18-2490

IN THE

United States Court of Appeals

FOR THE THIRD CIRCUIT

STEVEN PLAVIN,

Plaintiff-Appellant,

—v.—

GROUP HEALTH INCORPORATED,

Defendant-Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

BRIEF FOR PLAINTIFF-APPELLANT
AND JOINT APPENDIX
VOLUME I OF II
(Pages A1 to A45)

WILLIAM CHRISTOPHER CARMODY
ARUN SUBRAMANIAN
HALLEY W. JOSEPHS
SUSMAN GODFREY L.L.P.
1301 Avenue of the Americas,
32nd Floor
New York, New York 10019
(212) 336-8330

MICHAEL F. COSGROVE
J. TIMOTHY HINTON, JR.
HAGGERTY HINTON & COSGROVE LLP
203 Franklin Avenue
Scranton, Pennsylvania 18503
(570) 344-9845

Attorneys for Plaintiff-Appellant

CORPORATE DISCLOSURE STATEMENT

As an individual person, Plaintiff Appellant is not required to file a Corporate Disclosure Statement pursuant to FRAP 26-1.

Dated: New York, New York
October 10, 2018

Respectfully submitted,

SUSMAN GODFREY L.L.P.

By: *s/ William Christopher Carmody*

William Christopher Carmody
Arun Subramanian
Halley W. Josephs
SUSMAN GODFREY L.L.P.
1301 Avenue of the Americas, 32nd Floor
New York, NY 10019-6023
Tel.: 212-336-8330
Fax: 212-336-8340
bcarmody@susmangodfrey.com
asubramanian@susmangodfrey.com
hjosephs@susmangodfrey.com

J. Timothy Hinton, Jr., Esq. (PA ID 61981)
Michael F. Cosgrove, Esq. (PA ID 47349)
HAGGERTY HINTON & COSGROVE LLP
203 Franklin Avenue
Scranton, PA 18503
Tel: (570) 344-9845
timhinton@haggertylaw.net
mikecosgrove@haggertylaw.net

Attorneys for Plaintiff-Appellant and the Class

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INTRODUCTION

Plaintiff Steven Plavin brought this lawsuit on behalf of hundreds of thousands of public employees and retirees of the City of New York—including police officers like himself, teachers, and other government workers—alleging that GHI misled these public employees about the scope of out-of-network coverage under its "Comprehensive" Benefits Plan ("GHI Plan"). The class action Complaint alleges that GHI painted a broadly unrealistic picture of the out-of-network reimbursements available to these public employees—failing to disclose that on average, GHI reimbursed out-of-network services at a rate of just 23%, and that reimbursements could be as low as 9% for some procedures. GHI also concealed the fact that reimbursements were based on a hidden reimbursement schedule that had been virtually untouched since 1983 and would cover just a fraction of out-of-network charges. If this isn't misleading, consumer-oriented conduct, then nothing is. Accordingly, the lawsuit alleges that GHI's deceptive conduct violated New York General Business Law ("GBL") Sections 349 and 350 and New York Insurance Law Section 4226, and caused GHI to be unjustly enriched.

GHI's deception did not escape the government's notice. The New York Attorney General ("NYAG") investigated this very conduct and expressly found that GHI's practices "constitute repeated violations of . . . General Business Law

§§ 349 and 350," two of the primary claims asserted here. The NYAG made these findings in an Assurance of Discontinuance ("AOD"), which is a settlement agreement that GHI signed after the Government's investigation into the company's misdeeds against City employees and retirees (i.e., Plaintiff and the putative class members). Among numerous other findings of wrongdoing, the Government stated that "GHI does not sufficiently describe the limitations of GHI Plan's reimbursement of out-of-network providers and the resulting financial consequences to members and prospective members," "GHI does not explain that the reimbursement rates are comparatively low when measured against other reimbursement methodologies nor does it explain that members are likely to incur substantial out-of-pocket expenses when they use out-of-network providers," and "GHI's documents misrepresent the Schedule's updating of allowances or 'reimbursement amounts.'"

Despite this record, the District Court dismissed Plavin's original Complaint with prejudice, concluding that as a matter of law, New York's broad consumer protection laws *do not protect* members of employer-sponsored benefit programs because they are not the "public at large." This is not the law in New York. For example, the District Court concluded *as a matter of law* that Plaintiff and the putative class—consisting of hundreds of thousands of public employees and retirees—are not "consumers" within the meaning of New York's consumer

protection laws and Defendant's deceptive marketing of a purported PPO insurance plan with "comprehensive" out-of-network benefits to these employees was not "consumer-oriented."

As additional grounds for dismissal, the District Court categorized Plavin's lawsuit as a private contract dispute based on a contract between GHI and the City of New York—a contract that the Court has never seen, Plavin never received, and that is not in the record. While the City's contract with GHI may have been the product of private contract negotiations between sophisticated parties, Plavin's relationship with GHI was not. It was the product of Plavin—along with 311,880 other NYC employees and non-Medicare retirees (plus their family members)—receiving GHI's deceptive marketing materials touting its "comprehensive" out of network coverage, electing the GHI Plan, never receiving a policy or reimbursement schedule, and then finding out that GHI was reimbursing just a fraction of those charges.

If the District Court's rulings are permitted to stand, they will narrow New York's consumer protection laws in ways that contradict the legislature's broad statutory mandate and decades of interpretation by New York courts, and they will leave no recourse for members of employer-sponsored insurance plans when the insurer fails to deliver a policy or other express contract. For these reasons, and

those discussed further below, the opinion and order of the District Court should be reversed and the case remanded for further proceedings.

JURISDICTIONAL STATEMENT

The District Court had jurisdiction pursuant to 28 U.S.C. § 1332(d) because this is a class action arising under the Class Action Fairness Act of 2005 ("CAFA"), where Plavin is a citizen of Pennsylvania and GHI is a citizen of New York; the total number of members of the proposed Class is greater than 100; more than two-thirds of all of the members of the proposed Class in the aggregate are citizens of a state other than Pennsylvania, where the action was originally filed; and the total claims of the individual members of the proposed Class in this action are in excess of $5,000,000 in the aggregate, exclusive of interest and costs. This Court has jurisdiction under 28 U.S.C. § 1291 as an appeal from a final decision of the District Court dismissing all claims with prejudice dated June 22, 2018. A1–42. Plavin timely appealed on July 5, 2018. A43–45.

STATEMENT OF THE ISSUES

The issues presented, to be evaluated under a *de novo* standard of review, are:

1. Whether the District Court erred in holding that GHI's conduct was not "consumer oriented," where the conduct was directed at a broad group of similarly-situated insureds who procured health insurance for personal use? (Raised at A395–98; Ruled On at A17–23.)

2. Whether the District Court erred in holding, on a Rule 12(b)(6) motion to dismiss, that no reasonable consumer could have been misled by GHI's conduct? (Raised at A383–84, A398–401; Ruled On at A23–33.)
3. Whether the District Court erred in dismissing Plavin's claim without leave to amend under New York Insurance Law Section 4226 for failure to plead misleading statements or knowledge? (Raised at A394, A398–401, A411–12; Ruled On at A33-35.)[1]
4. Whether the District Court erred in dismissing the unjust enrichment claim based on a contract that is not part of the record, and where Plavin disputes the existence of a contract that covers of the scope of his claims? (Raised at A402–10; Ruled On at A35–39.)

The issue presented, to be evaluated under an abuse of discretion standard of review, is:

5. Whether the District Court abused its discretion in dismissing all claims with prejudice? (Raised at A413; Ruled On at A40-41.)

STATEMENT OF RELATED CASES

There are no related cases. This case has not previously been before the Third Circuit.

[1] As the District Court recognized, GHI failed to separately analyze the adequacy of Plavin's § 4226 claim in its motion to dismiss; rather, it argued that this claim should be dismissed "[f]or the same reasons" that the Complaint failed to plead a GBL claim. *See* A33-34.

STATEMENT OF THE CASE

I. Factual Background

GHI offers one of eleven health insurance plans made available to over 600,000 City of New York ("City") employees and retirees. A54-55 (Compl. ¶¶ 1, 2). During the relevant period, the GHI Comprehensive Benefit Plan (the "GHI Plan") was one of only two preferred provider organization ("PPO") plans that purported to provide "comprehensive coverage" for out-of-network medical services. A55 (*Id.* ¶ 2). (The other plans were HMOs, which typically provide coverage only for in-network services. A60 (*Id.* ¶ 20).)

GHI created and distributed to City employees and retirees two documents prior to each year's enrollment period. A55–56, A60 (*Id.* ¶¶ 5, 21). Those documents, a Summary Program Description and online Summary of Benefits & Coverage, falsely depicted the plan as a true PPO plan that gave members the "freedom to choose any provider worldwide" with extensive out-of-network coverage, while alluding only to the mere possibility that reimbursements might be less than the actual fee charged by out-of-network providers. A55 (*Id.* ¶ 4); *see* A80–83 (Summary Program Description); A84–99 (Summary of Benefits). GHI never delivered a policy, Certificate of Insurance, or reimbursement "schedule" to Plan Members at any point after enrollment. A61–62 (Compl. ¶¶ 24, 27). GHI

concealed the reimbursement schedule from insureds and denied access to the schedule when requested via email and phone. A56, A62 (*Id.* ¶¶ 7, 27).

GHI never told a single current or prospective Plan Member that reimbursement rates for virtually every out-of-network service would be just a fraction of the actual cost of that service. A55–58, A63–64 (*Id.* ¶¶ 5–11, 31–32). GHI told members out-of-network reimbursements would be based on a "schedule" that was "periodically updated" but in fact was left virtually untouched since 1983. A55–57, A62–64 (*Id.* ¶¶ 5, 7–8, 27–29, 31–32). GHI also promoted "additional" "Catastrophic Coverage" where GHI promised to pay "100% of the Catastrophic Allowed Charge as determined by GHI" in the event that a member's out-of-network expenses exceeded $1,500. A56–57, A64–65 (*Id.* ¶¶ 6, 10, 33–35). Although GHI represented it as an additional benefit and highlighted it as one of key six benefits in the Summary, in reality it provided the same amount that GHI already agreed to pay regardless of the $1,500 threshold and provided no benefit at all. *Id.*

GHI also sold, for an additional fee, an optional rider (the "Enhanced OON Rider" or "Rider") that provided an "enhanced schedule for certain services [that] increases the reimbursement of the basic program's [out-of-network] fee schedule, on average, by 75%." A56 (*Id.* ¶ 6). GHI failed to disclose in the marketing materials provided prior to plan selection that the Rider enhanced reimbursements

for inpatient services only and provided nothing for out-patient services. A58 (*Id.* ¶ 11) (noting out-patient services accounted for 65% of out-of-network charges during the Class Period); A65–66 (*Id.* ¶¶ 36–38).

GHI's unlawful scheme was lucrative. A58, A61–62, A66 (*Id.* ¶¶ 12, 25, 38). GHI had the highest enrollment of any health plan offered to City employees and retirees; as of 2012, 311,880 employees and non-Medicare retirees were enrolled, and membership totaled approximately 994,500 inclusive of family members. A61–62 (*Id.* ¶ 25). From 2011 to 2015, GHI earned an average of $172 million per year for administering the GHI Plan and $3 million per year on the optional Rider (after rebates to the City).[2] A58, A61–62, A66 (*Id.* ¶¶ 12, 25, 38).

GHI's deceptive conduct caught the attention of state authorities. The New York Attorney General ("NYAG") investigated GHI's conduct, including its extraordinarily low rates of reimbursement for the out-of-network claims of the hundreds of thousands of City employees and retirees enrolled in the GHI Plan. A66 (*Id.* ¶ 39). The NYAG's investigation and resulting Assurance of

[2] As part of their compensation and retirement packages, City employees and retirees are entitled to their choice of City-sponsored health insurance plans. The City pays either the entire premium or a large portion thereof depending on the plan the employee/retiree chooses. The amount the City contributes to each insurance policy is set by NYC Administrative Code § 12-126. When selecting a plan, employees and retirees direct compensation to which they are legally entitled to the insurer whose plan they select. A60 (Compl. ¶ 19).

Discontinuance ("AOD") covered some, but not all of the deceptive practices that are the subject of this lawsuit. *Id.*

For example, the NYAG focused on GHI's failure to make the Schedule available to current and prospective Plan Members, its failure to accurately describe the limitations of out-of-network reimbursement and resulting financial consequences to current and prospective members, and its misrepresentation of the frequency with which the 1983 reimbursement schedule is updated. A66 (*Id.* ¶ 39); A163–83 (AOD ¶¶ 8–17, 21–22). The NYAG determined that these practices harmed consumers, i.e., City employees and retirees, A163–83 (AOD ¶¶ 7, 13, 19, 20, 27, 34, 35), and constituted repeated violations of GBL §§ 349 and 350, A174 (*id.* ¶ 26). As a result of the investigation, GHI entered into an AOD, in which it agreed to make changes to its marketing materials. A66–67 (*Id.* ¶¶ 39–40); A174–75 (AOD ¶¶ 27–29). The AOD did not address the consequences of the illusory Catastrophic Coverage and worthless Rider. *See* A65–66 (Compl. ¶¶ 36–38). This AOD was one of four settlements GHI entered with the NYAG relating to its administration of the GHI Plan in a four-year period. A55 (*Id.* ¶ 3).

Plaintiff Steven Plavin is a retired New York City police officer who has enrolled and re-enrolled in the GHI Plan since 1984, paying for the Rider each time. A58 (*Id.* ¶ 13). Plavin, his wife, and his children are all covered by the GHI

plan. *Id.* In 2014, Plavin's wife received numerous medical services that GHI deemed out-of-network and paid just a fraction of the expenses for, leaving Plavin with significant financial responsibility. A67 (*Id.* ¶ 41). GHI saddled Plavin with out-of-network costs at various points through 2015. *Id.* For example, for a July 2014 out-of-network procedure, GHI did not inform Plavin until February 2015 that he was on the hook for a substantial percentage of the costs for that claim. *Id.*

II. Procedural History

The Complaint was filed in the United States District Court for the Middle District of Pennsylvania (where Plavin resides) on August 16, 2017, alleging that GHI misled consumers about the out-of-network reimbursements under the health insurance plan it offered to City employees and retirees, resulting in violations of: (1) New York General Business Law ("GBL") § 349; (2) New York GBL § 350; (3) New York Insurance Law § 4226; and giving rise to a claim of (4) unjust enrichment. A54–75.

GHI moved to dismiss under Fed. R. Civ. P. 12(b)(6). A102–44. On June 22, 2018, the Court dismissed all claims with prejudice, and without leave to amend, under Rule 12(b)(6). A1–42.

The Court correctly held that Plavin adequately alleged timely claims under the GBL and Insurance Law and on a theory of unjust enrichment, rejecting GHI's

argument that these claims are time-barred under the applicable statutes of limitations. A9–17.

Nevertheless, on the GBL §§ 349 and 350 claims, the Court concluded that GHI's conduct was not "consumer oriented" because the insurance was offered to hundreds of thousands of City employees and retirees rather than to every member of the general public, and was (according to the Court) purportedly based on a private contract between GHI and the City. A17–23. Reaching the merits of the materially misleading nature of GHI's statements, the Court concluded, as a matter of law, that no reasonable consumer could have been misled by GHI's statements. A23–33. To do so, the Court weighed the misrepresentations against purported disclaimers in the marketing materials. Finally, the Court discounted the NYAG's investigation of GHI's conduct and express finding that the conduct violated GBL §§ 349 and 350.

The District Court dismissed Plavin's Insurance Law § 4226 claim on the same ground that Plavin could not plead materially misleading statements as a matter of law. A33–34. The Court further concluded that Plavin failed to allege "scienter" or reliance, but did not provide leave to amend. A34–35.

On the unjust enrichment claim, the District Court—without reviewing the contract at issue, which Plavin never received and was never submitted to the Court by either party—concluded that Plavin was a third-party beneficiary of the

alleged contract between GHI and the City. A35–39. The Court did not reach GHI's arguments that the unjust enrichment claim should be dismissed as duplicative of the GBL claims or because Plavin failed to allege the elements of unjust enrichment. A39 n.6.

With respect to the class claims, the District Court dismissed those based on its findings that Plavin's causes of action must be dismissed. A40.

The District Court dismissed as moot GHI's premature request to strike Plavin's request for treble damages under the GBL and penalty damages under Insurance Law § 4226. A35 n.5.

Finally, the District Court concluded in a single sentence that leave to amend would be futile and dismissed all claims with prejudice. A40–41.

This appeal followed.

SUMMARY OF ARGUMENT

The Complaint alleges that between 2011 and 2015, Defendant GHI misled consumers—public employees including police officers like Plavin—about the scope of out-of-network reimbursements under its Comprehensive Benefits Plan ("GHI Plan"). GHI's conduct violated New York General Business Law ("GBL") Sections 349 and 350 and Insurance Law § 4226, and caused GHI to be unjustly enriched. The Complaint contains detailed allegations of GHI's misconduct affecting hundreds of thousands of consumers of health insurance that readily

satisfy the applicable pleading standards. The New York Attorney General has already concluded, in a settlement agreement with GHI, that GHI's misconduct is actionable under GBL §§ 349 and 350 because GHI told consumers they were getting "comprehensive" coverage for out-of-network services, but GHI based reimbursements on a secretive reimbursement schedule that had been hardly touched since 1983 and would cover just a fraction of the charges.

The District Court's opinion dismissing all of Plavin's claims with prejudice should be reversed for the following reasons: On the GBL claims, the District Court dismissed based on five conclusions that find no support in the statute or case law.[3] ***First***, the District Court grafted a "general public" rule onto the "consumer-oriented conduct" element, determining that GHI's conduct is not consumer-oriented because it offered the insurance plan to City employees and retirees (who number in the hundreds of thousands) rather than to every member of the general public. There is no support for this rule. Under New York law, all that is required to satisfy this element is to show "that the conduct at issue 'potentially

[3] This Court is bound by the decisions of New York's highest court (the New York Court of Appeals) interpreting state law. *Giordano v. City of N.Y.*, 274 F.3d 740, 754 (2d Cir. 2001) ("[T]he New York Court of Appeals['] . . . construction of New York State law binds this Court.") (citing *West v. AT&T Co.*, 311 U.S. 223, 237 (1940) (federal courts are bound to apply state law as interpreted by the state's highest court)); *see also V.S. v. Muhammad*, 595 F.3d 426, 432 (2d Cir. 2010) ("This Court is bound to apply the law as interpreted by a state's intermediate appellate courts unless there is persuasive evidence that the state's highest court would reach a different conclusion.").

affect[s] similarly situated consumers.'" *Wilson v. Nw. Mut. Ins. Co.*, 625 F.3d 54, 64 (2d Cir. 2010) (quoting *Oswego Laborers' Local 214 Pension Fund v. Marine Midland Bank*, 647 N.E.2d 741, 745 (N.Y. 1995)).

Second, the District Court concluded—based on an assumption that Plavin is a third-party beneficiary of a contract that appears nowhere in the record—that Plavin's claims amount to a "private contract" dispute. That holding is also in conflict with New York law. *See id.*

Third, the District Court resolved disputed issues of fact surrounding the fact-intensive "materially misleading" element by citing alleged disclaimers in GHI's marketing materials as grounds to conclude, *as a matter of law*, that no reasonable consumer could have been misled by GHI's statements. New York's highest court has already held that it is improper for a court to dismiss a GBL claim based on disclaimers. *Koch v. Acker, Merrall & Condit Co.*, 967 N.E.2d 675, 676 (N.Y. 2012).

Fourth, the District Court concluded that Plavin failed to allege reliance, but under New York law reliance is not an element of a GBL claim. *Id.* The Court's Opinion also erroneously suggested that omissions are not actionable under the GBL, but that conflicts with black-letter New York law holding that a "deceptive act or practice" is a "representation *or omission* likely to mislead a reasonable consumer acting reasonably under the circumstances." *Gaidon v. Guardian Life*

Ins. Co. of Am., 725 N.E.2d 598, 604 (N.Y. 1999) (emphasis added and internal quotation marks omitted).

Fifth, in reviewing the misleading statements, the District Court resolved numerous issues of fact against Plavin and drew all possible inferences in the light *least* favorable to Plavin—the opposite of what federal courts require at the motion to dismiss stage. *See McTernan v. City of York, Pa.*, 577 F.3d 521, 526 (3d Cir. 2009).

On the New York Insurance Law § 4226 claim, the District Court erred in dismissing this claim on the grounds that GHI's misrepresentations were not materially misleading (for the same reasons it dismissed the GBL claims) and that Plavin failed to allege "scienter" or reliance. Contrary to the District Court's conclusion, there is no fraudulent or "nefarious intent" requirement; rather, the "knowledge" requirement under § 4226 may be alleged generally under either Fed. R. Civ. P. 8(a) or Fed. R. Civ. P. 9(b) and the Complaint meets either standard. Moreover, the plain text of § 4226 confirms that there is no reliance requirement.

With respect to unjust enrichment, the District Court based its dismissal on a contract that Plavin never received, the Court has never seen, and which is not in the record. Unjust enrichment is an equitable claim that courts routinely permit to proceed where the existence, validity, or scope of a contract covering the claims is disputed. Here, Plavin brings this claim because there is no express contract that

Plavin can enforce against GHI to vindicate his claims. On this record, dismissal of this claim was error. *In re LIBOR-Based Fin. Instruments Antitrust Litig.*, 27 F. Supp. 3d 447, 483 (S.D.N.Y. 2014) ("[T]he predicate for dismissing quasi-contract claims is that [an enforceable] contract at issue clearly covers the dispute between the parties.") (internal quotation marks omitted).

Finally, the Court erred in dismissing these claims with prejudice, when it should have allowed Plavin to amend his pleadings to address any curable deficiencies.

ARGUMENT

I. Standard of Review with Respect to the General Business Law, Insurance Law, Unjust Enrichment, and Class Claims

A district court's decision on a motion to dismiss under Rule 12(b)(6) is subject to *de novo* review. *McTernan v. City of York, Pa.*, 577 F.3d 521, 526 (3d Cir. 2009). "[A]ll well-pleaded allegations of the complaint must be taken as true and interpreted in the light most favorable to the plaintiffs, and all [reasonable] inferences must be drawn in favor of them." *Id.*; *see Fellner v. Tri-Union Seafoods, L.L.C.*, 539 F.3d 237, 242 (3d Cir. 2008). This Court's role in reviewing dismissal on a Rule 12(b)(6) motion is to "determine whether, under any reasonable reading of the complaint, the plaintiff may be entitled to relief." *Phillips v. Cty. of Allegheny*, 515 F.3d 224, 231 (3d Cir. 2008) (internal quotation marks omitted).

II. The District Court Erred in Dismissing the Consumer-Protection Claims Under New York General Business Law Sections 349 and 350

New York General Business Law Sections 349 and 350 are consumer protection laws that broadly protect against "those acts or practices which undermine a consumer's ability to evaluate his or her market options and to make a free and intelligent choice. In this sense, the deception itself is the harm that the statute seeks to remedy: [c]onsumers have the right to an honest market place." *N. State Autobahn, Inc. v. Progressive Ins. Grp. Co.*, 953 N.Y.S.2d 96, 102 (N.Y. App. Div. 2012) (internal quotation marks omitted). These laws "appl[y] to virtually all economic activity." *Small v. Lorillard Tobacco Co.*, 720 N.E.2d 892, 897 (N.Y. 1999). There is no exception for insurance companies' deceptive acts or practices, *see Riordan v. Nationwide Mut. Fire Ins. Co.*, 756 F. Supp. 732, 739–40 (S.D.N.Y. 1990), *aff'd*, 977 F.2d 47 (2d Cir. 1992) ("[T]here is nothing in [the legislative history or case law] or in the statute itself which indicates a legislative intent to exclude the insurance industry from the statute's remedial scope."), as confirmed by the NYAG's investigation and Assurance of Discontinuance specifically identifying GHI's conduct as violating GBL §§ 349 and 350. A66–67 (Compl. ¶¶ 39–40); A168–74 (AOD ¶¶ 1, 23–26).

A plaintiff asserting a claim under GBL §§ 349 or 350 "must allege that a defendant has engaged in (1) consumer-oriented conduct that is (2) materially misleading and that (3) plaintiff suffered injury as a result of the allegedly

deceptive act or practice." *Autobahn*, 953 N.Y.S.2d at 101 (internal quotation marks omitted); *see Goshen v. Mut. Life Ins. Co. of N.Y.*, 774 N.E.2d 1190, 1195 n.1 (N.Y. 2002).

A. The District Court Erroneously Concluded that GHI's Conduct Against New York City Employees and Retirees is Not "Consumer-Oriented"

Conduct is "consumer oriented" if it "ha[s] a broader impact on consumers at large." *Oswego*, 647 N.E.2d at 744. This requirement is "construed liberally" because the GBL is "broadly applicable, extending far beyond the reach of common law fraud." *N.Y. v. Feldman*, 210 F. Supp. 2d 294, 301 (S.D.N.Y. 2002). A plaintiff need not allege that the deceptive conduct is persistent or repetitive—though Plavin does so here. *See Oswego*, 647 N.E.2d at 744. Further, the conduct at issue need not be directed at every member of the public. Rather, "[t]he 'consumer-oriented' requirement may be satisfied by showing that the conduct at issue 'potentially affect[s] similarly situated consumers.'" *Wilson*, 625 F.3d at 64 (quoting *Oswego*, 647 N.E.2d at 745) (alteration in original).

1. The District Court's Novel "General Public" Analysis is Contrary to New York Caselaw and the GBL's Broad Scope

The District Court's Opinion erred in dismissing Plavin's GBL claims by creating an unprecedented rule that significantly narrows the scope of New York's broad consumer protection laws. The District Court held, *as a matter of law*, that conduct is "consumer-oriented" only if the service or deceptive conduct at issue is

directed to the general public in its entirety. A18–23. In the District Court's view, GHI's deceptive conduct was not "consumer-oriented" because GHI offered insurance to Plavin and the putative class by virtue of their employment with the City, "[t]he contract was aimed to benefit only a circumscribed class of individuals," and "a member of the public cannot approach [GHI] and gain membership in the same plan that Plavin received." A20; *see* A21 ("the [GHI] plan cannot have been intended to be available to the public at large, because it is an exclusive plan that is the product of negotiations between the City and [GHI]").

The District Court's new rule finds no support in the case law or the plain language of the statute. The relevant inquiry is whether Plavin alleges conduct that is "standardized such that [it] potentially affect[ed] similarly situated consumers," *Autobahn*, 953 N.Y.S.2d at 103, *not* whether the insurance plan was available to every member of the public or the deceptive conduct was directed to the "public at large." A21–22.

The Second Circuit considered and rejected that exact same argument in *Koch v. Greenberg*, in which a purchaser of 2,600 bottles of high-end wine at auction brought GBL §§ 349 and 350 claims against the seller based on his misrepresentations about the provenance of 24 of those bottles. 626 F. App'x 335, 340 (2d Cir. 2015). On appeal from a jury verdict in the purchaser's favor, the Second Circuit rejected the seller's claims that his conduct was not "consumer

oriented" because "the wine was a high-end collectible because it sold at immodest prices, precluding the involvement of the general public." *Id.* at 340. The Second Circuit rejected the seller's "general public" argument, explaining that "consumer-oriented conduct within the meaning of the NYGBL is broadly interpreted and requires merely that the conduct at issue 'have a broader impact on consumers at large,'" and "so long as the conduct at issue can 'potentially affect similarly situated consumers,' the requirement of consumer-oriented conduct is met." *Id.* (quoting *Oswego*, 647 N.E.2d at 745). The Court concluded that the evidence showed "consumer-oriented" conduct "given that the defendant provided wine to be sold at auction to other consumers similarly situated to [plaintiff, i.e., other auction-goers]." *Id.*

The district court in *Millennium Health, LLC v. EmblemHealth, Inc.*[4] also rejected the argument that "the statute covers only 'deceptive acts directed to the public at large.'" 240 F. Supp. 3d 276, 285–86 (S.D.N.Y. 2017). "New York courts have consistently held that harm to insureds may form the basis of a § 349 claim," particularly where "the unlawful conduct alleged 'was not an isolated incident, but a routine practice that affected many similarly situated insureds.'" *Id.* (quoting *Elacqua v. Physicians' Reciprocal Insurers*, 860 N.Y.S.2d 229, 231 (N.Y.

[4] Group Health Incorporated, the Defendant here, is a subsidiary of EmblemHealth, Inc. *See* Dist. Ct. Dkt. 30 (GHI disclosure statement).

App. Div. 2008)). Applying these standards, the court concluded that the plaintiff, a clinical drug testing services provider, satisfied the consumer-oriented conduct element (despite not even being a consumer itself)[5] by alleging that the defendant insurer misrepresented to insureds that it would cover the costs of drug testing but then refused to pay over 27,000 claims for urine drug testing. *Id.* at 281, 285–86. The court determined that allegations of "harm to numerous insureds," and not to the "public at large," suffice under New York law. *Id.* at 286.[6]

Indeed, countless courts have found a defendant's conduct to be consumer-oriented under GBL §§ 349 and 350 when it is directed at members of a discrete, pre-existing group, or as the result of a pre-existing contract with either the consumer or a third party. In *Elacqua*, for example, a group of physicians sued their medical malpractice insurer under the GBL for failing to inform insureds of their right to select counsel in malpractice lawsuits. 860 N.Y.S.2d at 230–31. Because the GBL contains no "general public" requirement, the appellate court properly reversed the dismissal of plaintiffs' GBL claims following a bifurcated trial on liability, concluding plaintiffs adequately alleged the insurer's practice was consumer-oriented where it "was not an isolated incident, but a routine practice

[5] Section 349(h) of the GBL permits "any person who has been injured by reason of any violation of this section" to bring a lawsuit.

[6] *Cf. Monga v. Security Mut. Life Ins. Co.*, No. 2000/05164, 2002 WL 31777872, at *8 (N.Y. Sup. Ct. 2002) (concluding complaint alleged consumer-oriented conduct where insurance policy "was also sold to many other consumers").

that affected many similarly situated insureds"—even though medical malpractice insurance is (obviously) available only to medical professionals. *Id.* at 231 (remanding for trial on damages).

In *M.V.B. Collision*, an auto repair shop brought a GBL § 349 claim against Allstate Insurance Company for a deceptive "practice of dissuading or preventing consumers from using Mid Island" and declaring cars that Allstate insureds sought to have repaired at Mid Island a "total loss" to avoid paying Mid Island for repairs. *M.V.B. Collision, Inc. v. Allstate Ins. Co.*, 728 F. Supp. 2d 205, 213–14, 221 (E.D.N.Y. 2010). The court concluded that "a rational trier of fact could find . . . that this practice had a broad impact on consumers at large, *i.e.*, any Allstate customer who brought his car to Mid Island." *Id.* (denying defendant's motion for summary judgment on GBL claim). As with *Elacqua*, the deceptive conduct was directed only at members of a preexisting group (i.e., individuals who had already enrolled in Allstate's auto insurance plan and who needed work on their cars), and not the "public at large."

And in *Accredited Aides Plus, Inc.*, a New York appellate court concluded that plaintiffs sufficiently alleged a group self-insured trust that provided worker's compensation coverage to employees whose employers joined the trust engaged in consumer-oriented activity by distributing "materially misleading information about the trust to employers," which "jeopardized the worker's compensation

benefits of New York employers and their employees." *Accredited Aides Plus, Inc. v. Program Risk Mgmt., Inc.*, 46 N.Y.S.3d 246, 257 (N.Y. App. Div. 2017) (internal quotation marks omitted) (reversing trial court's dismissal of complaint for failure to allege consumer-oriented conduct).

In sum, the District Court's conclusion that conduct must be directed at every member of the general public and not based on membership in a pre-existing group, is not only inconsistent with cases from state and federal courts in New York—it has been repeatedly ***rejected*** by those courts.[7] If permitted to stand, the District Court's ruling will carve out a wide range of deceptive conduct from the GBL's reach and artificially divide consumers based on how they became exposed to a defendant's deceptive conduct (e.g., through the workplace, a professional association, a membership plan, or a pre-existing contractual relationship). In this case, upholding the Court's conclusion would mean barring any employee insured through an employer-sponsored plan from ever asserting a GBL claim. More broadly, it would also mean barring any individual who is subjected to deceptive

[7] For additional examples, see *McCracken v. Verisma Sys., Inc.*, 131 F. Supp. 3d 38, 46–47 (W.D.N.Y. 2015) (denying motion to dismiss patients' GBL § 349 claim against hospital and medical records provider who charged patients excessive amounts for copies of medical records, despite the fact that the conduct was directed at only consumers who had already received treatment from the medical provider); and *Hoover v. HSBC Mortg. Corp.*, 9 F. Supp. 3d 223, 253–54 (N.D.N.Y. 2014) (denying motion to dismiss borrowers' GBL § 349 claim against mortgage lenders and insurers who "force-placed" excessive flood insurance coverage on its borrowers, but not the general public, in kickback scheme).

conduct or marketing through his membership in a particular group from asserting a GBL claim. This is not the law. All that is required is allegations sufficient to show that a defendant's conduct had a broad impact on "numerous insureds." *See Millennium Health, LLC*, 240 F. Supp. 3d at 286. With 994,500 members enrolled in the GHI Plan, this test is unquestionably met.

2. The District Court Erred in Viewing Plavin's Claims as a Private Contract Dispute Unique to One Insured, When in Fact the Claims Concern Deceptive Marketing of Insurance to Multiple Insureds

Animating the District Court's "general public" analysis was its view that this case involves a private contract dispute. According to the District Court, because the original source of Plavin's relationship with GHI was a contract between GHI and the City of New York, and Plavin is purportedly a "third-party beneficiary" to this contract, the deceptive conduct was not consumer-oriented and this case is nothing more than a "private contractual dispute." *See, e.g.*, A18–19 (conduct not consumer-oriented because "the alleged deception arises out of a private contract").[8] This is both legally and factually incorrect.

First, the District Court erred in relying on and making assumptions about a contract that was not even part of the record. Without reviewing a single term in that contract, the Court concluded that Plavin must be a third-party beneficiary to

[8] The District Court also relied on this contract in dismissing Plavin's unjust enrichment claim. That issue is discussed in Section IV below.

the contract and therefore is not a consumer because his claims are incidental to a private third-party contract negotiated by sophisticated parties. A19-23. There is no basis for this conclusion.

A third-party beneficiary is a beneficiary with standing to sue under a contract to which it is not a party. *See, e.g.*, *Dormitory Auth. v. Samson Constr. Co.*, 94 N.E.3d 456, 459 (N.Y. 2018). The New York Court of Appeals has held that such right exists in only two situations: "when the third party is the only one who could recover for the breach of contract or when it is otherwise clear from the language of the contract that there was 'an intent to permit enforcement by the third party.'" *Id.* (quoting *Fourth Ocean Putnam Corp. v. Interstate Wrecking Co*., 485 N.E.2d 208, 212 (N.Y. 1985)). Neither circumstance is satisfied here. Plavin has no greater right to sue under the City's contract with GHI than a City resident would have to sue a waste management company for breach of its contract with the City. Indeed, the absence of such a right, coupled with GHI's failure to ever send GHI Plan members policies or other contracts, is precisely why Plavin is alleging a claim for unjust enrichment: there is no express contract that Plavin has to enforce against GHI for anything.

In concluding otherwise, the District Court made assumptions about a contract that it has not even seen. This is improper at any stage of the litigation, and particularly on a motion to dismiss, when courts are confined to the four

corners of the complaint (with limited exceptions). *See Schmidt v. Skolas*, 770 F.3d 241, 249 (3d Cir. 2014) ("To decide a motion to dismiss, courts generally consider only the allegations contained in the complaint, exhibits attached to the complaint and matters of public record.") (internal quotation marks omitted).

Second, the distinction between private contract disputes and "consumer-oriented" conduct is not whether a contract lurks in the background of the parties' relationship. Rather, the question is whether the plaintiff's claim arises from a "single shot transaction" and bears solely on the specific terms of his insurance policy or interaction with the insurer, or whether the claim concerns the insurer's conduct that does or could affect similarly situated insureds. *Compare Genesco Entm't v. Koch*, 593 F. Supp. 743, 752 (S.D.N.Y. 1984) (dispute over "single shot transaction" regarding sophisticated party's rental of a municipal stadium was the type of individualized, complex contract distinct from average consumers paying modest sums for a good or service), *with Kurschner v. Mass. Cas. Ins. Co.*, No. 08-0011, 2009 WL 537504, at *13–14 (E.D.N.Y. Mar. 3, 2009) (finding plaintiff alleged consumer-oriented activity where the dispute was "not limited to a challenge regarding coverage made on the basis of facts unique to a single insured" but rather concerned defendant's "actions in its dealings with multiple insureds") (internal quotation marks and alterations omitted).[9]

[9] *See Karlin v. IVF Am., Inc.*, 712 N.E.2d 662, 667 (N.Y. 1999) (GBL §§ 349 and

This case is not about a "single shot transaction," but rather broad deceptive conduct directed at hundreds of thousands of insureds. Indeed, that is precisely the reason why this case was filed as a class action. Plavin's claims here are about GHI's misleading advertisements to Plavin and similarly situated consumers who were in the market to purchase insurance—not the terms of GHI's contract with the City. Because a defendant's acts are "consumer oriented" if they "have an impact broader than the particular plaintiffs, as opposed to a private contract dispute," *U.S. ex rel. Krahling v. Merck & Co.*, 44 F. Supp. 3d 581, 605 (E.D. Pa. 2014), the terms of GHI's contract with the City are irrelevant to Plavin's GBL claims. Whatever those terms, GHI was not permitted to then mislead hundreds of thousands of City employees and retirees regarding out-of-network reimbursements. *See Gaidon*, 725 N.E.2d at 604, (merger provision in contract is "not determinative of plaintiffs' section 349 claims, which are based on deceptive business *practices*, not on deceptive contracts") (emphasis in original).

Courts regularly find that insurers' standardized practices towards multiple prospective or current insureds may subject them to GBL liability, just like any other seller in the market. The Court does not need to look further than *Gaidon*, which held that GBL claims alleging an insurer provided deceptive insurance

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350 claims not viable for "victims of deception in a single transaction in which the only parties truly affected by the alleged misrepresentations were plaintiffs and defendants").

illustrations to prospective policyholders "involved an extensive marketing scheme that had a broader impact on consumers at large," and therefore was not a "private contract dispute as to policy coverage." *Id.* (internal quotation marks omitted); *see Autobahn*, 953 N.Y.S.2d at 102 (rejecting insurer's argument that plaintiffs' claims were based on a "private contract dispute" or "single shot transaction" where defendant's standard practice was to "misle[a]d [insureds] . . . into believing that they must have their vehicles repaired at [authorized] repair shops" rather than independent shops of their choosing).[10]

For these reasons, the District Court's reliance on the *New York University* (A19–20) and *Sichel* (A23) cases was misplaced. *New York University* involved a dispute over the university's claim under its private, tailored commercial crime insurance policy. *New York Univ. v. Cont'l Ins. Co.*, 662 N.E.2d 763, 770 (N.Y. 1995). By contrast here, Plavin is not a sophisticated party with a unique insurance policy, the City is not the insured, this is not commercial insurance, and Plavin's claims have nothing to do with the terms of or negotiation surrounding the contract between the City and GHI.

Like *New York University*, *Sichel* involved an insured's private dispute with

[10] *See also Wilner v. Allstate Ins. Co.*, 893 N.Y.S.2d 208, 213, 216 (N.Y. App. Div. 2010) (collecting cases and concluding that allegations of insurer's deceptive policy effectively requiring insureds to litigate a claim on the insurer's behalf satisfied consumer-oriented standard where the disputed provision "is not unique to the plaintiffs, but is contained in every [homeowners' policy issued by defendant]").

his disability insurers, rather than consumer-oriented conduct, where he contested the diagnosis of a physician hired by the insurers to evaluate his ability to work following an injury. *Sichel v. UNUM Provident Corp.*, 230 F. Supp. 2d 325, 330 (S.D.N.Y. 2002). As the Court in *Sichel* recognized, an insurer's handling of unique claim processing disputes like the one in *New York University* is not comparable to a uniform marketing scheme directed at thousands of consumers, as was the case in *Gaidon* (and here). *Id.* at 330 (comparing *Gaidon*, 725 N.E.2d at 603–04, *with New York Univ.*, 662 N.E.2d at 770–71).

In this case, while the City's contract with GHI may have been the product of private contract negotiations between sophisticated parties, Plavin's relationship with GHI was not. It was the product of Plavin—along with 311,880 other NYC employees and non-Medicare retirees—receiving GHI's deceptive marketing materials touting its "comprehensive" out of network coverage, electing the GHI Plan, never receiving a policy or reimbursement schedule, and then finding out that GHI was reimbursing, on average, 23% of out-of-network costs, and for some procedures as low as 9%. A60–63 (Compl. ¶¶ 20–29).

Third, even if Plavin were a third-party beneficiary—which he is not—the Court did not identify a single case holding that third-party beneficiaries of a contract cannot also be consumers for purposes of the GBL or cannot bring GBL claims. Case law confirms there are no such restrictions on GBL lawsuits. *See*

Hart v. Moore, 587 N.Y.S.2d 477, 478–80 (N.Y. Sup. Ct. 1992) (concluding that a "third party beneficiary to an insurance policy may sue the insurance company for deceptive acts and practices under [GBL] 349" based on the "broad application" and "remedial" purpose of the statute, and permitting plaintiff, who was injured at a friend's home, to pursue GBL claims against friend's homeowners policy insurer based on "company-wide" practice of requiring general claim releases); *cf. Am. Med. Assoc. v. United Healthcare Corp.*, No. 00-2800, 2003 WL 22004877, at *1, *6 (S.D.N.Y. Aug. 22, 2003) (permitting New York public employees' unions to intervene in a lawsuit against United Healthcare to assert GBL claims on behalf of their United-insured members—"approximately two million New York State and municipal employees"—for deceptive conduct related to the insurer's out-of-network charge determinations). Reaching a different result here would impermissibly narrow New York's broad consumer protection laws.

3. The New York Attorney General's Investigation and Assurance of Discontinuance Support a Finding that Plavin Adequately Alleged Consumer-Oriented Conduct

The NYAG found that GHI engaged in "repeated" violations of GBL §§ 349 and 350 in marketing its insurance plan to City employees and retirees. A66 (Compl. ¶ 39); A174 (AOD ¶ 26). The District Court discounted the NYAG's finding by emphasizing that GHI admitted no wrongdoing, *see* A24–25, instead of construing this finding in the light most favorable to Plavin. Had the District Court

applied the correct standard, the NYAG's finding supports the plausibility of Plavin's allegations that GHI engaged in "consumer oriented" conduct. A66–67 (Compl. ¶¶ 39–40).[11]

These findings were predicated on a determination that Defendant's conduct was "consumer-oriented"—a necessary element of the GBL claims.[12] *See People ex rel. Schneiderman v. Orbital Pub. Grp., Inc.*, 21 N.Y.S.3d 573, 585–86 (N.Y. Sup. Ct. 2015) ("In order to make a prima face case under GBL § 349, the State must show that the respondents have engaged in a 'deceptive act or practice that is consumer oriented.'") (quoting *Gaidon*, 725 N.E.2d at 603). The District Court failed to acknowledge that NYAG applies the standard GBL elements in investigating claims pursuant to Article 22-A of the GBL, which includes §§ 349 and 350.

[11] *See, e.g.*, *Kucher v. Domino's Pizza, Inc.*, No. 16-2492, 2017 WL 2987214, at *3, *6–7 (S.D.N.Y. Feb. 13, 2017) (granting conditional certification in FLSA case based in part on finding that "material in the [New York Attorney General's] assurance of discontinuance . . . add[s] some credence to the Plaintiffs' allegations" and "at least undermine[s]" defendants' claims that Plaintiffs fail to identify a policy or practice of requiring workers at multiple restaurants to clock out before the end of their shifts).

[12] The NYAG repeatedly identified City employees and retirees as "consumers" in determining that GHI violated GBL §§ 349 and 350. A168–77 (AOD ¶¶ 7, 13, 19, 20, 27, 34, 35).

B. The District Court Ignored Binding New York Law and Prejudged the Merits in Concluding that GHI's Marketing Materials are Not Materially Misleading

A deceptive act or practice is misleading if it is "likely to mislead a reasonable consumer acting reasonably under the circumstances." *Cohen v. JP Morgan Chase & Co.*, 498 F.3d 111, 126 (2d Cir. 2007) (quoting *Oswego*, 647 N.E.2d at 745). Both affirmative representations and omissions are actionable under the GBL. *Gaidon*, 725 N.E.2d at 604, 610; *see In re Evergreen Mut. Funds Fee Litig.*, 423 F. Supp. 2d 249, 264 (S.D.N.Y. 2006) ("Omissions, as well as acts, may form the basis of a deceptive practices claim" under the GBL) (citing *Stutman v. Chemical Bank*, 731 N.E.2d 608, 611 (N.Y. 2000)). Whether a deceptive act or practice is materially misleading is almost always a question of fact that cannot be resolved on a motion to dismiss. *See Buonasera v. Honest Co.*, 208 F. Supp. 3d 555, 566 (S.D.N.Y. 2016) ("Courts have generally held that since this second factor requires a reasonableness analysis, it cannot be resolved on a motion to dismiss."). Dismissal is proper only when the "impressions that a reasonable consumer might draw are 'patently implausible' or 'unrealistic,'" meaning that, as a matter of law, *no* reasonable consumer could be misled. *Eidelman v. Sun Prods. Corp.*, No. 16-3914, 2017 WL 4277187, at *4 (S.D.N.Y. Sept. 25, 2017) (denying motion to dismiss because "the Court cannot conclude as a matter of law . . . that no reasonable consumer could be misled" by statements on a laundry detergent

bottle that the brand was recommended by dermatologists for sensitive skin when only other detergents within the brand, and not that particular formula, were recommended).

1. The District Court Erred in Deciding GHI's Conduct Was Not "Materially Misleading" as a Matter of Law Based on Disclaimers

In deciding that the Complaint failed to allege materially misleading conduct as a matter of law, the District Court principally relied on the presence of purported disclaimers in GHI's marketing materials. *See generally* A23–33 (weighing misrepresentations against disclaimers). The Court determined that GHI's statements that insureds "may" have to pay more for out-of-network services than shown in the coverage examples, that the examples were not "cost estimators," and that the optional Rider provided increased coverage only for "certain" services, meant that no reasonable consumer could rely on the coverage examples to accurately reflect levels of reimbursement. *See* A23–35.

New York's highest court has held that the presence of warnings or disclaimers in marketing materials or advertisements "do not bar plaintiffs' claims for deceptive trade practices at this stage of the proceedings [i.e., on a motion to dismiss], as they do not establish a defense as a matter of law." *Koch v. Acker, Merrall & Condit Co.*, 967 N.E.2d 675, 676 (N.Y. 2012) (reversing dismissal of GBL claims based on "disclaimers set forth in defendant's catalogs"); *Gaidon*, 725

N.E.2d at 604–05, 608 (reversing dismissal of GBL claims based on disclaimer because insurance illustrations can create "unrealistic expectations," notwithstanding the presence of a disclaimer); *see Orbital Pub. Grp., Inc*., 21 N.Y.S.3d at 586 (presence of disclaimer "does not justify dismissal," but rather "raises a question of fact" about misleading nature of deceptive statements). Accordingly, the District Court's dismissal of Plavin's GBL claims based on the purported disclaimers in GHI's marketing materials was error.

Even if the disclaimers were properly considered, the fact that the misleading examples of out-of-network coverage are qualified by boilerplate language that says "this is not a cost estimator" or that says reimbursements "may be less than the fee charged by the non-participating provider" does not mean as a matter of law that no reasonable insured could have been misled into thinking reimbursement rates would be higher than they actually were.[13] A27-31. *See*

[13] Just the opposite, when the NYAG analyzed GHI's deceptive practices, the presence of these purported "disclaimers" did not affect its conclusion that GHI plainly engaged in materially misleading conduct. Indeed, the NYAG found one of the disclaimers relied upon by the District Court to ***itself*** be a misleading statement: A169–70 (AOD ¶¶ 12–13) ("Documents prepared for prospective and current GHI Plan members merely suggest that it is only a possibility that members will be required to pay for out-of-network services. For example, the Summary Program Description states that '[t]he reimbursement levels as provided by the schedule, may be less than the fee charged by the non-participating provider.' . . . . However, it is highly likely that GHI Plan members will be required to pay for out-of-network services. The reimbursement amounts in the Schedule are in most, if not all, circumstances less – and in many instances, *far less* – than the actual fees charged by out-of-network providers. Thus, in many instances, the small

Gaidon, 725 N.E.2d at 604–05 ("Consumers vary in their level of sophistication and their ability to perceive the connection" between various statements in insurance marketing materials). Whether the disclaimers defeat Plavin's GBL claims on the merits is a fact question that the District Court prematurely decided at the pleadings stage, before discovery into GHI's practices has been completed or put before the Court. *Id.* (the "prospect" that "reasonable consumers could be misled in a material way . . . is enough to create a question of fact" where "[t]he very goal of the marketing scheme was to convince prospective purchasers" that the insurance illustrations were realistic).

2. The District Court Erred in Suggesting that Reliance is an Element of a GBL Claim and that Omissions are Not Actionable

Compounding the above errors, the District Court's Opinion also suggested that (a) reliance is an element of a GBL claim and that (b) omissions are not actionable. On reliance, the Opinion faulted Plavin for failing to allege he would not have chosen GHI's insurance plan had he known the truth about the out-of-network reimbursements. A30–32. But, under controlling New York law, Plavin is not required to allege or prove reliance. New York's highest court has made

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reimbursement amount will result in substantial out-of-pocket costs for the consumer. GHI's materials do not accurately set forth the potentially wide gap between the out-of-network reimbursement and out-of-network charges, and potentially substantial out-of-pocket amounts for which GHI Plan members will be responsible.") (emphasis in original).

clear that there is no "reliance requirement [for] General Business Law §§ 349 and 350 claims." *Koch*, 967 N.E.2d at 676 (reversing dismissal of GBL claims).[14]

On omissions, the Opinion stated that "Plavin does not allege any *explicit* misrepresentations so much as complain that the marketing materials should have contained more information about out-of-network coverage." A25. But, under New York law, both representations *and* omissions are actionable under the GBL. *Gaidon*, 725 N.E.2d at 604 ("This Court has defined a 'deceptive act or practice' as a representation or omission . . ."). The gravamen of Plavin's claims is that GHI portrayed the GHI Plan as a normal PPO that provides comprehensive coverage for out-of-network services, but failed to disclose highly unfavorable information about its out-of-network reimbursements prior to plan selection or renewal. These allegations fit squarely within *Gaidon*'s rubric.

3. As Confirmed by *Gaidon*, the Allegations are Sufficient to Support a Claim of "Materially Misleading" Statements

Plavin alleges that GHI's marketing materials deceived potential insureds into believing that the plan would provide "comprehensive" out-of-network coverage at reasonable levels of reimbursement that were consistent with GHI's coverage examples. A60–62 (Compl. ¶¶ 19–20, 25).

[14] Moreover, the only case cited by the District Court on this point analyzes a claim under Insurance Law § 4226, not GBL §§ 349 or 350. *See* A31.

Plavin alleges the following misrepresentations and omissions in GHI's materials: (a) GHI's illustrations, or coverage examples, showing a 66% reimbursement rate for a sample service, were nowhere near the average reimbursement rate of 23% and failed to apprise consumers that reimbursement rates for certain services could be as low as 9%; (b) GHI failed to disclose that the 1983 Schedule had effectively not been updated and did not provide reimbursement levels even close to the amounts reflected in the marketing materials; (c) GHI failed to disclose that the statement that reimbursement amounts "may be less" than the fee charged by the non-participating provider actually means "will be substantially less"; (d) GHI failed to disclose that the optional Rider excluded all out-patient out-of-network services; and (e) GHI touted the benefits of its "additional 'Catastrophic Coverage,'" when the coverage was not actually additional, did not provide what is commonly referred to as Catastrophic Coverage, and GHI's promise to pay "100% of the Catastrophic Allowed Charge" was meaningless because that was simply the same as the normal allowance. A55–58 (*Id.* ¶¶ 4–12), A62–67 (*Id.* ¶¶ 27–40). Considering the totality of these detailed allegations, the Complaint satisfies the plausibility standard applicable on a motion to dismiss.

These allegations are a far cry from the GBL claims—usually in the consumer goods context—that "border on fantasy" and do not raise a question of

fact sufficient to withstand dismissal. *In re Frito Lay N. Am., Inc. All Nat. Litig.*, No. 12-2413, 2013 WL 4647512, at *15-16 (E.D.N.Y. Aug. 29, 2013). The types of claims courts have dismissed as a matter of law include a plaintiff's claims he believed the net weight printed on a package of seasoned shrimp referenced only the shrimp and not the other ingredients listed on the label, *see Verzani v. Costco Wholesale Corp.*, No. 09-2117, 2010 WL 3911499, at *2 (S.D.N.Y. Sept. 28, 2010) ("net weight means the weight of an item exclusive of its packaging," not exclusive of the other listed ingredients), or a plaintiff's claims he believed a bottle of Advil had more pills in it based on the size of the bottle despite the front label listing the number of pills, *see Fermin v. Pfizer, Inc.*, 215 F. Supp. 3d 209, 210–11 (E.D.N.Y. 2016).

For its part, the District Court relied on a consumer goods GBL case that follows the same pattern and is readily distinguishable. A32. This case, where consumers were presented with insurance marketing materials that were designed to overstate the extent of out-of-network coverage *and which have already been found deceptive by the New York Attorney General*, cannot plausibly be compared to the District Court's example, involving consumers who should know that the Yankees do not directly sell tickets on the ticket *resale* site StubHub.com. *Id.* (citing *Weinstein v. eBay Inc.*, 819 F. Supp. 2d 219, 228 (S.D.N.Y. 2011)).

Instead, Plavin's claims are on all fours with *Gaidon*, the leading GBL

insurance marketing case, where New York's highest court concluded that plaintiff sufficiently alleged defendant insurer's conduct was materially misleading because it falsely advertised vanishing premium life insurance policies "by using illustrations that created unrealistic expectations" of future premium payments. *Gaidon*, 725 N.E.2d at 604.

4. The District Court's Opinion Failed to Draw Reasonable Inferences in Plavin's Favor

In addition to misconstruing the applicable law, the District Court's Opinion repeatedly erred in declining to draw reasonable inferences in Plavin's favor, and, instead, drawing all inferences in the light most favorable to GHI. This is evident throughout the District Court's "materially misleading" analysis.

For example, in considering Plavin's allegations about the optional Rider, the Court substituted its own judgment for that of a reasonable consumer and failed to construe the allegations in the light most favorable to Plavin. A29–30. GHI touted the Rider as an "enhanced schedule for certain services [that] increases the reimbursement of the basic program's non-participating provider fee schedule, on average, by 75%." A65 (Compl. ¶ 36). Plavin alleges that GHI failed to disclose that the Rider applied only to in-patient out-of-network services and excluded all out-patient out-of-network services—which accounted for 65% of out-of-network costs. A65–66 (*Id.* ¶¶ 36–38). The Court concluded that GHI "already disclosed" this information by stating that the Rider only covered "certain services." A29–30.

By far the most reasonable inference to draw from this language is that a reasonable consumer would expect that the Rider excludes particular medical treatments, not that it excludes the entire *category* of out-patient out-of-network services. At the pleading stage, the Court should have accepted this reasonable inference.

Similarly, the Court erred in suggesting that Plavin should have known that GHI's plan was too good to be true since it was the only PPO offered to NYC workers that did not require out-of-pocket payment of additional premiums (beyond the premiums the City paid on Plavin's behalf as part of his compensation). A26–27. But many employer-sponsored health plans do not require payment of premiums, including normal PPOs that pay reasonable amounts of reimbursement. And, like many other public employees, health insurance was an integral part of Plaintiff's compensation package. *See* n.2. Once again, the District Court's reasoning failed to construe the allegations in the light most favorable to Plavin, which is that "[t]he very goal of the marketing scheme was to convince prospective purchasers" that GHI's representations of comprehensive out-of-network coverage were realistic. *Gaidon*, 725 N.E.2d at 604–05.

And the District Court went to great lengths to discount the significance of the NYAG's findings, construing them as applying only to the unsophisticated consumer—the "ignorant, the unthinking and the credulous"—rather than the

reasonable consumer. A24. (quoting *People ex rel. Spitzer v. Applied Card Sys., Inc.*, 805 N.Y.S.2d 175, 177 (N.Y. App. Div. 2005)). But *Spitzer* addressed only the standard for investigations under New York Executive Law § 63—which, unlike the GBL, does not have a reasonable consumer limitation. 805 N.Y.S.2d at 177. *Spitzer* expressly recognized this; the court went on to explain in the same paragraph that the GBL requires a showing that a "reasonable consumer" would have been misled. *Id.* at 178 (citing *People ex rel. Spitzer v. Gen. Elec. Co.*, 756 N.Y.S.2d 520, 523 (N.Y. App. Div. 2003) ("Executive Law § 63(12) was meant to protect not only the average consumer, but also the ignorant, the unthinking and the credulous, ... In contrast, under [GBL] § 349, the plaintiff must prove that . . . the deceptive practice must be likely to mislead a reasonable consumer acting reasonably under the circumstances.") (internal quotation marks and citations omitted)).

The District Court's Opinion ignores that the NYAG's investigation was also authorized under Article 22-A of the GBL, and its findings of repeated violations of GBL §§ 349 and 350 by GHI were necessarily based on the "reasonable consumer" standard. *See Orbital Pub. Grp.*, 21 N.Y.S.3d at 585–86 (in a special proceeding brought under § 63 and Article 22-A, stating that GBL §§ 349 and 350 require the conduct to be deceptive to a "reasonable consumer"

and that the State "raise[d] a question of fact as to whether reasonable consumers would be materially misled").

In sum, the District Court repeatedly and consistently drew inferences in GHI's favor, going so far as to advance arguments and reach conclusions that GHI did not even advocate. This was error. *See Phillips*, 515 F.3d at 231 (appellate court's role in reviewing dismissal on a Rule 12(b)(6) motion is to "accept all factual allegations as true, construe the complaint in the light most favorable to the plaintiff, and determine whether, under any reasonable reading of the complaint, the plaintiff may be entitled to relief") (internal quotation marks omitted).

III. The District Court Erred in Dismissing the New York Insurance Law Section 4226 Claim

New York Insurance Law § 4226 permits "any person aggrieved" by an insurer (like Defendant) who "knowingly" circulates or causes to be circulated any statement "misrepresenting the terms, benefits or advantages of any of its policies or contracts." N.Y. Ins. Law § 4226(a)(1), (d). Section 4226(a)(1) "reflects State policy that insurers deal fairly with their insureds and the public at large." *Unibell Anesthesia, P.C. v. Guardian Life Ins. Co. of Am.*, 658 N.Y.S.2d 14, 15 (N.Y. App. Div. 1997). Plavin alleges that he was "aggrieved" within the meaning of § 4226 when his expectations were not met and he had to pay substantial out-of-network costs as a result of GHI's conduct. A67 (Compl. ¶ 41).

As with the GBL claims, the District Court dismissed Plavin's § 4226 claim based on the presence of purported disclaimers, and based on the Court's resolution of disputed issues of fact against Plavin. A33–34. For the reasons described *supra* Section II.B, this Court also should reverse the District Court's dismissal of the § 4226 claim.

The District Court also held that Plavin's allegations failed to satisfy § 4226's purported "scienter" element. *See* A34–35 (concluding that the Complaint lacks allegations of "nefarious intent" based on Court's reading of the purported disclosures in Defendant's marketing materials). This too was incorrect. Section 4226 on its face requires only a showing that an insurer knowingly mispresented the terms, benefits, or advantages of a policy. Accordingly, "[a]s with a General Business Law § 349 claim, no proof of fraudulent intent is required to sustain an Insurance Law § 4226 violation." *Russo v. Mass. Mut. Life Ins. Co.*, 711 N.Y.S.2d 254, 256 (N.Y. App. Div. 2000), *rev'd in part on other grounds sub nom.*, *Gaidon v. Guardian Life Ins. Co. of Am.* (*Gaidon II*), 750 N.E.2d 1078 (N.Y. 2001). The District Court's conjuring of a "nefarious intent" scienter requirement was contrary to law.

Further, there is no basis to impose a Rule 9(b) pleading standard for the type of § 4226 claim alleged here. Similar to GBL § 349 claims, which are not subject to Rule 9(b)'s heightened pleading requirement, *see Pelman ex rel. Pelman*

v. McDonald's Corp., 396 F.3d 508, 511 (2d Cir. 2005) (GBL § 349 claims are subject only to Rule 8(a)'s pleading requirements), § 4226 claims do not require fraudulent intent and are not required to be pleaded as fraud claims. *Cf. Russo*, 711 N.Y.S.2d at 256 (like GBL § 349 claims, § 4226 "contemplates actionable conduct that does not necessarily rise to the level of fraud") (internal quotation marks omitted).[15] Nonetheless, Plavin alleged the who, when, where, and what of how GHI "misrepresent[ed] the terms, benefits or advantages of any of its policies or contracts," § 4226(a)(1), and it is well established that "[m]alice, intent, knowledge, and other conditions of a person's mind may be alleged generally." Fed. R. Civ. P. 9(b); *see* A73 (Compl. ¶ 69).

Indeed, Plavin's allegations of GHI's knowledge go well beyond general allegations that GHI engaged in knowing and willful behavior. A55–58, A61–62, A65 (Compl. ¶¶ 4–11, 25, 35) (deceptive promotion to foster enrollment in GHI

[15] In *Brach Family Found., Inc. v. AXA Equitable Life Ins. Co.*, No. 16-740, 2016 WL 7351675, at *4–5 (S.D.N.Y. Dec. 19, 2016), the court concluded the particular § 4226 claim in that case was subject to Rule 9(b) where it sounded in fraud; the court granted leave to amend to identify specific misleading statements, but found that the complaint already adequately pled scienter. The § 4226 claim ultimately survived once Plaintiff alleged specific misleading statements. *Brach Family Found., Inc. v. AXA Equitable Life Ins. Co.*, 2017 WL 5151357, at *1–2 (S.D.N.Y. Nov. 3, 2017), *reconsideration denied*, 2018 WL 3632500 (S.D.N.Y. July 30, 2018). Here, there is no question that specific misleading statements are identified, the claim does not sound in fraud, and the District Court's requirement of a specific allegation of "nefarious intent" has no basis in the statute or caselaw. On the contrary, it violates Rule 9(b)'s mandate that conditions of mind may be alleged "generally."

Plan over others while hiding truth about out-of-network reimbursement); A62–65 (*Id.* ¶¶ 27–35) (deception and concealment of reimbursement schedule and empty promises of "Catastrophic Coverage"); A65–66 (*Id.* ¶¶ 36–38) (marketing of worthless Rider); A54–55, 66 (*Id.* ¶¶ 1, 3, 39) (history of violating New York law in marketing and administration of the Plan). And if the District Court had granted leave to amend, Plavin could have added additional allegations establishing GHI's knowledge.

Finally, the District Court erred to the extent it ruled that reliance is an element of a § 4226 claim. *See* A31.[16] The plain text of § 4226 requires only that the plaintiff show a knowing misrepresentation, and New York courts have declined to write a reasonable reliance requirement into the statute. *See, e.g.*, *Cilente v. Phoenix Life Ins. Co.*, No. 600313/08, 2014 WL 70336 (N.Y. Sup. Ct. 2014) (dismissing claims for fraud on "reasonable reliance" grounds but permitting claims under § 4226 to proceed), *aff'd as modified*, 134 A.D.3d 505, 507 (N.Y. App. Div. 2015) (dismissing § 4226 claim because defendants established that their conduct was "inadvertent and not knowing"). Section 4226 does not require reliance for the same reason that New York courts have found that similar statutes, like GBL §§ 349 and 350, do not require reliance: for "General Business Law

[16] The case cited in the District Court's Opinion did not impose a reliance standard on § 4226 claims; rather, it discussed whether the plaintiff had alleged injury-in-fact sufficient to establish Article III standing.

§§ 349 and 350 claims . . .[,] [j]ustifiable reliance by the plaintiff is not an element of the statutory claim." *Koch*, 967 N.E.2d at 676. In the alternative, the District Court erred in dismissing this claim with prejudice rather than granting leave to amend to allege facts supporting reliance.

IV. The District Court Erred in Dismissing the Unjust Enrichment Claim

Unjust enrichment is an equitable claim that may be pled where the existence, validity, or scope of a contract is disputed—or where no contract at all governs the plaintiff's claims. *See, e.g.*, *Dervan v. Gordian Grp. LLC*, No. 16-1694, 2017 WL 819494, at *12 (S.D.N.Y. Feb. 28, 2017) ("[C]ourts . . . have routinely allowed plaintiffs to advance past the pleading stage on an alternate theory of unjust enrichment" when the existence of a contract is disputed). The mere existence of a contract, even on the same subject matter, does not automatically foreclose an unjust enrichment claim. Instead, the contract must "clearly cover" the dispute in question. *In re LIBOR-Based Fin. Instruments Antitrust Litig.*, 27 F. Supp. 3d 447, 483 (S.D.N.Y. 2014) ("[T]he predicate for dismissing quasi-contract claims is that [an enforceable] contract at issue clearly covers the dispute between the parties.") (internal quotation marks omitted). The District Court dismissed Plavin's unjust enrichment claim on the grounds that Plavin must be the third-party beneficiary of the contract between the City and GHI and the contract must cover the dispute between the parties regarding GHI's

deceptive marketing practices. This was error, for at least two reasons.

First, the Court principally relied on a contract it has never seen between GHI and the City. *Supra* Section II.A. Plavin did not bring a contract claim based on this or any other contract. More importantly, GHI did not attach this contract to its motion or rely on it as a basis for dismissal of the unjust enrichment claim.[17] As explained above, before assuming that Plavin is a third-party beneficiary of the contract, and that Plavin has standing to enforce the terms of the contract, the Court would have to analyze the contract itself. *E.g.*, *Dormitory Auth.*, 94 N.E.3d at 460.

Second, without reviewing the terms of the contract, the District Court could not have reasonably concluded that the contract covers the subject matter of the dispute. Plavin disputes both that he is a third-party beneficiary of the City's contract and that the contract covers GHI's deceptive marketing of its insurance plan. A62–67 (Compl. ¶¶ 27–40). That is why he brought an unjust enrichment claim; there is no express contract that Plavin has to enforce against GHI for anything.[18] Moreover, Plavin alleges that he never received a copy of the policy, let alone GHI's contract with the City. A60–61 (*Id.* ¶¶ 22–24). In light of these

[17] GHI attached only a Certificate of Insurance (COI) purportedly for the GHI Plan, *see* A191–234, which GHI claims is a valid contract between Plavin and GHI but which Plavin alleges he never received. A61 (Compl. ¶ 24).

[18] If the District Court believed otherwise, it should have granted leave to amend to assert a contract claim. It did not. Plavin does not request that relief because, for the reasons stated, there simply is no contract that governs Plavin's claims.

allegations, dismissal of the unjust enrichment claim was error. *See Nat'l Convention Servs., L.L.C. v. Applied Underwriters Captive Risk Assur. Co.*, 239 F. Supp. 3d 761, 794–95 (S.D.N.Y. 2017) ("Because the scope of the contractual obligations and further factual developments regarding the conduct of the parties have yet to be determined, dismissing the plaintiffs' unjust enrichment claim at this stage would be premature.") (internal quotation marks omitted).

V. The District Court Erred in Dismissing the Class Claims

The District Court concluded that the class claims fail because Plavin failed to adequately plead the underlying elements of the GBL and unjust enrichment claims. A40. For the reasons outlined above in Sections II-IV, the District Court erred in analyzing the elements of Plavin's claims, and therefore Plavin should be permitted to proceed with these claims on an individual and class basis.

VI. The District Court Erred in Concluding Amendment Would Be Futile

A. Standard of Review

This Court reviews for abuse of discretion the District Court's conclusion that amendment of the Complaint would be futile. *Grayson v. Mayview State Hosp.*, 293 F.3d 103, 108 (3d Cir. 2002).

B. Argument

Under Fed. R. Civ. P. 15(a)(3), "[t]he court should freely give leave when justice so requires." Here, the District Court dismissed all of Plavin's claims with prejudice.

Plavin agrees that amendment would be futile for certain claims if the District Court's legal determinations were upheld. For example, if no member of an employer-sponsored insurance plan could ever bring a GBL claim, then there is obviously no GBL claim that Plavin could plead. However, for the reasons stated above, those rulings are plainly contrary to New York law and should be reversed.

For other purported deficiencies, leave to amend should be granted even if the District Court's determinations are upheld (which they should not be). For example, the District Court's Opinion appears to assume that GHI's coverage examples were factually accurate for the services depicted, and that cherry-picking coverage examples is not by itself deceptive. A27–28. If granted leave to amend, Plavin would plead that in addition to misrepresenting average levels of reimbursement, the coverage examples were themselves false and entirely fabricated. *Compare* A87 (Summary of Benefits representing that pregnant insureds' "cost if you use a non-participating provider" will be "0% co-insurance" for out-of-network delivery and inpatient services, as well as prenatal and postnatal care) *with* A56–57, A63–64 (Compl. ¶¶ 8–9, 31–32) (alleging that GHI only reimbursed 15.25% of out-of-network maternity care and delivery costs, saddling insureds with a $7,661 bill); *see also Millennium Health*, 240 F. Supp. 3d at 286–87 (granting leave to amend to more specifically allege materially misleading representations under GBL § 349). This allegation, and others, would also bolster

Plavin's allegations that GHI knowingly misrepresented facts in violation of Insurance Law § 4226, which the District Court found deficient.

Further, if the District Court was going to rely on and make assumptions about a contract with the City of New York that was not part of the record, it should have granted leave to amend so Plavin could obtain and attach that contract and plead allegations showing that (a) he is not a third-party beneficiary and (b) the contract does not cover Plavin's claims.

CONCLUSION

For the foregoing reasons, Plavin respectfully submits that the opinion and order of the District Court dismissing his GBL §§ 349 and 350, Insurance Law § 4226, and unjust enrichment claims, as well as the class claims, should be reversed.

Dated: New York, New York
October 10, 2018

Respectfully submitted,

SUSMAN GODFREY L.L.P.

By: *s/ William Christopher Carmody*

William Christopher Carmody
Arun Subramanian
Halley W. Josephs
SUSMAN GODFREY L.L.P.
1301 Avenue of the Americas, 32nd Floor
New York, NY 10019-6023
Tel.: 212-336-8330
Fax: 212-336-8340
bcarmody@susmangodfrey.com
asubramanian@susmangodfrey.com
hjosephs@susmangodfrey.com

J. Timothy Hinton, Jr., Esq. (PA ID 61981)
Michael F. Cosgrove, Esq. (PA ID 47349)
HAGGERTY HINTON & COSGROVE LLP
203 Franklin Avenue
Scranton, PA 18503
Tel: (570) 344-9845
timhinton@haggertylaw.net
mikecosgrove@haggertylaw.net

Attorneys for Plaintiff-Appellant and the Class

CERTIFICATION OF COUNSEL

I, William Christopher Carmody, hereby certify that:

1. I am a member of the bar of this court;

2. This brief complies with the type-volume limitation of Fed. R App. P. 32(a)(7)(B) because this brief contains 12,115 words, including parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii);

3. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman (14 point font);

4. The electronic version of this brief is identical to the text version in the paper copies filed with the court. This document was scanned using Bit Defender Version 6.2.23.932 (with updated definition file as of October 10, 2018) and that no viruses were detected.

5. On this date, Seven hard copies of the foregoing Brief for Plaintiff-Appellant and Joint Appendix Volume I of II were sent to the Clerk's Office. Pursuant to Local Appellate Rules 31.1(d) and 113.4(a), I caused the foregoing to be served on counsel for Defendant-Appellee via the Notice of Docket Activity generated by the Court's electronic filing system (i.e., CM/ECF) and via electronic mail.

Dated: New York, New York
October 10, 2018

Respectfully submitted,

SUSMAN GODFREY L.L.P.

By: *s/ William Christopher Carmody*

William Christopher Carmody
Arun Subramanian
Halley W. Josephs
SUSMAN GODFREY L.L.P.
1301 Avenue of the Americas, 32nd Floor
New York, NY 10019-6023
Tel.: 212-336-8330
Fax: 212-336-8340
bcarmody@susmangodfrey.com
asubramanian@susmangodfrey.com
hjosephs@susmangodfrey.com

J. Timothy Hinton, Jr., Esq. (PA ID 61981)
Michael F. Cosgrove, Esq. (PA ID 47349)
HAGGERTY HINTON & COSGROVE LLP
203 Franklin Avenue
Scranton, PA 18503
Tel: (570) 344-9845
timhinton@haggertylaw.net
mikecosgrove@haggertylaw.net

Attorneys for Plaintiff-Appellant and the Class