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**REDACTED VERSION OF DOCUMENT SOUGHT TO BE SEALED (L.R. 79-5(d)(1)(C))**

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND DIVISION

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| CHRISTOPHER CORCORAN, et al.,<br>Plaintiffs,<br>v.<br>CVS PHARMACY, INC.,<br>Defendants. | No. 15–CV–03504–YGR<br>CLASS ACTION<br>**OPPOSITION TO MOTION FOR CLASS CERTIFICATION**<br>Date: January 31, 2017<br>Time: 2:00 p.m.<br>Courtroom: 1<br>Judge: Honorable Yvonne Gonzalez Rogers |

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27
28

**TABLE OF CONTENTS**


TABLE OF AUTHORITIES .................... ii

STATEMENT OF ISSUES TO BE DECIDED .................... v

INTRODUCTION .................... 1

THE FACTS RELEVANT TO THE RULE 23 ANALYSIS .................... 3

A. The Pricing of Prescription-Drug Transactions .................... 3

B. The Health Savings Pass Program .................... 7

LEGAL STANDARD UNDER RULE 23 .................... 13

I. SEVEN OF THE FIFTEEN PLAINTIFFS LACK STANDING. .................... 13

II. THE CLASS IS NOT REASONABLY ASCERTAINABLE. .................... 16

III. INDIVIDUAL ISSUES PREDOMINATE; COMMON ANSWERS ARE LACKING. .................... 18

A. Whether CVS Misrepresented the U&C Price Does Not Have a Common Answer .................... 19

B. Whether the PBMs and Plaintiffs Relied, Directly or Indirectly, on CVS's Representations Regarding the U&C Price Does Not Have a Common Answer .................... 26

C. Whether Class Members Suffered Injury Does Not Have a Common Answer .................... 29

D. The Existence of Unique Affirmative Defenses Precludes a Common Answer to the Question Whether CVS Is Liable to the Class .................... 30

IV. CLASS ADJUDICATION WOULD NOT BE SUPERIOR .................... 32

A. Plaintiffs' Claims Are Not Subject to Common Legal Rules .................... 33

B. Plaintiffs Have Not Provided a Manageable Trial Plan .................... 34

V. PLAINTIFFS ARE ATYPICAL AND INADEQUATE. .................... 36

VI. PLAINTIFFS CANNOT PROVE THE PREREQUISITES OF RULE 23(b)(2). .................... 39

CONCLUSION .................... 40

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

## TABLE OF AUTHORITIES

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*Bias v. Wells Fargo & Co.*, 312 F.R.D. 528 (N.D. Cal. 2015) ....................13, 25, 33

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*Gutierrez v. Wells Fargo Bank, NA*, 704 F.3d 712 (9th Cir. 2012) .......... 28

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*In re WellPoint, Inc. Out-of-Network UCR Rates Litigation*, 2014 WL 6888549 (C.D. Cal. Sept. 3, 2014) .......... 24, 25

*Jones v. ConAgra Foods, Inc.*, 2014 WL 2702726 (N.D. Cal. June 13, 2014) .......... 22

*Jones v. ConAgra Foods*, No. 14-16327 (N.D. Cal. July 15, 2014) (stayed pending a decision in *Microsoft Corp. v. Baker*, No. 15-457 (U.S. Oct. 9, 2015), *cert. granted*, 136 S. Ct. 890 (2016)) .......... 16

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*Lubin v. Sybedon Corp.*, 688 F. Supp. 1425 (S.D. Cal. 1988) .......... 38

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*Paul v. Intel Corp. (In re Intel Corp. Microprocessor Antitrust Litig.)*, 2010 WL 8591815 (D. Del. July 28, 2010) ....................35

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## STATEMENT OF ISSUES TO BE DECIDED

Whether the Plaintiffs have failed to meet their burden of showing:

1. That they have ***Article III standing***, where seven of the 15 are not members of the class or were not overcharged (Part II).

2. That the class is ***ascertainable***, where it is not administratively feasible, as to nearly 260 million prescription-purchase transactions, to match the transactions with the applicable contracts in order to determine whether each transaction meets the class definition (Part III).

3. That there are common answers to the proposed common questions, and that common ***factual and legal issues predominate***, where:

a. The evidence reflects that the pharmacy benefit managers ("PBMs")—the direct recipients of CVS's alleged misrepresentations about the usual & customary price—believe that CVS did not make any misrepresentations and was not obligated to treat the Health Savings Pass ("HSP") price as the usual and customary price, and at best, the evidence varies from one PBM to another.

b. The evidence reflects the PBM did not consider the HSP price material to their calculation of the copayments paid by class members, and at best, the evidence varies from one PBM to another.

c. The evidence reflects that many Plaintiffs, too, did not consider the HSP price material, as they continued to buy their prescription drugs at CVS after filing this lawsuit and expressed differing views about the relative importance of price, convenience, and other factors in filling their prescriptions.

d. The evidence reflects that whether any class members suffered any injury will need to be determined individually, as that inquiry will depend on the particular terms of each class member's unique health plan.

e. Analysis of the law for the eleven states reflects that the elements of the several common law and statutory claims are not the same from state to state.

(Part IV).

4. That class treatment is a ***manageable*** or a ***superior*** way to proceed, where the law applicable to the 11 state classes, as to three common law claims and 10 statutory consumer-protection claims, is not common and would require instructing the jury on 11 states' laws (Part V).

5. That Plaintiffs are ***typical*** or ***adequate***, where the evidence reflects that some or all lack standing, did not suffer any injury, are subject to unique affirmative defenses, and/or display striking unfamiliarity with the basic nature of their claims and responsibilities (Part VI).

6. That Plaintiffs satisfy the ***prerequisites for a Rule 23(b)(2)*** class, where they seek individual monetary damage awards, the damages claims are not incidental to the claim for injunctive relief, and the conduct they seek to enjoin relates to a program that no longer exists (Part VII).

## INTRODUCTION

This case is not brought against CVS Pharmacy, Inc. by pharmacy benefit managers ("PBMs"), but by CVS customers—customers who contracted to receive prescription benefits from scores of health insurers, which in turn contracted with scores of different PBMs to administer those benefits, each of which in turn contracted with CVS. In this lawsuit, those customers complain about the amount of their copayments—amounts calculated by each PBM pursuant to the customer's particular insurance plan. The PBMs stand at the fulcrum of the relationship between the customer and her insurer with CVS.

And this case is not about anything CVS said or failed to say to Plaintiffs[1] about the Health Savings Pass ("HSP") program. Plaintiffs contend that the HSP price of $9.99 (later $11.99) for a 90-day supply of selected prescription drugs was the most commonly charged price for those drugs, and, therefore, CVS should have reported that price to PBMs as the usual and customary ("U&C") price. Thus, Plaintiffs' theory is indirect misrepresentation—i.e., CVS made a direct misrepresentation to PBMs by failing to submit the HSP price as its U&C price, and the PBMs, in turn, instructed CVS to collect an excessive copayment from the customer. The PBMs also stand at the fulcrum of the alleged indirect misrepresentation.

The first and most important common question is whether CVS had an obligation to treat the HSP price as the U&C price and, thus, whether it in fact made misrepresentations to the PBMs when it did not do so. In the context of class certification, the Court must determine whether there is a ***common answer*** to that question. There can be no common answer. As to each Plaintiff (and putative class member), the answer depends on which PBM adjudicated the particular transaction, how that CVS/PBM contract defined the U&C price, and what the PBM's understanding of that contractual definition was. And Plaintiffs and class members here all had different health plans administered by different PBMs (and over time, often more than one plan and PBM), which, in turn, had different contracts with CVS, with differently worded definitions of U&C. Individual facts predominate in this regard because the evidence shows the largest

[1] We refer throughout to the 15 putative class representatives as "Plaintiffs."

PBMs, which controlled more than 75% of the market (i) knew about HSP during the program's existence, (ii) did not believe that the HSP price should have been treated as the U&C price, and (iii) did not expect CVS to submit the HSP price as the U&C price. These PBMs neither received, nor passed on, a misrepresentation about the U&C price. If other PBMs had the same understanding, CVS is entitled to summary judgment; if other PBMs had a different understanding, then that fact merely establishes that there is no common answer for all PBMs and all class members.

Individual fact questions predominate as to each Plaintiff as well as to each PBM. Some are not even members of the class, because they did not use their insurance to make the allegedly overpriced purchases. Some paid less than the HSP price and suffered no injury. Some, by reason of the terms of their insurance, suffered no injury, as they would have paid CVS the same amount regardless of the alleged misrepresentation. Some, if their insurance qualifies as an "employee benefit plan," have claims preempted by ERISA. Some cannot prove reliance or materiality because they continued to buy their drugs at CVS after learning of the alleged overcharges and even after filing this lawsuit. Thus, the Plaintiffs themselves demonstrate that this putative class should not be certified. Almost all are atypical because they lack standing, because they lack injury, or because an affirmative defense forecloses their claims. And, because of their startling unfamiliarity with the basic elements of their claims, they also fail the test of adequacy.

These individualized fact issues make a class action trial unmanageable. And so does Plaintiffs' proposal for 11 state classes. Neither the elements of their claims, nor the burdens of proof, are entirely the same from state to state. Plaintiffs' Trial Plan does not begin to explain how it is practical to instruct the jury on the law of 11 states regarding four common law claims and one statutory claim under each state's law (other than Georgia and Ohio).

The evidence in the record, from the persons who know whether CVS misrepresented the correct price—namely, the PBMs—is that CVS acted appropriately, honestly, and in accord with its contractual obligations, and did not misrepresent the U&C price. For purposes of Rule 23,

however, assuming there are PBMs that believe differently—and that is only an assumption—individual facts predominate, because at the very least there must be a plaintiff-by-plaintiff, policy-by-policy, PBM-by-PBM determination of what information the PBM contract with CVS required. Thus, class certification is not appropriate.

## THE FACTS RELEVANT TO THE RULE 23 ANALYSIS

In most cases, whether a class should be certified turns on whether common issues of fact and law predominate. Here, they do not. The reasons why are found in differences between and among (i) a "cash purchase" at a pharmacy and purchases made using insurance or another form of prescription benefit, such as CVS's HSP membership program; (ii) definitions of the U&C price contained in CVS's many different contracts with PBMs; (iii) the record amassed from PBMs concerning their understanding of whether the HSP program fell within those U&C definitions; and (iv) the individual circumstances of each Plaintiff, which have unique insurance benefits, unique reasons for shopping at CVS, and unique vulnerability to affirmative defenses.

### A. The Pricing of Prescription-Drug Transactions

When a customer walks into the pharmacy with a new prescription from his or her doctor that needs filling, the pharmacist will take the script, count out the number of pills, affix a label to the bottle, and include in the package the patient information sheet. As for payment, this is dependent on whether the customer has insurance or some other prescription benefit or, by contrast, is a "cash-paying customer."

**The cash customer**. If the customer is cash paying she pays the retail price set by the pharmacy. That price is typically referred to as the "cash" price—whether the customer literally pays with cash, credit card, or otherwise. There are no constraints, other than the constraints of competition, that limit what the pharmacy can charge the cash customer. That price can change from day to day and be different from store to store.[2] And it can obviously vary based on the medication, dosage, and quantity. When that retail or cash price is reported to an insurance company or its claims processor (described more below), the price is called the U&C price.

[2] Ex. 27, Declaration of Edward McGinley ("McGinley Decl.") ¶¶ 11–13.

**The insured customer**. In this day and age, most customers, are not cash customers but have health insurance that provides coverage for prescription drugs. Insurance may be provided by a large health plan such as Aetna or a BlueCross plan, or it may be provided by an employer, union, or pension plan, which then still typically contracts with an insurance company to administer its self-insured health plan. Insurance companies and self-insured health plans are sometimes referred to as Third Party Payors ("TPPs"). The TPP in turn typically contracts with one of any number of pharmacy benefits managers ("PBMs") to administer their prescription benefits, including the process for "adjudicating" claims and contracting with retail pharmacies like CVS.[3]

When an insured customer (sometimes called a "member" of the TPP) fills a prescription, the TPP typically pays part of the price, and the customer pays part (in the form of a copayment, coinsurance, or deductible). The benefit plan design dictates the dollar amount the customer pays and is part of the contract terms of the customer's health insurance policy—i.e., her contract (or her employer's contract) with the TPP. TPPs can offer thousands of plan designs.

That benefit plan design also determines what drugs are covered (i.e., the formulary), whether there are limits on quantities for certain drugs, whether a deductible must be satisfied, and whether coinsurance or a copay applies (and copayment tiers for different drugs), among other matters. Under some policies, the insured pays out-of-pocket up to a cap and then bears no cost for additional prescriptions. The total price the insured customer and TPP typically pay is equal to or less than the cash price. That is because there have been negotiations between (i) the TPP and its PBM and, in turn, (ii) the PBM and the pharmacy.[4] Thus, when the insured customer stands ready at the counter to pick up and pay for her prescription, an interlocking web of contracts at three levels comes into play, including her insurance policy, to determine that price.

With access to the various pharmacy's, health plan's and customer's information, the PBM adjudicates the customer's claim in real-time and, within seconds, transmits a response to

[3] Ex. 26, Declaration of John Jones ("Jones Decl.") ¶¶ 11–13. Some health plans own and operate a PBM themselves.

[4] *Id.* ¶¶ 11, 18–28.

the pharmacy indicating whether the claim has been approved (i.e., whether the customer has coverage and the drug is covered) and what copay, if any, CVS should collect. Unlike with a medical benefit, the copay amount is not printed on the benefit card. Rather the TPP has sent all forms of plan design to its PBM, which loads that information into its system. Any TPP may have hundreds or, in the case of a health plan, thousands of different plan designs. CVS has no insight into how the copayment is calculated; CVS simply collects from the customer what the PBM instructs it to collect.[5]

**The "usual and customary" price term**. To ensure that the insured customer is getting a price less than the cash-paying customer, the TPP/PBM contract sometimes includes a term stating that the TPP's member is entitled to the lesser of, for example, the drug's (1) average wholesale price, an industry-published price; (2) maximum allowable cost, a PBM-determined price; and (3) the usual and customary ("U&C") price, the pharmacy's cash price. It is for this reason that the CVS/PBM contracts may require CVS to submit the U&C price for a drug in connection with each purchase by an insured customer because the U&C price may be part of the PBM's pricing logic.[6] But not all contracts define U&C, and, for those that do, the definition of U&C can vary significantly:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[5] McGinley Decl. ¶ 18; Jones Decl. ¶¶ 33–38; Ex. 20, CVS Pharmacy, Inc. 30(b)(6) Deposition ("30(b)(6) Dep.") 153:1–8, 154:7–16.

[6] Jones Decl. ¶ 25; Ex. 23, Deposition of John Zevzavadjian ("Zevzavadjian Dep.") 55:9–13.

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3 See Exhibit 74 (chart listing relevant differences across contracts).
4 Clearly, these definitions are worded differently across contracts. Most importantly, and
5 contrary to Plaintiffs' repeated assertions, ***none*** of the contracts define the U&C price as the price
6 "most frequently paid."[7]
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13 .[9] Exhibit 74 is a
14 chart listing relevant differences in these contracts, including but not limited to the U&C price
15 definitions. [10]
16 CVS, like other pharmacies, submits during adjudication its U&C price in a data field
17 established by the National Council for Prescription Drug Programs ("NCPDP"), an industry
18 standard-setting organization. That field, 426-DQ ("Usual and Customary Charge"), is not
19 mandatory under the law; submission is only
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22 [7] Ex. 21, Declaration of Thomas Gibbons ("Gibbons Decl.") ¶ 7. Plaintiffs so characterize the U&C price without ever citing a CVS/PBM contract that so defines the term.
23 [8] Jones Decl. ¶¶ 39–41; Ex. 47, Deposition of Elizabeth Wingate ("Wingate Dep.") 69:8–70:5.
[9]
24
25 [10] Plaintiffs have appended to their Motion as Exhibit 12 a partial list of 1,217 contracts—main agreements, amendments thereto, and fee schedules—they claim are relevant contracts for
26 purposes of their class definition. Setting aside CVS's serious objections to the accuracy of Exhibit 12, for present purposes, what matters is that those contracts vary, even in seemingly-
27 standard terms, in part because each PBM's form contract typically served as the starting point for negotiations and because the contractual relationship is supplemented by each
PBM's "Provider Manual." Jones Decl. ¶ 24; Zevzavadjian Dep. 198:2–6.
28

1 NCPDP defines field 426-DQ as the [redacted]
2 [redacted][11]
3 **B. The Health Savings Pass Program**
4 CVS launched HSP on November 9, 2008. By that time, low-cost generic pricing had
5 become well-known in the industry. In 2006, Walmart began offering 30-day supplies of certain
6 generic drugs for $4 to all Walmart customers. Other big-box retailers, grocers, and pharmacies
7 followed suit, including Kmart and Kroger. In response, the pharmacy chains started membership
8 programs. After Walgreens and Rite Aid, two of CVS's direct competitors, introduced generic
9 drug membership programs, CVS responded with HSP.[12]
10 **The small size of HSP**. Unlike Walmart, which offered its $4 price to everyone,
11 Walgreens and Rite Aid created programs that limited special pricing to members. The
12 Walgreens program required a membership fee, and when CVS introduced HSP, it also required a
13 membership fee. Membership programs provide a special price for a list of drugs, as does
14 insurance, but they are not insurance. Membership programs require customers to enroll, agree to
15 terms and conditions (e.g., waiver of HIPAA rights), and pay a membership fee in order to obtain
16 special pricing, which typically applies to a limited set of medications.[13]
17 [redacted]
18 [redacted]
19 [redacted]
20 [redacted]
21 [redacted]
22 [redacted]
23 [redacted][15] HSP
24
25 [11] Ex. 25, Declaration of Catherine C. Graeff ("Graeff Decl.") ¶¶ 15–16, 18.
26 [12] Ex. 45, Deposition of Thomas E. Morrison ("Morrison TX Dep.") 66:1–67:1, 72:16–73:3; Jones Decl. ¶¶ 39–41, 47.
[13] Jones Decl. ¶¶ 41–42.
27 [14] Ex. 86, CVS Pharmacy Team Huddle Guide at 2, 5.
[15] *Id.* at 5.
28

offered members a set price—$9.99 through December 31, 2010; $11.99 thereafter—for a 90-day supply of 400-plus generic drugs.[16]

HSP had the hallmarks of a classic membership program. CVS required prospective HSP members to complete a written application; agree to the program's terms and conditions, including a waiver under the HIPAA; and pay an annual membership fee—$10 through December 31, 2010; $15 thereafter. The fee was significant to customers: they complained about it, noting they could pay a similar price for the drugs at other pharmacies (like Walmart) without paying an up-front fee.[17] Plaintiffs' own testimony confirms that customers viewed the fee as significant. Asked whether he would have paid $10 to join HSP, had he known about it, Plaintiff Clark said, "I'd have to consider all the costs versus what my costs would be under my insurance plan."[18] And asked whether he regarded $10 as significant, he replied, "Yeah, I do."[19] Five other Plaintiffs gave similar testimony, as demonstrated in the chart attached as Exhibit 2. This view of the fee was rational from a purely economic standpoint, for a $10 (or $15) fee acted to offset the discounted price for the average cash customer, who purchases relatively few prescriptions each year.[20]

The HSP program was small from start to finish.

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[16] HSP members could fill prescriptions for less than a 90-day supply, but the price remained $9.99 or $11.99, respectively. *See id.* at 4; Ex. 82, Health Savings Pass FAQs at 1–2. For the sake of simplicity, we refer throughout to the HSP price as $9.99, with the understanding that the price changed after December 31, 2011, and that certain drugs in certain states were priced higher.

[17] *See, e.g.*, Ex. 72, Compilation of Customer Complaints about HSP Membership Fee.

[18] Ex. 33, Deposition of Tyler Clark ("Clark Dep.") 315:14–18.

[19] *Id.* 341:18–20.

[20] Ex. 24, Declaration of Brett Barlag ("Barlag Decl.") ¶ 53a. *Id.* ¶ 53 fig. 11.

[21] *See id.* ¶ 42 fig. 8.

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4 .[22] CVS discontinued HSP on February 1, 2016.[23]

5 **The public nature of HSP**. CVS publicized the HSP program at launch, including to the
6 industry and investors. The company posted details about HSP on its website, issued a press
7 release, secured coverage on NBC's *Today* show, and placed an "op-ed" piece by the CEO in *The*
8 *Boston Globe*.[24] CVS also announced the program on its 2008 Q3 earnings call, which was
9 attended by investors and a number of PBMs and health insurers, including Express Scripts,
10 Medco, Aetna, RxAmerica, UnitedHeathcare, and Prime Therapeutics.[25] And after HSP's launch,
11 news articles that discussed prescription-drug discount programs often mentioned HSP.[26] In
12 2010, CVS's treatment of the HSP price—i.e., not reporting it as U&C—received coverage in the
13 popular press after Connecticut Medicaid amended its U&C regulation to capture that pricing and,
14 in response, CVS threatened to discontinue HSP there rather than change its U&C.[27]

15 CVS executives responsible for the company's relationships with PBMs told them directly
16 about the program. Among others, they told Caremark, Express Scripts, and Medco—the three
17 largest PBMs—about HSP, including that CVS did not consider the HSP price to be the U&C
18 price.[28] Moreover, PBMs could see, in the claim submission itself, its that CVS was not reporting
19 HSP as its U&C. In short, the program was no secret—least of all to PBMs, whose business it is
20 to follow drug pricing. Had any PBM disagreed with CVS's position that the HSP price was not

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22 [22] *Id.* ¶¶ 40 & figs. 5–6; 58–60; 69 fig. 15.
[23] Gibbons Decl. ¶ 9.
[24] Ex. 95, Thomas M. Ryan, Editorial, *Patient-Centered Healthcare*, Boston Globe, June 26,
23 2009, at A15; Ex. 90, Laura Klepacki, *Discount Generics Programs Flood Retail*, Drug Store
News, Nov. 17, 2008, at 50; Ex. 91, *Ryan: Discount Generics a Response to Economy, Not*
24 *Competition*, Drug Store News, Nov. 17, 2008, at 4.
[25] Ex. 75, Event Report for 2008 3Q CVS Caremark Earnings Call.
25 [26] *See, e.g.*, Ex. 100, Kristen Gerencher, *Save at the Drugstore*, Patriot News, Dec. 4, 2011, at
B5.
26 [27] *See*, *e.g.*, Ex. 97, Melissa Korn & Nathan Becker, *Connecticut Launches Probe of CVS*
*Caremark*, Wall St. J. Online (June 23, 2010); Ex. 98, Stephen Singer, *Conn., CVS in Dispute*
27 *Over Discount Program*, Associated Press Online (June 23, 2010).
[28] Wingate Dep. 105:10–15, 114:6–11, 124:11–125:13, 126:1–13, 127:13–128:3.
28

the U&C price, the PBM could have contested it. None did, to CVS's knowledge.[29]

**The PBMs' understanding of HSP**. There are dozens of PBMs in the United States, and CVS has contracts with more than 50 PBMs.[30] The U&C price is commonly a defined term in CVS/PBM contracts. Despite different formulations of the definition, the definitions share a common element, [REDACTED] HSP's special pricing, however, was available only to its members. For that reason, CVS did not treat the HSP price as its U&C price. ***PBMs knew this and agreed with CVS***.

Amber Compton is a Vice President of Express Scripts, one of the two largest PBMs in the United States. Her testimony is that "I was aware that CVS was not submitting to Express Scripts the membership program prices as CVS's U&C price on prescription drug claims.

[REDACTED][31]

John Lavin is a Senior Vice President for Caremark, another large PBM.[32] His testimony is that "Caremark considers, and has always considered, HSP a 'Club Plan.' Accordingly, ***CVS, like all other pharmacy companies with whom Caremark contracts and who operate Club Plans, was not required nor expected to submit its HSP program price as its usual and customary price on Caremark claims***."[33] That is because "a critical distinction exists between (1) a Set Price Generic Program [like Walmart's] and (2) a Club Plan [in which] the price … is

[29] Gibbons Decl. ¶ 8; Zevzavadjian Dep. 132:18–133:2, 195:5–19; Ex. 46, Deposition of Thomas Morrison ("Morrison Corcoran Dep.") 206:15–208:1; Wingate Dep. 105:10–15, 114:6–11, 124:11–125:13, 126:1–13, 127:13–128:3.

[30] Jones Decl. ¶ 15; Gibbons Decl. ¶ 2.

[31] Ex. 12, Declaration of Amber Compton ("Compton Decl.") ¶ 17. All emphases are added unless otherwise indicated.

[32] Caremark and CVS Pharmacy, Inc. are both subsidiaries of CVS Health Corporation. Caremark and CVS Pharmacy, Inc. are separate and distinct business entities, negotiate PBM-Pharmacy Provider agreements at arms-length, and have a firewall between key business units to prevent the sharing of competitively sensitive financial information.

[33] Ex. 14, Declaration of John Lavin ("Lavin Decl.") ¶ 20.

1 reserved for those customers who have taken steps to enroll in a program in order to obtain the
2 program's benefits." Thus, "pharmacies offering Club Plans are ***not contractually required*** to
3 submit to Caremark the Club Plan price as their usual and customary prices."[34]

4 William Strein spent 13 years in the PBM industry and was Vice President at Medco—one
5 of the largest PBMs at that time—from 2008 through 2012. His testimony is the same. He was
6 aware of membership-based programs with special pricing from "a variety of sources (e.g.,
7 network pharmacies)," he and his colleagues "determined that Medco's definition of 'usual and
8 customary' in its Pharmacy Services Manual did not encompass membership program prices";
9 and, thus, Medco concluded that "***CVS was not required to submit the HSP price as its U&C***
10 ***price on Medco claims***."[35] His colleague, Franceen Spadaccino, is equally unequivocal. A
11 Senior Director at Medco from 2006 through 2013, she was responsible for negotiating contracts
12 with network pharmacies. Her testimony, too, is that Medco "decided that pharmacies who
13 charged customers a fee to enroll in a membership-based generic program were not required to
14 submit the program price as U&C." [36]

15 OptumRx, today one of the big three PBMs, held the same view.
16
17 Optum "took a consistent position with respect to membership-based generic programs
18 offered by pharmacies other than CVS. If a pharmacy required a customer to enroll in a program
19 in order to access the membership program's prices, then neither Optum nor [its predecessor]
20 required the pharmacy to submit the program's prices as U&C."[37]

21 MedImpact, another leading PBM, also viewed membership-program pricing as not the
22 U&C price.
23

24 25 26 27 28

[34] *Id.* ¶¶ 16–17.
[35] Ex. 17, Declaration of William Strein ("Strein Decl.") ¶¶ 8–9, 11.
[36] Ex. 16, Declaration of Franceen Spadaccino ("Spadaccino Decl.") ¶ 6. CVS obtained testimony from Spadaccino and Strein after their former Medco colleague, Calvin Corum, could not recall anything about the HSP program. Ex. 13, Deposition of Cal Corum 53:13–21. CVS took Mr. Corum's deposition because he, on Medco's behalf, signed a letter confirming that CVS's HSP program price was not the U&C price under Medco's definition. Ex. 93, E-mail from Beth Wingate to Cal Corum (Apr. 28, 2009); Ex. 94, Letter from Cal Corum to Tina Egan (Apr. 29, 2009).
[37] Ex. 15, Declaration of Michael Reichardt ("Reichardt Decl.") ¶¶ 11–12.

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8 The contemporaneous documentary evidence reflects this understanding. In 2008, the
9 Deputy Director of Texas Medicaid told CVS "that [the] U&C provided to your routine customers
10 would be your U&C, not this new program."[39] The North Carolina State Health Plan noted in
11 2009 that the "cash" price is the price the pharmacy charges to the general public "without
12 requiring them to take any action such a[s] joining a 'discount program' or paying a fee."[40] And
13 the President of the PBM PeformRx, told *Drug Benefit News* in 2010, with reference to HSP,
14 "'this is not pricing that is generally available to the general public and is therefore not to be
15 included when calculating best price to the general public.'"[41] One PBM (MedMetrics) that
16 emailed to ask whether CVS planned to submit the HSP price as U&C was unequivocally told
17 "no," and did not object.[42]
18
19 [43] Two months before the agreement's effective date, CVS
20 and Aetna officials had a meeting during which HSP was a specific agenda item for discussion.[44]
21

22 [38] Ex. 11, Deposition of Bill Barre ("Barre Dep.") 24:4–19; 27:23–28:14; 32:10–16.
[39] Ex. 87, Handwritten Notes from Thomas Morrison Call with Andy Vasquez (Oct. 30, 2008) at
23 1; *see also* Ex. 89, Thomas Morrison E-mail to Andy Vasquez (Nov. 4, 2008).
[40] Ex. 96, E-mail from Mike Ayotte to Robert Greenwood (Nov. 29, 2009) at 2.
24 [41] Ex. 99, *CVS Caremark at Odds with Conn. Medicaid over Discount Program*, Drug Benefit
News (July 15, 2010).
25 [42] Ex. 88, E-mail from Sharon Edmunds to David Calabrese (Nov. 4, 2008).
[43]
26 [44] Ex. 84, Aetna Meeting Agenda (Nov. 13, 2008). More contemporaneous documents indicate
other PBMs were aware of HSP as well. Ex. 85, E-mail from Sharon Edmunds to John
27 Giacovelli (Nov. 3, 2008) (Excellus) ("I just saw this LA times [sic] article about CVS' new
generic program."); Ex. 92, E-mail from Bari Harlam to Doug Ghertner (Jan. 19, 2009)
28 (Horizon-Blue Cross Blue Shield) ("she brought up the topic of the Health Savings Pass"); Ex.

There is no contrary evidence from any PBM in the record.

## LEGAL STANDARD UNDER RULE 23

The Court knows well the requirements for class certification. *See* Fed. R. Civ. P. 23; *McKinnon v. Dollar Thrifty Auto. Grp., Inc.*, 2016 WL 879784, at *4–5 (N.D. Cal.); *Bias v. Wells Fargo & Co.*, 312 F.R.D. 528, 537–38 (N.D. Cal. 2015); *Kosta v. Del Monte Foods, Inc.*, 308 F.R.D. 217, 222–23 (N.D. Cal. 2015), *appeal filed*, No. 15-16974 (9th Cir. Oct. 2, 2015); *Faulk v. Sears Roebuck & Co.*, 2013 WL 1703378, at *5 (N.D. Cal.).

## I. SEVEN OF THE FIFTEEN PLAINTIFFS LACK STANDING.

It is fundamental that a class representative must have standing "for each of her claims and for each form of relief sought." *In re Carrier IQ, Inc., Consumer Privacy Litig.*, 78 F. Supp. 3d 1051, 1064–65 (N.D. Cal. 2015) (quotations omitted); *Lujan v. Defs of Wildlife*, 504 U.S. 555, 560–61 (1992). The question of standing takes on added significance here, for Plaintiffs seek certification of 11 state classes, six of which (Arizona, Georgia, Massachusetts, New Jersey, Ohio, and Pennsylvania) have only one representative.[45] If any one of those Plaintiffs lacks standing, the putative state class is "headless" and cannot be certified.

**No Insurance**. The proposed class definition requires that class members have been (i) "insured for the purchase(s) through a third-party payor plan" and (ii) have "paid CVS an out-of-pocket payment for the purchase greater than the HSP price for a 90-day supply of the prescription." Mot. at iii. Caine† and (for certain transactions) Avis† and Corcoran did not purchase their prescriptions from CVS with insurance, but with "cash discount cards," which are not insurance.[46] Thus, when Avis, Caine, and Corcoran used cash discount cards to purchase the

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[45] Those Plaintiffs are Avis (AZ), Caine (GA), Garber (MA), Hagert (PA), Jenks (IL), and Wulff (OH). We designate these sole representatives with a "†."

[46] Ex. 76, Cash Discount Cards. The cards state on their face: "This program is not insurance."

1 drugs at issue, they were not persons who were "***insured*** for the purchase(s)," as the class
2 definition requires. As the documentation demonstrates, Avis used an UNA Rx Card; Caine, a
3 Georgia Drug Card; and Corcoran, a Welldyne Rx Card and FamilyWize Card.[47] Therefore, they
4 do not satisfy the class definition. *McKinnon*, 2016 WL 879784, at *9 (putative class
5 representative not a class member and "[i]n light of [that] finding, Tran . . . lacks standing").

6 **No Overcharge**. The class definition also requires that class members have "paid CVS an
7 out-of-pocket payment for the purchase greater than the HSP price for a 90-day supply of the
8 prescription." Mot. at iii. Brown, Hagert†, Odorisio, Wulff†, and (for certain transactions) Avis†
9 and Corcoran, do not meet that aspect of the class definition: They paid less than the HSP price,
10 not more, according to their interrogatory answers.

11 To circumvent this disqualifying fact, Plaintiffs contend that the HSP price was not one
12 price (e.g., $9.99), but two-thirds of that price (e.g., $6.66) when the customer purchased a 60-day
13 supply or one-third of that price (e.g., $3.33) when the customer purchased a 30-day supply. Mot.
14 at iii. On this basis, Plaintiffs define the class to include persons who paid more than the HSP
15 price for a 90-day supply or "greater than a price ***proportionate to*** the HSP price for a prescription
16 less than or greater than a 90-day supply." Mot. at iii; *id.* at 9 n.12. Brown, Hagert†, Odorisio,
17 Wulff†, Avis†, and Corcoran paid more than $3.33 when they bought 30-day supplies and so,
18 according to Plaintiffs, paid more than the HSP price and fall into the class.

19 But Plaintiffs' contention about pro-rated prices is counter-factual in two ways. *See Wal-*
20 *Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350–52 (2011) ("rigorous analysis" that court must

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22 [47] *See* Pl. Ex. 27. [redacted]
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conduct to evaluate certification "[f]requently" will entail determination of the merits (quotations omitted)).

First, CVS instructed the PBMs administering the HSP program not to pro-rate the HSP price for quantities less than a 90-day supply.[48] There is no evidence that either PBM departed from CVS's instructions, or that HSP members "routinely" paid $3.33 for a 30-day supply or $6.66 for a 60-day supply (or $3.99 and $7.98 when the HSP price rose to $11.99). Rather, the evidence is that over the seven-plus-year life of HSP, out of more than 5.8 million HSP transactions overall, there were 11 HSP transactions at $3.33, three at $6.66, and when the HSP prices went up to $11.99, two at $3.99 and none at $7.98. Thus, the percentage of "pro-rated" transactions was 0.0001%.[49]

Second, Plaintiffs' expert wrongly says "it was a common occurrence for CVS to offer prorated prices based on the HSP price."[50] The expert purports to identify 2,509,883 cash ***and*** HSP purchases where the patient paid less than the HSP price, but fails to disclose that of these 2.5 million transactions, only 6,637—or ***0.26%***—are HSP purchases. Put in proper perspective, the expert's analysis itself proves that CVS pharmacists collected the full HSP price more than 99% of the time and apparently departed from CVS's policy requiring full payment of the HSP price an average of only one time per store during the program's existence.[51]

The nub of Plaintiffs' claim is that CVS overcharged the putative class "by excluding from consideration [of the U&C price] the most common and customary cash prices it actually charges to the general public: the price CVS offers ***under its HSP program***." Mot. at 1. But, in fact, CVS offered set minimum prices of $9.99 or $11.99 "under its HSP program," not pro-rated prices for 30-day and 60-day supplies. Thus, insofar as Plaintiffs define the class to include persons who paid "a price proportionate to the HSP price" for a less-than-90-day supply, the definition is based on a fiction. Avis†, Brown, Hagert†, Odorisio, and Wulff† did not pay more than $9.99 or $11.99; they paid ***less*** than "the price CVS offers under its HSP program." For that

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[48] Ex. 83, E-mail from Lisa Schuldes to Doug Ghertner (Aug. 7, 2008).
[49] Barlag Decl. ¶ 78.
[50] Declaration of Dr. Joel Hay ("Hay Decl.") [Dkt. No. 172-6] ¶ 42.
[51] Barlag Decl. ¶ 79.

reason, they lack standing to pursue claims that CVS overcharged the class. *Moore v. Apple Inc.*, 309 F.R.D. 532, 543 (N.D. Cal. 2015) ("Plaintiff's proposed class is overbroad and cannot be certified under *Mazza* because it necessarily includes individuals who could not have been injured by Defendant's alleged wrongful conduct as a matter of law.").[52]

In sum, seven of the 15 Plaintiffs lack standing on one or both grounds. The Court should dismiss their claims, and, because Avis†, Caine†, Hagert†, and Wulff† are the sole Plaintiffs for the Arizona, Georgia, Pennsylvania, and Ohio classes, the Court should deny the motion to certify classes for those states.

## II. THE CLASS IS NOT REASONABLY ASCERTAINABLE.

The Ninth Circuit, in two pending cases, is expected to clarify what it means for a class to be "ascertainable."[53] This Court has held that class certification must be denied unless the plaintiff demonstrates that: (i) "members of the proposed class are readily identifiable by objective criteria," and (ii) "it is administratively feasible to determine whether a particular person is a member of the class." *Kosta*, 308 F.R.D. at 227; *McKinnon*, 2016 WL 879784, at *8. Plaintiffs fail that test.

Plaintiffs do not explain how class members can be "readily identifi[ed]" or whether it is "administratively feasible" to do so. They simply assert that "the members of the class are readily identifiable through CVS's own transaction data" and that, "[w]ith this data matched with CVS's contracts," their expert can ascertain who is in the class. Mot. at 16. Notably, Plaintiffs' approach examines ***CVS's contracts*** to determine whether the putative class members were "insured through a TPP or PBM that required CVS not to charge amounts higher than its U&C

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[52] Although the issue is not ripe for discussion now, Plaintiffs assertion that the HSP price was the "most commonly charged price" badly distorts the evidence. Plaintiffs so assert only by analyzing a carefully selected subset of CVS's total transactions designed, knowingly, to overweight the effect of HSP purchases and underweight cash purchases. For the reasons explained in the Barlag Report, Plaintiffs' method "essentially ensures that the HSP program price will be selected as the 'most common cash price'" and is far from a fair reflection of CVS's purchase data. Barlag Decl. ¶ 74.

[53] *Jones v. ConAgra Foods*, No. 14-16327 (N.D. Cal. July 15, 2014) (stayed pending a decision in *Microsoft Corp. v. Baker*, No. 15-457 (U.S. Oct. 9, 2015), *cert. granted*, 136 S. Ct. 890 (2016)); *Bruton v. Gerber Prods. Co.*, No. 15-15174 (N.D. Cal. Jan. 30, 2015) (scheduled for oral argument on Dec. 13, 2016).

price." *Id.* This assertion about matching the transaction with the applicable contract is important on two levels.

First, it is a belated recognition that it is the contracts between CVS and PBMs that allegedly "require" CVS to treat the HSP price as the U&C price. CVS is a retail pharmacy, after all; it can charge a customer whatever price it chooses, unless it has negotiated with, and entered into, a contract with a PBM or TPP to charge a lower price. This fact would seem obvious, but, at the time of the motion-to-dismiss briefing, Plaintiffs insisted that contracts had nothing to do with their misrepresentation claims and that the gravamen of those claims was that CVS violated industry standards and affirmatively misrepresented to Plaintiffs the availability of the HSP program and the class members' ability to join the program.[54]

Now, however, Plaintiffs acknowledge that the PBM contracts define both who is a class member and whether CVS overcharged them. Thus, Plaintiffs have revised the class definition to exclude from the class those persons whose prescription-drug purchases were governed by ***contracts*** that "did not use usual and customary pricing or expressly excluded discount programs from usual and customary pricing." Mot. at iii; *cf.* 3d Am. Compl. ("TAC") [Dkt. No. 101] ¶ 83. Plaintiffs have attached a listing of 1,217 ***contracts*** that allegedly fall within the class definition. Mot. at iii; Pl. Ex. 12 [Dkt. No. 172-5] at 60. And Plaintiffs' class-certification expert has opined that the source of the alleged obligation to treat HSP prices as U&C prices is contractual, *i.e.*, that pharmacies submit U&C prices to PBMs "according to their ***contract terms***," and "the claims adjudication system [of the PBM] compares the charges with the terms of the patient's benefit plan and ***pharmacy contract***."[55] This acknowledgment takes on special significance given Plaintiffs' failure to establish that there are common answers to the common questions and that common issues of fact predominate. *See* Part III, *infra*.

Second, Plaintiffs' assertion that their expert will match transaction data with PBM contracts in order to identify class members is also important to the ascertainability of the putative class. Plaintiffs are correct that, essential to the task, is identifying the PBM contract(s) that

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[54] March 14, 2016 Order [Dkt. No. 96] at 19 (summarizing Plaintiffs' allegations).
[55] Declaration of Robert P. Navarro ("Navarro Decl.") [Dkt. No. 172-4] ¶ 16.

govern each transaction. The hitch is that doing so is administratively infeasible, where there are more than 260 million transactions at issue. Plaintiffs' expert proposes to use the "Condor code," a CVS-assigned identification number not validated by PBMs, to identify the PBM associated with each transaction, and, in turn, to identify the applicable contract—and more precisely, the applicable U&C definition. [REDACTED].[56]

Here, where an estimated ***38 million*** class members were allegedly overcharged in ***nearly 270 million*** transactions, the potential amount of detective work is overwhelming.[57]

## III. INDIVIDUAL ISSUES PREDOMINATE; COMMON ANSWERS ARE LACKING.

"'What matters to class certification … is not the raising of common "questions"—even in droves—but, rather the capacity of a classwide proceeding to generate ***common answers*** apt to drive the resolution of the litigation.'" *Stitt v. S.F. Mun. Transp. Agency*, 2014 WL 1760623, at *3 (N.D. Cal.) (Gonzalez Rogers, J.) (quoting *Dukes*, 564 U.S. at 350). Plaintiffs must show that trying their claims will resolve "'in one stroke,'" at one trial, the issues that are central to the validity of all the class members' claims. *Id.* (*quoting Dukes*, 564 U.S. at 350). Typically, this can happen only when common issues of fact and law predominate. For this reason, we treat the

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[56] Ex. 18, Declaration of Susan Colbert ("Colbert Decl.") ¶¶ 4–18; Ex. 19, Deposition of Susan Colbert ("Colbert Dep.") 30:14–31:9 ("They have to kind of be detectives to figure it out.").

[57] Although disputes about which contracts fall inside or outside of the proffered class will be a fight in the event the Court certified a class, CVS wishes to make clear that it has identified serious inaccuracies in Exhibit 12 attached to Plaintiffs' Motion for Class Certification—i.e., "the Chart of Relevant Contracts," cited in Plaintiffs' Motion. By way of example only, Exhibit 12 identifies contracts that terminated before the putative class period, contracts whose definitions of U&C [REDACTED], and contracts for lines of business other than prescription drug insurance (i.e., cash discount cards).

requirements of Rule 23(a)(2) and (b)(3) as one, except where there is reason to make a distinction.

Here, Plaintiffs have failed to show that there can be common answers to any of the four major questions: (1) whether CVS misrepresented the U&C price; (2) whether CVS's alleged misrepresentations were material either to the PBMs, who were the direct recipients of the alleged misrepresentations, or to class members, who received them only indirectly; (3) whether Plaintiffs and class members relied on the alleged misrepresentations; and (4) whether any class member suffered injury. Moreover, Plaintiffs are subject to different affirmative defenses that cannot be litigated on a common basis.

### A. Whether CVS Misrepresented the U&C Price Does Not Have a Common Answer

In opposing CVS's motions to dismiss, Plaintiffs told the Court that their misrepresentation claim had three aspects. They argued that: (1) CVS had made affirmative misrepresentations to the class about the HSP program; (2) CVS had failed to disclose HSP to the class; and (3) that CVS had misrepresented the "true" U&C price to PBMs, and, through the PBMs, indirectly to class members.[58] Now, however, only misrepresentations of the third kind—the indirect misrepresentations—remain at issue for purposes of class certification.[59]

**Affirmative Misrepresentations about HSP.** In response to CVS's two motions to dismiss, Plaintiffs argued that CVS had made affirmative misrepresentations about HSP to them: CVS, they said, "misrepresents to customers that [the HSP program] cannot apply to their transactions." Opp'n to Mot. to Dismiss [Dkt. No. 71] at 4; Opp'n to Mot. to Dismiss [Dkt. No. 104] at 3. The Court acknowledged this contention. *Corcoran v. CVS Health Corp.*, 169 F. Supp. 3d 970, 988 (N.D. Cal. 2016) ("Plaintiffs additionally allege that CVS misrepresented the availability of the HSP program and their ability to participate therein.").

Plaintiffs' interrogatory answers and deposition testimony now make clear, however, that Plaintiffs have no such claim, and never did. Asked to identify the alleged misrepresentations

[58] Opp'n to Mot. to Dismiss [Dkt. No. 71] at 9–10.
[59] Plaintiffs' Motion for Class Certification ("Mot.") [Dkt. No. 172].

made to them, Plaintiffs each gave the same interrogatory answer—that the misrepresentation was the communication of the price, and nothing else.[60] And when they were later deposed, Plaintiffs to a person testified that CVS did not make any statements or representations to them about the HSP program. Hagert was asked, "Has anyone at CVS ever said anything to you that you regarded as false or misleading?" "Not that I can think of," he said. When Jenks was asked, "So you do not recall any statements made by CVS to you about the Health Savings Pass program that you would consider false?" he said, "I don't remember them making any statements to me at all." And so on for each of Plaintiffs, as catalogued in Exhibit 4.

It follows that Plaintiffs have disclaimed any contention that CVS said anything orally or in writing that misrepresented the HSP program, and, even if some Plaintiffs cling to the contention, there is no affirmative misrepresentation that was ***common*** to the class. *See McKinnon*, 2016 WL 879784, at *6 (no common answers where employees' "provision of oral disclosures … varied temporally and by location"); *Kosta*, 308 F.R.D. at 229 (no commonality where "variations" in challenged statements raised "individual issues"); *Berger v. Home Depot USA, Inc.*, 741 F.3d 1061, 1070 (9th Cir. 2014) (where "oral representations are a fundamental part of the alleged misrepresentation … the individualized determination of the nature of those statements support[s] denial of class certification").

**Omissions about HSP.** In responding to CVS's motions to dismiss, Plaintiffs also asserted that CVS was guilty of misrepresentation by omission, claiming that "CVS avoids informing customers who use insurance about the HSP program."[61] This was an odd claim to begin with, for what retailer has a legal obligation to tell a customer that there is a sale running or a membership or loyalty program available for a fee? A fiduciary, or someone in a special relationship to the customer, may have a duty to disclose, but that is rarely the case in a

[60] Ex. 48–62, Pls.' Resps. Interrog. No. 12 ("Plaintiff states that each instance where CVS (1) sold Plaintiff a drug on the HSP program list, (2) reported to Plaintiff's third-party health insurer … a U&C price that was higher than CVS's true U&C price for such sale, … and (3) communicated to and collected from Plaintiff a copayment that exceeded CVS's true U&C price for such sale, constituted a false and misleading statement….").

[61] Opp'n to Mot. to Dismiss [Dkt. No. 71] at 4; Opp'n to Mot. to Dismiss [Dkt. No. 104] at 3; 2d Am. Class Action Compl. [Dkt. No. 49] ¶ 80.

commercial context. The Court so held: "Plaintiffs contend they have adequately pled a duty on the part of CVS to disclose information relevant to drug pricing. Defendants do not argue that the [Second Amended Complaint] fails to plead a duty sufficiently. Rather, they claim that ***no such duty exists*** as a matter of law. … The Court agrees." *Corcoran*, 169 F. Supp. 3d at 989.

**Indirect Misrepresentation.** The remaining claim—and what has always been Plaintiffs' central contention—is that CVS indirectly misrepresented the U&C price to customers. The mechanism by which indirect misrepresentation occurs is the three-step "adjudication" process: (1) CVS submits the U&C prior to the drug being dispensed; (2) the PBM verifies the insurance and determines the copay; and (3) the PBM directs CVS what copay to collect.[62]

Recognizing these three steps is important to a proper analysis of the common answer/predominance requirement. The first step involves a direct representation by CVS to the PBM, and the third step involves a direct representation by the PBM (and indirect representation by CVS) to the customer. When one focuses on the first step—the need to prove that CVS made a direct misrepresentation to the PBMs—it becomes apparent that there can be no common proof. The only evidence whether CVS deceived the PBMs is that it did not: The PBMs knew about HSP (and membership programs like it) and did not expect CVS to submit the HSP price as the U&C price. Equally important, insofar as some PBMs may have taken a different view, (none has been identified), that fact would merely establish that the evidence is not common, but differs from PBM to PBM, for the scores of PBMs that acted on behalf of class members.

**The PBM Testimony.** The evidence in the record is that most PBMs knew about the HSP program and did not consider the HSP price to be the U&C price. The PBM executives responsible for the contracts with CVS for Express Scripts, Medco, Caremark, OptumRx, and MedImpact have all testified that their contracts did ***not*** require CVS—or any pharmacy with a membership program—to treat HSP prices as U&C prices. The contemporaneous documentary evidence confirms this understanding. Thus, from the standpoint of the PBMs—whose contracts are at issue and who were the ***direct*** recipients of the alleged misrepresentations—CVS did not

[62] SAC ¶¶ 52–53; Navarro Decl. ¶ 24.

misrepresent the U&C price at all.

On the merits, this testimony gives the lie to Plaintiffs' claim of misrepresentation. Even more telling, for purposes of class certification, this evidence shows that there can be no common answer to Plaintiffs' first and most important common question: "Whether, in setting and reporting its U&C prices, CVS was required to include its HSP prices for drugs on the HSP formulary." Mot. at 13. CVS has asked the PBMs who are the market leaders whether CVS misrepresented the U&C price, and they have answered that it did not. If there are PBMs who hold a different view, their contrary testimony would only serve to show that each class member's claim will depend on different proof, depending on whether the PBM(s) that processed her prescriptions was Express Scripts, Caremark, Medco, Optum, MedImpact, etc. on the one hand, or was some as-yet-unidentified PBM, on the other hand, that believed its contract with CVS required the HSP price to be the U&C price. That is, the proof will differ, not only class member by class member, but prescription by prescription, because it is not uncommon for a class member to have had different insurance policies, administered by different PBMs, from 2008 through the end of the program.

In situations like this, class certification is inappropriate. *See Jones v. ConAgra Foods, Inc.*, 2014 WL 2702726, at *14 (N.D. Cal.) (finding "a lack of cohesion among the class members" where the alleged misrepresentations "varied," but "more importantly because even if the challenged statements were facially uniform, consumers' understanding of those representations would not be," and that this is especially so given the representations at issue had "no fixed meaning" (quotations and emphases omitted)); *Monaco v. Bear Stearns Cos.*, 2012 WL 10006987, at *6 (C.D. Cal.) (denying certification even where "the Court is satisfied that the … documents are uniform with respect to the material language," because defendant "may have individualized defenses to the putative Subclass's members' claims depending on their circumstances" that would "require[] individualized evidence"); *Gregurek v. United of Omaha Life Ins.*, 2009 WL 4723137, at *7 (C.D. Cal.) (decertifying class where the factors incorporated into calculating a contractually required "cost of insurance charge" were "ambiguous," and

"resolution of the ambiguity [could not] be made on a class-wide basis" because "whether an agent provide[d] details" or responded to "questions raised by a particular customer," varied across each putative class member).

**The Contracts**. Plaintiffs now acknowledge that whether CVS should have reported HSP prices as U&C prices to PBMs is a matter of contract. First, Plaintiffs have revised the class definition: It now turns on how the CVS/PBM contracts define the U&C price and [REDACTED] [REDACTED]. Second, Plaintiffs attach to the Motion a listing of the contracts that supposedly match the class definition. *See supra* note 57. Third, the Motion refers repeatedly to the U&C price as a term defined by the CVS/PBM contracts.[63] Fourth, Plaintiffs' expert, Robert Navarro, acknowledges that any duty to treat a membership price as the U&C price depends on the terms of the specific CVS/PBM contract, because pharmacies submit U&C prices "according to their contract terms."[64]

Plaintiffs blithely assert that "all of the contracts pertaining to class members have the same or substantially similar 'Lower of U&C' provision (i.e., that the pharmacy collect the "lower of" the U&C or retail price), so that no individual contractual analysis is necessary." Mot. at 6. But that does not answer the predicate question of whether the HSP price should even be considered the U&C price, given the contracting parties' intent. Plaintiffs assert that the HSP price was the U&C price (and, thus, triggered the "lower of" provision). But the only ***evidence*** in the record about the parties' understanding and implementation of these contracts is from Express Scripts, Caremark, Medco, etc., and they are unequivocal that their contracts with CVS did ***not*** require it to submit the HSP price as the U&C price. Contrary evidence from other PBMs, if any, would only underscore that there can be no common, affirmative answer to the question whether

[63] Mot. at 1 (CVS submits the "U&C price for the drug being purchased under its contractual arrangements with the insurer."); *id.* at 4 ("The PBMs and TPPs have agreements with pharmacies, including CVS, which govern … the prices that CVS may charge for prescription drugs purchased by the insured patients."); *see also id.* at 5–6 & nn. 6–7.

[64] Navarro Decl. ¶¶ 13, 16; Ex. 28, Deposition of Robert Navarro ("Navarro Dep.") at 37:23–25 ("In general, the contract and related documents would outline the terms of reimbursement for the pharmacy and the obligations of both parties in this relationship.").

1 CVS was required to treat the HSP price as the U&C price.[65]

2 Two recent decisions involve analogous facts and explain why certification is
3 inappropriate. In *Stitt v. Citibank, N.A.*, 2015 WL 9177662 (N.D. Cal.), the plaintiffs sought to
4 certify a class of persons who were allegedly charged an improper and undisclosed property
5 inspection fee when they purchased a home. Although the plaintiffs alleged tortious
6 misrepresentation, this Court determined that "[t]he terms of the mortgage itself govern whether a
7 property inspection fee was validly charged," and, therefore, that "Citi's liability rises or falls on
8 whether a fact-finder determines that a property inspection fee was authorized by the borrower's
9 mortgage agreement." *Id.* at *4–5. Reviewing the mortgage agreements showed that "class
10 members' agreements had 'distinct terms,'" and therefore "that common proof could not be used
11 to determine the validity of property inspection fees." *Id.* at *5.

12 Like Plaintiffs here, the plaintiffs in *In re WellPoint, Inc. Out-of-Network UCR Rates*
13 *Litigation*, 2014 WL 6888549 (C.D. Cal.), were health insurance subscribers. They alleged that
14 WellPoint failed to reimburse them fully by artificially reducing the "usual, customary, and
15 reasonable" ("UCR") rate, a factor in calculating reimbursement. *Id.* at *1. The court denied
16 class certification, because it found that WellPoint's "UCR obligations are governed by its
17 contracts, and the relevant terms of those contracts vary across the proposed classes." *Id.* at *4.
18 Finding significant differences across WellPoint's several plans, and explaining that it could not
19 "determine what UCR obligations WellPoint had under the terms of its various plans without
20 analyzing the specific terms of those plans," the court was "not persuaded that WellPoint's UCR
21 obligations can be determined on a classwide basis." *Id.* at *7; *accord Gustafson v. BAC Home*
22 *Loans Servicing, LP*, 294 F.R.D. 529, 542 (C.D. Cal. 2013) (denying certification, given the
23 "sheer number of form contracts at issue"); *Westways World Travel, Inc. v. AMR Corp.*, 2005 WL
24 6523266, at *9 (C.D. Cal.) (denying certification where the "sheer number of … agreements, even
25 though many are form contracts, suggests that individualized issues would predominate"),

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27 [65] There can also be no common answer, as some class members (like some Plaintiffs) had more than one health insurer during the relevant period; some TPPs had more than one PBM; and
28 some PBMs had more than one contract with CVS during the relevant period. Thus, each class member's claim will depend on consideration of a unique "package" of PBM contracts.

1 *aff'd*, 265 F. App'x 472 (9th Cir. 2008); *Church v. Consol. Freightways, Inc.*, 1991 WL 284083,
2 at *13 (N.D. Cal.) (denying certification where "there were at least ten different variations of
3 contract used," and "the circumstances surrounding the creation and termination of each of these
4 contracts, or whether there were any modifications to such contracts (or whether such
5 modifications were enforceable), would undeniably vary").

6 Here, as in *Stitt* and *WellPoint*, there are many contracts, with differing definitions of the
7 term in dispute, that have been interpreted and applied differently by the PBMs (assuming
8 *arguendo* that there are PBMs who interpret their contracts differently than Express Scripts,
9 Caremark, and Medco have. In *WellPoint*, the plaintiffs "offer[ed] a purported industry definition
10 of UCR" and "seem[ed] to think that the Court [could] ignore the actual text of WellPoint's plans
11 and decide a common UCR rate in a vacuum." 2014 WL 6888549, at *10. Similarly, here,
12 Plaintiffs offer a supposed industry definition of U&C (the most commonly charged cash price)
13 that cannot be found in any of the contracts to which they point the Court. And, as in *WellPoint*,
14 Plaintiffs say "that any differences in plan terms are immaterial, because WellPoint itself treated
15 all plans similarly." *Id.* The court in *WellPoint* rejected that argument because it "simply ignores
16 the fact that any analysis of WellPoint's obligations must begin with the text of [the contracts]."
17 *Id.*

18 Plaintiffs wrongly rely on the Court's opinion in *Bias v. Wells Fargo & Co.*, 312 F.R.D.
19 528, 537–38 (N.D. Cal. 2015). *Bias* found that variations in the relevant contractual term were
20 irrelevant only because the claims were "independent of any particular … contract language," and
21 that "[c]ritically, … Wells Fargo does not identify any provision … that would authorize a
22 mortgage servicer to charge borrowers an undisclosed mark-up on the [appraisal] fee" at issue. *Id.*
23 at 536–37 (emphasis omitted). But, here, Plaintiffs' very definition of the class constitutes a tacit
24 concession that their claim depends on how the CVS/PBM contracts define the U&C price. And
25 their expert, Dr. Navarro, concedes the contract definition controls.[66] Moreover, unlike Wells
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[66] Navarro Dep. 104:1–14.

Fargo, CVS has marshalled evidence from the counterparties to the contracts that the definitions of the U&C price do not mean what Plaintiffs contend, but just the opposite.

Even if there were a common definition of the U&C price that included HSP prices, that definition would be found in a contract ***between CVS and the PBM***, not a contract between CVS and any class member. Plaintiffs assume that any such definition operates for their benefit, but that would be true only if the class members were third-party beneficiaries, which is itself a matter of contract. *See, e.g.*, *GECCMC 2005-C1 Plummer St. Office LP v. JPMorgan Chase Bank, N.A.*, 671 F.3d 1027, 1033 (9th Cir. 2012). [redacted][67] None of the listed contracts provides that insured customers ***are*** third-party beneficiaries. If class members enjoy the right to pay the U&C price, that right exists by virtue of their health insurance policies, not the CVS/PBM contracts, and CVS would not be a proper defendant in a Plaintiff's suit to enforce her policy rights. Again, individual questions predominate.

**B. Whether the PBMs and Plaintiffs Relied, Directly or Indirectly, on CVS's Representations Regarding the U&C Price Does Not Have a Common Answer**

**Reliance of PBMs.** The predominance of individual questions of fact becomes even clearer when one considers what further issues arise if there turns out to be a PBM that says CVS ***did*** misrepresent the U&C price. Was that PBM aware of HSP? It is certainly the business of PBMs to know about such programs. If the PBM did not know about HSP, then why not? After all, CVS disclosed HSP to the industry in conspicuous ways—by website, press release, television appearance, op-ed article and earnings call (attended by Express Scripts, Medco, Aetna, RxAmerica, UnitedHeathcare, and Prime Therapeutics). *See* p.9, *supra*. If a PBM did know about HSP, then why did the PBM fail to ask whether or not CVS was treating the HSP price as

[67] [redacted]

the U&C price? All these questions prompt PBM-specific inquiries. Thus, there can be no common answer to the question whether PBMs—the direct recipients of CVS's alleged misrepresentation—***reasonably*** relied on it.

The decision in *In re Pharmaceutical Industry Average Wholesale Price Litigation*, 252 F.R.D. 83 (D. Mass. 2008) ("*AWP*"), also sheds light on why reliance does not have a common answer. In that case, the plaintiffs alleged that the defendant-manufacturers had inflated the price of branded drugs by misstating the posted Average Wholesale Prices ("AWP"). The court found that the TPPs knew this as of a certain date, however, and that "the misrepresentation claims of plaintiffs who continued to make payments based on AWP even after learning the truth … could be undermined in jurisdictions requiring plaintiffs to prove the element of reliance." *Id.* at 97. Accordingly, the *AWP* court denied class certification under the laws of states that require reliance, "[b]ecause many of the proposed class consumer members were beneficiaries of the TPP plans, [and] the knowledge of the TPP is imputed to the consumer." *Id.* (citing Restatement (Third) of Agency § 5.03 (Am. Law Inst. 2006)). Applied here, the *AWP* decision means that class members whose PBMs understood and accepted that CVS would not report HSP prices as U&C prices cannot show reliance. Whether the PBM for each class member for each prescription-drug purchase had that understanding, however, is an individualized inquiry.

**Reliance by Plaintiffs.** Plaintiffs argue they are entitled to a presumption of reliance, either because consumer-protection statutes adopt a "reasonable consumer" standard or because the class members would not have purchased the drugs unless they were implicitly relying on the quoted price as the correct price. Mot. at 19–21. Assuming *arguendo* that Plaintiffs enjoy a presumption, however, that presumption is rebuttable, and Plaintiffs' testimony demonstrates there will be class-member-by-class-member rebuttal evidence.

"Plaintiffs' continued patronage [of CVS] may later be evidence relevant to materiality," the Court has said. *Corcoran*, 169 F. Supp. 3d at 987 (citing *Red v. Kraft Foods, Inc.*, 2011 WL 4599833, at *12 (C.D. Cal.) (plaintiffs' continued purchases would have "almost certainly destroyed the ability of the class to ever establish reliance and/or materiality of the alleged

1 misrepresentations”)). The Court was right. Two things distinguish this case from other
2 deceptive-pricing cases. First, the Third Amended Complaint alleges continued patronage of
3 CVS by almost all class members. Except for the Texas Plaintiffs, all Plaintiffs allege that they
4 “anticipate[] filling future prescriptions for these generic drugs at a CVS pharmacy.”[68] In other
5 words, all but two Plaintiffs assert that they will continue to buy the very drugs for which they
6 were allegedly overcharged from the very pharmacy that overcharged them. Strange as that
7 allegation is, Plaintiffs’ deposition testimony confirms that they did indeed continue to buy
8 prescription drugs from CVS. Asked whether, when she reviewed the Third Amended
9 Complaint, she “intend[ed] to continue to fill prescriptions at CVS?” Gilbert (TX) answered,
10 “Yes.” Asked whether she had, in fact, “filled prescriptions at CVS since April 4th, 2016,
11 correct?” she again said, “Yes.”[69] And Gilbert is not alone: 11 other Plaintiffs also continued to
12 patronize CVS, as reflected in the charts attached as Exhibits 1 and 73.

13 This kind of evidence was significant in the Court’s denial of class certification in *Faulk v.*
14 *Sears Roebuck & Co.*, 2013 WL 1703378 (N.D. Cal.). Like Plaintiffs here, Faulk argued that
15 materiality and reliance are subject to an objective standard that can be determined on a classwide
16 basis. But his “own tire purchase history and deposition testimony cast doubt on whether Faulk
17 himself found [Sears’s allegedly deceptive conduct] material,” for he had continued to purchase
18 Sears tires even after he became aware of Sears’ failure to disclose all terms and conditions of its
19 tire warranties. *Id.* at *9. This showed, “at least as to the Named Plaintiff, materiality may not be
20 susceptible to proof by objective criteria.” *Id.*

21 Plaintiffs argue that their continued patronage of CVS “[does] not change the classwide
22 evidence of reliance and materiality.” Mot. at 21 (citing *Gutierrez v. Wells Fargo Bank, NA*, 704
23 F.3d 712, 729 (9th Cir. 2012)). But *Gutierrez* is factually distinguishable. Indeed, there were no
24 “facts” establishing continued patronage by the plaintiffs there; the defendant in *Gutierrez* asked
25 the court to “speculat[e]” that “some class members would have engaged in the same conduct”
26 regardless of the alleged deceptive conduct. 704 F.3d at 729 (quotations omitted). Here, in
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[68] 3d Am. Compl. [Dkt. No. 101] ¶¶ 16–35.
[69] Ex. 37, Deposition of Amanda Gilbert (“Gilbert Dep.”) 85:8–17.

1 contrast, there is ***evidence*** that 12 out of 15 Plaintiffs did not rely on CVS's alleged conduct,
2 because they continued to shop for prescription medicines at CVS. This fact confirms that
3 reliance and materiality will need to be determined class member by class member.

4 **C. Whether Class Members Suffered Injury Does Not Have a Common Answer**

5 It is commonplace that the calculation of damages typically varies from class member to
6 class member. That circumstance alone, we appreciate, rarely justifies the denial of class
7 certification. Here, certainly, determination of the class members' damages would be a set of
8 individual calculations. But the predicate question is whether the class members suffered an
9 injury ***at all***. That question—whether the Plaintiff would have paid a different amount but for the
10 alleged misrepresentation—does not have a common answer, because it depends on the terms of
11 the class member's health insurance policy.

12 Two examples illustrate the problem. First, [REDACTED]
13 [REDACTED]
14 [REDACTED]
15 [REDACTED].[70] Second, [REDACTED]
16 [REDACTED]
17 [REDACTED][71] Under the arrangement, the insured pays 100% of
18 the cost of his prescription drugs up to the amount of the annual cap, and after that the insurance
19 plan pays 100%. (The percentages can vary from policy to policy.) With this kind of coverage, a
20 class member can have been overcharged by CVS (according to Plaintiffs' theory), but have
21 suffered no injury, as a simplified example illustrates. Assume that CVS collects a copayment of
22 $20 per prescription instead of collecting an HSP price of $10. After purchasing five
23 prescriptions, the customer will have paid a total of $100 and been "overcharged" $50, but he will
24 also have reached his out-of-pocket cap for the year. If he then fills five more prescriptions
25 before the end of the year, he will incur another $100 of costs, but pay nothing more. For the
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27 [70] Ex. 44, Deposition of Linda Krone ("Krone Dep.") 234:1–235:10. Plaintiffs withdrew Krone as a class representative following her deposition.

28 [71] CVS does not know the terms of Clark's prescription drug insurance policy, as he did not produce it in discovery, despite CVS's document request. This failure is not unique to Clark.

1 year, he will have paid $100 for his 10 prescriptions, or $10 per prescription, which is the HSP
2 price. Therefore, he suffers no injury. Said differently, CVS's alleged failure to submit the
3 "correct" U&C price did not injure this customer, because he would have incurred the same $100
4 in out-of-pocket costs regardless.

5 In short, the nature of the class member's insurance policy—and the pattern of his
6 purchases—can affect whether he suffers any injury. As Plaintiffs' own authority holds, such
7 individualized issues foreclose a finding of predominance. *See, e.g.*, *In re NCAA Student-Athlete*
8 *Name & Likeness Licensing Litig.*, 2013 WL 5979327, at *8 (N.D. Cal.) (denying certification
9 where "the fact of injury cannot be determined by a virtually mechanical task" without
10 individualized inquiries (quotations omitted)) (cited in Mot. at 14); *see also In re Graphics*
11 *Processing Units Antitrust Litig.*, 253 F.R.D. 478, 490 (N.D. Cal. 2008) (denying certification
12 where no "common proof" of injury across the class and noting if injury "is particular to" each
13 class member, "individual questions … would overwhelm the common questions" (quotations
14 omitted)). Moreover, making that determination would require identifying and securing a copy of
15 each class member's policy, which is no easy matter. CVS requested production of the Plaintiffs'
16 own policies, and they failed to produce them.

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18 **D. The Existence of Unique Affirmative Defenses Precludes a Common Answer to the Question Whether CVS Is Liable to the Class**

19 Class certification is inappropriate when "affirmative defenses … may depend on facts
20 peculiar to each plaintiff's case." *Abed v. A.H. Robins Co. (In re N. Dist. of Cal., Dalkon Shield*
21 *IUD Prods. Liab. Litig.)*, 693 F.2d 847, 853 (9th Cir. 1982); *see Ellis v. Costco Wholesale Corp.*,
22 657 F.3d 970, 984 (9th Cir. 2011) (reversing certification given Costco's claim that "it has unique
23 defenses against each of the named Plaintiffs"). The evidence demonstrates that such affirmative
24 defenses are present here.

25 First, seven Plaintiffs—Avis†, Brown, Caine†, Corcoran, Hagert†, Odorisio, and Wulff†
26 —lack standing. *See* Part I, *supra*; *McKinnon*, 2016 WL 879784, at *9 (denying class
27 certification and finding that the named plaintiff's "claims are subject to unique defenses,
28

including that she lacks standing"). Whether putative class members likewise have similar issues will have to be determined case by case.

Second, 12 Plaintiffs—Avis†, Barrett, Brown, Caine†, Clark, Corcoran, Garber†, Gargiulo†, Gilbert, Hagert†, Jenks, and Washington—assert claims that are barred by the voluntary payment doctrine, which provides that "a person cannot use the courts to recover money voluntarily or consensually paid with full knowledge of all of the facts and without fraud, duress, or extortion in some form." 66 Am. Jur. 2d *Restitution and Implied Contracts* § 92 (West 2016). Insofar as Plaintiffs continued to patronize CVS after they knew the relevant facts, and even after the filing of this lawsuit, the doctrine would bar their claims under the law of most states. *See Monaco*, 2012 WL 10006987, at *9−10 & n.5 (denying certification given individualized affirmative defenses, such as voluntary payment doctrine); *Endres v. Wells Fargo Bank*, 2008 WL 344204, at *12 (N.D. Cal.) (denying certification where "the voluntary-payment doctrine … may bar any claims made by class members who continued to incur and voluntarily pay the overdraft protection fee[]").

Third, the Court held that the substitution of Gilbert and Brown as Texas representatives salvaged the Texas statutory claims because they "do not allege that they intend to purchase generic drug prescriptions from CVS in the future." *Corcoran v. CVS HealthCorp.*, 2016 WL 4080124, at *4 (N.D. Cal.). But Gilbert and Brown conceded in their depositions that they did, in fact, continue to fill prescriptions at CVS after discovering the alleged overcharge.[72] The divergence between their allegation and their evidence only underscores that the defense is individualized and must be determined case by case.

Fourth, an unknown number of Plaintiffs and class members may be subject to a defense of preemption under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. Not all insurance plans qualify as an "employee benefit plan" under ERISA, but ERISA preempts "any and all State laws insofar as they … relate to any employee

[72] Ex. 31, Dep. of Gilbert Brown ("Brown Dep.") 86:11–19, 87:8–11; Gilbert Dep. 85:14–20.

benefit plan." 29 U.S.C. § 1144(a).[73] Common evidence cannot answer whether each class member's insurance is a qualifying "employee benefit plan." That inquiry is individual to each class member and her plan. Complicating this inquiry is the fact that most Plaintiffs have not produced their health plan documents—apparently because they do not have them. To litigate this defense would therefore require that the plan documents be subpoenaed from scores of TPPs—a further fact that highlights the fact-intensive, individualized nature of the inquiry.

The Plaintiffs are by no means identical, and a class trial would not be a simple matter of putting on common evidence of liability. Plaintiffs had different insurance policies, with different terms, and many of them continued to patronize CVS. Those facts subject them to affirmative defenses based on individual evidence and render a single trial unmanageable. Plaintiffs have not begun to show otherwise.

## IV. CLASS ADJUDICATION WOULD NOT BE SUPERIOR.

Class certification often turns on whether the common questions can be answered by common evidence because, where individual questions of fact predominate, a class action trial would be unmanageable and unfair—unmanageable, as it is too hard to separate the common from the individual evidence for multiple class representatives; and unfair, as the fate of class members should not rise or fall with that of the class representatives, where their claims may be based on individual proof or subject to individual defenses. Part III above explains why individual issues of fact predominate, and for that reason alone, a class-action trial would not be manageable. The problem of class adjudication is compounded, however, by the fact that

[73] The term "state law" includes common law causes of action as well as state statutes. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004). A state law claim may relate to ERISA if it has "a connection with or reference to such a plan." *Or. Teamster Emp'rs Tr. v. Hillsboro Garage Disposal, Inc.*, 800 F.3d 1151, 1155–56 (9th Cir. 2015) (quotations omitted), *cert. denied*, 136 S. Ct. 1495 (2016). And a claim has "'reference to'" an ERISA plan if "'the existence of an ERISA plan is a critical factor in establishing liability under a state cause of action.'" *Edwards v. Lockheed Martin Corp.*, 617 F. App'x 648, 650 (9th Cir.) (quoting *Wise v. Verizon Commc'ns, Inc.*, 600 F.3d 1180, 1190 (9th Cir. 2010)), *cert. denied*, 136 S. Ct. 409 (2015). The "reference to" standard is broad. *Gobeille v. Liberty Mut. Ins.*, 136 S. Ct. 936, 947 (2016) (Thomas, J., concurring) ("Section 1144 contains what may be the most expansive express pre-emption provision in any federal statute."). Here, Plaintiffs' claims have "reference to" their health plans, for those plans define the respective obligations of insured and insurer for payment of prescription drugs.

Plaintiffs seek to certify 11 state classes, each subject to a different state's laws. Plaintiffs have not met their burden to show that it is manageable to try a case with 15 plaintiffs and 11 sets of jury instructions.

**A. Plaintiffs' Claims Are Not Subject to Common Legal Rules**

The Court has ruled that the Plaintiffs have standing to bring claims only under the statutory and common law of the state in which they reside, purchased drugs from CVS, and were allegedly injured by CVS's pricing system. Accordingly, Plaintiffs do not contend that one state's law applies to all their claims, nor that the consumer protection laws of the 11 states or the common law of fraud, misrepresentation and unjust enrichment in the 11 states are the same.

Indeed, the laws of the 11 states are not the same, as the courts have held, even as to a claim as basic as negligence. "The law of negligence, including subsidiary concepts such as duty of care, foreseeability, and proximate cause, may as the plaintiffs have argued forcefully to us differ among the states only in nuance," the court said in denying class certification in *In re Rhone-Poulenc Rorer Inc.*, 51 F.3d 1293, 1300 (7th Cir. 1995). "But nuance can be important, and its significance is suggested by a comparison of differing state pattern instructions on negligence and differing judicial formulations of the meaning of negligence and the subordinate concepts." *Id.* The Ninth Circuit, too, recognized the importance of these "differing judicial formulations of the meaning" of familiar common law claims in *Mazza v. American Honda Motor Co.*, 666 F.3d 581, 596 (9th Cir. 2012). *Mazza* held that, "[b]ecause the law of multiple jurisdictions applies here to any nationwide class of purchasers or lessees …, variances in state law overwhelm common issues …." *Id.* In *Mazza*, as here, one of the claims was for unjust enrichment, and the Ninth Circuit held "unequivocally" that "[t]he elements necessary to establish a claim for unjust enrichment also vary materially from state to state." *Id.* at 591; *Bias*, 312 F.R.D. at 540 (noting the Ninth Circuit's "unequivocal statement that unjust enrichment laws vary materially from state to state").

Attached as Exhibits 7–10 are a set of charts which identify both the clear differences and nuances in state law for each claim of Plaintiff's claims. There are common elements, to be sure.

But Plaintiffs' analysis begins and ends with those common elements and ignores the differences. The question is whether these indisputable differences are manageable.

**B. Plaintiffs Have Not Provided a Manageable Trial Plan**

It is Plaintiffs' burden to establish the superiority of class certification by presenting a "manageable trial plan adequate to deal with individualized issues and variances in state law." *Zinser v. Accufix Research Inst., Inc.*, 253 F.3d 1180, 1190 (9th Cir. 2001); *accord Daniel F. v. Blue Shield of California*, 305 F.R.D. 115, 132 (N.D. Cal. 2014) (denying certification where manageability, a "key factor" in assessing superiority, not established). Plaintiffs attached a "Trial Plan" to their brief which does not address the question of whether it is manageable to instruct the jury on the law of 11 states, as applied to three common law claims and a consumer-protection claim in each state (and two such claims, in the case of the California class).

Plaintiffs say that, because they seek certification of 11 state classes, "there are no choice of law issues." Trial Plan at 1. But that is not an answer to the question of manageability. With 11 state classes, the problem is applying the law of 11 states to four claims, not choosing which law to apply. Giving that problem short-shrift, the Trial Plan devotes only ***one sentence*** to the manageability of applying 11 states' law: "[T]he courts may utilize common jury instructions, verdict forms and special interrogatories to consolidate issues where appropriate." *Id.* at 7. But, if the law is not uniform, as the court in *Mazza* said it was not, then the Court cannot give common instructions and use a common verdict form.

Do Plaintiffs really imagine that a jury can make sense of 11 sets of jury instructions and can apply them faithfully to as many as 15 Plaintiffs, each of whom had different insurance, administered by a different PBM, which, in turn, had a different contract with CVS and may have had a different understanding of whether CVS should have reported HSP prices as U&C prices? What court has ever presided over such a trial? The complexities of such a proceeding render "certification of a class spanning multiple jurisdictions … hen's-tooth rare." *AWP*, 252 F.R.D. at 94. The court in *Gianino v. Alacer Corp.*, 846 F. Supp. 2d 1096, 1104 (C.D. Cal. 2012), saw clearly the impracticality of a class trial where the law of multiple jurisdictions must be applied: "The trial would devolve quickly into an unmanageable morass of divergent legal issues. Certain

evidence would be admissible for some class members but not others. ***Fifty different sets of jury instructions and verdict forms would have to be crafted with the jury having the daunting task of applying those instructions and verdicts to a nationwide class encompassing millions of consumers***." *Id.*; *see Doll v. Chi. Title Ins.*, 246 F.R.D. 683, 688–89 (D. Kan. 2007) (denying certification because of variations in laws of 18 jurisdictions)); *In re Prempro Prods. Liab. Litig.*, 230 F.R.D. 555, 565 (E.D. Ark. 2005) ("While a multitude of subgroups might solve the variation of laws problem, it would lead to monumental case management problems.").[74]

Plaintiffs propose 11 classes, not 50, but the problem is hardly less daunting. Plaintiffs have not attempted to show that the 11 states can be grouped in some way that makes instructing the jury manageable. The state-law charts attached as Exhibits 7–10 make clear that attempting to group the law of the 11 states is like solving a Rubik's cube. The groupings would have to be different from claim to claim, and, even for one claim, the grouping that aligns the elements of the claim is not the same grouping needed to align the various burdens of proof.

Plaintiffs cite *In re ConAgra Foods, Inc.*, 90 F. Supp. 3d 919 (C.D. Cal. 2015), and *Petersen v. Costco Wholesale Co.*, 312 F.R.D. 565 (C.D. Cal. 2016), for the proposition that a class action encompassing 11 or nine single-state classes "is eminently manageable." Mot. at 24. But those two cases are distinct outliers, and even they lend weak support to Plaintiffs' position. The court in *ConAgra* noted the plaintiffs' concession that the various consumer-protection laws "require proof of different elements" but did not explain how it proposed to instruct the jury in a comprehensible way while preserving those differences. 90 F. Supp. 3d at 1033–34. The court seemed to suggest that, because the MDL Panel had consolidated the cases for pretrial purposes, it made sense to certify the several state classes "at this stage," while noting that "the court could, in its discretion, sever the classes following certification for separate adjudication of the claims of the state classes." *Id.* at 1034. In *Petersen*, the court certified nine state classes, but it did not find

[74] *Accord Paul v. Intel Corp.* (*In re Intel Corp. Microprocessor Antitrust Litig.*), 2010 WL 8591815, at *60–61 (D. Del.) (Plaintiffs "offer [a] 26-class alternative … [T]his alternative eliminates any efficiencies that might have been gained by the use of the class action mechanism and creates insurmountable manageability concerns."); *Carpenter v. BMW of N. Am., Inc.*, 1999 WL 415390, at *6 (E.D. Pa.) (same); *Willis v. Thorn Ams. Inc.*, 1996 WL 117436, at *2 (E.D. Pa.) (same).

1 that a single class-action trial was manageable. To the contrary, even though it was dealing with
2 only one cause of action, for which the law of the several states was "'virtually identical,'" the
3 court said it could manage the differences in the law "'by holding separate trials for each state-
4 wide class.'" 312 F.R.D. at 582 (quoting *In re Welding Fume Prods. Liab. Litig.*, 245 F.R.D. 279,
5 294 (N.D. Ohio 2007)).[75]

6 **V. PLAINTIFFS ARE ATYPICAL AND INADEQUATE.**

7 There are 15 Plaintiffs. But this is not a case where all that matters is that ***one*** Plaintiff be
8 a typical and adequate class representative. Plaintiffs seek to certify ***11 state classes***, and there
9 must be typical and adequate class representatives for each class. As explained below, all 15
10 Plaintiffs are either atypical or inadequate or both.

11 **Typicality**. "To demonstrate typicality, Plaintiffs must show … other [class] members
12 have the same or similar injur[ies], … the action is based on conduct which is not unique to the
13 named plaintiffs, and … other class members have been injured by the same course of conduct."
14 *Ellis*, 657 F.3d at 984 (quotations omitted). Fourteen Plaintiffs are atypical.

15 By definition, Plaintiffs who are not members of the class do not have "the same or similar
16 injuries" and were not "injured by the same course of conduct." Seven Plaintiffs are atypical for
17 that reason. Caine† is not a member of the class because she did not purchase her at-issue
18 prescription from CVS using insurance, but with a cash discount card. Brown, Hagert†, Odorisio,
19 and Wulff† are not class members because they paid less than the HSP price, not more. (Even if
20 they could be considered class members according to a literal application of the class definition,
21 they did not suffer any injury if they paid less than $9.99, and their claims are not typical of those
22 who paid more.) And Avis† and Corcoran are atypical for both reasons; they used a cash
23 discount card for some purchases and, for others, paid less than the HSP price. *See* pp.13–16,
24 *supra*.

25

26 [75] We do not understand Plaintiffs to advocate for 11 separate class-action trials. If that were Plaintiffs' answer to the problem of manageability, it would be especially important to
27 consider Rule 23(b)(3)(C), which requires examination of "the desirability or undesirability of concentrating the litigation of the claims *in the particular forum*." If there were to be 11
28 trials, it is unclear why this Court and eleven California juries should undertake the burden of hearing the claims of consumers from ten other states, involving conduct in those states.

1 Putative class representatives also lack typical claims if they are subject to unique
2 affirmative defenses. *Ellis*, 657 F.3d at 984 (a "motion for class certification should not be
3 granted if there is a danger that absent class members will suffer if their representative[s] [are]
4 preoccupied with [unique] defenses" (quotations omitted)). That is true here of 12 Plaintiffs—
5 everyone except Odorisio, Samuelson, and Wulff. *See supra* pp.30–32.
6 Overall, 14 of the 15 Plaintiffs (everyone except Samuelson) are not typical for either or
7 both of these reasons. And because the Arizona, Georgia, Massachusetts, New Jersey, Ohio, and
8 Pennsylvania classes lack a typical representative, those six classes cannot be certified.
9 **Adequacy**. Thirteen Plaintiffs are not adequate—i.e., everyone except Caine and Hagert.
10 The Court held in *Bodner v. Oreck Direct, LLC*, 2007 WL 1223777 (N.D. Cal.), that a named
11 plaintiff could not meet the threshold requirement for adequacy where he displayed "undeniable
12 and overwhelming ignorance regarding the nature of this action, the facts alleged, and the theories
13 of relief against defendant." *Id.* at *2. In the reported decisions, few putative class
14 representatives are deemed to be so lacking, but at least thirteen Plaintiffs here are just that
15 deficient in their understanding and are otherwise inadequate.
16 All Plaintiffs "know" this much—that CVS overcharged them in some way. Most "know"
17 this based only on counsel's say-so, but few know anything more. Two facts are central to
18 Plaintiffs' allegations: (1) that the HSP program offered a lower price; and (2) that CVS failed to
19 report the HSP price as the U&C price. An adequate class representative, even if she knows little
20 else, should certainly understand the importance to the litigation of these two central facts; she
21 should know what the HSP program is and what function U&C pricing plays. But, at their
22 depositions, taken 11-16 months after the complaint was filed, five of 15 Plaintiffs testified they
23 had never heard of the HSP program. Consider Brown:

24 Q. Do you know what the Health Savings Pass program is?"
25 A. No, not really.
Q. Do you know what HSP is?
26 A. No.
* * *
27 Q. … Do you have any understanding of how, if at all, the allegations
28 in this litigation relate to the Health Savings Pass Program?

A. No.

Exhibit 5 compiles the similar testimony of Barrett, Gargiulo, Odorisio, and Washington.

Those Plaintiffs who had heard of the HSP program knew about it only because counsel told them, but knew little or nothing about the program or its significance to the litigation. Gilbert is illustrative:

> Q. Outside of what you have discussed with your attorneys, what do you know about Health Savings Pass?
>
> A. I didn't know anything.
>
> Q. Do you know, sitting here today, whether the Health Savings Pass had an enrollment fee?
>
> A. No.
>
> Q. Do you know whether the Health Savings Pass covered a certain list of drugs?
>
> A. No.

*See* Exhibit 5 regarding the similar testimony of Avis†, Clark, and Corcoran.

The same is true for Plaintiffs' knowledge of "U&C" pricing. Barrett acknowledged that the Third Amended Complaint makes several references to the U&C price, but asked whether she took "steps . . . to understand what the term means?," she said "I did not." And asked, "Sitting here today, do you know what the usual and customary price is?," she answered "No" again. *See* Exhibit 5 regarding the similar testimony of Avis†, Brown, Corcoran, Garber†, Gilbert, Odorisio, and Wulff†.

Putative representatives who are so uninformed and disengaged are not "adequate." *See Welling v. Alexy (In re Cirrus Logic Sec.)*, 155 F.R.D. 654, 659 (N.D. Cal. 1994) (class representative inadequate where he "apparent[ly] [was] unfamiliar[] with the allegations in the amended complaint and the overall status of the proceedings"; "failed to exhibit an interest in supervising the attorneys in th[e] case;" "ceded control to his lawyers;" and was "unaware that his lawyers had filed an amended complaint"); *Burkhalter Travel Agency v. MacFarms Int'l, Inc.*, 141 F.R.D. 144, 153–54 (N.D. Cal. 1991) (class representative inadequate where he "knows very little" about the litigation); *Lubin v. Sybedon Corp.*, 688 F. Supp. 1425, 1462 (S.D. Cal. 1988) (class representative inadequate where he demonstrated "an inadequate knowledge of the circumstances underlying this suit").

Plaintiffs' striking unfamiliarity with the key elements of the litigation is compounded by their total deference to counsel. Plaintiffs are passive clients, not the engaged, reasonably well-informed representatives envisioned by Rule 23. This is not surprising, because, as in *Bodner*, "[i]t is clear from the record that plaintiff's counsel, and not plaintiff, is the driving force behind this action." 2007 WL 1223777, at *2–3. Odorisio and Samuelson (the only two New York Plaintiffs) were solicited by their pharmacist, who was acting as a "runner" for counsel. Washington testified that counsel had access to his medical records in connection with another case, and "from their access to my medical records, I was made aware of [the *Corcoran*] litigation." The same is true of Barrett, Brown, Gilbert, and Wulff. And the testimony of Corcoran and Garber suggests that they did not find counsel; counsel found them. *See* Ex. 6; *Bodner*, 2007 WL 1223777, at *2 ("Solicitation of clients for the commencement or continuation of a class action is improper, sufficient to warrant denial of class action certification." (quotations omitted)); *see In re TFT-LCD (Flat Panel) Antitrust Litig.*, 267 F.R.D. 291, 309 (N.D. Cal. 2010) (*Bodner* applies where the record suggests the named plaintiff "was 'recruited'").[76]

In summary, every Plaintiff is either atypical or inadequate or both, which means that the proposed state classes for Arizona, Georgia, Massachusetts, New Jersey, Ohio, and Pennsylvania do not have a representative.

## VI. PLAINTIFFS CANNOT PROVE THE PREREQUISITES OF RULE 23(b)(2).

Plaintiffs' invocation of Rule 23(b)(2)—which is limited to cases where the defendant "has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief … is appropriate respecting the class as a whole"—is so patently wrong Plaintiffs initially told CVS the reference to that provision was a scrivener's error.[77] Rule 23(b)(2) is intended to apply "primar[ily]" to civil rights cases, as Plaintiffs' own authority makes clear. *Parsons v.*

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[76] *Accord Sanchez v. Wal-Mart Stores, Inc.*, 2009 WL 1514435, at *3 (E.D. Cal.) (class representative inadequate where she "learned that she allegedly had a claim against Defendants only after … class counsel contacted her and told her so"); *Stuart v. RadioShack Corp.*, 2009 WL 281941, at *10 n.4 (N.D. Cal.) (*Bodner* applies where "there [is] … evidence that plaintiff's counsel [had] constructed the lawsuit before it had a plaintiff … *i.e.*, the plaintiff became the plaintiff by responding to an advertisement by counsel" (alteration and quotations omitted)).

[77] Ex. 101, E-mail from Rob Gilmore to Luba Shur (Dec. 2, 2015).

*Ryan*, 754 F.3d 657, 686 (9th Cir. 2014). Mot. at 25. Now, however, Plaintiffs seek to transform a typographical mistake into a basis for certification of 11 state classes covering many millions of purported class members. Plaintiffs had it right when they said they were wrong.

First, "[u]nder Rule 23(b)(2), claims for monetary relief may not be certified 'where (as here) the monetary relief is not incidental to the injunctive … relief.'" *Faulk*, 2013 WL 1703378, at *5 n.4 (quoting *Dukes*, 564 U.S. at 360). Plaintiffs claim that CVS has overcharged them to the tune of more than ***$1 billion***—relief that is clearly not "incidental" to their claim for injunctive relief. *In re Flash Memory Antitrust Litig.*, 2011 WL 1301527, at *7 (N.D. Cal.) (holding that damages were the "predominant" relief, because "Plaintiffs clearly state that the crux of their claims is that [they] … paid artificially-inflated prices"). As this Court has said, "Rule 23(b)(2) 'does not authorize class certification when each class member would be entitled to an individualized award of monetary damages,'" *Faulk*, 2013 WL 1703378, at *5 n.4 (quoting *Dukes*, 564 U.S. at 360–61), which is the relief Plaintiffs seek here.

Second, there is nothing to enjoin. HSP was discontinued as of February 1, 2016.[78] This is not a flaw that can be fixed by amending the class definition again. What exists at CVS today is a cash discount card—provided by ScriptSave, and usable at CVS (as well as at tens-of-thousands of non-CVS pharmacies across the country). The price these cardholders pay is not a set price and is determined by ScriptSave, not CVS.[79] Simply put, the cash card is not CVS's product.

Third, the Court said that Plaintiffs' continued patronage of CVS might be evidence disproving materiality. Plaintiffs declared their intention not to patronize CVS anymore. If the Court takes them at their word again, then there is no point to an injunction.

## CONCLUSION

CVS respectfully requests that the Court deny Plaintiffs' Motion for Class Certification.

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[78] Gibbons Decl. ¶ 9; CVS 30(b)(6) Dep. 200:7–201:21.

[79] Gibbons Decl. ¶ 14.

Dated: November 21, 2016

Respectfully submitted,

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