United States Court of Appeals
for the
Third Circuit

Case No. 18-2490

STEVEN PLAVIN,

Plaintiff-Appellant,

– v. –

GROUP HEALTH INCORPORATED,

Defendant-Appellee.

ON APPEAL FROM AN ORDER ENTERED IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF PENNSYLVANIA IN CASE NO. 3-17-CV-01462 ROBERT D. MARIANI, U.S. DISTRICT JUDGE

BRIEF FOR DEFENDANT-APPELLEE

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United States Court of Appeals for the Third Circuit

Corporate Disclosure Statement and Statement of Financial Interest

No. 18-2490

Steven Plavin

v.

Group Health Inc.

Instructions

Pursuant to Rule 26.1, Federal Rules of Appellate Procedure any nongovernmental corporate party to a proceeding before this Court must file a statement identifying all of its parent corporations and listing any publicly held company that owns 10% or more of the party's stock.

Third Circuit LAR 26.1(b) requires that every party to an appeal must identify on the Corporate Disclosure Statement required by Rule 26.1, Federal Rules of Appellate Procedure, every publicly owned corporation not a party to the appeal, if any, that has a financial interest in the outcome of the litigation and the nature of that interest. This information need be provided only if a party has something to report under that section of the LAR.

In all bankruptcy appeals counsel for the debtor or trustee of the bankruptcy estate shall provide a list identifying: 1) the debtor if not named in the caption; 2) the members of the creditors' committee or the top 20 unsecured creditors; and, 3) any entity not named in the caption which is an active participant in the bankruptcy proceedings. If the debtor or the bankruptcy estate is not a party to the proceedings before this Court, the appellant must file this list. LAR 26.1(c).

The purpose of collecting the information in the Corporate Disclosure and Financial Interest Statements is to provide the judges with information about any conflicts of interest which would prevent them from hearing the case.

The completed Corporate Disclosure Statement and Statement of Financial Interest Form must, if required, must be filed upon the filing of a motion, response, petition or answer in this Court, or upon the filing of the party's principal brief, whichever occurs first. A copy of the statement must also be included in the party's principal brief before the table of contents regardless of whether the statement has previously been filed. Rule 26.1(b) and (c), Federal Rules of Appellate Procedure.

If additional space is needed, please attach a new page.

Pursuant to Rule 26.1 and Third Circuit LAR 26.1, Group Health Inc.
makes the following disclosure: (Name of Party)

1) For non-governmental corporate parties please list all parent corporations: Group Health Inc.'s direct corporate parent is Health Insurance Plan of Greater New York, Inc., which is a direct subsidiary of EmblemHealth, Incorporated.

2) For non-governmental corporate parties please list all publicly held companies that hold 10% or more of the party's stock:

None.

3) If there is a publicly held corporation which is not a party to the proceeding before this Court but which has as a financial interest in the outcome of the proceeding, please identify all such parties and specify the nature of the financial interest or interests:

4) In all bankruptcy appeals counsel for the debtor or trustee of the bankruptcy estate must list: 1) the debtor, if not identified in the case caption; 2) the members of the creditors' committee or the top 20 unsecured creditors; and, 3) any entity not named in the caption which is active participant in the bankruptcy proceeding. If the debtor or trustee is not participating in the appeal, this information must be provided by appellant.

/s/ John Gleeson
(Signature of Counsel or Party)

Dated: 11/16/18

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Defendant-Appellee Group Health Incorporated ("GHI") respectfully submits this brief in opposition to the appeal filed by Plaintiff-Appellant Steven Plavin ("Plaintiff") from the Memorandum Opinion and Order of the United States District Court for the Middle District of Pennsylvania (Robert D. Mariani, J.), dated June 22, 2018 ("Dist. Ct. Op.") (A1, A42),[1] that dismissed with prejudice the Complaint pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure for failure to state a claim.

COUNTER-STATEMENT OF THE ISSUES

This is an appeal from the District Court's dismissal of the Complaint. The allegations centered around a New York City-sponsored health insurance plan offered by GHI (the "GHI Plan"). The City of New York (the "City") negotiated the benefits offered under the GHI Plan in cooperation with the Municipal Unions that represent City employees. Plaintiff, a retired City police officer, has been enrolled as a member in the GHI Plan since 1984. Thirty-three years into Plaintiff's membership, he filed the Complaint on behalf of himself and a putative class and alleged that GHI, through documents summarizing the benefits offered under the GHI Plan, misled members concerning the amount of reimbursement GHI would provide for certain medical services. The Complaint asserted claims for violations of New York General Business Law (the "GBL") (second and third

[1] "A" refers to the Appendix filed in this appeal.

claims) and New York Insurance Law (the "Insurance Law") (fourth claim), and for unjust enrichment (first claim). The District Court dismissed all of the claims with prejudice.

The following issues presented on Plaintiff's appeal are reviewed *de novo*:

1. Whether the District Court properly dismissed the GBL claims on the ground that the alleged deceptive acts failed to implicate "consumer-oriented conduct" because they relate to one of the 11 private contracts of insurance negotiated by the City and the Municipal Unions that represented the interests of City employees. (Raised at A125-128, A431-433; Ruled on at A17-23).

2. Whether the District Court properly dismissed the GBL and Insurance Law claims where the summary documents explaining the GHI Plan contained no false statements and are not materially misleading to a reasonable person acting reasonably under the circumstances. (Raised at A128-134, A433-435; Ruled on at A23-35).

3. Whether the District Court properly dismissed the Insurance Law claim because the Complaint contained no allegations of scienter, *i.e.*, that GHI made allegedly deceptive statements knowingly and in knowing violation of the Insurance Law. (Raised at A140-142, A441; Ruled on at A33-35).

4. Whether the District Court properly dismissed the unjust enrichment claim where (i) the subject matter of the claim is governed by contract (*i.e.*, the GHI

Plan); (ii) the claim is duplicative of Plaintiff's statutory claims; and (iii) Plaintiff failed to plead the elements of an unjust enrichment claim. (Raised at A134-139; Ruled on at A435-439).

5. Whether this Court should affirm dismissal of the Complaint on the alternative ground that the claims all are barred by the applicable statutes of limitations given that Plaintiff has been a member of the GHI Plan for 33 years, and has submitted out-of-network claims and received allegedly inadequate reimbursement from GHI since 2004. (Raised at A134-139, A424-430; Ruled on at A35-39).

The following issue presented on this appeal is reviewed for abuse of discretion:

1. Whether the District Court properly exercised its discretion in dismissing the Complaint in its entirety without leave to amend given that any attempted amendment would be futile and that Plaintiff waived the right to request leave to amend. (Raised at A413; Ruled on at A40-41).

STATEMENT OF RELATED CASES

There are no related cases.[2] This case has not previously been before this Court.

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[2] For the sake of completeness, GHI notes that Plaintiff's co-counsel in the proceedings below, Steve Cohen, was a plaintiff-relator in the case captioned *Cohen et al. v. Group Health Incorporated, et al.*, Index No. 101160/2014, filed in

STATEMENT OF THE CASE AND PROCEEDINGS BELOW

I. THE GHI PLAN.

GHI is a not-for-profit corporation organized under the laws of New York that is authorized to operate as an indemnity insurer. *See* Compl. ¶ 14 (A58). The City offers 11 health plans to its employees and retirees and their families as part of their compensation and retirement packages. *Id.* ¶ 2, 19 (A55, 60). Among them (and at issue here) is GHI's Comprehensive Benefits Plan (the "GHI Plan"), a preferred provider organization (PPO) plan, which provides in-network coverage as well as partial reimbursement for out-of-network services. *Id.* ¶¶ 1-2 (A54-55). The GHI Plan is sponsored and paid for entirely by the City, and members pay no out-of-pocket premiums. *Id.* ¶¶ 19-20 (A60). The GHI Plan is the only PPO plan offered by the City that does not require members to pay premiums out of pocket. *Id.* ¶ 2 (A55).

The GHI Plan is provided to City employees and retirees pursuant to a contract between the City and GHI, which the City negotiated in cooperation with the Municipal Unions that represent City employees. Summary Program Description at 1 (A327) ("Through collective bargaining agreements, the City of

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the Supreme Court of the State of New York, New York County. The plaintiffs-relators in *Cohen* asserted claims for alleged violations of the New York False Claims Act based, in part, on the GHI Plan. GHI filed a motion to dismiss in *Cohen*, and the case was voluntarily discontinued with prejudice on October 16, 2018.

New York and the Municipal Unions have cooperated in choosing health plans and designing the benefits for the City's Health Benefits Program.").

Information about the GHI Plan is available to City employees and retirees in a Summary Program Description (the "SPD") and an online Summary of Benefits & Coverage (the "SBC"). *See* Compl. ¶ 5 (A55-56). The SBC and excerpts of the SPD were attached as exhibits to the Complaint (Compl. Exs. A & B (A80, 84)) and GHI submitted the full SPD in support of its motion to dismiss. (A325).

The SPD is prepared by the New York City Office of Labor Relations – which is responsible for administering the 11 different health plans offered by the City – and summarizes certain details concerning these plans. *See* Compl. ¶ 22 (A60-61). The SBC and SPD are provided to City employees and retirees "to help them select health plans" by allowing them to compare the GHI Plan to the various other plans offered by the City. *Id.* The actual coverage and benefits provided under the GHI Plan are described in a Certificate of Insurance, which is publicly available on the website of GHI's parent company, EmblemHealth, and which GHI submitted on its motion to dismiss. *See* Certificate of Insurance (A191).[3]

[3] *Availalble at* https://www.emblemhealth.com/~/media/Files/PDF/NYC%20Certificate%20of%20Insurance.pdf.

II. ALLEGATIONS OF THE COMPLAINT.

Plaintiff is a retired New York City police officer who is a resident of Pennsylvania. Compl. ¶ 13 (A58). Plaintiff has been a member of, and covered by, the GHI Plan since he first enrolled in 1984, and his coverage has at times extended to members of his family. *Id.* On August 16, 2017, Plaintiff filed a Complaint in the United States District Court for the Middle District of Pennsylvania on behalf of himself and a putative class of "[a]ll persons who were members of [the GHI Plan] from 2011 to 2015." *Id.* ¶ 42 (A68). The Complaint alleged that the SPD and SBC "convey[ed] the impression that employees faced little risk of incurring large reimbursement deficits" (*id.* ¶ 6 (A56)) and failed to disclose that the reimbursement rates for out-of-network medical services under the GHI Plan "would be a fraction of the actual cost of that service." *Id.* ¶ 5(A55-56). The Complaint also alleged that GHI misrepresented "catastrophic coverage" under the GHI Plan, and misled potential enrollees about the so-called optional "Enhanced Out-of-Network Rider." *Id.* ¶¶ 10-11 (A57-58).

Plaintiff and members of his family received reimbursement under the GHI Plan for hundreds of out-of-network claims since at least 2004. Manalansan Decl. ¶ 6 (A163-64). Plaintiff specifically claims that he was injured when his wife received out-of network services in February 2013, March 2014, and July 2014, and GHI did not provide the amount of reimbursement under the GHI Plan that

Plaintiff anticipated. Compl. ¶ 41 (A67). The Complaint does not identify the particular medical procedures Plaintiff's wife received, nor does the Complaint identify any specific misrepresentations GHI purportedly made that would have led a reasonable person to believe that the reimbursement rates for those procedures would have been greater than the reimbursement Plaintiff actually received. Rather, the Complaint makes the unsupported and conclusory allegation that out-of-network coverage was "functionally illusory." *Id.* ¶ 7 (A56).

The SPD and SBC – which Plaintiff claims contained the purported misleading statements – do not provide or identify actual reimbursement rates for any services, nor do they suggest that specific rates apply for certain services. Rather, the documents are provided for the express purpose "to help [prospective members] select health plans" by comparing the GHI Plan to other plans offered by the City. *Id.* ¶ 22 (A60-61). The summary documents explain in bold type that they provide "**only a summary**" of the GHI Plan, and that members "can get the complete terms in the policy or plan document at www.emblemhealth.com or by calling 1-800-624-2414." Compl. Exs. B-1 at 1 (A85) & B-2 at 1 (A92) (emphasis in original). Although the Complaint alleges that Plaintiff never received the Certificate of Insurance (Compl. ¶ 24 (A61)), it does not allege that during the three decades Plaintiff was a member of the GHI Plan he ever attempted to obtain

the complete terms of the plan by visiting GHI's website or by calling the phone number identified in the documents.

The summary documents include service specific coverage examples, which Plaintiff complains were "deceptive and misleading," not because they included any false information, but because they did not identify how much GHI "would reimburse for out-of-network services and what the member's financial responsibility would be." *Id.* ¶ 32 (A64). The coverage examples, however, plainly state that "**This is not a cost estimator,**" and advise prospective members: "Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different." Compl. Exs. B-1 at 6 (A90) & B-2 at 7 (A98) (emphasis in original). The documents identify the "assumptions behind the Coverage Examples," expressly state that the examples are for "comparative purposes only," and advise prospective members that "[their] own costs will be different depending on the care [they] receive, the prices [their] <u>**providers**</u> charge, and the reimbursement [their] health plan allows." Compl. Exs. B-1 at 7 (A91) & B-2 at 8 (A99) (emphasis in original). The documents also expressly state that the coverage examples assume that "[t]he patient received all care from in-network <u>**providers**</u>. If the patient had received care from out-of-network <u>**providers**</u>, costs would have been higher." *Id.* (emphasis in original).

The Complaint further alleges that the reimbursement rates for out-of-network services were based on a document from 1983 and that because that document "had not been updated in two decades, the reimbursement rates were a fraction of actual costs of services." Compl. ¶¶ 27, 29 (A62-63). But that information was plain on the face of the summary documents, which stated that the reimbursement rates for out-of-network services "were originally based on 1983 procedure allowances" and that the reimbursement levels, as provided by the Schedule, may be less than the fee charged by the non-participating provider." Compl. Ex. A at 2 (A82). The summary documents also inform prospective members that "[t]he subscriber is responsible for any difference between the fee charged and the reimbursement." *Id.*

In sum, the Complaint fails to identify any misstatements GHI made, but rather boils down to Plaintiff's apparent dissatisfaction with the level of reimbursement he received under the GHI Plan and his apparent failure to determine the applicable reimbursement rates for particular medical procedures.

III. THE ASSURANCE OF DISCONTINUANCE.

The Complaint and Plaintiff's brief on this appeal both rely heavily on a now four-year-old Assurance of Discontinuance (No. 14-181) (Sept. 8, 2014) (the "AOD") between GHI and the New York Attorney General ("NYAG"). Compl. ¶¶ 1, 3, 39-40 (A54, 55, 66-67); Pl. Br. at 1-2, 8-9, 11, 30-31, 34, 40-41. The

NYAG did *not* conclude that GHI deceived or defrauded its members with respect to limitations for out-of-network services. Although the NYAG concluded in the AOD that GHI did not sufficiently inform plan members of the limitations on reimbursement for out-of-network services (AOD ¶ 7 (A168)), the NYAG discontinued its investigation without GHI admitting any liability. *Id.* at 9 (A174).

IV. THE DISTRICT COURT'S DISMISSAL OF THE COMPLAINT WITH PREJUDICE.

On October 6, 2017, GHI moved pursuant to Federal Rule of Civil Procedure 12(b)(6) to dismiss the Complaint in its entirety for failure to state a claim upon which relief could be granted. *See* A102-44. On June 22, 2018, the District Court, in a 41-page opinion, granted GHI's motion and dismissed all of Plaintiff's claims with prejudice. *See* Dist. Ct. Op. at 41-42 (A41-42).

The District Court dismissed the GBL claims because the Complaint failed to allege consumer-oriented conduct (a threshold requirement for a claim under GBL §§ 349 and 350) or a material deception actionable under the GBL. The District Court held that the conduct of which Plaintiff complained was not "consumer-oriented" because "the alleged deception arises out of a private contract negotiated between [GHI], a health insurance company, and the City of New York, [Plaintiff's] former employer." *Id.* at 18 (A18). The District Court explained that Plaintiff "was only able to receive the benefits of [GHI]'s plan by virtue of being an employee of the City of the New York, which bargained with [GHI] on behalf

of its employees – and only its employees – on the terms of employee benefit plans." *Id.* at 19 (A19). Relying on binding precedent of the New York Court of Appeals, the District Court held that because Plaintiff was a member of the GHI Plan, which was negotiated between "two sophisticated institutions in this case," Plaintiff was "not a mere consumer of the public," and therefore the alleged deceptive conduct was not "consumer-oriented." *Id.* As a result, it was not actionable under the GBL.

The District Court also dismissed the GBL claims because Plaintiff "does not allege any *explicit* misrepresentations so much as complain that the marketing materials should have contained more information about out-of-network coverage." *Id.* at 25 (A25) (emphasis in original). The District Court methodically reviewed the Complaint's allegations and Plaintiff's arguments, and rejected Plaintiff's "twisted reading" (*id.* at 28 (A28)) and "farfetched interpretations" of the summary documents (*id.* at 32 (A32)), as well as Plaintiff's "unreasonable assumption[s]." *Id.* at 26 (A26). The District Court concluded that a "reasonable consumer would not have been materially misled by [GHI]'s statements about out-of-network coverage." *Id.* at 25 (A25).

Because a material misrepresentation also is an element of the Insurance Law claim, the District Court dismissed that claim, too. The District Court also

dismissed the Insurance Law claim for the independent reason that Plaintiff failed to allege scienter. *Id.* at 34 (A34).

The District Court dismissed the unjust enrichment claim because it was predicated on "benefits that [GHI] is *contractually obligated* to provide under the policy negotiated by [Plaintiff's] employer." *Id.* at 35 (A35) (emphasis in original). Unjust enrichment is an equitable claim, and under either New York or Pennsylvania law, it is "precluded by the existence of a valid and enforceable written contract governing the particular subject matter." *Id.* at 37 (A37). Because the District Court dismissed the unjust enrichment claim on this ground, it did not reach GHI's additional arguments for dismissal, including that the unjust enrichment claim was duplicative of Plaintiff's statutory claims and that the Complaint failed to plead the requisite elements of the claim. *Id.* at 39 n.6 (A39).

The District Court held that because Plaintiff's claims failed, the class claims also must fail, and dismissed all claims with prejudice because any "amendment would be futile." *Id.* at 40 (A40).

GHI also had argued that all of Plaintiff's claims were barred by the applicable statutes of limitations. Although the District Court "maintain[ed] reservations" that Plaintiff's claims were timely (*id.* at 16 (A16)), the District Court declined to consider Plaintiff's full out-of-network claims history because that history was not explicitly cited in the Complaint.

Plaintiff filed a notice of appeal on July 5, 2018. (A43).

SUMMARY OF THE ARGUMENT

The District Court properly dismissed all of Plaintiff's claims with prejudice. The GHI Plan was negotiated by the City and the Municipal Unions, both of which are sophisticated parties with extensive experience evaluating health insurance plans, and negotiating those plans, on behalf of City employees. Accordingly, the District Court correctly held that the allegedly misleading materials provided by GHI did not implicate consumer-oriented conduct necessary to sustain a GBL claim. The District Court also correctly held that both the GBL and Insurance Law claims fail because the GHI Plan summary documents do not contain any materially misleading statements. As the District Court noted, Plaintiff's "characterization[s] do[ ] not accurately reflect the actual text of the [SPD]" and Plaintiff's assumptions were simply "unreasonable." Dist. Ct. Op. at 25-26 (A25-26). Although Plaintiff relies heavily on the AOD, that settlement has no bearing on this case because the Plaintiff's burden here is vastly different from the relaxed standard that applies to the NYAG's investigation of a consumer-protection enforcement action. Additionally, courts recognize that allegations contained in regulatory settlements carry no weight in cases brought by private plaintiffs.

The District Court properly dismissed the unjust enrichment claim because the subject matter of the claim is governed by the GHI Plan – a valid contract – and

therefore the claim is precluded by the existence of that contract. That Plaintiff was not a party to that contract is of no legal consequence. Moreover, GHI raised numerous additional grounds for dismissing the unjust enrichment claim that the District Court did not reach (*i.e.*, the unjust enrichment claim was duplicative of the statutory claims and that the Complaint failed to plead the requisite elements of the claim). Those grounds also support affirmance of the dismissal of the unjust enrichment claim.

This Court alternatively can affirm dismissal of the Complaint on the ground that all claims are time barred. Plaintiff has been a member of the GHI Plan for more than three decades, and has submitted claims for reimbursement for out-of-network benefits since 2004. The District Court expressed reservations about the timeliness of Plaintiff's claims, but declined to consider Plaintiff's full claims history at the pleading stage. Plaintiff's claims history is properly before the Court, however, and provides an alternative ground to affirm dismissal, should the Court find it necessary to reach that issue.

Finally, the District Court properly dismissed all of Plaintiff's claims (and the class claims) with prejudice. Plaintiff did not properly preserve his request for leave to amend and any amendment would be futile given that it is clear from the face of the summary documents that Plaintiff's claims fail as a matter of law.

STATEMENT OF THE STANDARD OF REVIEW

I. DISMISSAL OF THE COMPLAINT.

This Court reviews *de novo* the dismissal of a complaint for failure to state a claim, *Vorchheimer v. Philadelphian Owners Ass'n*, 903 F.3d 100, 105 (3d Cir. 2018), and "may affirm the judgment below on any basis that is supported by the record." *Phila. Taxi Ass'n, Inc v. Uber Techs., Inc.*, 886 F.3d 332, 338 (3d Cir.), *cert. denied*, No. 18-32, 2018 WL 3306879 (U.S. Oct. 1, 2018).

A complaint must be dismissed pursuant to Federal Rule of Civil Procedure 12(b)(6) if it does not "contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). The plausibility standard "requires showing 'more than a sheer possibility that a defendant has acted unlawfully.'" *Burtch v. Milberg Factors, Inc.*, 662 F.3d 212, 221 (3d Cir. 2011) (quoting *Iqbal*, 556 U.S. at 678). Rather, the complaint must show the plaintiff's entitlement to relief with its facts. *Steedley v. McBride*, 446 F. App'x 424, 425 (3d Cir. 2011). "[W]here the well-pleaded facts do not permit the court to infer more than the mere possibility of misconduct, the complaint has alleged – but it has not 'show[n]' – 'that the pleader is entitled to relief.'" *Iqbal*, 556 U.S. at 679 (second alteration in original) (quoting Fed. R. Civ. P. 8(a)(2)).

In assessing a motion to dismiss, a court may "consider 'documents that are attached to or submitted with the complaint, and any matters incorporated by reference or integral to the claim, items subject to judicial notice, matters of public record, orders, [and] items appearing in the record of the case.'" *Beto v. Barkley*, 706 F. App'x 761, 765–66 (3d Cir. 2017) (quoting *Buck v. Hampton Twp. Sch. Dist.*, 452 F.3d 256, 260 (3d Cir. 2006)).

II. DENIAL OF LEAVE TO AMEND.

This Court reviews for abuse of discretion denial of leave to amend a complaint. *United States ex rel. Petratos v. Genentech Inc.*, 855 F.3d 481, 486 (3d Cir. 2017).

ARGUMENT

I. THE DISTRICT COURT PROPERLY DISMISSED THE GBL CLAIMS.

The District Court properly dismissed the GBL claims because the Complaint failed to allege two essential elements of a GBL claim, particularly that GHI "engaged in (1) consumer-oriented conduct that is (2) materially misleading." *City of N.Y. v. Smokes-Spirits.com, Inc.*, 12 N.Y.3d 616, 621 (2009); *see also Goshen v. Mut. Life Ins. Co. of N.Y.*, 98 N.Y.2d 314, 324 n.1 (2002) (noting that the standards of GBL §§ 349 and 350 are substantively "identical").

A. The Complaint Failed to Allege Consumer-Oriented Conduct.

Sections 349 and 350 of the GBL "do[] not grant a private remedy for every improper or illegal business practice." *Carlson v. Am. Int'l Grp., Inc.*, 30 N.Y.3d 288, 309 (2017) (internal quotation marks omitted). Rather, these statutes only provide a cause of action for wrongs directed "against the consuming public." *Oswego Laborers' Local 214 Pension Fund v. Marine Midland Bank, N.A.*, 85 N.Y.2d 20, 24 (1995). "[T]hus, as a threshold matter, plaintiffs claiming the benefit of section 349 [and section 350] – whether individuals or entities . . . – must charge conduct of the defendant that is consumer oriented." *Id.* at 25.

The District Court correctly held that Plaintiff failed to plead consumer-oriented conduct because the New York Court of Appeals has held that where the challenged practice arises out of a private contract of insurance negotiated by sophisticated parties, as is the case here, it "do[es] not constitute consumer-oriented conduct." *N.Y. Univ. v. Cont'l Ins. Co.* ("*NYU*"), 87 N.Y.2d 308, 321 (1995). In *NYU*, the university alleged, among other things, that its insurer had conducted a sham investigation of a claim, vindictively refused to renew the university's policy, and engaged in nationwide bad faith practices. *Id.* at 314. In dismissing the university's GBL claim because it had not sufficiently alleged consumer-oriented conduct, New York's highest court held:

> The parties were a major university acting through its director of insurance, and a large national insurance company. The policy was not a standard policy, although it contained standard provisions, but was tailored to meet the purchaser's wishes and requirements. . . . The sale was handled by one of the largest brokerages in the Nation . . . which managed, through negotiation, to obtain several enhancements to the policy for plaintiff's benefit. . . .
>
> Manifestly, this transaction is wholly unlike that in *Oswego*, which involved a bank customer receiving the standard forms and advice supplied to the ***consuming public at large***, and in which the parties occupied disparate bargaining positions.

Id. at 321 (emphasis added).

The District Court correctly held that *NYU* requires dismissal of Plaintiff's GBL claims because the GHI Plan was negotiated by highly sophisticated institutional parties: GHI, the City of New York Office of Labor Relations, and the group of Municipal Unions that represent City employees and retirees. *See* Dist. Ct. Op. at 18-19 (A18-19). As described in the SPD's introduction that was provided to City employees and retirees:

> Through collective bargaining agreements, the City of New York and the Municipal Unions have cooperated in choosing health plans and designing the benefits for the City's Health Benefits Program. These benefits are intended to provide you with the fullest possible protection that can be purchased with the available funding.

A327.

These sophisticated parties representing the interests of City employees and retirees worked with GHI to "design[ ] the benefits" of the Plan and tailor it to the needs of City workers, retirees, and all their families. *Id.* To borrow from the New York Court of Appeals, "this was not the 'modest' type of transaction the statute was primarily intended to reach" involving a "standard policy" that "affect[ed] the consuming public at large." *NYU*, 87 N.Y.2d at 321. Rather, parties with equal bargaining power reached a private contract of insurance, and Plaintiff's claim is a "dispute over policy coverage . . . which is unique to these parties, not conduct which affects the consuming public at large." *Id.*

Plaintiff incorrectly argues that GHI's conduct was consumer-oriented because it allegedly affected more than one plan member and thus is not akin to the type of "single shot transaction" that courts have held do not constitute consumer-oriented conduct. Pl. Br. at 26-27 (citing, *e.g.*, *Genesco Entm't v. Koch*, 593 F. Supp. 743, 752 (S.D.N.Y. 1984)). Plaintiff's argument, however, ignores that the GBL provisions at issue do not extend to claims that arise from privately-negotiated contracts. The GBL was designed "to even the playing field in [consumers'] disputes with better funded and superiorly situated fraudulent businesses." *Teller v. Bill Hayes, Ltd.*, 213 A.D.2d 141, 148 (N.Y. App. Div. 1995). Accordingly, the statute does not apply when the parties are on equal footing, such as when sophisticated entities are on both sides of the contract

negotiations. *See NYU*, 87 N.Y.2d at 321; *see also Teller*, 213 A.D.2d at 149 (finding no consumer-oriented conduct, in part, because of the lack of "disparity of bargaining power" between the parties).

This principle applies equally where a sophisticated entity acts as the plaintiff's intermediary. As the New York Court of Appeals emphasized in *NYU*, the conduct at issue was not consumer-oriented where a large brokerage firm had assisted the plaintiff in the negotiations for the underlying contract. *Compare NYU*, 87 N.Y.2d at 321 (non-party brokerage firm "managed, through negotiation, to obtain several enhancements to the [insurance] policy for plaintiff's benefit"), *with* SPD at 1 (A327) ("[T]he City of New York and the Municipal Unions have cooperated in choosing health plans and designing the benefits for the City's Health Benefits Program."). Accordingly, as the District Court correctly held, Plaintiff was "not a mere consumer of the public" under these circumstances. Dist. Ct. Op. at 19 (A19).

For this reason, every case Plaintiff cites (Pl. Br. at 18-24) is factually distinguishable. None involve circumstances in which the conduct – as in this case – relates to a multi-million-dollar insurance contract negotiated by highly sophisticated parties who acted on the plaintiff's behalf, or in the interest of the plaintiff or the consumers to whom the alleged deceptive conduct was directed:

- In *Koch v. Greenberg*, 626 F. App'x 335, 340 (2d Cir. 2015), a purchaser of wine (a consumer product) at an auction alleged that the defendant misrepresented the wine's authenticity. *See also Koch v. Greenberg*, 14 F. Supp. 3d 247, 261-62 (S.D.N.Y. 2014) (providing the underlying facts).

- In *M.V.B. Collision, Inc. v. Allstate Ins. Co.*, 728 F. Supp. 2d 205, 220-21 (E.D.N.Y. 2010), a car repair company brought a GBL claim against an insurance company arising out of a "standard form contract" that the insurer had entered into with its policyholders.

- In *Elacqua v. Physicians' Reciprocal Insurers*, 52 A.D.3d 886, 887 (N.Y. App. Div. 2008), physicians claimed that their medical malpractice insurance company failed to inform them, as it was legally required to do, that the physicians had a right to select independent counsel of their choosing at the insurer's expense.

- In *McCracken v. Verisma Systems, Inc.*, 131 F. Supp. 3d 38 (W.D.N.Y. 2015), patients claimed that a hospital charged them excessively for copies of their medical records.

Plaintiff's reliance on *Millennium Health, LLC v. EmblemHealth, Inc.*, 240 F. Supp. 3d 276 (S.D.N.Y. 2017) similarly is misplaced. In that case, the court

actually dismissed the GBL claim because – like the Complaint here – the plaintiff failed to identify any misleading statements. *Id.* at 286-87. With respect to the alleged "consumer-oriented" conduct, the analysis in *Millennium* is inapposite because the GBL claim in that case was that an insurer failed to make payments under an *implied-in-fact* contract despite telling its policyholders that it would cover the costs of their health care services. *See id.* at 280. No such implied-in-fact contract is at issue here.

The GBL is a consumer-protection law. To determine its applicability, courts must analyze the circumstances giving rise to the contract and conduct at issue – including the sophistication of the parties or other entities involved and the size of the underlying transaction – to determine whether it bears the requisite indicia of consumer-oriented conduct. The allegation that "GHI received total premiums in excess of $2 billion" underscores the point. Compl. ¶12 (A58). In distinguishing private contracts of insurance from the "modest" consumer transactions that are subject to GBL claims, both the New York Court of Appeals and federal courts sitting in diversity have recognized that policies with large premiums negotiated by sophisticated parties fall outside the sphere of "consumer-oriented" conduct. *NYU*, 87 N.Y.2d at 321 ("The policy was not a standard policy . . . . The premiums were in excess of $55,000 and the policy provided coverage for losses up to $10 million . . . ."); *Interested Underwriters v. Church Loans and*

Invs. Tr., 432 F. Supp. 2d 330, 333 (S.D.N.Y. 2006) (size of agreement plays a "prominent role" in determining defendant's conduct was not "modest" and consumer-oriented) (citing cases).

Plaintiff's last-ditch argument is that the District Court's decision would "bar[ ] any employee insured through an employer-sponsored plan from ever asserting a GBL claim." Pl. Br. at 23. But the only claims the District Court's decision will bar are ones brought by plaintiffs who were represented by sophisticated entities with relatively equal bargaining power – here the City itself and the Municipal Unions. These are claims to which the GBL was not designed or intended to apply. Unsurprisingly, Plaintiff has not cited a single case upholding a GBL case brought by an employee concerning an employer-sponsored health plan, or other benefit plans, alleging similar claims.

B. The Complaint Failed to Identify Materially Misleading Statements.

GBL §§ 349 and 350 require a plaintiff to show that the challenged act or practice "was misleading in a material way," *Stutman v. Chem. Bank*, 95 N.Y.2d 24, 29 (2000), and a GBL claim cannot stand when the challenged practice is "fully disclosed." *Fink v. Time Warner Cable*, 714 F.3d 739, 742 (2d Cir. 2013) (internal quotation marks omitted). A challenged practice is deceptive only if it is "likely to mislead a reasonable consumer acting reasonably under the circumstances." *Id.* (internal quotation marks omitted). Thus, "[a] party does not

violate the [GBL] by simply publishing truthful information and allowing consumers to make their own assumptions about the nature of the information." *Gomez-Jimenez v. New York Law Sch.*, 103 A.D.3d 13, 17 (N.Y. App. Div. 2012) (affirming dismissal of GBL claims brought by law students claiming that law school published false or misleading employment statistics).

The District Court correctly held that "the Complaint has not plausibly alleged how the statements from the [SPD] and the [SBC] would be *materially* misleading to the reasonable prospective member choosing among the eleven plans offered by the City of New York." Dist. Ct. Op. at 30 (A30) (emphasis in original). "It is well settled that a court may determine as a matter of law that an allegedly deceptive [statement] would not have misled a reasonable consumer." *Fink*, 714 F.3d at 741; *see, e.g.*, *Rodriguez v. Cheesecake Factory Inc.*, No. 16CV2006JMAAKT, 2017 WL 6541439, at *5 (E.D.N.Y. Aug. 11, 2017) (collecting cases and observing that "courts regularly determine, as a matter of law [on motions to dismiss], that a defendant's conduct would not have misled a reasonable consumer").

Plaintiff does not – and cannot – cite any statements in the summary documents that would lead a reasonable person to believe that the reimbursement rates for the out-of-network services Plaintiff's wife received (Compl. ¶ 41 (A67)) would have been greater than what Plaintiff actually received. Rather, Plaintiff

identifies five categories of purportedly misleading statements (Pl. Br. at 37), but as the District Court held, Plaintiff's "twisted reading" of the summary documents is objectively implausible. Dist. Ct. Op. at 28 (A28).

First, Plaintiff's argument that a coverage example "showing a 66% reimbursement rate for a sample service[ ] [was] 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%" (Pl. Br. at 37), fails to identify any objectively false or misleading statement. As the District Court correctly observed, the materials of which Plaintiff complains "never purported to state *how much* reimbursement the insured would receive, or even provided a general range of reimbursement rates for the reader." Dist. Ct. Op. at 25 (A25) (emphasis in original). Rather, as the documents explain, the coverage examples simply "help[] [members] see how deductibles, co-payments and co-insurance can add up" and, "in general, how much financial protection a sample patient might get if they are covered under different plans." Compl. Exs. B-1 at 6, 7 (A90-91) & B-2 at 7, 8 (A98-99). As the District Court stated, a 66% reimbursement rate for one coverage example "cannot be imputed to the actual average cost of out-of-network expenses across the spectrum of all potential services. It is clearly a hypothetical designed to illustrate how coverage may be calculated." Dist. Ct. Op. at 28 (A28).

Plaintiff's argument ignores the context in which the service-specific "Coverage Examples" are presented. Directly adjacent to the examples is an explanatory note in large bold font that states: "**This is not a cost estimator.**" Compl. Ex. B-1 at 6 (A90) & B-2 at 7 (A98) (emphasis in original). The statement continues: "Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples and the cost of that care also will be different." *Id.* The next page provides questions and answers about the coverage examples. The first answer tells members: "If the patient had received care from out-of-network **providers**, costs [for these services] would have been higher." Compl. Ex. B-1 at 7 (A91) & B-2 at 9 (A99) (emphasis, underlining in original). The other answers reinforce that the examples do not represent actual costs or reimbursements:

> **What does a Coverage Example Show?**
> For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.
>
> . . .
>
> **Does the Coverage Example predict my own care needs?**
> **No.**[[4]] Treatments shown are just examples.
>
> . . .
>
> **Does the Coverage Example predict my future expenses?**

[4] Next to the word "**No.**" is a graphic containing an "X" mark.

> **No.**[5] Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition . . . .

Id. (emphasis, underlining in original). As the District Court explained, "[a] reasonable prospective member would not extrapolate from these statements the idea that the coverage examples reflected actual average reimbursement[] costs across all medical expenses." Dist. Ct. Op. at 29 (A29).

Contrary to Plaintiff's argument, these explanatory statements regarding the GHI Plan are not "disclaimers" (Pl. Br. at 33-35) that purport to change or contradict the meaning of other statements in the summary documents. *Cf. SmithKline Beecham Consumer Healthcare, L.P. v. Johnson & Johnson-Merck Consumer Pharm. Co.*, 906 F. Supp. 178, 182 (S.D.N.Y. 1995) (in the context of false advertising claims under the Lanham Act, disclaimers "either contradict, clarify or change the meaning of the main claim of the advertisement").

The two Court of Appeals cases cited by Plaintiff (Pl. Br. at 33-34) involving disclaimers, therefore, are inapposite. *Koch v. Acker, Merrall & Condit Co.*, for example, addressed a claim against an auction house based on statements in a sales catalog concerning wine that "touted the meticulous inspection of the wines, their provenance, and authenticity" but also included a legal disclaimer providing that the defendant "shall not be liable for any description" and that the statements "shall not be relied upon by any bidder." No. 6012202008, 2009 WL

[5] Next to the word "**No.**" is a graphic containing an "X" mark.

9115681 (N.Y. Sup. Ct. Apr. 8, 2009). These "disclaimers" negated the express representations in the catalog, and the New York Court of Appeals held that "the disclaimers set forth in defendant's catalogs do not bar plaintiff's claims for deceptive trade practices at this stage of the proceedings." 18 N.Y.3d 940, 941 (2012) (internal quotation marks, and alterations omitted).

Likewise, the GBL claim in *Gaidon v. Guardian Life Ins. Co. of Am.* stemmed from "industry-wide litigation" based on life insurance policies that insurers marketed as having an out-of-pocket premium that would "vanish" after eight years because after that time, defendants claimed, dividends would cover the premium costs. 94 N.Y.2d 330, 339-42 (1999). As part of their pitch, the defendants used "individualized projections" that assured the premiums would vanish and marketing slogans such as "Pay One Vanish" and "pay one and done." *Id.* at 345-46. Despite making express guarantees that premiums would "vanish," the marketing materials included "limitations" that stated "[f]igures depending on dividends are neither estimated nor guaranteed, but are based on the [current year's] dividend scale." *Id.* at 339. The Court of Appeals held that this disclaimer language did not shield the defendant from a GBL claim because "defendant's created the[ ] expectations [that premiums would vanish] with illustrations based on the unrealistic dividend/interest forecasts." *Id.* at 345-46.

In stark contrast to the statements in *Koch* and *Gaidon*, the summary documents at issue here did not include any statements that turned out to be false or misleading, nor did they include any legal disclaimers or other statements that contradicted or denied guarantees provided elsewhere in the documents. Rather, the documents simply explained how the GHI Plan works, and provided clearly labeled "examples" and described their intended purpose.

Second, Plaintiff's argument that "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" (Pl. Br. at 37) is flatly contradicted by the express language of the SPD itself. The SPD states: "The rate at which you will be reimbursed for a particular service is contained within the Schedule. These reimbursement rates were originally ***based on 1983 procedure allowances***, and ***some*** have been increased periodically." Compl. Ex. A at 2 (A82) (emphasis added). As the District Court aptly noted, "the [SPD] clearly states that reimbursement rates would be based on '1983 procedure allowances' and that only some, not all, procedure rates would be increased." Dist. Ct. Op. at 26 (A26). A reasonable person reading these materials in 2013 or 2014 would understand that the reimbursement rates for out-of-network services were tied to a Schedule of Allowances that was 30 years old.

Third, despite Plaintiff's argument that "GHI failed to disclose that the statement that reimbursement amounts 'may be less' than the fee charged by non-participating provider actually means 'will be substantially less'" (Pl. Br. at 37), no reasonable person reading the summary documents would understand that the GHI Plan provided anything other than partial reimbursement for services obtained from out-of-network providers. The SPD expressly states that "[t]he reimbursement levels . . . may be less than the fee charged by the non-participating provider" and "[t]he subscriber is responsible for any difference between the fee charged and the reimbursement." Compl. Ex. A at 2 (A82). The summary documents do not assure any particular level of reimbursement, and as the District Court correctly observed, Plaintiff never alleges what he actually expected the reimbursement rates to be, let alone that those rates would be close to their full cost. *See* Dist. Ct. Op. at 26 (A26).

Fourth, Plaintiff's argument that "GHI failed to disclose that the optional Rider excluded all out-patient out-of-network services" (Pl. Br. at 37) is once again flatly contradicted by the SPD. The SPD states: "**Optional Rider (continued)**
• Enhanced schedule for *certain* services increases the reimbursement of the basic program's non-participating fee schedule, on average, by 75%." Compl. Ex. A at 2 (A82) (bolded emphasis in original; italicized emphasis added). As the District Court correctly reasoned, "[i]nherent in these statements is the caveat that only

certain services, not all services, would increase reimbursement levels for out-of-network expenses." Dist. Ct. Op. at 29-30 (A29-30). There is nothing misleading about the statement in the SPD simply because it does not identify which particular services are covered under, or excluded from, the Optional Rider.

Fifth, Plaintiff's argument that 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" (Pl. Br. at 37) is unsupported by the plain language of the summary documents. As the District Court explained:

> The Description does not hold out 'Catastrophic Coverage' as conferring *additional* benefits to the plan. It is, as the Complaint concedes, an integral feature of the plan itself. Furthermore, the Description states that 'Catastrophic Coverage' is only applicable to expenses over $1,500 for 'non-participating providers for predominantly in-hospital care,' which is a narrowly defined category of expenses. The Complaint fails to demonstrate how this fairly narrow feature could 'confuse NYC employees and retirees, induce them to select the [GHI] Plan, and cause them to incur substantial out-of-pocket costs that [GHI] led them to believe they were protected against.

Dist. Ct. Op. at 30 (A30) (emphasis in original) (citations omitted).

The District Court also correctly observed, and Plaintiff apparently concedes, that Plaintiff "does not allege any *explicit* misrepresentations so much as complain that the marketing materials should have contained more information about out-of-network coverage." *Id.* at 25 (A25) (emphasis in original); Pl. Br. at 36 (noting that the gravamen of the claims are GHI's alleged failure to disclose certain information). But the law does not require what Plaintiff seeks. Under New York law, a defendant does not engage in materially misleading conduct by "simply publishing truthful information and allowing consumers to make their own assumptions about the nature of the information." *Gomez-Jimenez*, 103 A.D.3d at 17. Although not the case here, that would remain so even if "there [were] no question" that the materials left "some consumers with an incomplete, if not false, impression." *Id.*

The inferences Plaintiff asks the Court to draw (Pl. Br. at 39-42) are unreasonable. The District Court reviewed the summary documents on GHI's motion to dismiss and applied common sense – as the U.S. Supreme Court has directed – in finding that Plaintiff failed to state a GBL claim. *Weinstein v. eBay, Inc.*, 819 F. Supp. 2d 219, 228 (S.D.N.Y. 2011) ("*Iqbal* directs the Court to apply its common sense when determining the plausibility of a claim."). Given that all of the information relating to the allegedly misleading statements was on the face of the Complaint and the exhibits thereto, the District Court rightly rejected Plaintiff's

"farfetched interpretations" and implausible inferences at the pleading stage. Dist. Ct. Op. at 32 (A32).

C. The AOD Has No Bearing on Plaintiff's Claims.

Although Plaintiff emphasizes the AOD to support its arguments that GHI's conduct was "consumer-oriented" and materially misleading (Pl. Br. at 30-31, 34), the AOD is entirely irrelevant for two independent reasons.

First, Plaintiff's burden here is vastly different from the relaxed standard that applies to the NYAG's investigation of a consumer-protection enforcement action. Specifically, New York Executive Law § 63 – a statutory tool reserved exclusively for the Attorney General – empowers her "to protect *not only the average consumer, but also the ignorant, the unthinking and the credulous.*" *People ex rel. Spitzer v. Applied Card Sys., Inc.*, 27 A.D.3d 104, 106 (N.Y. App. Div. 2005) (emphasis added) (quoting *People ex rel. Spitzer v. Gen. Elec. Co.*, 302 A.D.2d 314 (N.Y. App. Div. 2003)); *see also Guggenheimer v. Ginzburg*, 43 N.Y. 2d 268, 273 (1977).

When the GBL was amended in 1980 to provide a private right of action, the New York Court of Appeals was "mindful of the potential for a tidal wave of litigation against businesses that was not intended by the Legislature." *Oswego*, 85 N.Y.2d at 26. New York's highest court, therefore, holds private plaintiffs to a more stringent, objective standard: the acts or practices for which private plaintiffs

may seek relief under the GBL are "limited to those likely to mislead *a reasonable consumer acting reasonably under the circumstances*." *Id.* (emphasis added); *see also Karlin v. IVF Am., Inc.*, 93 N.Y.2d 282, 294 (1999) (*Oswego*'s objective test avoided "the possibility of excessive litigation under the consumer protection statutes").

In short, the NYAG's conclusion – issued pursuant to Executive Law § 63 – that the summary documents did not sufficiently describe the limitations of the GHI Plan's reimbursement for out-of-network providers does not and cannot support Plaintiff's claim that it is likely that a reasonable person acting reasonably under the circumstances would have been misled. The District Court correctly "note[d] that the objective standard of 'a reasonable consumer acting reasonably under the circumstances' cannot be equated to the consumer that the Attorney General is charged to protect." Dist. Ct. Op. at 24 (A24). Other courts granting motions to dismiss GBL § 349 claims by private plaintiffs specifically have noted the significance of the more stringent standard. *See Weinstein*, 819 F. Supp. 2d at 227-28 (citing *Oswego* and rejecting "least sophisticated consumer" standard).

Second, where, as here, a plaintiff merely recasts the unproven allegations of a regulator, courts regularly (i) strike the allegations, (ii) dismiss the underlying claims, or (iii) do both. *Clugston v. Nationwide Mut. Ins. Co.*, No. 3:05-CV-2680, 2006 WL 1290450, at *4 (M.D. Pa. May 10, 2006) (Vanaskie, C.J.) ("[R]eferences

to preliminary steps in litigation or administrative proceedings that did not result in an adjudication on the merits or legal or permissible findings of fact are, as a matter of law, immaterial under Rule 12(f) of the Federal Rules of Civil Procedure.") (internal quotation marks omitted); *see, e.g.*, *Platinum & Palladium Commodities Litig.*, 828 F. Supp. 2d 588, 593-94 (S.D.N.Y. 2011) (striking allegations that "recast" regulatory settlement and dismissing claims); *Dent v. U.S. Tennis Ass'n, Inc.*, No. CV-08-1533 RJD VVP, 2008 WL 2483288, at *2 (E.D.N.Y. June 17, 2008) (striking references to NYAG settlement agreement); *In re Rough Rice Commodity Litig.*, No. 11 C 618, 2012 WL 473091, at *5 (N.D. Ill. Feb. 9, 2012) (dismissing claims).[6]

Thus, the allegations in the AOD – through which the NYAG discontinued its investigation without bringing charges and in which GHI admitted no liability – carry no weight.

II. THE DISTRICT COURT PROPERLY DISMISSED THE NEW YORK INSURANCE LAW CLAIMS.

Like the GBL claims, the Insurance Law claim fails because the summary documents are not misleading for the reasons discussed in Sections I.B-C, *supra*. As with the GBL claims, a claim under the Insurance Law requires Plaintiff to

[6] *See also Lipsky v. Commonwealth United Corp.*, 551 F.2d 887 (2d Cir. 1976) (striking references to SEC complaint); *In re Trilegiant Corp., Inc.*, 11 F. Supp. 3d 82, 131 (D. Conn. 2014) ("[B]ecause facts related to unadjudicated investigations or settlements are not permitted to prove liability, . . . the settlement by the states' attorneys general are immaterial and impertinent to the present action").

allege and prove that GHI made a materially misleading statement. *See Phillips v. Am. Int'l Grp., Inc.*, 498 F. Supp. 2d 690, 699 (S.D.N.Y. 2007) (dismissing GBL § 349 and Insurance Law § 4226 claims on grounds that the plaintiff had failed to allege misleading statements); *Gaidon v. Guardian Life Ins. Co. of Am.*, 255 A.D.2d 101, 102 (N.Y. App. Div. 1998), *aff'd as modified*, 94 N.Y.2d 330 (1999) (dismissing plaintiffs' claims for both GBL § 349 and Insurance Law § 4226 given "the absence of any deceptive or misleading practice").

The Insurance Law claim fails for the additional, independent reason that the Complaint fails to allege scienter. Dist. Ct. Op. at 34 (A34). By proscribing only "knowing[ ]" violations, the Insurance Law requires a sufficient allegation that an insurer acted with scienter, *i.e.*, that it *knew* it was violating the law. In *Cilente v. Phoenix Life Ins. Co.*, a case cited by Plaintiff (Pl. Br. at 45), the Appellate Division of the New York Supreme Court held on a motion for summary judgment that the plaintiff's Insurance Law claim failed as a matter of law given the lack of evidence "concerning [the insurers'] *knowledge of the noncompliance with the statutes*." 134 A.D.3d 505, 507 (N.Y. App. Div. 2015) (emphasis added).

Although Plaintiff argues that the Insurance Law includes no such scienter requirement (Pl. Br. at 43), analogous language in other consumer-protection statutes, including GBL § 349, confirms that proof of scienter is required. Under GBL § 349(h), for example, a court may award treble damages if it "finds the

defendant willfully or knowingly violated [§ 349].” This provision permits treble damages only where the defendant adduces “proof of scienter” – *i.e.*, “the defendant’s intent to defraud or mislead.” *Oswego*, 85 N.Y.2d at 26 (citing GBL § 349(h)). Similarly, GBL § 391-g, which requires a “knowing violation,” requires a plaintiff to prove the defendant *knew* its conduct was unlawful. *See People ex rel. Vacco v. Alamo Rent A Car, Inc.*, 174 Misc. 2d 501, 504 (N.Y. Sup. Ct. 1997) (because an element of GBL § 391-g is a “knowing violation,” the petitioner must “must establish that respondents were aware that their conduct was unlawful”).

The Complaint lacks any factual allegations to support an inference that GHI made any material misrepresentations, let alone that the alleged deceptive statements were made knowingly and in knowing violation of the Insurance Law. Therefore, the Insurance Law claim was properly dismissed.

III. THE DISTRICT COURT PROPERLY DISMISSED THE UNJUST ENRICHMENT CLAIM.

A. A Quasi-Contract Claim Cannot Lie Because Plaintiff’s Relationship With GHI Is Governed by Contract.

The District Court properly dismissed the unjust enrichment claim because a valid contract – namely, the GHI Plan – governs the subject matter of the dispute. Under New York law, “the existence of a valid contract governing the subject matter” of a dispute precludes an unjust enrichment claim “arising out of the same subject matter.” *EBC I, Inc. v. Goldman, Sachs & Co.*, 5 N.Y.3d 11, 23 (2005).

Plaintiff's relationship with GHI plainly is governed by contractual terms and conditions, including those terms governing payment of out-of-network benefits under the GHI Plan. *See* Compl. ¶ 2 (A55); Compl. Ex. A at 2 (A82) ("Payment for [out-of-network] services is made directly to you under the NYC Non-Participating Provider Schedule of Allowable Charges."). Whether Plaintiff has seen the Certificate of Insurance (Pl. Br. at 47) is of no consequence. *See Statler v. Dell, Inc.*, 775 F. Supp. 2d 474, 485 (E.D.N.Y. 2011) ("Where a valid contract governs the subject matter in a lawsuit, a plaintiff may not recover in quasi-contract, and it is appropriate to dismiss a claim for unjust enrichment.").

If Plaintiff or putative class members believe they did not receive the out-of-network benefits to which they were entitled under the GHI Plan, they are not without recourse; they can assert a breach of contract claim (though that claim also would fail here because no contractual terms have been breached). *See* Certificate of Insurance at 36 (A227) (referring to member lawsuits against GHI). Plaintiff cannot, however, bring a claim for unjust enrichment because "the disputed terms and conditions fall entirely within the insurance contract" and thus "there is no valid claim for unjust enrichment." *Goldman v. Metro. Life Ins. Co.*, 5 N.Y.3d 561, 572 (2005) (affirming dismissal of putative class action alleging unjust enrichment based on interpretation of insurance contract terms).

Plaintiff's argument that he is not a third-party beneficiary (Pl. Br. at 47-48) is legally irrelevant and factually incorrect. "Numerous decisions applying New York law have held that an unjust enrichment claim is barred 'if there is a valid contract governing the subject matter of the dispute, *even if one of the parties to the claim is not a party to that contract*.'" *Mueller v. Michael Janssen Gallery Pte. Ltd.*, 225 F. Supp. 3d 201, 207 (S.D.N.Y. 2016) (quoting *Vista Food Exch., Inc. v. Champion Foodservice, LLC*, 124 F. Supp. 3d 301, 312 (S.D.N.Y. 2015)) (emphasis in original) (citing cases). In any event, because Plaintiff can enforce the contract for benefits to which he is entitled as a member of the GHI Plan, there can be no real dispute that he is a third-party beneficiary, and the unjust enrichment claim properly was dismissed. *See* Dist. Ct. Op. at 39 (A39) ("Where there is a relationship in the form of a promise to, or for the benefit of, the plaintiff, he has the right to recover on the promise . . . [t]he existence of that right, however, precludes a claim of unjust enrichment.") (citation and quotation marks omitted); *Dormitory Auth. v. Samson Constr. Co.*, 30 N.Y.3d 704 (2018) (holding that a party is a third-party beneficiary if it is clear "that there was an intent to permit enforcement by [that party]") (internal quotation marks omitted).

B. The Unjust Enrichment Claim Fails for Additional, Independent Reasons.

Plaintiff's unjust enrichment claim also fails because (i) the claim is duplicative of the statutory claims and (ii) Plaintiff has failed to plead adequately

the elements of an unjust enrichment claim. Although the District Court did not address these independent grounds for dismissal (Dist. Ct. Op. at 39 n.6 (A39)), this Court may affirm on these additional grounds. *See Phila. Taxi Assoc.*, 886 F.3d at 338 ("We . . . may affirm the judgment below on any basis that is supported by the record.").

1. The Unjust Enrichment Claim Is Duplicative of the Statutory Claims.

The unjust enrichment claim fails because it is based on the same set of operative facts and alleged conduct as the other statutory causes of action (*i.e.*, that GHI provided purportedly misleading information about the scope of coverage). As the New York Court of Appeals has made clear, a claim for unjust enrichment "is available only in unusual situations when, though the defendant has not breached a contract nor committed a recognized tort, circumstances create an equitable obligation running from the defendant to the plaintiff." *Corsello v. Verizon N.Y., Inc.*, 18 N.Y.3d 777, 790 (2012). "Typical cases are those in which the defendant, though guilty of no wrongdoing, has received money to which he or she is not entitled." *Id.* (citing cases). An unjust enrichment claim "is not a catchall cause of action to be used when others fail" and "is not available where it simply duplicates, or replaces, a conventional contract or tort claim," or statutory claims, such as the GBL. *Id.*

Plaintiff's unjust enrichment claim is duplicative of his other claims because it "relies on the same facts as [plaintiff's] other causes of action." *Nelson v. MillerCoors, LLC*, 246 F. Supp. 3d 666, 679 (S.D.N.Y. 2017) (dismissing unjust enrichment claim as duplicative of other claims, including GBL claims). Plaintiff simply incorporates by reference the same factual allegations upon which he relies to support his other claims and asserts that GHI has been unjustly enriched through its "wrongful conduct." Compl. ¶¶ 52-53 (A70). These allegations cannot sustain an unjust enrichment claim. *See, e.g.*, *Ideavillage Prod. Corp. v. Bling Boutique Store*, No. 16-CV-9039 (KMW), 2018 WL 3559085, at *4 (S.D.N.Y. July 24, 2018) ("Plaintiff has provided no explanation for why this situation is 'unusual' or why its unjust enrichment claim differs in any respect from its other claims."); *Borenkoff v. Buffalo Wild Wings, Inc.*, No. 16-CV-8532 (KBF), 2018 WL 502680, at *5 (S.D.N.Y. Jan. 19, 2018) (dismissing unjust enrichment claim where the factual allegations duplicate the GBL claim); *Hu v. Herr Foods, Inc.*, 251 F. Supp. 3d 813, 824 (E.D. Pa. 2017) (same). "To the extent [plaintiff's other] claims succeed, the unjust enrichment claim is duplicative; if plaintiff['s] other claims are defective, an unjust enrichment claim cannot remedy the defects." *Corsello*, 18 N.Y.3d at 791.

Plaintiff lacks any credible argument that the unjust enrichment claim is not duplicative. Plaintiff argued below that a jury could reject his statutory claims but

find that GHI was unjustly enriched because it did not mail the insurance policy to the policyholders. A407. Leaving aside that the Complaint did not advance this theory in support of the unjust enrichment claim, the simple failure to send terms to policyholders – even had it occurred – would not render it inequitable for GHI to retain the premium payments for insurance coverage that it indisputably provided to Plaintiff. Plaintiff's unjust enrichment claim, as set forth in the Complaint, is premised upon the contention that it would be inequitable for GHI to retain premiums paid for a policy with terms that allegedly differed from what GHI had represented, not that it was inequitable for GHI to retain premiums paid for a policy it did not physically send (but which was nonetheless made available) to Plaintiff. *See* Compl. ¶¶ 12, 31-38, 49-54 (A58, A63-66, A79).

2. The Complaint Fails to State a Claim for Unjust Enrichment.

A plaintiff asserting an unjust enrichment claim must establish "(1) that the defendant benefitted; (2) at the plaintiff's expense; and (3) that equity and good conscience require restitution." *Beth Israel Med. Ctr. v. Horizon Blue Cross & Blue Shield of N.J., Inc.*, 448 F.3d 573, 586 (2d Cir. 2006). "The essence of unjust enrichment is that one party has received money or a benefit at the expense of another." *City of Syracuse v. R.A.C. Holding, Inc.*, 258 A.D.2d 905, 905 (N.Y. App. Div. 1999). The "general rule" is that for an unjust enrichment claim to lie, "the plaintiff *must have suffered a loss*." *State v. Barclays Bank of N.Y., N.A.*, 76

N.Y.2d 533, 540 (1990) (emphasis in original) (internal quotation marks omitted). But where a plaintiff never possesses an interest in the property that is conferred upon the defendant, the plaintiff "cannot be said to have suffered a loss," and the claim for unjust enrichment fails. *Id.* at 541.

Any benefit that was conferred upon GHI for Plaintiff's enrollment in the GHI Plan was not at Plaintiff's expense. The Complaint alleges "the City contributes to each City worker's health insurance policy," and that the GHI Plan selected by Plaintiff "did not require the payment of out-of-pocket premiums." Compl. ¶¶ 19-20 (A60). Accordingly, any benefit received by GHI in the form of premiums was paid by the City, not Plaintiff. Plaintiff never acquired an ownership interest in the property that was conferred upon GHI (*i.e.*, premium payments), and any restitution to be made for GHI's purported unjust enrichment would inure to the City, not Plaintiff. *See Barclay's Bank of N.Y.*, 76 N.Y.2d at 540-41 (affirming dismissal of unjust enrichment claim against bank that paid to third parties proceeds of forged checks due to plaintiff because "[t]he checks were never actually or constructively delivered to plaintiff. [Plaintiff], therefore, never acquired a property interest in them and cannot be said to have suffered a loss"); *Navana Logistics Ltd. v. TW Logistics, LLC*, No. 15-CV-856 (PKC), 2016 WL 796855, at *7-8 (S.D.N.Y. Feb. 23, 2016) (plaintiff failed to plausibly allege a

claim for unjust enrichment where plaintiff did not itself provide a benefit to defendants).

IV. THIS COURT MAY AFFIRM DISMISSAL ON THE ADDITIONAL GROUND THAT THE COMPLAINT IS TIME BARRED.

In addition to the numerous reasons on which the District Court relied in dismissing the Complaint, Plaintiff's claims independently fail because all are time barred. Plaintiff asserted the claims 33 years after first becoming a member in the GHI Plan, and at least 13 years after first submitting claims for reimbursement for out-of-network benefits.

A statute of limitations defense may be raised on a motion to dismiss where, as here, the defense "appear[s] on the face of the complaint," *Benak ex rel. All. Premier Growth Fund v. All. Cap. Mgmt. L.P.*, 435 F.3d 396, 400 n.14 (3d Cir. 2006), and any matters incorporated by reference or integral to the claim. *Smith v. Pallman*, 420 F. App'x 208, 213 (3d Cir. 2011). Although Plaintiff's "nebulous allegations" caused the District Court to express reservations concerning the timeliness of Plaintiff's claims, the District Court did not believe it could consider Plaintiff's full out-of-network claims history on GHI's motion to dismiss to hold that the claims were conclusively time barred. Dist. Ct. Op. at 13 (A13).

Although GHI argued below that Plaintiff's claims accrued when he first enrolled in the GHI Plan in 1984, the District Court reasoned that Plaintiff's claims accrued when GHI reimbursed him for out-of-network expenses because that is

when his (unreasonable) expectations purportedly were not met. *Id.* at 16 (A16). Even assuming that Plaintiff's claims accrued when GHI first provided reimbursement for out-of-network claims that did not meet Plaintiff's expectations (*id.* at 15 (A15)), it is clear from Plaintiff's out-of-network claims history that his claims are untimely, which provides an independent basis for this Court to affirm dismissal.[7]

The Complaint referenced treatments that Plaintiff's wife received in February 2013, March 2014, and twice in July 2014. Compl. ¶ 41 (A67). Although Plaintiff claims he received inadequate reimbursement for all of those out-of-network claims, the Complaint conspicuously omits the dates that Plaintiff received reimbursement for all but one of those claims. Plaintiff alleges that he received reimbursement in February 2015 for one of the July 2014 out-of-network services, which "[c]oincidentally, . . . fall[s] just within the statute of limitations period." Dist. Ct. Op. at 15 (A15). It is apparent, however, from documents that are integral to the Complaint that Plaintiff submitted claims for hundreds of out-of-network services (and received reimbursement for them) under the GHI Plan

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[7] The limitations period is three years for the GBL and Insurance Law claims and six years for the unjust enrichment claim. *See Gaidon v. Guardian Life Ins. Co. of Am.* (*Gaidon II*), 96 N.Y.2d 201, 210 (2001) (GBL §§ 349, 350); *Dolce v. Nw. Mut. Life Ins. Co.*, 272 A.D.2d 432, 432 (N.Y. App. Div. 2000) (Insurance Law § 4266); *Cohen v. S.A.C. Trading Corp.*, 711 F.3d 353, 364 (2d Cir. 2013) (unjust enrichment).

beginning in 2004. Manalansan Decl. ¶ 6 (A163-64). Accordingly, Plaintiff was aware of the reimbursement rates under the GHI Plan *13 years before he filed suit*.

The District Court declined to consider Plaintiff's undisputed claims history. Although it expressed "reservations that the February 2015 reimbursement would have been the first time that [Plaintiff] learned that his expectations regarding reimbursement levels were not met," Dist. Ct. Op. at 16 (A16), the District Court felt constrained to consider only the claims referenced in the Complaint on the ground that the rest of Plaintiff's claims history was neither integral to nor explicitly relied upon in the Complaint. *Id.* at 10 (A10).

In deciding whether a document outside the pleadings may properly be considered on a motion to dismiss, the "critical" factor "is whether the claims in the complaint are based on an extrinsic document and not merely whether the extrinsic document was explicitly cited." *In re Burlington Coat Factory Sec. Litig.*, 114 F.3d 1410, 1426 (3d Cir. 1997) (internal quotation marks omitted) (Alito, J.). This is because "the primary problem raised by looking to documents outside the complaint—lack of notice to the plaintiff—is dissipated where plaintiff has actual notice and has relied upon these documents in framing the complaint." *Id.* (internal quotation marks and alterations omitted).

Plaintiff's entire Complaint is based on GHI's reimbursements to him for out-of-network services, which total 538 dating back to 2004. Manalansan Decl.

¶ 6 (A163-64). Plaintiff himself made his claims history part of the Complaint's allegations, and the entirety of that history is as integral to the Complaint as the handful of claims Plaintiff cited. Just as a plaintiff may not maintain a claim simply by "extracting an isolated statement from a document and placing it in the complaint, even though if the statement were examined in the full context of the document, it would be clear that [there was no claim]" (*id.*), Plaintiff cannot cherry-pick a handful of out-of-network services to allege that he did know of GHI's reimbursement rates until 2015, particularly when the Complaint cites claims in 2013 and 2014 for which Plaintiff was allegedly inadequately reimbursed. Consequently, even accepting the District Court's conclusion that Plaintiff's claims accrued when he first was reimbursed by GHI for out-of-network services, his claims have been time barred for many years.

V. THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION IN DISMISSING THE COMPLAINT WITHOUT GRANTING LEAVE TO AMEND.

The decision whether to permit leave to amend a dismissed complaint is committed to the "sound discretion" of the district court. *See Cureton v. Nat'l Collegiate Athletic Ass'n*, 252 F.3d 267, 272 (3d Cir. 2001). This Court will set aside such a decision only upon a showing that the district court abused its discretion by applying an "erroneous view of the law." *Travelers Indem. Co. v. Dammann & Co*., 594 F.3d 238, 243 (3d Cir. 2010). The District Court acted well

within its discretion in denying Plaintiff's request for leave to amend for two independent reasons.

First, Plaintiff waived his request to amend the Complaint. Although the last sentence of Plaintiff's brief submitted to the District Court (A413) requested leave to amend under Federal Rule of Civil Procedure 15(a)(2), Plaintiff provided no reason why this request "was appropriate or what his amendment would have looked like." *Petratos*, 855 F.3d at 493. A "cursory request for leave . . . contained in the final clause of [Plaintiff's] brief opposing [GHI's] motion to dismiss" is "insufficient" under Rule 15 and fails to preserve the issue on appeal. *Id.* at 493-94 (declining to consider the appellant's argument that the district court abused its discretion in denying leave to amend because appellant "did not properly seek leave to amend" in the district court); *see also United States ex rel. Zizic v. Q2Administrators, LLC*, 728 F.3d 228, 242-43 (3d Cir. 2013).

Plaintiff "also neglected to attach a draft amended complaint, a failure that is fatal to a request for leave to amend." *Zizic*, 728 F.3d at 243 (internal quotation marks omitted). Because it is well-established that "district courts act within the bounds of their discretion when they reject undeveloped requests for leave to amend that, like [Plaintiff's], are unaccompanied by a proposed amended pleading," *Garza v. Citigroup Inc.*, 724 F. App'x 95, 101 (3d Cir.), *cert. denied sub*

nom. Lopez Garza v. Citigroup Inc., 138 S. Ct. 2625 (2018), the District Court here did not abuse its discretion by dismissing the Complaint with prejudice.

Second, even if Plaintiff had properly presented the request, any amendment would be futile. As an initial matter, Plaintiff concedes that if this Court affirms dismissal of the GBL claims on the ground that Plaintiff did not allege consumer-oriented conduct, "then there is obviously no GBL claim that [Plaintiff] could plead." Pl. Br. at 49.

Additionally, Plaintiff's proposed amendments – which he did not raise below – would not cure the Complaint's deficiencies. *See, e.g.*, *Fallon v. Mercy Catholic Med. Ctr. of Se. Pa.*, 877 F.3d 487, 494 (3d Cir. 2017) (amendment is futile if it "would nonetheless be subject to dismissal for failure to state a claim"). Plaintiff contends that, if granted leave, he would allege the coverage examples were false (Pl. Br. at 49), but offers no support for that assertion. This argument, like the rest of the Complaint, rests on "farfetched interpretations" of the summary documents. Dist. Ct. Op. at 32 (A32).

Plaintiff's remaining argument that Plaintiff should be granted leave to amend so he can "obtain" the contract between GHI and the City (Pl. Br. at 50) makes no sense. A plaintiff first must plead a plausible claim before he is entitled to discovery. *See Iqbal*, 556 U.S. at 678-79 ("Rule 8 . . . does not unlock the doors of discovery for a plaintiff armed with nothing more than conclusions."). In any

event, Plaintiff's access to the contract cannot salvage the Complaint. As the District Court correctly held, the summary documents on their face are not misleading. Nothing in the contract can change that fact. Additionally, the contract would only serve to illuminate that the GHI Plan was heavily negotiated by the City, the Unions, and GHI, further underscoring the District Court's conclusion that Plaintiff's claims do not implicate consumer-oriented conduct.

CONCLUSION

For the foregoing reasons, GHI respectfully requests that the Court affirm the District Court's opinion and order dismissing the Complaint with prejudice.

Dated: New York, New York
November 16, 2018

Respectfully submitted,

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CERTIFICATION OF ADMISSION TO BAR

I, John Gleeson, certify as follows:

1. I am a member in good standing of the bar of the United States Court of Appeals for the Third Circuit.

2. Pursuant to 28 U.S.C. § 1746, I certify under penalty of perjury that the foregoing is true and correct.

By: /s/ John Gleeson
John Gleeson

CERTIFICATE OF COMPLIANCE WITH FEDERAL RULE OF APPELLATE PROCEDURE 32(a) AND LOCAL RULE 31.1

Pursuant to Fed. R. App. P. 32(a)(7)(C), I certify the following:

This brief complies with the type-volume limitation of Rule 32(a)(7)(B) of the Federal Rules of Appellate Procedure because this brief contains 11,520 words, excluding the parts of the brief exempted by Rule 32(a)(7)(B)(iii) of the Federal Rules of Appellate Procedure.

This brief complies with the typeface requirements of Rule 32(a)(5) of the Federal Rules of Appellate Procedure and the type style requirements of Rule 32(a)(6) of the Federal Rules of Appellate Procedure because this brief has been prepared in a proportionally spaced typeface using the 2008 version of Microsoft Word in 14 point Times New Roman font.

This brief complies with the electronic filing requirements of Local Rule 31.1(c) because the text of this electronic brief is identical to the text of the paper copies, and the Vipre Virus Protection, version 3.1 has been run on the file containing the electronic version of this brief and no viruses have been detected.

Dated: November 16, 2018

By: /s/ John Gleeson
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CERTIFICATE OF FILING AND SERVICE

I, Elissa Diaz, hereby certify pursuant to Fed. R. App. P. 25(d) that, on November 16, 2018 the foregoing Brief for Defendant-Appellee was filed through the CM/ECF system and served electronically.

Unless otherwise noted, copies have been sent to the court on the same date as above for filing via Express Mail.

/s/ Elissa Diaz
Elissa Diaz