because—although the pharmacy had the amount of the Overcharges on its computer screen at the time Plaintiff submitted her prescriptions to be filled—Defendants prohibited the pharmacy from disclosing this material information to Plaintiff. ¶¶ 70(c), 70(d), 159. By blocking disclosure of the Overcharges, Defendants' procedures unduly inhibited and hampered the initiation of claims in violation of Rule 503-1(b)(3). Accordingly, for this additional reason, Plaintiff is deemed to have exhausted

[9] Many courts have held that such a failure to provide the mandated notice excused the exhaustion requirement. For example, in *Corsini v. United Healthcare Corp.*, 965 F. Supp. 265 (D.R.I. 1997), plaintiffs alleged that their copayments should have been reduced by pharmacy discounts. The court held that "even if the co-payment claim is regarded as a claim for 'benefits,'" in the absence of notice of a denial, the exhaustion requirement would not apply. *Id*. at 269. "Because the exhaustion requirement rests on the assumption that notice of denial has been provided, a fiduciary who has not provided notice that benefits have been denied is foreclosed from insisting upon exhaustion of administrative remedies." *Id*.; *see also, e.g*., *In re Blue Cross of W. Pennsylvania Litig.*, 942 F. Supp. 1061, 1064 (W.D. Pa. 1996) (exhaustion requirement does not apply where defendant fails to inform plan participant of a denial of benefits); *Smith v. United HealthCare Services, Inc*., 2000 WL 1198418 *4 (D. Minn. 2000) (exhaustion doctrine does not apply unless defendant establishes that it provided notice explaining why benefits were denied).

at the time her prescriptions were filled. *Negron*, 300 F. Supp. 3d at 354-55.

Third, Plaintiff is deemed to have exhausted because Defendants failed to follow their own claims procedures. Rule 503-1 requires plans to establish—***and follow***—reasonable procedures governing the notification of appeals of adverse benefit determinations. Plaintiff filed a grievance on April 26, 2018 (Pl. Ex. A),[10] after Defendants filed their motion to dismiss.[11] Plaintiff's 2014 (and later) Plans require the Plan to decide and notify the Plaintiff of the results of a pre-service grievance within 15 days (here, by May 11, 2018). *See, e.g.*, Def. Ex. 4 at 83. Because Defendants May 25 response missed this deadline (Pl. Ex. B), Plaintiff should be deemed to have exhausted her administrative remedies. ¶¶ 155-57.

Defendants attempt to avoid their failure to follow the Plans' procedures by arguing that Plaintiff's claim is "post-service" rather than "pre-service" and thus a response was not due for 30 days. MTD at 15. But a "pre-service claim" is clearly defined as "a request that a service or treatment be approved before it has been received."[12] This is precisely what happens when an in-network pharmacy submits a claim before dispensing drugs. ¶¶ 41, 70, 144-145, 155-157. Had Plaintiff's claims not been approved, she would not have received her drugs, and Defendants would have been required to send her notice of an adverse benefit determination, which they did not do. Moreover, that Defendants treat such in-network pharmacy claims as pre-service claims is demonstrated by letters sent to plaintiffs in *UnitedHealth*, which described the relevant claims as pre-service. *See* Pre-Service Letters, Pl. Ex. C. They cannot change course now.

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[10] Plaintiff's exhibits, cited herein as "Pl. Ex. __," are attached to the Declaration of Craig A. Raabe filed herewith.

[11] In her grievance letter, Plaintiffs expressly reserved all of her rights. *Id.* ("While reserving all rights to dispute that the exhaustion doctrine even applies, we are filing this Grievance with the expectation that your clients will continue in their denial of any liability for collecting 'spread.'")

[12] ECF 31-1 at 521 at 1263. Because the pharmacy submits the claim for benefits before the prescription drugs are received by the patient (¶¶ 41, 155-156) and the claim and cost-sharing payment are approved before the drugs are dispensed, Plaintiff's claims are "pre-service."

Perhaps recognizing this error, Defendants now reframe Plaintiff's pre-service claims by saying she is "seeking reimbursement for prior purchases." MTD at 15. This is wrong because under her Plans, Plaintiff was required to pay 100% of the price for the drugs at issue. Because she is not entitled to any "reimbursement" for her purchases, she is only seeking damages for the Overcharge. Similarly, Defendants call this a "post-service claim seeking benefits after the prescription was purchased." MTD at 15. This excuse fails because, as discussed below, this case does not concern a claim for benefits because Plaintiff *received her benefits in full*—which Defendants themselves acknowledge. MTD at 14 (noting that the "regulations do not treat a participant's submission of a prescription to a pharmacy as a claim for benefits subject to the claims procedure rules"). Similarly, Defendants' response to Plaintiff's grievance was wrongly titled "Notice of Adverse Benefit Determination" and misleadingly refers to Plaintiff's grievance as a request for benefits. But, since Plaintiff received her benefits in full, Defendants cannot recharacterize Plaintiff's grievance as the claim for benefits.[13]

2. Exhaustion does not apply

Even if Plaintiff is not deemed to have exhausted, the exhaustion affirmative defense does not apply because the Plan procedures do not apply to the Overcharge claims in this case.

2011-13 Plans. The 2011-13 Plans contain a provision entitled "Legal Action," which contains no limitation based on administrative procedures, stating that "no action at law or in equity may be maintained against Us for any expense or bill unless brought within the statute of limitations for such cause."[14] Since "plan participants will not be required to exhaust

[13] Contrary to Defendants' argument, a grievance is a ***not*** "post-service claim." MTD. at 15. A "grievance" is submitted in response to Defendants' claim determination. *See, e.g.*, 2014 Plan, ECF 52-1 at 823 of 1273 ("If You disagree with Our claim determination You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate."). Accordingly, the "claim" necessarily precedes the "grievance," and a "grievance" is a challenge to a decision on a claim. Here, the grievance was submitted on a pre-service claim.

[14] 2011 Plan, MTD Ex. 1 at 103; 2012 Plan, MTD Ex. 2 at 101; 2013 Plan, MTD Ex. 3 at 101.

administrative remedies where they reasonably interpret the plan terms not to require exhaustion and do not exhaust their administrative remedies as a result," *Kirkendall*, 707 F.3d at 181, Plaintiffs were not required to exhaust under this Plan language.

Furthermore, the Grievance and Appeal Procedure Defendants focus on is limited solely to Adverse Determinations. The Plans state, "The Grievance and Appeal procedure is a procedure to be used after you have received an initial Adverse Determination concerning a claim for benefits or an administrative issue."[15] The Plans define "Adverse Determination" as "Our determination that an admission, extension of stay, or other Health Care Service, is not Medically Necessary based on a review of the information provided. Additionally, an Adverse Determination will be rendered if We do not receive a response to Our request for information necessary to review your case."[16] Since this case does not concern either whether healthcare is "Medically Necessary" or any "request for information," Plaintiff reasonably interpreted the Grievance and Appeal Procedure to not apply. Accordingly, this Court should "find that plaintiff[] ha[s] plausibly stated that the plan terms do not set forth administrative procedures that unambiguously address [her] claims of being overcharged for prescription drugs." *Negron*, 300 F. Supp. 3d at 352; *see also id*. at 353-54.

Moreover, as the court noted in *UnitedHealth*, the Grievance and Appeal procedure is "designed for" "denials based on benefit exclusions or limitations and claims payment disputes." 2017 WL 6512222, at *7. In comparison to the *UnitedHealth* complaint, the Complaint here contains numerous new detailed factual allegations demonstrating that this case does not concern any benefit denial or claims payment dispute. As Defendants admit, the Grievance and Appeal

[15] 2011 Plan, MTD Ex. 1 at 48; 2012 Plan, MTD Ex. 2 at 46; 2013 Plan, MTD Ex. 3 at 46.

[16] 2011 Plan, MTD Ex. 1 at 41; 2012 Plan, MTD Ex. 2 at 39; 2013 Plan, MTD Ex. 3 at 39. Although this definition of Adverse Determination is found in the Utilization Review Appeals section, it is the only definition of this term in the Plans.

Procedure applies where "benefits were wrongfully denied." MTD at 13; *see also id*. at 15 (procedures allow presentation of "any disputes she may have regarding her prescription drug benefits"). *Compare* Complaint ¶¶ 140-153 *with UnitedHealth* Complaint ¶¶ 193-200. Specifically, once the pharmacy collected the cost-sharing payments and dispensed the drugs, Plaintiff had received her prescriptions and had received her benefits in full. Since the benefits had been received and the benefit claim had been paid in full, this case does not concern a denial of benefits or payment of a claim; this case concerns an unlawful Overcharge. ¶¶ 41, 145. *See Smith,* 2000 WL 1198418 at *4 (D. Minn. 2000) (in suit against Oxford's parent company, court held: "the exhaustion policy does not apply here because Smith was never denied a benefit by UHC. Smith was given his prescription medications upon request, just not at the promised premium cost.").[17] Since Plaintiff has received her benefits in full, Defendants' argument that "the administrative review process allows Mohr to file a claim with Oxford for benefits due" is irrelevant. MTD at 13. *See Negron*, 300 F. Supp. 3d at 353-54.

2014-16 Plans. The "Time to Sue" provisions in the 2014-16 Plans contain no limitation based on exhaustion of administrative remedies, stating that that "no action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within 3 years from the date the claim was required to be filed." ¶ 147. Because the pharmacy electronically submitted the written claim to Defendants (¶¶ 144-147) more than sixty days ago, this sole pre-suit requirement has been met. Specifically, the Plan provides that when participants use a participating provider, they need not submit a claim form.

[17] The Plans provide for a complaint procedure. *See, e.g.*, MTD Ex. 1 at 50-52. As with grievances, the complaint appeal procedures only apply where there is an "Adverse Determination." MTD Ex. 1 at 51-52. Since there has been no Adverse Determination, these procedures do not apply.

¶ 144. Instead, the pharmacy submits the claim to Defendants through an online adjudication system at the point of sale. ¶¶ 41, 70, 144-147.

Defendants claim that "the regulations do not treat a participant's submission of a prescription to a pharmacy as a claim for benefits subject to the claim procedure rules." MTD at 14. But Plaintiffs do not allege submission of a prescription **by the patient to a pharmacy** is a claim for benefits. Rather, the claim for benefits is made **by the in-network pharmacy to the Defendants** through an online claim adjudication system. ¶¶ 41, 70, 145. Moreover, the Regulation itself is clear: a claim for benefits is broadly defined as any "request for a plan benefit or benefits made by a claimant in accordance with ***a plan's*** reasonable procedure for filing benefit claims." Rule 503-1(e) (emphasis added). Under Plaintiff's Plan, the claim for benefits is the request sent by the in-network pharmacy. While the Regulation may not have required this claim submission procedure, it does require compliance with the procedures established by Defendants and, thus, Defendants are bound by their decision.

3. Mohr's second-level appeal would be futile

Futility is the third independent reason Plaintiff was not required to exhaust. "The exhaustion requirement . . . is not absolute." *Kirkendall*, 707 F.3d at 179. Plaintiffs are not required "to exhaust their administrative remedies where they 'make a clear and positive showing that pursuing available administrative remedies would be futile."' *Id.* (quoting *Kennedy*, 989 F.2d at 594). Defendants only point to the *UnitedHealth* decision, but the Complaint here contains additional factual allegations in support of futility (*see, e.g.*, ¶¶ 161-164). Similar allegations of a "fixed company-wide policy" to not pay benefits have been found to overcome the failure-to-exhaust affirmative defense on a motion to dismiss. *See, e.g., Peck v. Aetna Life Ins. Co.*, 2005 WL 1683491, at *3 (D. Conn. July 19, 2005); *Am. Med. Ass'n v. United Healthcare Corp.*, 2002 WL 31413668, at *5 (S.D.N.Y. Oct. 23, 2002). Plaintiff alleges a far more brazen company-wide

policy than in *Peck*, and thus has plausibly alleged a "clear and positive showing" of futility. Moreover, because all administrative appeals are handled by Defendants' outside counsel in this action (Pl. Ex. B), there is little reason to believe that an appeal would lead to a different result.[18]

B. Defendants are fiduciaries and breached their ERISA duties (Count IV)

The duties charged to ERISA fiduciaries are "the highest known to the law." *Donovan v. Bierwirth*, 680 F.2d 263, 272 n.8 (2d Cir. 1982).

1. Defendants are fiduciaries

Defendants are fiduciaries for many reasons.[19] *See* ¶ 100. ***First***, unlike in *UnitedHealth*, Plaintiff now alleges that Oxford was specifically granted discretionary authority concerning the computation of any and all payments under the Plans (¶¶ 98-99) and Oxford delegated this authority, at least in part, to Optum (¶¶ 40, 97, 103). An entity that has discretion to determine the amount of benefits due and payment of claims is a fiduciary. *Negron*, 300 F. Supp. 3d at 355-56 (citation omitted). To the extent that Oxford delegated the discretion to control pricing, Oxford assumed the duty to monitor the PBMs' exercise of that authority. ¶¶ 97, 103, 115, 120(p), 119. And to the extent there was an informal designation of authority to Optum, primary

[18] That outside counsel handles all grievances, and the denial of Plaintiff's grievance are material facts that were not before the Minnesota court in deciding whether the futility exception to the exhaustion requirement applied.

[19] "Congress intended that the term 'fiduciary' be broadly construed." *Negron*, 300 F. Supp. 3d at 355 (citing *LoPresti v. Terwilliger*, 126 F.3d 34, 40 (2d Cir. 1997)). Regardless of whether someone is named a fiduciary, a person is a functional fiduciary under ERISA if: (1) "he *exercises* any *discretionary* authority or discretionary control respecting management of such plan" *or* (2) he "*exercises any* authority or control respecting management or disposition of its assets," or (3) "he *has* any *discretionary* authority or discretionary responsibility in the administration of such plan." 29 U.S.C. § 1002(21)(A) (emphasis added). ERISA imposes "fiduciary status on those who exercise discretionary authority, regardless of whether such authority was ever granted" and "those individuals who have actually been granted discretionary authority, regardless of whether such authority is ever exercised." *Bouboulis v. Transport Workers Union of Am.*, 442 F.3d 55, 63 (2d Cir. 2006). An entity that exercises ***any*** "authority or control" over management or disposition of plan assets is a fiduciary regardless of whether such authority or control is "discretionary." *See, e.g.*, *Bd. of Trs. of Bricklayers*, 237 F.3d 270, 273 (3d Cir. 2001); *Leimkuehler v. Am. United Life Ins. Co.*, 713 F.3d 905, 912-13 (7th Cir. 2013).

[20] Oxford cannot contest that it is responsible for the acts of Optum and its other PBMs in that, at the very least, it had a duty to monitor them. *See., e.g.*, *Jackson v. Truck Drivers' Union Loc. 42 Health & Welfare Fund*, 933 F. Supp. 1124, 1141 (D. Mass. 1996); *In re Merck & Co., Inc. Sec., Derv. & ERISA Litig.*, 2006 WL 2050577 at *17 (D.N.J. 2006).

fiduciary responsibility remains with Oxford.

Second, irrespective of whether Defendants were granted fiduciary authority, they exercised discretionary authority or control over plan management by setting cost-sharing payments greater than allowed under the Plans and by requiring pharmacies to charge and collect Overcharges. ¶ 100. The Complaint contains numerous new allegations that cure the deficiencies identified in *UnitedHealth*. While *UnitedHealth* found that "Plaintiffs do not allege facts demonstrating that Defendants had discretion over the instantaneous calculations they were performing, except to the extent that Plaintiffs allege Defendants did not apply the correct calculations [by mistake]" (UnitedHealth, 2017 WL 6512222 at *9), the Amended Complaint contains numerous new factual allegations demonstrating that Defendants intentionally exercised discretion to overcharge participants. For example, Defendants used the Optum platforms to create and implement their unlawful Overcharge Scheme (¶ 71); exercised discretion to program and manipulate the service platforms, including inputting Overcharge data into the system, to violate the Plan's terms (*id.*; *see also* ¶ 100(b)); exercised discretion to manipulate the Optum systems to misrepresent to patients "Cost-Sharing Amounts (*e.g.*, copayment, coinsurance and deductible payments) that were inflated, false and in violation of the Plans (¶ 72); exercised discretion to require pharmacies to charge and collect Overcharges (¶ 73); and exercised discretion to violate the Plan terms and overcharge Plaintiffs. ¶ 100(a). *See generally* ¶ 100. Unlike in *UnitedHealth*, the Complaint here plausibly alleges that Defendants "have power to make decisions." *UnitedHealth,* 2017 WL 6512222 at *9.

In *Negron*, the court found that plaintiffs "have alleged that defendants' exercise of discretion violated the plan terms by instituting the charging of cost-sharing payments greater than the amount paid to the pharmacy" (emphasis in original), and "that plaintiffs have asserted a

plausible claim of fiduciary status based on defendants' exercise of discretion as to computation of benefits that violated the plan terms." *Negron*, 300 F. Supp. 3d at 356. *Negron* distinguished *UnitedHealth* as a case where plaintiffs alleged only ministerial acts. Because the allegations here are materially the same as the allegations in *Negron*, the Court should similarly find that the Complaint alleges that Defendants are fiduciaries

In *Everson v. Blue Cross & Blue Shield of Ohio*, 898 F. Supp. 532 (N.D. Ohio 1994), plaintiffs alleged that Blue Cross and Blue Shield of Ohio breached its fiduciary duties by forcing plaintiffs to pay excessive copayments. The plans limited copayments to 20% of the provider's reasonable charge, but Blue Cross charged 20% of the billed amount, which did not account for discounts. The court held that Blue Cross was a fiduciary in administering claims through "defendant's secret discount scheme" "which cause[d] insureds to overpay their contractual share of covered health expenses[.]" *Id*. at 539-40. Like *Negron* and *Everson,* Defendants exercised discretion to charge patients excessive cost-sharing payments through a secret scheme in violation of the Plans, and this Court should reach the same result.[21]

Express Scripts/Anthem ERISA Litig., 285 F. Supp. 3d 665, 679 (S.D.N.Y 2018), cited by Defendants, helps Plaintiffs. MTD at 18-19. The court dismissed the case because it concluded that (unlike here) the insurer followed the contract terms. *Id*. at 683–84 But it acknowledged that the result would have been different if the insurer misconstrued or interpreted the plans in a way that benefitted the insurer to the plaintiffs' detriment. *Id.* Plaintiff has alleged exactly that.

Trying to shoehorn this Complaint into *UnitedHealth*, Defendants misrepresent Plaintiff's

[21] *See also Sun Life Assur. Co. of Canada v. Diaz*, 2015 WL 1826088, at *3 (D. Conn. Apr. 22, 2015) (Bolden, J.) (defendants are fiduciaries because they have discretionary authority to determine "the amount of benefits due" and are "responsible for paying claims under the" plans); *Sixty-Five Security Plan v. Blue Cross and Blue Shield of Greater New York*, 583 F. Supp. 380, 387-88 (S.D.N.Y. 1984) (defendant was fiduciary because it had responsibility for implementing the computerized claims processing system and had total control over information pertinent to the health care program, which Defendants similarly had here concerning cost-sharing payments).

claims by arguing that negotiating and executing contracts with pharmacies are not fiduciary acts. *UnitedHealth,* 2017 WL 6512222 at *10. Plaintiff does not allege that Defendants are liable because of the amounts they agreed to pay the pharmacies. Rather, Defendants violated Plan terms by charging Plaintiff ***more*** than Defendants agreed to pay the pharmacies. Because Defendants' cited cases do not concern the violation of Plan terms but instead concern claims where Defendants acted *consistent* with the plans or merely implemented plan terms over which they had no discretion, they are irrelevant.[22] *See Negron*, 300 F. Supp. 3d at 359-60.

Third, Defendants exercised discretion to set and take their own compensation by dictating the amount of the Spread and taking Clawback compensation in violation of the Plans. *See, e.g.*, ¶¶ 100(c)-(f). In *Negron*, the court "[found] that plaintiffs have alleged that defendants acted as fiduciaries by dictating the amount of Spread to charge that would ultimately [be paid back] to compensate defendants." *Negron*, 300 F. Supp. 3d at 357. Because the allegations here are materially the same as *Negron*, the Court should also find that Defendants exercised discretion over factors that determined their compensation.[23] Because Defendants exercised discretion to

[22] *See, e.g.*, *Chicago Dist. Council of Carpenters Welfare Fund v. Caremark, Inc.*, 474 F.3d 463, 475 (7th Cir. 2007) ("Under any reading of the contracts, Caremark was not obliged to pass along all of the savings it negotiated with drug retailers."); *Moeckel v. Caremark, Inc*., 622 F. Supp. 2d 663, 680 (M.D. Tenn. 2007) ("Absent a provision in the governing documents requiring . . . Caremark to . . . to share the "spread" or other discounts, the court cannot impose a duty on Caremark to so act."); *Bickely v. Caremark, Rx, Inc.*, 361 F. Supp. 2d 1317, 1331 (N.D. Ala. 2004) (Defendant not fiduciary where explicitly allowed to receive rebates under agreement). *Pharm. Care Mgt. Assoc. v. Rowe*, 429 F.3d 294 (1st Cir. 2005), and *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997), concerned the preemption of state statutes concerning prescription drug sales. They had nothing to do with ERISA plans and, in particular, the duties of parties under those plans. In particular, the courts did not remotely consider anything like the administration of prescription drug plans or the specific terms of such plans as is the case here.

[23] Consistent with *Negron*, the Second Circuit has explained that "after a person has entered into an agreement with an ERISA-covered plan, the agreement may give it such control over factors that determine the actual amount of its compensation that the person thereby becomes an ERISA fiduciary with respect to that compensation." *F.H. Krear & Co. v. Nineteen Named Trustees*, 810 F.2d 1250, 1259 (2d Cir. 1987). *Accord United Teamster Fund v. MagnaCare Admin. Servs., LLC*, 39 F. Supp. 3d 461, 470-71 (S.D.N.Y. 2014) (allegation that service provider charged fees that were not expressly set by contract was sufficient to defeat a motion to dismiss); *Sixty–Five Security Plan v. Blue Cross & Blue Shield*, 583 F. Supp. 380, 387–88 (S.D.N.Y. 1984) (plaintiff stated claim that defendant breached its fiduciary duties where its fees were based on a percentage of claims paid and had complete discretion and control over what claims would be paid); *Golden Star, Inc. v. Mass Mut. Life Ins. Co*., 22 F. Supp. 3d 72, 81 (D. Mass. 2014) ("The caselaw is clear that a service provider's retention of discretion to set compensation

require "copayments or coinsurance outside of what was required by the plan documents," *UnitedHealth* does not apply. *UnitedHealth,* 2017 WL 6512222 at *9.

Fourth, Defendants wrongly claim that they are not fiduciaries for misrepresenting cost-sharing amounts because Plaintiff failed to comply with Rule 9(b). MTD at 27. But a fiduciary claim brought under ERISA should be pleaded under Rule 8(a) "regardless of whether the claims are based on an underlying fraud." *In re Morgan Stanley ERISA Litig.*, 696 F. Supp. 2d 345, 364 (S.D.N.Y. 2009).[24] Moreover, the Complaint easily satisfies the "who, what, when, where, and how" standard of Rule 9(b) by alleging, among other things, that Defendants manipulated the Optum systems to misrepresent to plan participants the "Cost-Sharing Amounts" (¶ 72); Defendants required the pharmacies (the who) to make these misrepresentations (*id.*); and Plaintiff went to BJ Drugs (the who) in Forest Hills, NY (the where) (¶ 284); the dates she was overcharged (the when) (¶ 283); and the copayment she was told to pay on each of those dates (the what) (*id.*). The Complaint also explains how these statements were false (the how).[25]

Fifth, Defendants are fiduciaries because they exercised authority or control over plan assets—namely, the ASO and insurance-policy contracts giving rise to the Overcharges. ¶¶ 101-

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can create fiduciary duties under ERISA with respect to its compensation."); *Glass Dimensions, Inc. v. State Street Bank & Trust Co.*, 931 F. Supp. 2d 296, 304 (D. Mass. 2013) (same).

[24] The duty to tell participants the truth is well-settled and flows from the duty of loyalty. "ERISA requires a 'fiduciary' to 'discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries.'" *Varity Corp. v. Howe*, 516 U.S. 489, 506 (1996) (quoting ERISA § 404(a)). To knowingly participate in deceiving participants to reap secret profits at the participants' expense is not to act "solely in the interest of the participants and beneficiaries." *See id*. Put more simply: "[l]ying is inconsistent with the duty of loyalty owed by all fiduciaries and codified in section 404(a)(1) of ERISA." In *McConocha v. Blue Cross and Blue Shield of Ohio*, 898 F. Supp. 545 (N.D. Ohio 1995), the court considered "whether defendant breached a duty to plaintiffs by not informing them of its practice of computing copayments before applying the discounts to the hospital charges." *Id.* at 550 (citation omitted). The court held that a "fiduciary may not materially mislead those to whom the duties of loyalty and prudence are owed," must "inform participants of existing benefits . . . and not affirmatively misrepresent potential benefits. *Id.* at 551 (citation omitted).

[25] Defendants argue that the truth would be no benefit to participants. MTD at 19 n.20. But the truth would have prevented Defendants from engaging in this massive Overcharge scheme and saved participants money.

102. *Negron*, 300 F. Supp. 3d at 358.[26] In *Everson*, 898 F. Supp. 532, the court determined that plaintiffs' group health insurance policy was a plan asset, and defendant wrongfully profited from the misuse of that plan asset. *Id.* at 540. Defendants here are similarly misusing the ASO agreements and health insurance policies, which are plan assets, to implement and profit from their illegal Spread scheme. Accordingly, Defendants exercised authority and control over plan assets. *See also* 29 U.S.C. § 1103 (recognizing insurance policies are plan assets).[27]

In *UnitedHealth*, the court stated that Mohr did not allege how Defendants leveraged these contracts at the expense of insureds or the Plans. *UnitedHealth,* 2017 WL 6512222 at *11. Here, like in *Negron*, Plaintiff now allege that Defendants used the agreements for their benefit to execute their Overcharge scheme in violation of the Plans. ¶ 102; *see Negron*, 300 F. Supp. 3d at 358. Accordingly, like in *Negron*, the Court should find that Plaintiffs have plausibly pleaded fiduciary status by alleging that "defendants have exerted their discretionary control, albeit allegedly unauthorized, over the agreements to impose the Spread and Clawbacks that resulted in the inflated prescription . . . charges." *Id*. at 358-59.[28]

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[26] "ERISA does not expressly define the term 'assets of the plan.'" *Acosta v. Pac. Enterprises*, 950 F.2d 611, 620 (9th Cir. 1991), as amended on reh'g (Jan. 23, 1992). In interpreting the meaning of this term, courts consider "whether the item in question may be used to the benefit (financial or otherwise) of the fiduciary at the expense of plan participants or beneficiaries." *Id. Accord Grindstaff v. Green*, 133 F.3d 416, 432 (6th Cir. 1998); *Metzler v. Solidarity of Labor Organizations Health & Welfare Fund*, 1998 WL 477964, at *7 (S.D.N.Y. Aug. 14, 1998), *aff'd sub nom. Herman v. Goldstein*, 224 F.3d 128 (2d Cir. 2000).

[27] Defendants claim that Mohr lacks standing to represent a class that includes participants in coinsurance plans. *See* MTD at 19. The Second Circuit, however, has explained that the standard for class standing is different than the standard for Article III standing. "[A] plaintiff has class standing if he plausibly alleges (1) that he personally has suffered some actual . . . injury as a result of the putatively illegal conduct of the defendant and (2) that such conduct implicates **the same set of concerns** as the conduct alleged to have caused injury to other members of the putative class by the same defendants." *NECA-IBEW Health & Welfare Fund v. Goldman Sachs & Co.*, 693 F.3d 145, 162 (2012) (emphasis added). Here, the **same** conduct has caused harm to participants in both copayment and coinsurance plans and thus Plaintiff has class standing to represent participants in coinsurance plans. The fact that payments under coinsurance Plans were not "clawed back" is irrelevant because coinsurance participants are still overcharged and Defendants still profit from the scheme. MTD at 19. Defendants profit from Overcharges under coinsurance Plans because they pay less than they should have (for example, under a 20% coinsurance plan where a participant is overcharged, and thus effectively pays more than 20%, the insurer will profit by paying less than 80%.

[28] *See also Trustees of Laborers' Local No. 72 Pension Fund v. Nationwide Life Ins. Co.*, 783 F. Supp. 899, 902 (D.N.J. 1992); *Fechter v. Connecticut Gen. Life Ins. Co.*, 800 F. Supp. 182, 200 (E.D. Pa. 1992); *Eversole v.*

2. Defendants breached their fiduciary duties[29]

While Defendants argue that they were not fiduciaries, they do not raise any substantive arguments that they did not breach fiduciary duties,[30] and they therefore concede these allegations. Defendants breached their fiduciary duties in at least 16 ways. *See* ¶ 118; ERISA § 404. As the Court held in *Negron*, by charging excessive cost-sharing payments, Defendants violated the express language of the plans and, therefore, breached their fiduciary duties. *Negron*, 300 F. Supp. 3d at 358; *see also Dardaganis v. Grace Capital Inc*., 889 F.2d 1237, 1242 (2d Cir. 1989).[31] Here, "the complaint implicates plausible breach of fiduciary duties, including the duty based on the fiduciary's profiting from imposing Spread and taking Clawbacks . . . ; and the duty not to misrepresent that the actual practices of the cost-sharing payments for prescription drugs differ from the plan terms." *Negron*, 300 F. Supp. 3d at 361. This is not a "good faith dispute over plan language," where "any claim for benefits" would be a breach of fiduciary duty. MTD at 22. Plaintiff does not allege "incorrect or mistaken calculations." Rather, Defendants "violated the plan terms by instituting the charging of cost-sharing payments greater than the amount paid to the pharmacy." *Negron*, 300 F. Supp. 3d at 356 (emphasis in original). And, it is a scheme that UnitedHealth unsuccessfully tried once before. *Smith v. United Healthcare Services, Inc.,* 2003 WL 22047861 (D. Minn. Aug. 28, 2003).

C. Defendants engaged in prohibited transactions (Counts II and III)

Like in *Negron*, Plaintiff here plausibly alleges that Defendants engaged in transactions

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Metropolitan Life Insurance Co., 500 F. Supp. 1162, 1165 (C.D. Cal. 1980).

[29] The Amended Complaint contains numerous additional allegations concerning fiduciary breaches than the *UnitedHealth* Complaint. *See, e.g*., ¶¶ 118(d), (e), (f), (g), (h), (i), (l), (m), 119.

[30] While Defendants attempt to rely on the *UnitedHealth* decision, the complaint here is materially different.

[31] *See also Piacente v. Intl. Union of Bricklayers & Allied Craftworkers*, 2015 WL 5730095, at *23 (S.D.N.Y. Sept. 30, 2015) (finding that defendant violated "the clear directive of § 1104(a)(1)(D) to act 'in accordance with the documents and instruments governing the plan,'" and granting summary judgment as to liability).

prohibited by ERISA § 406.[32] Defendants argue only that Plaintiff has failed to allege Defendants used plan assets for their benefit. MTD at 22-23. Contrary to Defendants' assertion that all prohibited transaction rules concern plan assets (*id.* at 23), violations of ERISA § 406(a)(1)(C) and § 406(b)(2) do not. Accordingly, Defendants concede allegations concerning these claims and have raised no element-related basis to seek their dismissal. The remaining prohibited transaction claims concerning plan assets are discussed above at 19-20.[33] *See Negron*, 300 F. Supp. 3d at 359-61.

D. Plaintiff's ERISA § 502(a)(3) claims are proper (Count VI)

Defendants argue Plaintiff's claims are solely for benefits allegedly due and she is limited to the remedy available under ERISA § 502(a)(1)(B) and may not bring claims under ERISA § 502(a)(3). MTD at 23-24. But, because Plaintiff has already received her benefits (as discussed above at 13), Plaintiff's § 502(a)(1)(B) claim seeks only to enforce her rights and clarify her future rights under the plans. ¶ 170. *Negro*n, 300 F. Supp. 3d at 350, 352. By contrast, Counts II-VII seek *equitable* relief under § 502(a)(3), including, *inter alia*, disgorgement of profits not available under a claim for benefits § 502(a)(1)(B), for breach of fiduciary duty and prohibited transactions. *See* ¶¶ 183, 193, 205, 212, 221 and 226.

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[32] ERISA § 406 supplements an ERISA fiduciary's general duties under ERISA § 404 "by categorically barring certain transactions likely to injure the pension plan." *Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc*., 530 U.S. 238, 241-42 (2002). To enhance protections for plan beneficiaries, Congress enacted *per se* prohibitions against certain transactions. *See* 29 U.S.C. § 1106; *C.I.R. v. Keystone Consol. Indus., Inc.*, 508 U.S. 152, 160 (1993); *Henry v. Champlain Enters., Inc.*, 445 F.3d 610, 618 (2d Cir. 2006). Although ERISA provides for exemptions from § 406(a), strict adherence to the conditions and requirements of the exemptions ensures that Congress' goal of preventing abuse is not undermined. *See, e.g.*, *Howard v. Shay*, 100 F.3d 1484, 1488 (9th Cir. 1996); *Reich v. Hall Holding Co*., 990 F. Supp. 955, 966-67 (N.D. Ohio 1998), *aff'd* 285 F.3d 415 (6th Cir. 2002). The exemptions are affirmative defenses that the defendant must prove. *Lowen v. Tower Asset Mgmt., Inc*., 829 F.2d 1209, 1213, 1215 (2d Cir. 1987). ERISA does not provide any exemptions from the relevant portions of § 406(b).

[33] Defendants cite *Alves v. Harvard Pilgrim Healthcare, Inc.,* 204 F. Supp. 2d 198 (D. Mass. 2002). MTD at 23. Although that case concerned a claim that co-payments exceeded drug prices negotiated with drug providers, it did *not* concern plan terms that forbade a cost-sharing payment exceeding pharmacy payments. *Id.* at 204; 208-09. To the contrary, the copay in *Alves* was a specific dollar amount, not subject to a limit based on the amount actually paid to the pharmacy, and not subject to change based on an exercise of discretion by the defendant. Indeed, *Alves* supports Plaintiffs here. *See also id.* at 207.

ERISA authorizes a number of distinct causes of action to remedy violations of the statute, to enforce the terms of a benefit plan or to provide other available relief. *See generally* 29 U.S.C. 1132(a)(1)-(11) (listing civil causes of action under ERISA). Moreover, *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996), does not preclude a private cause of action for breach of fiduciary duty under § 502(a)(3), where claims are also asserted under other subsections of § 502(a). Rather, both claims should proceed, and at the conclusion of the case, the court can determine whether "appropriate" equitable relief is available on the § 502(a)(3) claim should both succeed. *Devlin v. Empire Blue Cross and Blue Shield*, 274 F.3d 76 (2d Cir. 2001); *N.Y. State Psychiatric Ass'n v. UnitedHealth Grp.*("NYSPA"), 798 F.3d 125, 134 (2d Cir. 2015).[34]

Plaintiff asserts separate claims and seeks different relief under § 502(a)(3) than she does under § 502(a)(1)(B), particularly based on Defendants' argument that Court I is limited solely to a claim for benefits. MTD at 23. In particular, Defendants may contend that a "claim for benefits" does not include, for example, equitable claims for disgorgement, readjudication of claims, surcharge, an injunction, etc. (*see, e.g.*, ¶ 218), and Plaintiff's ERISA § 502(a)(3) claims should be permitted to proceed to seek these forms of relief. At the very least, the issue should be resolved at the end of the case, not on a motion to dismiss. *See* Negron, 300 F. Supp. 3d at 362 (citing *NYSPA*, 798 F.3d at 134).[35]

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[34] After *Devlin*, the Supreme Court ruled in *Cigna Corp. v. Amara*, 563 U.S. 421, 438 (2011), that where plaintiffs cannot obtain relief under ERISA § 502(a)(1)(B) for benefits, plaintiffs may be able to obtain equitable relief — including surcharge — under § 502(a)(3). *Id.* at 726-27. Subsequent to *Amara*, the Second Circuit ruled in *NYSPA*. 798 F.3d at 135 (citing *Amara*, 563 at 1879-80).

[35] *Frommert v. Conkright*, 433 F.3d 254 (2d Cir. 2006), does not support Defendants' argument. MTD at 34. In *Frommert*, the Second Circuit *reversed* the district court's dismissal of plaintiff's claim under ERISA § 502(a)(3) as duplicative. Moreover, the Second Circuit in *NYSPA* recognized the consistency in *Devlin* and *Frommert*, in holding that "*Varity Corp.* did not eliminate a private cause of action for breach of fiduciary duty when another potential remedy is available…[rather if a plaintiff] succeeds on both claims…the district court's remedy is limited to such equitable relief as is considered appropriate." *NYSPA*, 798 F.3d at 134; s*ee also Silva v. Metro Life Insurance Co.*, 762 F.3d 711, 726 (8th Cir. 2014); *Moyle v. Liberty Mut. Ret. Ben. Plan*, 823 F.3d 948 (9th Cir. 2016); *Stiso v. Int'l Steel Group*, 604 F. App'x 494, 498 (6th Cir. 2015).

V. PLAINTIFF HAS STATED RICO CLAIMS (COUNTS VII-IX)

Plaintiff does not plead a breach of "garden-variety business relationships," or a "garden variety . . . breach of contract." MTD at 26, 29. To the contrary, Defendants engaged in a widespread, fraudulent scheme that they concealed from consumers through gag clauses and enforcement provisions. ¶¶ 5, 6, 13, 75, 241, 247, 251–52, 272–75, 280, 282–84, 288. In an attempt to evade liability, Defendants' arguments (1) ignore the detailed allegations of a pervasive, continuous, and concealed Overcharge scheme, (2) distort well-pleaded facts, and (3) disregard the massive harm caused to Plaintiff and plan participants—harm that attracted the attention of the federal and state governments, ¶¶ 81–84, 90, 92, and inspired investigative journalism, ¶¶ 85–91.

A. Plaintiff has adequately pleaded predicate acts of mail and wire fraud.

Plaintiff's allegations regarding Defendants' predicate acts of racketeering more than satisfy Rule 9(b). A plaintiff may satisfy Rule 9(b) in either of two ways. *Aghaeepour v. N. Leasing Sys., Inc.*, 2015 WL 7758894, at *4 (S.D.N.Y. Dec. 1, 2015) (collecting cases). First, where plaintiffs allege "that the mails or wires were simply used in furtherance of a master plan to defraud . . . a detailed description of the underlying scheme and the connection therewith of the mail and/or wire communications, is sufficient to satisfy Rule 9(b)." *In re Sumitomo Copper Litig.*, 995 F. Supp. 451, 456 (S.D.N.Y. 1998). Second, where a plaintiff alleges that mail or wire communications were fraudulent *per se*, she must plead "the contents of the [fraudulent] communications, who was involved, where and when they took place, and explain why they were fraudulent." *Mills v. Polar Molecular Corp.*, 12 F.3d 1170, 1176 (2d Cir. 1993). Plaintiff has easily satisfied both standards.

First, Plaintiff's complaint details how the fraudulent billing scheme worked, and includes specific misrepresentations by Defendants. Defendants intentionally misrepresented that cost-

sharing amounts provided were based on the amount that the pharmacy agreed to accept for the drugs, when, in fact, they had a present intent to charge more. *See, e.g.*, ¶¶ 5, 6, 13, 75, 241, 247, 251–52, 272–75, 280, 282-84, 288. Defendants also "acted in concert in making intentionally misleading statements to the media to try to continue to disguise this Overcharge Scheme as it was being exposed." ¶ 243.

Second, Plaintiff's allegations that Defendants' wires and mail transmissions were fraudulent *per se* satisfy Rule 9(b). For example, "on October 30, 2015, Defendants unilaterally determined that Plaintiff had to pay a $15 copayment to a pharmacy to purchase a prescription drug and required the pharmacy to collect this amount from the patient. Unbeknown to Plaintiff, the $15 copayment Defendants required the pharmacy to collect from her was 250% more than the contracted fee the pharmacy was paid to fill the prescription. Specifically, Defendants' contract with the pharmacy provided that the pharmacy would be paid only $4.19 for the prescription. But, Defendants unilaterally directed and required the pharmacy to charge and collect the $15 copayment from Plaintiff, thereby forcing Plaintiff to pay not only $4.19 contracted cost of the drug, but an additional $10.81." ¶ 8. *See also* ¶¶ 251-52 (detailing specific transactions including date, location, amount of copayment, and amount of Spread/Clawback); 282-84 (same). Plaintiff specifically alleges that these predicate acts of fraud involved the use of U.S. Mail and interstate wires facilities. ¶¶ 251, 252, 254, 283, 284, 286.

In *Negron*, the court held that plaintiffs had alleged "more than an entitlement to lower-cost prescription drugs or breach of contract," *id.* at 364, and that they had alleged that Cigna "created a mechanism through which [it] could obtain additional monies beyond what plaintiffs should have paid under their plan for prescription drugs." *Id.* The court also held that Cigna had "allegedly designed and entered in the Clawback scheme with the intent to defraud insureds who

paid for excessive prescription drug costs . . . intentionally s[eeking] to charge excess amounts for prescription drugs and . . . requir[ing] the pharmacies to conceal from the insureds the amounts of the prescription drug costs," *Negron*, 300 F. Supp. 3d at 364-65. Just as in *Negron*, Plaintiff's allegations regarding Defendants' predicate acts, under either standard, more than satisfy Rule 9(b)'s particularity requirement. *Negron*, 300 F. Supp. 3d at 364-65.

Contrary to Defendants' assertion, the Minnesota court did not consider "nearly identical allegations of predicate acts" and did not conclude that Defendants did not make fraudulent statements or conduct a fraudulent scheme. MTD at 26. *UnitedHealth*'s determination — that some plaintiffs did not plausibly allege a material misrepresentation or omission—did not apply to Plaintiff, but rather to the "Plaintiffs without plans entitling them to the discounted rate." *UnitedHealth*, 2017 WL 6512222, at *13 n.13. *UnitedHealth* assumed that Plaintiff was entitled to the discount rate. *Id.* at *4.

B. Optum is a separate, distinct RICO enterprise[36]

Defendants argue that Count VII should be dismissed because Optum and Oxford are sister corporations and thus Optum is not sufficiently distinct.[37] MTD at 27-28. Contrary to Defendants' assertion, there is no per se rule against RICO liability where the enterprise is a subsidiary or affiliate of the Defendant. Rather, "corporate defendants are distinct from RICO enterprises **when they are functionally separate, as when they perform different roles within the enterprise or use their separate legal incorporation to facilitate racketeering activity**."

[36] *UnitedHealth* addressed only the sufficiency of association-in-fact enterprises. Here, Plaintiffs have pleaded two distinct legal-entity enterprises, which require different proof and different relationships between the entities. Whether Optum constitutes a legal-entity enterprise and whether each provider in Optum's network is a legal-entity enterprise are not issues that were before the court in the Minnesota action. Thus, even if the dismissal was not without prejudice, issue preclusion could not bar Plaintiff's RICO claim.

[37] According to Defendants' Rule 7.1 disclosures in *UnitedHealth*: OptumRx is owned by OptumRx Holdings which is owned by Optum Inc. which is owned by UnitedHealth Services which is owned by UnitedHealth Group. Oxford is owned by UnitedHealthcare Insurance which is owned by UHIC Holdings which is owned by UnitedHealth Services which is owned by UnitedHealth Group.

In re ClassicStar Mare Lease Litig., 727 F.3d 473, 492 (6th Cir. 2013) (emphasis added).[38] "It would be strange indeed to absolve a parent corporation of liability for doing precisely what RICO was designed to prevent: the use of an association of legally distinct entities 'as a vehicle through which unlawful . . . activity is committed.'" *Id.* at 493 (quoting *Cedric Kushner Promotions, Ltd. v. King*, 533 U.S. 158, 164 (2001)).

In *Securitron Magnalock Corp. v. Schnabolk*, 65 F.3d 256 (2d Cir. 1995), the defendant-appellants challenged the distinctiveness of the RICO enterprise, which consisted of, among others, two companies that were owned by the same person and shared the same office. Despite being owned by the same person, the Second Circuit held that the companies were distinct from each other explaining, *inter alia*, that the companies were in distinct lines of business and that their distinctiveness facilitated the scheme. The same reasoning applies here. Moreover, the question of whether an enterprise exists is a fact-intensive inquiry, *City of New York v. Fedex Ground Package Sys., Inc.*, 175 F. Supp. 3d 351, 372 (S.D.N.Y. 2016), and the Complaint alleges that Optum is sufficiently distinct for RICO liability. OptumRx and Oxford are separate legal entities with different rights and responsibilities, operating distinct lines of business. ¶ 237. Both are incorporated in different jurisdictions (Oxford in New York and OptumRx in California) and have their principal places of business in different jurisdictions (Oxford in Connecticut and OptumRx in California). ¶¶ 32–33. Each company is a separate ongoing business with a separate customer base and is free to act independently and advance its own interests contrary to those of the other company. *See U.S. v. Goldin Industries, Inc.*, 219 F.3d 1271, 1277 (11th Cir. 2000). Optum, for example, has contracts with and provides services to

[38] *Accord U1IT4less, Inc. v. FedEx Corp.*, 157 F. Supp. 3d 341, 351 (S.D.N.Y. 2016) (RICO liability should be limited "in the parent-subsidiary context to circumstances in which separate incorporation facilitates the racketeering is also consistent with the text and purposes of the RICO statute").

several of UnitedHealth's and Oxford's competitors. *See Negron*, 300 F. Supp. 3d at 350 (describing services that OptumRx provided to Cigna). *Cf. U1it4less*, 871 F.3d at 206. Since Oxford and Optum are not "guided by a single corporate consciousness," they are sufficiently distinct.[39] *See also* ¶ 243.[40]

C. Optum controlled the affairs of the Pharmacy Enterprises

To conduct or participate in the conduct of an enterprise, "one must participate in the operation or management of the enterprise itself." *Reves v. Ernst &* Young, 507 U.S. 170, 185 (1993). This requires only that the defendant have "played ***some*** part in directing the affairs of the RICO enterprise." *Baisch v. Gallina*, 346 F.3d 366, 376 (2d Cir. 2003) (citation omitted; emphasis added). "[T]he 'operation or management' test typically has proven to be a relatively low hurdle for plaintiffs to clear, especially at the pleading stage." *First Capital Asset Mgmt., Inc. v. Satinwood, Inc.*, 385 F.3d 159, 176 (2d Cir. 2004) (footnote and citations omitted).

Optum's Provider Manual does not merely define "garden-variety business relationships" with pharmacies, (MTD at 29), but instead "help[s] determine the enterprise's modus operandi." *131 Main St. Assocs. v. Manko*, 897 F. Supp. 1507, 1528 (S.D.N.Y. 1995). Optum "exploited and abused the uniform contracts and agreements it entered with providers to implement the fraudulent Overcharge Scheme, knowing that the Plans did not permit the Overcharge Scheme." ¶ 271. Optum's control of the Optum Pharmacy Enterprises through its Provider Manual (1) dictates excessive cost-sharing payments and Spread pricing, ¶ 267; (2) requires participating

[39] For the same reasons, Oxford and Optum are sufficiently distinct that they may make up a RICO conspiracy under 28 U.S.C. ¶ 1962(d).

[40] "OHI, however, also directs the Optum Enterprise to serve an unlawful purpose; that is, to create a mechanism through which OHI could obtain additional monies beyond what Plaintiffs and Class members should have paid under their Plans for medically necessary prescription drugs. This fraudulent Overcharge Scheme, was not legitimate and OHI uses Optum as a separate and distinct legal entity to disguise and perpetuate the fraudulent scheme. OHI uses Optum as a tool to create an appearance of legitimacy as a PBM when, in fact, it is using Optum to enforce the fraudulent scheme, which is not a legitimate function of a PBM. . . ." ¶ 243.

pharmacies to collect the undisclosed Overcharge from the consumers, *id.*; (3) requires pharmacies to pay Defendants the Clawback, *id.*; and (4) maintains the secrecy of and enforces compliance with the Overcharge Scheme, *id.* at ¶¶ 269–70. If a pharmacy does not adhere to Optum's written controls, and thereby threatens the fraudulent Overcharge Scheme, Optum can fine the pharmacy $5,000, kick the pharmacy out of Optum's network and ban the pharmacy from petitioning for readmission—a request that is within Optum's sole discretion to grant—for five years. ¶¶ 269–70. These are binding mandates designed to control pharmacies, maintain the network and perpetuate Optum's fraudulent Overcharge Scheme, not hypothetical scenarios. ¶ 77 and n.18. Accordingly, Optum was "doing more than providing services as part of its routine and legitimate business operations," and was instead the "key participant[]" in the Overcharge Scheme, which it effectuated "by making critical misrepresentations." *United States Fire Ins. Co. v. United Limousine Serv., Inc.*, 303 F. Supp. 2d 432, 453 (S.D.N.Y. 2004).

Like in *Negron*, because "[P]laintiffs [here] have alleged that [Oxford] designed the Clawback scheme, that it required OptumRx . . . to misrepresent the cost-sharing amounts, and that it directed OptumRx . . . to forward the Clawbacks," "the Court cannot hold as a matter of law that [P]laintiffs have failed to allege that [Oxford] directly or indirectly participated in the alleged enterprises' affairs through racketeering activity." *Negron*, 300 F. Supp. 3d at 364 (rejecting Cigna's nearly identical "control" argument).[41]

[41] None of the cases Defendants cite are to the contrary. *Reves v. Ernst & Young*, 507 U.S. 170, 179 (1993); *Dep't of Econ. Dev. v. Arthur Andersen & Co. (USA)*, 924 F. Supp. 449, 466 (S.D.N.Y. 1996); and *Hayden v. Paul, Weiss, Rifkind, Wharton & Garrison*, 955 F. Supp. 248, 254 (S.D.N.Y. 1997), all involved claims against outside professionals who did not make or carry out the decisions of the enterprise, and were outside the enterprise's chain of command. In contrast, the pharmacies involved in the pharmacy enterprises carried out Optum's directive to overcharge and remit the Overcharge to Defendants, and to keep the Overcharges secret from their customers. *River City Mkts., Inc. v. Fleming Foods W., Inc.*, 960 F.2d 1458, 1463 (9th Cir. 1992), is also distinguishable. There, the court held that there was no evidence of "contemplated . . . deceit, nondisclosure . . . or any other unethical conduct" by the alleged participants. *Id.* Here, Plaintiff has alleged not just contemplated deceit and nondisclosure. She has alleged actual deceit and nondisclosure. ¶¶ 5, 6, 13, 75, 241, 243, 247, 251–52, 272–75, 280, 282–84, 288. Finally, Defendants' reliance on *Forest Ambulatory Surgical Assocs., L.P. v. Ingenix, Inc.*, 2013 U.S. Dist. LEXIS 190701,

D. Plaintiff has adequately pleaded a RICO conspiracy claim

Defendants' argument that Plaintiff has not stated a RICO conspiracy claim because her "underlying substantive claim is insufficiently pled" fails for the reasons discussed above. MTD at 30. Defendants' argument that Plaintiff's RICO conspiracy claim should be dismissed because it is conclusory should also be rejected. "[T]he requirements for RICO conspiracy charges under § 1962(d) are less demanding . . . In the civil context, a plaintiff must allege that the defendant 'knew about and agreed to facilitate the scheme.'" *Baisch v. Gallina*, 346 F.3d 366, 376–77 (2d Cir. 2003) (quoting *Salinas v. United States*, 522 U.S. 52, 65 (1997)). As described in detail above, Plaintiff provides more than adequate factual allegations of the scheme and alleges that Oxford and/or Optum "intended to defraud Plaintiff," ¶ 292, "reasonably foresaw that the U.S. Mail and/or interstate wire would be used in furthering the Overcharge Scheme," *id.*, and "knew that their predicate acts were part of a pattern of racketeering activity and agreed to commission of those acts to further the "Overcharge Scheme," *id.* at ¶ 293. *See also* ¶¶ 243, 247–51, 272–278, 280–83; ¶¶ 292–93; *Negron*, 300 F. Supp. 3d at 367. As Plaintiff has alleged, "[t]his is not a matter of mistaken or innocently erroneous calculations: it is a pervasive, intentional scheme to overcharge Plaintiff and everyone similarly situated in connection with their prescription drug purchases." ¶ 4. These allegations are sufficient to state a claim under 18 U.S.C. § 1962(d).

VI. CONCLUSION

For the foregoing reasons, Plaintiff respectfully requests that the Court should find in her favor and deny Defendants' motion to dismiss in its entirety.

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at *18 (C.D. Cal. Dec. 13, 2013), is unavailing. There, the plaintiff had alleged only that the insurance company had "promoted" and "propagated" "flawed reimbursement technologies," not that the defendant had secretly required the other enterprise participants to secretly and unlawfully collect Overcharges in violation of the plaintiff's insurance plan and under threat of fines and network expulsion, as Plaintiff has alleged here.

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Respectfully submitted,

s/ Craig A. Raabe

Robert A. Izard
Craig A. Raabe
Christopher M. Barrett
IZARD, KINDALL & RAABE, LLP
29 South Main Street, Suite 305
West Hartford, CT 06107
Telephone: 860-493-6292
Facsimile: 860-493-6290
rizard@ikrlaw.com
craabe@ikrlaw.com
cbarrett@ikrlaw.com

William H. Narwold
Mathew Jasinski
MOTLEY RICE LLC
One Corporate Center
20 Church Street, 17th Floor
Hartford, CT 06103
Telephone: 860-882-1681
Facsimile: 860-882-1682
bnarwold@motleyrice.com
mjasinski@motleyrice.com

Joseph P. Guglielmo
Carey Alexander
SCOTT+SCOTT,
ATTORNEYS AT LAW, LLP
The Helmsley Building
230 Park Avenue, 17th Floor
New York, NY 10169
Telephone: 212-223-6444
Facsimile: 212-223-6334
jguglielmo@scott-scott.com
calexander@scott-scott.com

Erin Green Comite
SCOTT+SCOTT, ATTORNEYS AT LAW, LLP
156 South Main Street
P.O. Box 192
Colchester, CT 06415
Telephone: 860-537-5537

Facsimile: 860-537-4432
ecomite@scott-scott.com

Derek W. Loeser
Gretchen S. Obrist
KELLER ROHRBACK, LLP
1201 Third Avenue, Suite 3200
Seattle, WA 98101-3052
Telephone: 206- 623-1900
Facsimile: 206-623-3384
dloeser@kellerrohrback.com
gobrist@kellerrohrback.com

Ronen Sarraf
Joseph Gentile
SARRAF GENTILE LLP
14 Bond Street, Suite 212
Great Neck, NY 11021
Telephone: 516-699-8890
Facsimile: 516-699-8968
ronen@sarrafgentile.com
joseph@sarrafgentile.com

Attorneys for Plaintiff

CERTIFICATE OF SERVICE

I, Craig A. Raabe, certify that, on July 19, 2018, I caused a true and correct copy of the foregoing document to be served on counsel for all parties via the Court's Electronic Document Filing System.

Executed this 19th day of July 2018 at West Hartford, Connecticut.

s/ Craig A. Raabe

Craig A. Raabe
IZARD, KINDALL & RAABE, LLP
29 S. Main St., Suite 305
West Hartford, CT 06107
(860) 493-6292
(860) 493-6290 fax
craabe@ikrlaw.com