IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
CIVIL DIVISION

STATE OF ARKANSAS, ex rel.
TIM GRIFFIN, ATTORNEY GENERAL **PLAINTIFF**

v. **CASE NO. 60CV-24-_____**

OPTUM, INC.; OPTUMRX, INC.; OPTUMINSIGHT LIFE SCIENCES, INC.; OPTUMINSIGHT, INC.; UNITEDHEALTH GROUP, INC.; THE LEWIN GROUP, INC.; EVERNORTH HEALTH, INC.; EXPRESS SCRIPTS, INC.; EXPRESS SCRIPTS ADMINISTRATORS, LLC; ESI MAIL PHARMACY SERVICE, INC.; EXPRESS SCRIPTS PHARMACY, INC.; EXPRESS SCRIPTS SPECIALTY DISTRIBUTION SERVICES, INC.; and MEDCO HEALTH SOLUTIONS, INC. **DEFENDANTS**

COMPLAINT

I. INTRODUCTION

1. This case arises from Defendant Optum's and Defendant Express Scripts's role in causing and furthering the worst man-made epidemic in modern medical history: the misuse, abuse, diversion, and over-prescription of opioids.

2. Defendants are pharmacy benefit managers ("PBMs").[1] As PBMs, Defendants are uniquely situated in the prescription drug arena as the only players to interact with health plans, drug manufacturers, and pharmacies. Defendants quite literally serve as gatekeepers to the prescribing, fulfilling, and dispensing of opioids throughout the nation, including Arkansas.

3. As the epicenter of the prescription drug world, Defendants watched pill by pill, dollar by dollar, as opioid use turned into a crisis and then an epidemic.

4. Due to Defendants actions and inactions, opioid abuse has ravaged the State of Arkansas.

5. The State brings this suit to hold Defendants accountable for the devastating opioid crisis they helped cause, contributed to, and maintained.

A. PBMs

6. PBMs are the middleman in most pharmaceutical transactions in the United States.[2] Hired by insurance companies, government payors, and employers to negotiate prescription benefits with pharmaceutical manufacturers, PBMs play a significant role in determining which medications are covered by insurance and at what cost.

7. PBMs rank drugs on "formularies" to determine how much consumers must pay as co-payment. These formularies are tiered, with the highest tiered products having the lowest out-of-pocket cost to consumers. Because drug manufacturers want their products to be the most

[1] PBMs have been around since the late 1960s, but originally were designed by private insurance companies merely to assist with claims administration. *See* Robin J. Strongin, The ABCs of PBMs, *Issue Brief, No. 749*, NAT'L POL'Y HEALTH F. (Oct. 1999), https://www.ncbi.nlm.nih.gov/books/NBK559746/.

[2] *FTC Deepens Inquiry into Prescription Drug Middlemen*, FED. TRADE COMM'N (May 17, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/05/ftc-deepens-inquiry-prescription-drug-middlemen.

accessible to consumers, they work with PBMs to get their drugs higher on the formulary.

8. Though PBMs are expected to consider a multitude of factors on behalf of payors and consumers, often the financial incentives of manufacturer rebates alone dictate a drug's higher or lower placement on the formulary.

9. With rebates and profits being the primary driver of formulary placement, Arkansans' interests were forgotten. Rather than consider factors like pre-approval[3] or other consumer safety measures, PBMs focused mainly on rebates.

10. As a result, PBMs benefited financially from the opioid crisis by negotiating favorable deals with opioid manufacturers and by not taking sufficient action to curb excessive opioid prescriptions as detailed herein.

11. The actions of the PBMs, including Defendants, combined with those of the manufacturers, distributors, and pharmacies created the opioid crisis, which the State continues to face.

B. The Opioid Crisis

12. The opioid crisis is "directly related to the increasingly widespread misuse of powerful opioid pain medications."[4]

13. Starting in the late 1990s, opioids began to be widely diverted and improperly used,

[3] Pre-approval, also referred to as "prior authorization," is the process by which government payors and insurance companies (or PBMs on their behalf) consider the efficacy, safety, and value of drugs prior to covering all or part of their purchase. This process is often required by payors to "help avoid inappropriate drug use and promote the use of evidence-based drug therapy." *See Prior Authorization*, ACAD. OF MANAGED CARE PHARMACY (July 2019), https://www.amcp.org/about/managed-care-pharmacy-101/concepts-managed-care-pharmacy/prior-authorization.

[4] *See* Robert M. Califf, *et al.*, *A Proactive Response to Prescription Opioid Abuse*, 374 N. ENG. J. MED. 1480 (2016).

and the widespread use of the drugs resulted in a national epidemic of opioid overdose deaths and addictions.[5] The opioids responsible include brand-name prescription medications such as OxyContin, Opana ER, Vicodin, Subsys, and Duragesic, as well as generics like oxycodone, hydrocodone, and fentanyl.

14. Most Americans have been affected, either directly or indirectly, by the opioid epidemic. In 2017, the CDC estimated that prescription opioid misuse cost the United States $1.02 trillion, considering healthcare expenses, lost productivity, addiction treatment, and criminal-justice involvement.[6] Using the same approach as the CDC, the United States Congressional Joint Economic Committee estimated that the opioid crisis cost the United States nearly $1.5 trillion in 2020, which is a 37% increase from 2017.[7]

15. In addition to the above effects, the death toll has been staggering. In 2015, over 33,000 Americans died because of opioid overdose, while an estimated two million people in the United States suffered from substance abuse disorders related to prescription opioids.[8] By 2020,

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[5] *See* Nora D. Volkow & A. Thomas McLellan, *Opioid Abuse in Chronic Pain—Misconceptions and Mitigation Strategies*, 374 N. ENG. J. MED. 1253 (2016).

[6] Curtis S. Florence, *et al.*, *The Economic Burden of Opioid Use Disorder and Fatal Opioid Overdose in the United States, 2017*, NAT'L LIBRARY OF MED. (2017), https://pubmed.ncbi.nlm.nih.gov/33121867/.

[7] *JEC Analysis Finds Opiod Epidemic Cost U.S. Nearly $1.5 Trillion in 2020*, JOINT ECON. COMM. (Sept. 28, 2022), https://www.jec.senate.gov/public/index.cfm/democrats/2022/9/jec-analysis-finds-opioid-epidemic-cost-u-s-nearly-1-5-trillion-in-2020.

[8] Rose A. Rudd, *et al.*, *Increases in Drug and Opioid-Involved Overdose Deaths—United States, 2010–2015*, 65 MORBIDITY & MORTALITY WKLY. REP. 1445 (2016), https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm; Substance Abuse and Mental Health Servs. Admin., *National Survey on Drug Use and Health, 2015 Detailed Tables* (2016), U.S. DEP'T OF HEALTH AND HUMAN SERVS. https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf.

the number of Americans who died because of opioid overdose increased to 93,655.[9]

16. The death toll continued to rise in 2021, when there were an estimated 107,622 overdose deaths.[10] That is an almost 15% increase from the estimated overdose deaths in 2020. Overdose deaths again topped 100,000 in 2022, and overdose is now the leading cause of death for people under 50.[11]

17. Most of the overdoses from non-prescription opioids are also directly related to prescription pills. Many opioid users have turned to heroin, having become addicted to, but no longer able to obtain, prescription opioids. According to the American Society of Addiction Medicine, 80% of people who began using heroin in the past decade started with prescription opioids—which, at the molecular level and in their effect, closely resemble heroin. In fact, people who are addicted to prescription opioids are 40 times more likely than people not addicted to prescription opioids to become addicted to heroin, and the CDC identified addiction to prescription opioids as the strongest risk factor for heroin addiction.[12]

C. Opioids in Arkansas

18. Arkansas has been ravaged by the opioid crisis.

19. The State was flooded with almost 1.5 billion dosage units of these dangerous and

[9] *U.S. Overdose Deaths in 2021 Increased Half as Much as in 2020 – But Are Still Up 15%*, CTRS. FOR DISEASE CONTROL AND PREVENTION (May 11, 2022), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm.

[10] *Id.*

[11] *Hundreds of Communities Take Action on Overdose Crisis*, VITAL STRATEGIES (Aug. 29, 2023), https://www.vitalstrategies.org/hundreds-of-communities-take-action-on-overdose-crisis/#:~:text=Overdose%20is%20now%20the%20leading,under%2050%20in%20the%20U.S.

[12] *Today's Heroin Epidemic*, CTRS. FOR DISEASE CONTROL AND PREVENTION (July 7, 2015), https://archive.cdc.gov/#/details?url=https://www.cdc.gov/vitalsigns/heroin/index.html.

addictive drugs between 2006 and 2014.

20. In 2013, 120.9 opioid prescriptions were dispensed for every 100 Arkansans (approximately 3.5 million prescriptions). In that same year, the average U.S. rate was 79.3.[13]

21. By 2016, Arkansas had the second-highest opioid prescribing rate in the nation, with 114.6 opioids being dispersed for every 100 Arkansans, nearly twofold greater than the U.S. average.[14] There were more opioids delivered into the State than there were Arkansans—235,934,613 to be exact, which was enough to supply every man, woman, and child with 78 opioid doses each.

22. This trend continued in 2017 with Arkansas maintaining the second highest opioid prescription rate in the country at 106 prescriptions per 100 persons.[15] By 2019, Arkansas still had the second highest dispensing rate of any State, at 80.9 prescriptions for every 100 persons while the national average was 46.7.[16]

23. Despite the State's best abatement efforts, opioids were still by far the most

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[13] *U.S. State Opioid Dispensing Rates, 2013*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://archive.cdc.gov/#/details?q=Opioid%20Dispensing%20Rate%20Maps&start=0&rows=10&url=https://www.cdc.gov/drugoverdose/rxrate-maps/state2013.html (last visited June 20, 2024).

[14] *U.S. State Opioid Dispensing Rates, 2016*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://archive.cdc.gov/#/details?url=https://www.cdc.gov/drugoverdose/rxrate-maps/state2016.html (last visited June 20, 2024).

[15] *U.S. State Opioid Dispensing Rates, 2017*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://archive.cdc.gov/#/details?url=https://www.cdc.gov/drugoverdose/rxrate-maps/state2017.html (last visited June 20, 2024).

[16] *U.S. State Opioid Dispensing Rates, 2019*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://archive.cdc.gov/#/details?url=https://www.cdc.gov/drugoverdose/rxrate-maps/state2019.html; *Opioid Dispensing Rate Maps*, CTRS. FOR DISEASE CONTROL AND PREVENTION (May 7, 2024), https://www.cdc.gov/overdose-prevention/data-research/facts-stats/opioid-dispensing-rate-maps.html.

commonly prescribed class of controlled substances in Arkansas in 2022,[17] and Arkansas had the second-highest opioid prescribing rate in the nation with 72.2 opioids being dispersed for every 100 Arkansans (approximately 2.2 million prescriptions), nearly twofold greater than the U.S. average of 39.5.[18]

24. As the availability of opioids has skyrocketed in Arkansas, so too have overdose deaths. The CDC estimates 546 people died because of overdoses in Arkansas in 2020—a rate of 19.1 deaths per 100,000 persons.[19] This represents a 350% increase from a rate of 5.4 overdose deaths per 100,000 residents in 2000, just 17 years earlier.[20] The number of overdose deaths rose to 637 in 2021.[21] And the number of overdose decreased slightly to 617 in 2022.[22]

25. The human toll on Arkansas's citizens is not only measured by deaths, but by births as well. The number of infants born with neonatal abstinence syndrome ("NAS") in Arkansas

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[17] *Prescription Drug Monitoring Program – 2022 Annual Report*, ARK. DEP'T OF HEALTH, https://www.healthy.arkansas.gov/images/uploads/pdf/PDMP_Annual_Report_2022_FINAL.pdf (last visited June 20, 2024).

[18] *U.S. State Opioid Dispensing Rates, 2022*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/overdose-prevention/data-research/facts-stats/opioid-dispensing-rate-maps.html (last visited June 20, 2024).

[19] *Drug Overdose Mortality by State, 2020*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm (last visited June 20, 2024).

[20] *Drug Overdose Deaths in Arkansas – 2000-2016*, ARK. DEP'T OF HEALTH, https://www.healthy.arkansas.gov/images/uploads/pdf/Mortality_Report_-_2017_v3.pdf. (last visited June 20, 2024).

[21] *Drug Overdose Mortality by State, 2021*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm (last visited June 20, 2024).

[22] *Drug Overdose Mortality by State, 2022*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm (last visited June 20, 2024).

increased from 0.4 per 1,000 births in 2004 to 4.8 per 1,000 births in 2017—a twelvefold increase.[23] Studies show that NAS births *are still on the rise* with an all-time high of 5.1 cases per 1,000 births in 2021.[24]

26. The number of children in Arkansas's foster care system has also spiked. For example, the number of children in the system grew from 3,806 in 2015 to 5,209 as of September 28, 2016.[25] And, according to the Division of Children and Family Services at the Arkansas Department of Human Services, from July 1, 2020, to June 30, 2021, more than 1,600 children in Arkansas were placed in foster care in part due to parental drug and or alcohol abuse.[26]

27. Arkansas has also seen a dramatic surge in drug treatment and emergency services linked to opioid abuse. According to the Substance Abuse and Mental Health Services Administration ("SAMHSA"), Arkansas's addiction to opioids was so dire that in **a single day** in 2019, 1,431 Arkansans were receiving medication-assisted opioid therapy.[27] And in 2023, there were 4,270 emergency medical calls that required the administration of naloxone to treat

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[23] *2018 Annual Report*: *Prescription Drug Monitoring Program*, ARK. DEP'T OF HEALTH (2018), https://www.healthy.arkansas.gov/images/uploads/pdf/2018_Annual_Report_09_09_19.pdf.

[24] *Neonatal Abstinence Syndrome in Arkansas 2000-2021*, ARK. DEP'T OF HEALTH, https://healthy.arkansas.gov/images/uploads/pdf/NAS_Report.pdf (last visited June 20, 2024).

[25] Steve Brawner, *Director: Foster spike's cause hard to pinpoint; some caseworkers erring on side of removal*, TALK BUSINESS & POLITICS (Nov. 29, 2016), https://talkbusiness.net/2016/ll/director-foster-spikes-cause-hard-to-pinpoint-some-caseworkers-erring-on-side-of-removal.

[26] Evident Change, *Annual Report Card State Fiscal Year 2021*, ARK. DEP'T OF HUMAN SERVS., https://humanservices.arkansas.gov/wp-content/uploads/ARC-SFY-2021-FINAL.pdf. (last visited June 20, 2024).

[27] *2019 State Profile – Arkansas, Nat'l Survey of Substance Abuse Treatment Servs.*, U.S. DEP'T OF HEALTH AND HUM. SERVS. (2019), https://www.samhsa.gov/data/sites/default/files/quick_statistics/state_profiles/NSSATS-AR19.pdf.

overdoses.[28]

28. Many of these overdoses, deaths, and other consequences could have been avoided if Defendants had fulfilled their duties to the State and its citizens, including their duty to implement effective controls against diversion and to exercise due diligence to prevent the dispensing of opioid prescriptions that were illegitimate and likely to be diverted.

D. Role of PBMs in Causing the Opioid Epidemic

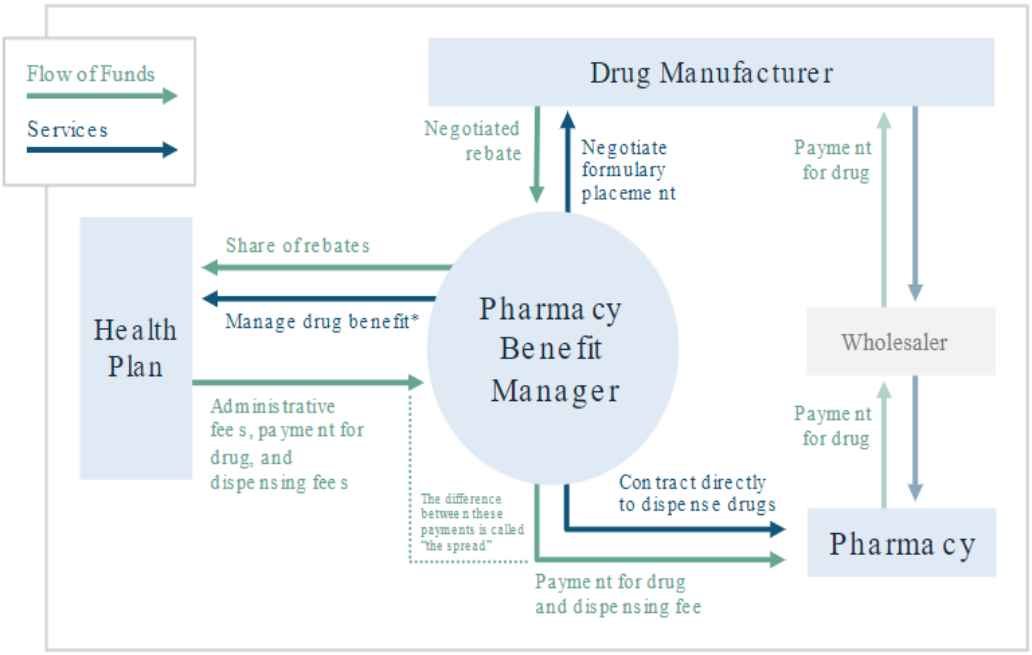
29. The opioid epidemic was created and sustained by a wide array of actors in the opioid supply-and-payment chain: the opioid manufacturers, distributors, pharmacies, and PBM Defendants.

30. For at least the last two decades, Defendants had a central role in facilitating the oversupply of opioids. Defendants ignored the necessary safeguards in order to ensure increased opioid prescriptions and sales. These defendants intentionally inserted themselves into the chain of distribution and dispensing of prescription opioids, thereby assuming duties to act reasonably.

31. This chart[29] illustrates the central role the PBM Defendants play in the prescription-drug market:

[28] *2023 Naloxone Administration Incidence by County*, ARK DEP'T OF HEALTH (2023), https://experience.arcgis.com/experience/2ad87ac5b6934707a7625fc6068bb198/page/Home/?draft=true&views=2023%2C2023--%2C2023-%2CEMS-Naloxone-Administration-Incidence#data_s=id%3AdataSource_2-Opioid_County_5206%3A16.

[29] *Pharmacy Benefit Managers and Their Role in Drug Spending*, THE COMMONWEALTH FUND (Apr. 22, 2019), https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending.



32. Defendants sit at the center of prescription-drug dispensing because they contract with the manufacturers who make the drugs, the pharmacies who dispense them, and the third-party payors who pay for them. Defendants' specific conduct that drove the increases and led to oversupply included:

a. colluding with, and aiding and abetting, Purdue Pharma and other opioid manufacturers in the fraudulent and deceptive marketing and oversupply of opioids;

b. colluding with Purdue Pharma and other opioid manufacturers to increase opioid sales through favorable placement on national formularies in exchange for rebates and fees;

c. colluding with Purdue Pharma and other opioid manufacturers to eliminate or limit utilization management measures on national formularies that would have restricted opioid prescribing;

d. representing that they would diligently implement effective drug utilization review measures and deliberately failing to do so;

e. electing not to act on the vast stores of information they had about the epidemic to limit the flood of opioids into communities across the Unites States, including in Arkansas; and,

f. dispensing huge quantities of prescription opioids through their mail-order pharmacies without proper controls against diversion.

33. Defendants are legally responsible for their role in causing, contributing to, and maintaining the opioid epidemic because, among other things:

a. their conduct in colluding with the opioid manufacturers to increase the supply of opioids through false and fraudulent misrepresentations was intentional and negligent, and unlawful;

b. they represented that they would offer formularies, utilization management protocols, and drug utilization review measures that would ensure safe and appropriate use of opioid medications, but instead, worked with the opioid manufacturers to increase the supply of opioids without regard to the safety or appropriateness of the drugs;

c. they intentionally and negligently decided, acted, and continued to offer only formularies, utilization management protocols, and drug utilization measures that placed no meaningful restrictions on the prescribing and use of opioids despite knowing, through the vast stores of data they had, that: (i) such unrestricted access to opioids was causing, and foreseeably would continue to cause, harm (including the foreseeable harm of diversion) to Arkansas communities; and, (ii) those harms could be addressed through measures that Defendants intentionally decided not to make available; and,

d. their conduct with respect to opioid prescribing and dispensing was unlawful as well as intentional and negligent because they failed to comply with Arkansas

law, both in their own dispensing through their mail order pharmacies and in their other activities that increased the risks of diversion.

34. Defendants' role in the opioid epidemic was made possible by their unique combination of knowledge and power that gave them an extraordinary ability to control the opioid supply throughout the United States.

35. No other actor in the nation's healthcare system was in a better position to deliver more immediate and more impactful changes to the opioid epidemic than the PBMs.

36. The PBMs' powerful position is highlighted not only from an information perspective ("robust point-of-dispensing screening and intervention"), but also as "an intermediary between the physician, pharmacist, patient, pharmaceutical manufacturer, health systems, and other components of the industry," which situates Defendants "in an ideal position to drive improvements in education and awareness of the dangers of opioid therapy[.]"[30]

37. PBMs provide services to prescription drug benefit plans sponsored by health insurers, self-insured employers, and state and federal government agencies. Defendants collect and maintain (and sell) unprecedented amounts of data about the extent of opioid prescribing, far exceeding what any individual manufacturer, distributor, or pharmacy chain has access to. For as long as they have existed as PBMs, Defendants have received, analyzed, and tracked detailed claims data for the billions of prescriptions they process each year, including opioid prescriptions. Controlling prescription drug benefits for 160+ million Americans, Defendants are in possession of detailed information about every prescription they process, regardless of which company manufactured the drug, which doctor prescribed it, what pharmacy it was filled at, or which state it was dispensed in. Defendants know when patients whose benefits they manage fill opioid

[30] *Id*.

prescriptions written by multiple doctors, and when they fill them at multiple pharmacies. They know how many times every opioid prescription they cover is refilled, and they know when a patient who was prescribed opioids is later treated for substance use disorder. They know if one of their covered individuals is having the lethal "Holy Trinity" of prescriptions (opioids, benzodiazepines, and sleep aids) filled concurrently. In short, Defendants have had a unique vantage point that allowed them access to the entire landscape of the unfolding opioid epidemic for two decades. Defendants were able to follow each pill from manufacturer to patient, observing in real time the abusive prescribing patterns and associated misuse.

38. Defendants encouraged and influenced prescribing, dispensing, and sales primarily through the national formularies they offer to pharmacy benefit plans and through what they chose to offer in terms of standard "utilization management" ("UM") rules.

39. Formularies are lists of drugs covered by a pharmacy benefit plan and control which drugs are available to the plan participants. They are often constructed in tiers, where drugs listed on higher tiers require larger copays, or as so-called exclusionary formularies, where preferred brand drugs are included and nonpreferred drugs are not included.

40. Standard UM programs include various protocols for managing access and use of particular drugs, including: (i) step therapy, where a beneficiary is required to try a different drug or therapy first before trying the restricted drug; (ii) quantity limits, which are limits on the dosage or days' supply that a patient may receive for any given prescription(s); and, (iii) prior authorizations, which are rules that require a physician to confirm that a given prescription is therapeutically appropriate before the drug is dispensed. Data shows that, when implemented, disfavored formulary placement and UM reduce inappropriate prescribing by making non-preferred drugs and those drugs subject to UM restrictions more difficult and more costly to obtain.

By contrast, Defendants and the opioid manufacturers knew that favorable formulary placement and the absence of UM restrictions created a scenario where prescriptions were written and dispensed with ease and frequency, at the expense of public safety.

41. Through their formulary and UM tools, Defendants, in conjunction with opioid manufacturers, are and have been uniquely situated to influence and control the prescribing and dispensing of opioids to their 160+ million covered individuals. Indeed, opioids that received preferred status on PBM formularies had significantly greater sales than drugs that were either excluded or disadvantaged. In this sense, Defendants function as the gatekeepers to the opioid market.

42. Defendants used their hugely profitable roles to grow into vertically-integrated colossuses that have come to dominate access to prescription drugs. The current Fortune 500 list ranking of the largest corporations in America by revenue has healthcare conglomerates UnitedHealth Group (OptumRx) and Cigna (Express Scripts) sitting at fourth and sixteenth, respectively. Defendant Express Scripts surpassed $100 billion in annual revenue as early as 2017. Defendant OptumRx has also seen its revenue grow, reaching nearly $100 billion in 2022.

43. These two corporate leviathans are: (1) two of the three largest PBMs in the United States, collectively managing prescription drug coverage for 160+ million covered individuals and processing more than 1.5 billion claims per year; (2) two of the top five dispensing pharmacies in the United States; (3) owned by two of the largest insurance companies in the world (UnitedHealth Group and Cigna); and, (4) among the largest healthcare data, consulting, and analytics companies in the United States.

44. Defendants interact with patients, pharmacies, prescribers, and payers. Thus, they are uniquely situated to collect data when patients receive and fill opioid prescriptions under their

pharmacy benefits. Instead of using their vast stores of information and extensive power to manage the floodgates of opioid prescriptions and limit abuse of these dangerous drugs, Defendants worked together and with the opioid manufacturers to negotiate contracts and structure formulary and UM offerings that encouraged opioid prescribing, while facilitating easy and inexpensive dispensing and sales of those drugs. The result is that the market for prescription opioids grew as prescribing, dispensing, and sales increased, and Defendants and opioid manufacturers reaped the profits of their contracts and relationships. For Defendants, the profits came from rebates and fees they earned from the branded opioid manufacturers by making opioids freely available and from pricing spreads and fees they captured from generic opioid sales.

45. Defendants also contributed substantially to the opioid crisis by knowingly promoting prescription opioid use and dispensing far greater quantities of prescription opioids than could be necessary for legitimate medical uses through their mail-order pharmacies, while failing to take any steps to monitor orders or report suspicious orders. This oversupply thereby directly contributed to the fueling of an illegal secondary market.

46. Defendants have not been mere bystanders in the opioid crisis. Rather, they colluded with the opioid manufacturers, placed profits over safety, and engaged in a scheme to increase the sale of prescription opioids, despite the known dangers of these drugs.

47. Defendants' conduct has exacted, and foreseeably so, a financial burden on the State. Categories of damages sustained by the State include, but are not limited to, prospective damages associated with abating the nuisance Defendants created.

48. The State brings this action exclusively under the laws of the State of Arkansas. No federal claims are being asserted, and to the extent that any claim or factual assertion set forth herein may be construed to have stated any claim for relief arising under federal law, such claim

is expressly disavowed and disclaimed by the State.

49. In addition, under no circumstances is the State bringing this action against, or bringing an action or claim of any kind directed to, any federal officer or person acting under any office of the United States for or relating to any act under color of such office. Nothing in this Complaint raises such an action, and to the extent that anything in the Complaint could be interpreted as potentially bringing an action against or directed to any federal officer or person acting under any office of the United States for or relating to any act under color of such office, then all such claims, actions, or liability, in law or in equity, are denied and disavowed in their entirety.

50. Nor does the State bring this action on behalf of a class or any group of persons that can be construed as a class. The claims asserted herein are brought solely by the State and are wholly independent of any claims that individual users of opioids may have against Defendants.

II. PARTIES

A. Plaintiff

51. This action is brought by the State by and through Arkansas Attorney General Tim Griffin. The State brings this case in a *parens patriae* capacity to advance the public interest. *See Parens Patriae*, Black's Law Dictionary (11th ed. 2019) (*Parens patriae* is a "doctrine by which a government has standing to prosecute a lawsuit on behalf of a citizen[.] No state agencies, which are independent legal entities, are parties in this case. *See Taylor v. Zanone Properties*, 342 Ark. 465, 473–74 (2000) ("Governmental agencies are independent entities who must be joined as parties even if the [the State] is a party to the action."). Nor does the Attorney General represent any state agencies in this action, who have not requested such representation. *Id.* at 474 (citing Ark. Code Ann. § 25-16-702(a)) ("The Attorney General represents the agencies and departments

of the State *only* when his services are needed and the request for services has been certified by the agency to the Attorney General.") (emphasis added).

B. Defendants

52. The State is informed and believes, and based thereupon alleges, that at all times relevant to the ongoing opioid epidemic: each PBM Defendant has occupied agency, employment, joint venture, or other relationships with each of the other named Defendants; each PBM Defendant has acted within the course and scope of that agency, employment, joint venture, and other relationship; each other PBM Defendant has ratified, consented to, and approved the acts of its agents, employees, joint venturers, and representatives; and, each has actively participated in, aided and abetted, or assisted one another in the commission of the wrongdoing alleged in this Complaint.

1. *UnitedHealth Group/Optum Entities*

53. Defendant UnitedHealth Group, Inc. ("UHG") is a Delaware corporation with its principal place of business in Minnetonka, Minnesota. UHG operates through two connected divisions: Optum and UnitedHealthcare ("UHC"). UHC provides health insurance and health benefit services. Optum provides pharmacy benefit management services; mail order pharmacy services; and data, analytics, consulting, and research services.

54. In 2015, UHG acquired what was then the fourth largest PBM in the nation, Catamaran, for $12.8 billion. UHG integrated Catamaran into its internal PBM unit OptumRx.

55. For 2022, UHG listed revenue in excess of $324 billion. UHG revenues grew in both the first and second quarters of 2023. UHG's 2023 second quarter revenues grew 16% to $92.9 billion year-over-year, including double-digit growth at both Optum and UHC.

56. More than one-third of UHG's total revenue is derived from OptumRx, which

operates a network of more than 67,000 pharmacies.

57. UHG, through its executives and employees, controls the company-wide policies that inform both UHC and Optum's lines of business, including policies that shape its PBM services and formulary design, to maximize profits across the corporate family.

58. According to UHG's financial reports, UHG is responsible for determining "which drugs will be included in formulary listings and selecting which retail pharmacies will be included in the network offered to plan sponsors' members …."[31]

59. Defendant Optum, Inc. is a Delaware corporation with its principal place of business located in Eden Prairie, Minnesota. Optum, Inc. is a wholly owned subsidiary of UHG and manages other subsidiaries that administer UHG's pharmacy benefits, including OptumRx, Inc. ("OptumRx"). Upon information and belief, OptumRx operates as a subsidiary of Optum, Inc. and as the PBM for UHG.

60. Optum, Inc. is directly involved, through its executives and employees, in the company policies that inform its PBM services, including the design of formularies used throughout Arkansas. At all times relevant to the ongoing opioid epidemic,[32] these formularies included opioids.

61. Upon information and belief, the CEO of Optum, Inc. is directly responsible for its business units—OptumInsight, OptumHealth, and OptumRx—and the CEOs of these companies

[31] UHG Form 10-K for the fiscal year ended December 31, 2023 at 44, U.S. SECS. AND EXCH. COMM'N (Feb. 28, 2024), https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2023/UNH-Q4-2023-Form-10-K.pdf.

[32] *Understanding the Opioid Overdose Epidemic*, CTRS. FOR DISEASE CONTROL AND PREVENTION, (Apr. 5, 2024), https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html.

report directly to Optum, Inc. regarding their policies, including those that inform the at-issue formulary design and mail-order activities.

62. Defendant OptumRx, Inc. is a California corporation, registered to do business in Arkansas, with its headquarters in Irvine, California.

63. Prior to 2011, OptumRx was known as Prescription Health Solutions. As outlined above, UHG purchased the PBM company Catamaran for $12.8 billion in 2015.

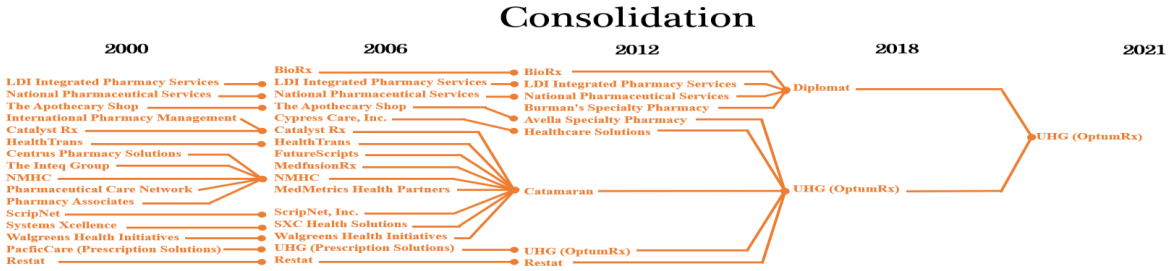
64. Catamaran was formed in 2012 through the merger of two large competing PBMs, SXC Health Solutions and Catalyst Health Solutions, Inc.

65. Before they were purchased by UHG, Prescription Health Solutions, Catalyst Health Solutions, Inc., and Catamaran Corp. were engaged in the at-issue PBM and mail-order activities.

66. As of 2023, OptumRx, Inc. provided services to more than 67,000 retail pharmacies. In 2022, OptumRx, Inc. managed $124 billion in pharmaceutical spending.

67. OptumRx, Inc. operates as a subsidiary of OptumRx Holdings, LLC, which, in turn, operates as a subsidiary of Defendant Optum, Inc.

68. The consolidations that led to the emergence of OptumRx in its current form are shown on the chart below:



69. OptumRx and all its predecessors, including but not limited to Prescription Health Solutions, Catalyst Health Solutions, Inc., and Catamaran Corp., are referred to herein as

"OptumRx."

70. According to UHG's 2020 Sustainability Report, OptumRx "works directly with pharmaceutical manufacturers to secure discounts that lower the overall cost of medications and create[s] tailored formularies—or drug lists—to ensure people get the right medications…." OptumRx also operates mail-order pharmacies and "work[s] directly with drug wholesalers and distributors to ensure consistency of the brand and generic drug supply, and a reliance on that drug supply."[33]

71. Defendant The Lewin Group, Inc. is a North Carolina corporation, registered to do business in Arkansas, with its principal place of business in Eden Prairie, Minnesota.

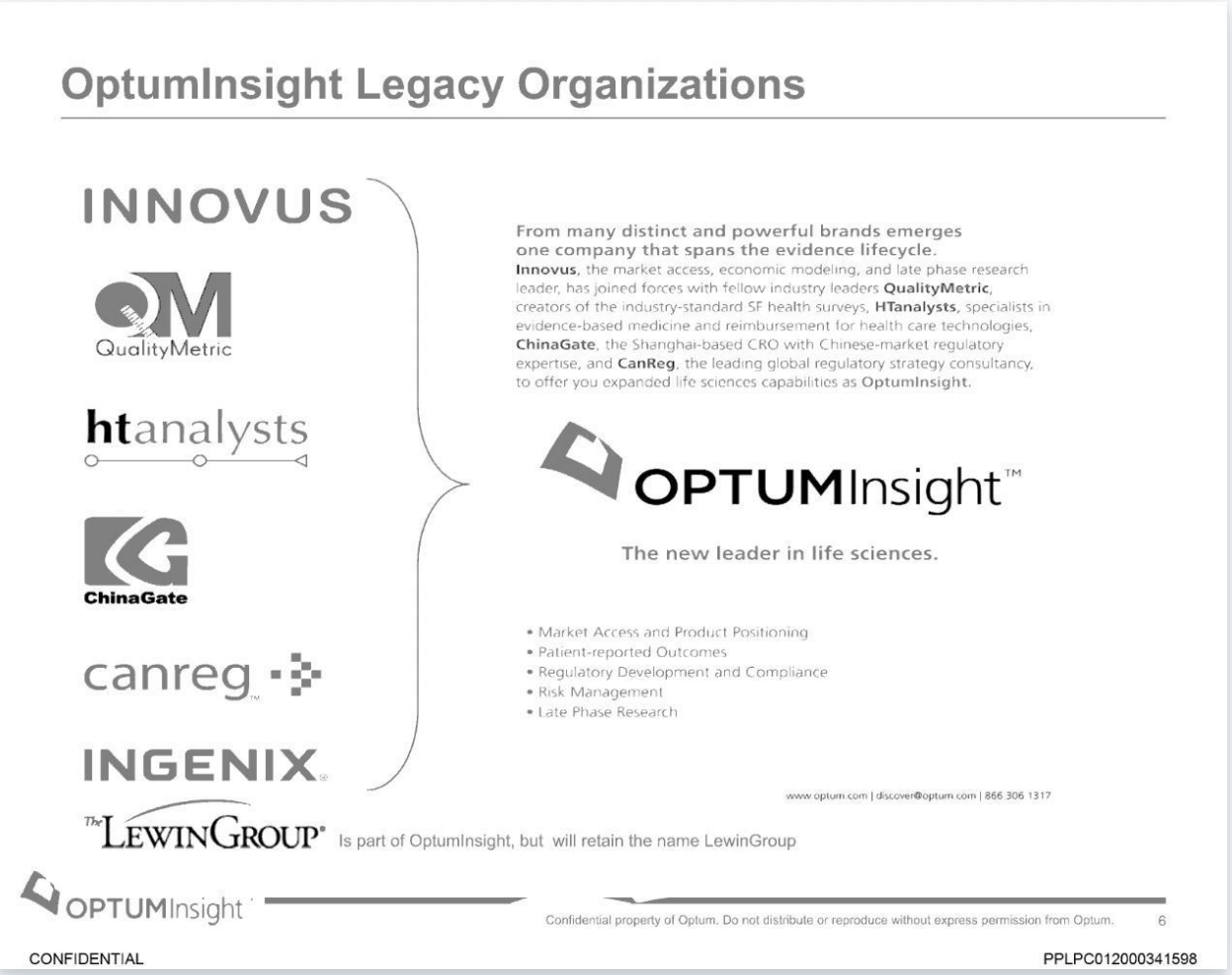
72. Defendant OptumInsight Life Sciences, Inc. is a Delaware corporation with its principal place of business in Eden Prairie, Minnesota.

73. Defendant OptumInsight, Inc. is a Delaware corporation, registered to do business in Arkansas, with its principal place of business located in Eden Prairie, Minnesota.

74. OptumInsight, Inc. was formerly known as Ingenix, Inc. In 2011, UHG renamed Ingenix as OptumInsight. The name change came after the State of New York investigated Ingenix in relation to a scheme to defraud consumers by manipulating reimbursement rates. The investigation resulted in a $50 million settlement with New York.

75. OptumInsight emerged from a collection of entities acquired by UHG over the years. Those legacy entities include Innovus, QualityMetric, HTAnalysts, ChinaGate, CanReg, Ingenix, and the Lewin Group.

[33] UNITEDHEALTH GROUP (2020), https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2024/sustainability/2020-sustainability-report.pdf.



76. OptumInsight, Inc., OptumInsight Life Sciences, Inc., Ingenix, and the Lewin Group, Inc., as well as their predecessors, successors, and affiliates, are referred to herein as "OptumInsight."

77. OptumInsight is an integral part of the conduct that gives rise to this Complaint. As discussed in detail below, at all times relevant to the ongoing opioid epidemic, OptumInsight worked directly with opioid manufacturers to create, provide, support, and disseminate opioid manufacturers' marketing messages in a variety of ways, including but not limited to:

a. OptumInsight made data and data portals available to manufacturers to help them target their messages and develop marketing strategies;

b. OptumInsight also partnered with manufacturers to conduct studies and

develop data to bolster manufacturers deceptive messaging; and,

c. OptumInsight assisted with the dissemination of deceptive messaging through "educational" materials provided to the people that they covered.

78. Opioid manufacturers had dedicated executives assigned to expand and strengthen the ties between UHG, OptumInsight, OptumRx, and the manufacturers.

79. OptumInsight was paid tens of millions of dollars by opioid manufacturers for its work to expand the opioid market.

80. OptumInsight analyzed data and other information concerning opioid prescription claims data and health plans' opioid utilization for use in its research and consulting efforts in coordination with opioid manufacturers' efforts to expand the opioid market and increase opioid utilization nationwide, including Arkansas.

81. As a result of numerous interlocking directorships and shared executives, UHG, OptumRx Holdings, LLC and Optum, Inc. are directly involved in the conduct and control of OptumInsight's and OptumRx's operations, management and business decisions related to the at-issue formulary construction, negotiations, and mail-order pharmacy services to the ultimate detriment of the State of Arkansas. For example:

a. UHG directly or indirectly owns all the stock of Optum, Inc., OptumRx Inc., and OptumInsight;

b. The UHG corporate family does not operate as separate entities. The public filings, documents, and statements of UHG present its subsidiaries as divisions of a single company. "UnitedHealth Group Incorporated (individually and together with its subsidiaries, 'UnitedHealth Group' and the 'Company') is a health care and well-being company…Our two distinct, yet complementary business platforms—Optum and

UnitedHealthcare —are working to build a modern, high-performing health system…for the individuals and organizations the Company is privileged to serve."[34] The day-to-day operations of this corporate family reflect these public statements. These entities constitute a single business enterprise and should be treated as such as to all legal obligations detailed in this Complaint.

c. These parent and subsidiaries have common officers and directors, shared reporting structures, and executive functions including:

i. Andrew Witty is the CEO and on the Board of Directors for UHG and previously served as CEO of Optum, Inc.;

ii. Dirk McMahon is President and COO of UHG. He served as President and COO of Optum from 2017 to 2019 and as CEO of OptumRx from 2011 to 2014;

iii. John Rex has been an Executive Vice President and CFO of UHG since 2016 and previously served in the same roles at Optum beginning in 2012;

iv. Erin McSweeney was named Executive Vice President and Chief People Officer in 2022. From 2017 to 2021 she served as EVP and Chief Human Resources Officer of Optum;

v. Dan Schumacher is Chief Strategy and Growth Officer at UHG and is CEO of Optum Insight, having previously served as president of Optum, Inc.;

vi. Terry Clark has served as chief marketing officer at UHG since 2014

[34] UHG Form 10-Q for the quarterly period ended June 30, 2023, at 7, U.S. SECS. AND EXCH. COMM'N (Aug. 2, 2023), https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2023/UNH-Q2-2023-form-10-Q.pdf.

while also serving as chief marketing and customer officer for Optum since 2022;

vii. Thomas Roos has served since 2015 as Senior Vice President and chief accounting officer for UHG and Optum, Inc.;

viii. Heather Cianfrocco joined UHG in 2008 and has held numerous leadership positions within Optum and UnitedHealthcare. She is the former CEO and current President of Optum; and Eric Murphy, now retired, was the Chief Growth and Commercial Officer for Optum, Inc. and also was CEO of OptumInsight beginning in 2017;

ix. All the executives of Optum, Inc., OptumRx, Inc., and OptumInsight ultimately report to the executives, including the CEO of UHG; and,

x. UHG's executives and officers are directly involved in the policies and business decisions of Optum, Inc., OptumRx, Inc., and OptumInsight that give rise to this Complaint.

82. Collectively, UHG, OptumRx, and OptumInsight are referred to as "UHG/Optum."

83. UHG/Optum is named as a Defendant in its capacity as a: (1) PBM; (2) data, analytics, consulting, and research provider; and (3) mail-order pharmacy. Nationwide, UHG/Optum delivers 520,000 adjusted prescriptions daily, including prescriptions for opioids. During the ongoing opioid epidemic, UHG/Optum contracted directly with opioid manufacturers in each of these capacities and performed services and derived substantial revenue in Arkansas.[35]

84. At all times relevant to the ongoing opioid epidemic, UHG/Optum offered PBM services and designed standard formularies used throughout Arkansas that included opioids.

[35] *OptumRX Overview*, OPTUMRX, https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2022/conference/IC_22_OptumRx_Overview_Highlights.pdf.

85. UHG/Optum delivers 190 million prescriptions to consumer homes annually throughout the U.S., including prescriptions for opioids. At all times relevant to the ongoing opioid epidemic, UHG/Optum offered mail-order pharmacy services and dispensed opioids in Arkansas.

2. *Evernorth/Express Scripts Entities*

86. Defendant Evernorth Health, Inc. ("Evernorth"), formerly known as Express Scripts Holding Company, is a Delaware corporation with its principal place of business in St. Louis, Missouri.

87. In 2018, Evernorth (then known as Express Scripts) merged with Cigna Corporation, a global health service company, in a $67 billion deal to consolidate their health insurance, PBM, and mail-order pharmacy businesses.

88. Prior to the merger with Cigna, Evernorth was the largest stand-alone PBM in the United States.

89. Evernorth is the immediate or indirect parent of the subsidiaries identified below that provide PBM and mail-order pharmacy services throughout Arkansas and engaged in the activities that give rise to this Complaint.

90. Evernorth, through its executives and employees, controls the company policies that inform its mail-order and PBM services, including formulary design, with respect to the at-issue drugs, as well as Express Scripts's analytics and research services.

91. Evernorth has represented that it either directly, or through its subsidiaries, evaluates drugs for efficacy to assist its customers with selecting "clinically appropriate" drugs and formularies designed by Evernorth which "prioritize access, safety and affordability."[36]

[36] The Cigna Group Form 10-K for the period ended December 31, 2023, at 4, U.S. SECS. AND EXCH. COMM'N (Feb. 29, 2024), https://d18rn0p25nwr6d.cloudfront.net/CIK-0001739940/3d4e5959-a432-4d52-885e-1b77451772c8.pdf.

92. Defendant Express Scripts, Inc. is a Delaware corporation, registered to do business in Arkansas, and a wholly owned subsidiary of Defendant Evernorth, with its principal place of business at the same location as Evernorth.

93. Express Scripts, Inc. is the immediate or indirect parent of the subsidiaries identified below that provide PBM and mail-order pharmacy services throughout Arkansas and engaged in the conduct that gives rise to this Complaint.

94. Express Scripts, Inc. was directly involved in PBM and mail-order pharmacy services that give rise to this Complaint, generating revenue of $140 billion in 2022.

95. Defendant Express Scripts Administrators, LLC, doing business as Express Scripts and formerly known as Medco Health, LLC, is a Delaware limited liability company, registered to do business in Arkansas, with its principal place of business at the same location as Evernorth.

96. Express Scripts Administrators, LLC provided the PBM services in Arkansas that give rise to this Complaint.

97. Defendant Medco Health Solutions, Inc. ("Medco") is a Delaware Corporation, registered to do business in Arkansas, with its principal place of business at the same location as Evernorth.

98. In 2012, Express Scripts acquired Medco for $29 billion.

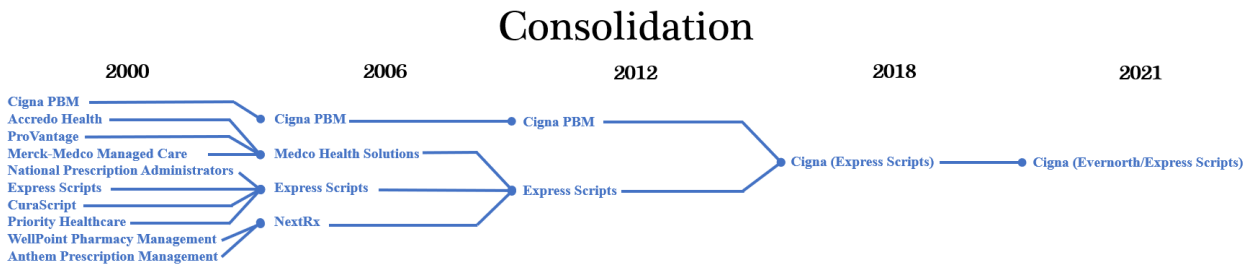
99. Prior to the merger, Express Scripts and Medco were two of the largest PBMs in the United States.

100. Prior to the merger, Medco provided the at-issue PBM and mail-order services in Arkansas that give rise to this Complaint.

101. Following the merger, all of Medco's PBM and mail-order pharmacy functions were combined into Express Scripts. The combined company (Medco and Express Scripts)

continued under the name Express Scripts, with all of Medco's payor customers becoming Express Scripts' customers.

102. The chart represents the consolidation of PBM entities that that are now all part of Express Scripts today:



103. Defendant ESI Mail Pharmacy Service, Inc. is a Delaware corporation and a wholly owned subsidiary of Defendant Evernorth, with its principal place of business at the same location as Evernorth.

104. During the ongoing opioid epidemic, ESI Mail Pharmacy Services, Inc. provided mail-order pharmacy services in Arkansas that give rise to this Complaint.

105. Defendant Express Scripts Pharmacy, Inc. is a Delaware corporation, registered to do business in Arkansas, and a wholly owned subsidiary of Defendant Evernorth, with its principal place of business at the same location as Evernorth.

106. During the ongoing opioid epidemic, Express Scripts Pharmacy, Inc. provided mail-order pharmacy services in Arkansas that give rise to this Complaint.

107. Defendant Express Scripts Specialty Distribution Services, Inc. is a Delaware corporation, registered to do business in Arkansas, and a wholly owned subsidiary of Defendant Evernorth, with its principal place of business at the same location as Evernorth.

108. During the ongoing opioid epidemic, Express Scripts Specialty Distribution Services, Inc. provided or assisted in providing PBM services that give rise to this Complaint.

109. As a result of numerous interlocking directorships and shared executives, Evernorth (f/k/a Express Scripts Holding Company, Inc.) and Express Scripts, Inc. control Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Medco Health Solutions, Inc., Express Scripts Pharmacy, Inc., and Express Scripts Specialty Distribution Services, Inc.'s operations, management, and business decisions related to the at-issue formulary construction, negotiations, and mail-order pharmacy services to the ultimate detriment of the State. For example:

a. During the ongoing opioid epidemic, these parent and subsidiaries have had common officers and directors:

i. Officers and directors shared between Express Scripts, Inc. and Evernorth include: Bradley Phillips, Chief Financial Officer; David Queller, President; Jill Stadelman, Managing Counsel; Dave Anderson, Vice President of Strategy; Matt Perlberg, President of Pharmacy Businesses; Bill Spehr, Senior Vice President of Sales; and, Scott Lambert, Treasury Manager Director.

ii. Executives shared between Express Scripts Administrators, LLC and Evernorth include: Bradley Phillips, Chief Financial Officer; and, Priscilla Duncan, Associate Senior Counsel.

iii. Officers and directors shared between ESI Mail Pharmacy Service, Inc. and Evernorth include: Bradley Phillips, Chief Financial Officer; Priscilla Duncan, Associate Senior Counsel; and, Joanne Hart, Treasury Director; and

iv. Officers and directors shared between Express Scripts Pharmacy, Inc. and Evernorth include: Bradley Phillips, Chief Financial Officer; Jill Stadelman, Managing Counsel; Scott Lambert, Treasury Manager Director; and, Joanne Hart, Treasury Director.

b. Evernorth directly or indirectly owns all the stock of Express Scripts Administrators, LLC, Medco Health Solutions, Inc., ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy, Inc., and Express Scripts, Inc. These entities constitute a single business enterprise and should be treated as such as to all legal obligations detailed in this Complaint.

c. All executives of Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy, Inc., and Express Scripts, Inc. ultimately report to the executives, including the CEO, of Evernorth.

d. As stated above, Evernorth's CEO and other executives and officers are directly involved in the policies and business decisions of Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Medco Health Solutions, Inc., Express Scripts Pharmacy, Inc. and Express Scripts, Inc. that give rise to this Complaint.

110. Collectively, Defendants Evernorth Health, Inc., Express Scripts, Inc., Express Scripts Administrators, LLC, ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy, Inc., Express Scripts Specialty Distribution Services, Inc., and Medco, including all predecessor and successor entities, are referred to as "ESI."

111. ESI is named as a defendant in its capacities as a (1) PBM; (2) data, analytics, and research provider; and, (3) mail-order pharmacy. ESI contracted directly with opioid manufacturers in each of these capacities.

112. At all times relevant to the ongoing opioid epidemic, in its capacity as a PBM, ESI coordinated with opioid manufacturers for the placement of opioids on ESI's standard formularies that are used nationwide, including in Arkansas.

C. Agency and Authority

113. All actions described in this Complaint are part of, and in furtherance of, the unlawful conduct alleged herein, and were authorized, ordered, and done by Defendants' officers, agents, employees, or other representatives while actively engaged in the management of Defendants' affairs within the course and scope of their duties and employment, and with Defendants' actual, apparent, and ostensible authority.

III. JURISDICTION & VENUE

114. This Court has jurisdiction over this action pursuant to Ark. Code Ann. § 16-13-201, as the State seeks equitable and legal relief, and this matter brings claims arising under the laws of this State that are not exclusively cognizable in another court.

115. This Court has personal jurisdiction over Defendants as they conduct business in Arkansas, purposefully direct or directed their actions toward Arkansas, and have the requisite minimum contacts with Arkansas necessary to constitutionally permit the Court to exercise jurisdiction.

116. The Complaint does not confer diversity jurisdiction upon the federal courts pursuant to 28 U.S.C. § 1332, as the State is not a citizen of any state, and this action is not subject to the jurisdiction of the Class Action Fairness Act of 2005. Likewise, federal question subject matter jurisdiction pursuant to 28 U.S.C. § 1331 is not invoked by the Complaint, as it sets forth herein exclusively viable state law claims against Defendants. Nowhere herein does the State plead, expressly or implicitly, any cause of action or request any remedy that arises under federal law. Moreover, the Complaint could not have been originally filed in federal court and, thus, cannot be removed. *Caterpillar, Inc. v. Williams*, 482 U.S. 386, 392 (1987). The issues presented in the allegations of this Complaint do not implicate any substantial federal issues and do not turn

on the necessary interpretation of federal law. No federal issue is important to the federal system as a whole under the criteria set by the Supreme Court in *Gunn v. Minton*, 568 U.S. 251 (2013) (*e.g.*, federal tax collection seizures, federal government bonds). Specifically, the causes of action asserted, and the remedies sought herein, are founded upon the positive statutory, common, and decisional laws of Arkansas. Further, the assertion of federal jurisdiction over the claims made herein would improperly disturb the congressionally approved balance of federal and state responsibilities. Accordingly, any exercise of federal jurisdiction is without basis in law or fact.

117. The Complaint does not confer jurisdiction upon the federal courts pursuant to 28 U.S.C. § 1442(a)(1). The State makes no allegations against "[t]he United States or any agency thereof or any office (or any person acting under that officer) of the United States or of any agency thereof, in an official or individual capacity, for or relating to any act under color of such office." 28 U.S.C. § 1442(a)(1).

118. In this Complaint, the State cites federal statutes and regulations. The State does so to state the duty owed under Arkansas tort law, not to allege an independent federal cause of action and not to allege any substantial federal question. To be clear, the State cites federal statutes and federal regulations for the sole purpose of stating the duty owed under Arkansas law to the residents of Arkansas. Thus, any attempted removal of this complaint based on a federal cause of action or substantial federal question is without merit.

119. Venue is proper in Pulaski County under Ark. Code Ann. § 16-60-104. Defendants: (1) do business in Arkansas and purposefully direct or directed their actions toward Arkansas; (2) committed torts in part in Arkansas against the State and Arkansas residents; (3) solicited and continue to seek business, and performed and continue to conduct business services, such as marketing, advertising, promoting, distributing, and dispensing of their products and services in

Arkansas; and, (4) have the requisite minimum contacts with Arkansas necessary to constitutionally permit the Court to exercise its jurisdiction.

120. Venue is also proper before this Court under Ark. Code Ann. § 16-60-101(a) and (c).

IV. FACTUAL ALLEGATIONS COMMON TO ALL CLAIMS

A. As Pharmacy Benefit Managers, Defendants Fueled the Opioid Epidemic in Arkansas by Increasing Opioid Utilization.

121. PBM Defendants are hired to administer and manage prescription drug benefits on behalf of commercial health plans, self-insured employer plans, and government health benefits programs.

122. PBM Defendants administer prescription drug benefits for health plans and purchase drugs from manufacturers on behalf of those plans. In addition, PBM Defendants negotiate payment terms for pharmacies that dispense drugs to patients.

123. PBM Defendants also create lists of drugs that are selected to be covered by health plans. These lists are known as "formularies."

124. PBM Defendants' formularies are divided into tiers, which establish the out-of-pocket costs that consumers are required to pay for a chosen drug. Drugs placed in the first tier of a drug formulary by a PBM Defendant will be less expensive for the consumer than drugs placed in higher tiers.

125. PBM Defendants influence drug utilization by placing preferred drugs on lower tiers of their formularies. Consumers are more likely to utilize drugs that have been placed on lower-cost tiers by PBMs.

126. PBM Defendants also influence drug utilization through the implementation, or non-implementation, of utilization management tools that allow them to: (1) limit the quantity of

drugs dispensed; (2) require prior authorization before dispensing specific drugs; and, (3) implement "step edits" which require patients to try safer medication before progressing to more dangerous drugs. These utilization management tools can be used to limit or restrict the number of opioids dispensed by pharmacies.

127. PBM Defendants create standard formularies and recommendations regarding utilization management tools. PBM Defendants incentivize their clients to adopt their standard formularies by implementing financial consequences for deviating from them.

128. By incentivizing use of their standard formularies and utilization management tools, PBM Defendants dictated the consumer cost and restrictions (or lack of restrictions) placed on prescription opioids. By designing formularies with opioids placed on lower tiers and fewer restrictions, Defendants ensured that they could deliver opioid drug sales to their drug manufacturer partners.

129. PBM Defendants' standard plan designs and formularies also controlled what less addictive pain treatments, if any, were available as alternatives to opioids, and whether those alternatives would be required prior to the patient's utilization of opioids.

130. By working to increase opioid utilization, Defendants directly contributed to the dispensing of more opioid pills to individuals than were needed for legitimate medical purposes.

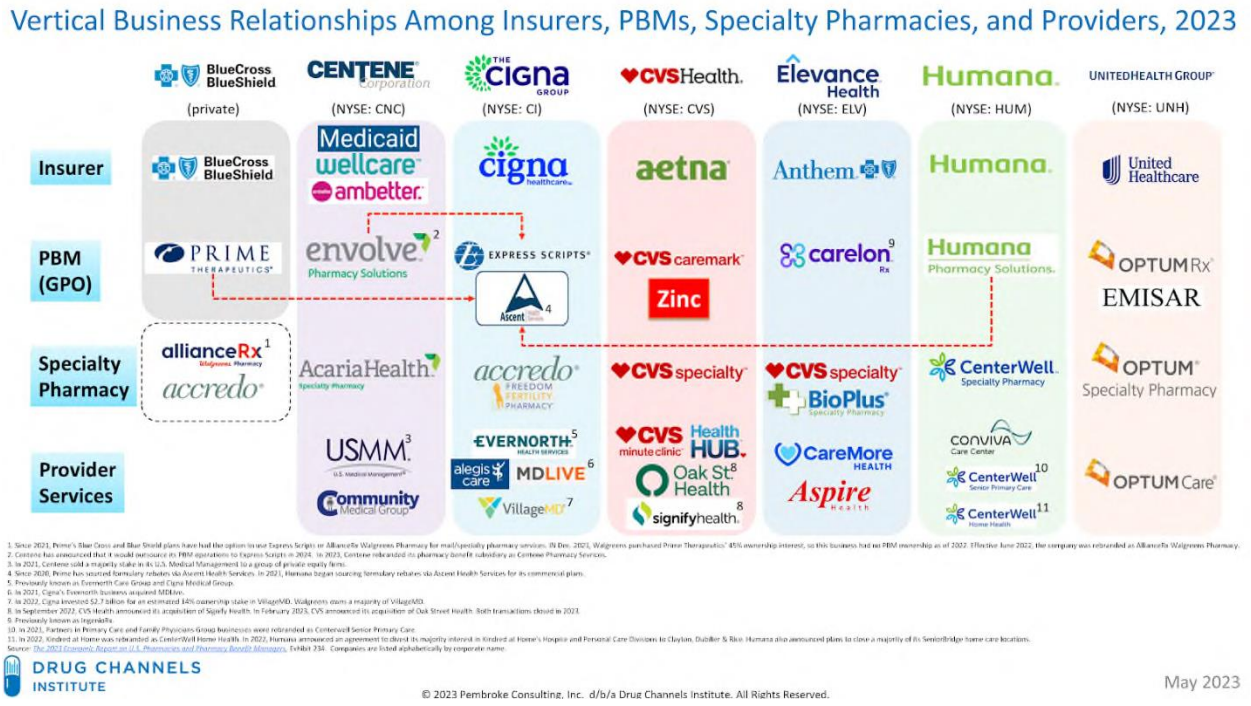
131. Defendants falsely represented to their clients, patients, and the public that they designed drug formularies and drug programs in a manner that was cost effective and promoted the safe use and appropriate prescription of opioids.

132. Although Defendants claimed that their formularies were designed to achieve favorable health outcomes for patients, Defendants' plans and formularies were, in fact, designed to maximize profits for Defendants by encouraging increased opioid utilization.

133. Defendants negotiated rebate payments, fees, and other incentives from opioid drug manufacturers in exchange for preferential placement of their drugs on PBM formularies.

134. Opioid manufacturers paid Defendants to ensure that utilization management tools are not implemented so that access to opioids remained less restricted. Thus, Defendants and opioid manufacturers were both incentivized to increase opioid utilization for profit. Defendants have been extremely successful at earning profits from sales of opioids.

135. The PBM industry has become increasingly consolidated and increasingly powerful over the past several years. As the chart below demonstrates, as of 2023, all major health insurers had vertically integrated with their own PBM subsidiaries.



136. As a result of numerous mergers and acquisitions, as of 2023, just three PBMs controlled 80% of the prescription drug market, with each of the big three PBMs bringing in

billions of dollars of revenue annually.[37]

137. In 2019, the five largest health insurance companies, PBMs, and healthcare provider conglomerates outpaced the earnings of the five biggest tech companies (Facebook, Amazon, Apple, Netflix, and Google) combined. The financial success of these healthcare conglomerates was due, in no small part, to the enormous revenues earned by their PBM subsidiaries.[38]

138. Defendants are each vertically-integrated behemoths that dominated the opioid reimbursement and delivery chain—currently sitting at 5th (UHG/Optum) and 13th (ESI) on the Fortune 500 list of corporations by revenue.

139. Defendants are among the largest PBMs and the largest healthcare data, consulting, and analytics companies in the United States.

140. More than any actor in the pharmaceutical distribution and payment chain, Defendants had insight into and control over the flow of opioids into communities across the country, including Arkansas.

141. The opioid epidemic was fueled and sustained by pharmacy benefit managers, including Defendants.

B. As Online Retail Pharmacies, Defendants' Mail-Order Pharmacies Fueled the Opioid Epidemic by Dispensing Billions of Morphine Milligram Equivalents of Opioids.

142. Defendants operate some of the largest pharmacies in the country that have

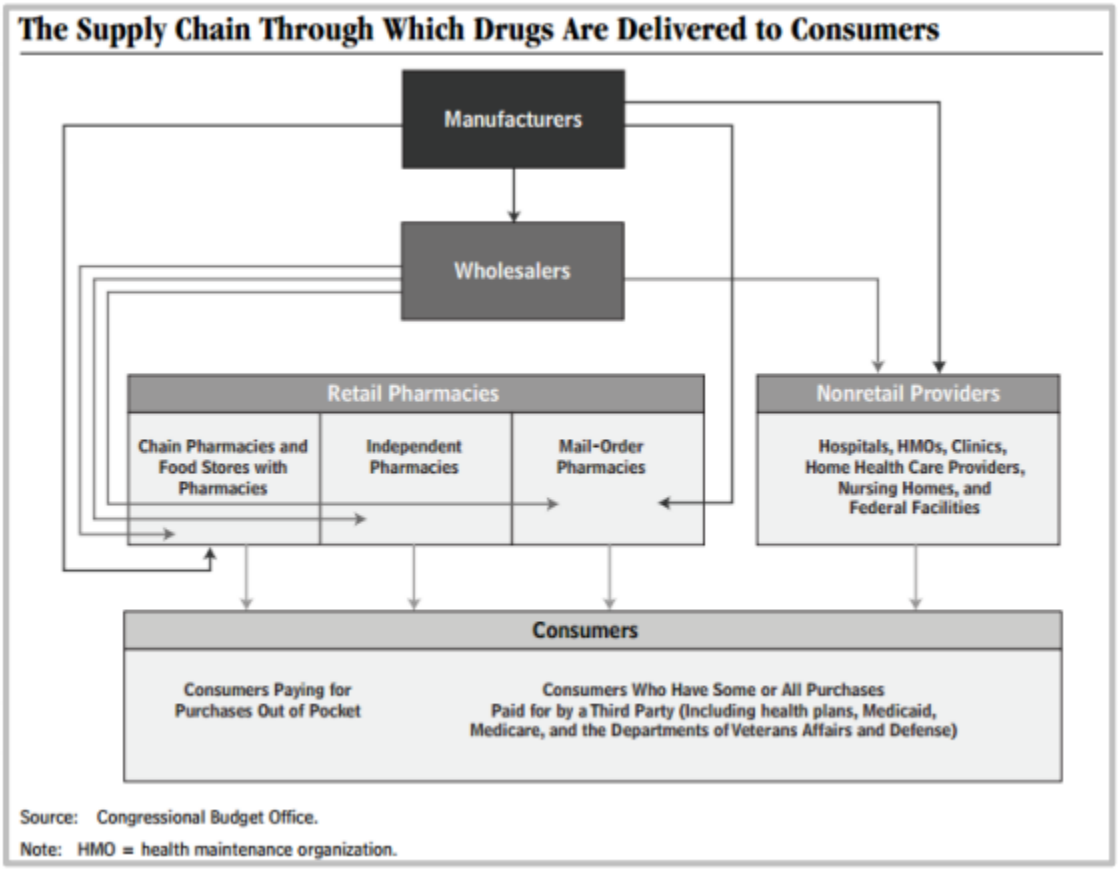
[37] Arthur Allen, *What to know about the drug price fight in those TV ads*, SHOTS - HEALTH NEWS FROM NPR (July 7, 2023), https://www.npr.org/sections/health-shots/2023/07/07/1186317498/pharmacy-benefit-manager-pbm-ads-congress.

[38] Bob Herman, *Health insurance is as big as Big Tech*, AXIOS.COM (Feb. 11, 2019), https://www.axios.com/2019/02/11/health-insurers-pbms-revenue-big-tech.

purchased, dispensed, and profited from dispensing opioids.

143. Pharmacies are the final step on the pharmaceutical supply chain before drugs reach the patient. Pharmacies purchase drugs from wholesalers, occasionally directly from manufacturers, and then take physical possession of the drugs. After purchasing drugs, pharmacies assume responsibility for their safe storage and dispensing to consumers.

144. The process described above is illustrated in the chart below:[39]



145. Opioids are regulated as Schedule II controlled substances under both Arkansas and

[39] Henry C. Eickelberg, *The Prescription Drug Supply Chain "Black Box:" How it Works and Why You Should Care*, AM. HEALTH POL'Y INST. (2015), https://terrygroup.com/app/uploads/2015/12/December-2015_AHPI-Study_Understanding_the_Pharma_Black_Box.pdf.

federal law.

146. Because of their specific and significant dangers, opioids are distributed within a "closed" system under which different entities within the pharmaceutical supply chain supervise the discrete links in the chain to reduce the widespread diversion of those drugs outside of legitimate channels.

147. Defendants' mail-order pharmacies have each operated within the federally regulated closed system for controlled substances. As such, Defendants owe, and owed, the duties set forth below as dispensers of prescription opioids.

148. The federal Controlled Substances Act ("CSA") and its implementing regulations create restrictions on the distribution of controlled substances. The Arkansas Controlled Substances Act and accompanying Arkansas agency rules and regulations incorporate by reference relevant federal laws and regulations. References made to the CSA, 21 U.S.C. § 801, *et seq.*, are for reference only and to state the duty owed under Arkansas tort law, *not* to allege any substantial federal question. *See* Section III, *infra*.

149. The CSA authorizes the Drug Enforcement Administration ("DEA") to establish a registration program for manufacturers, distributors, and dispensers of controlled substances. Any entity that seeks to become involved in the production or chain of distribution of controlled substances must first register with the DEA. 21 U.S.C. § 822; 21 C.F.R. 1301.11. Registrants are then required to comply with all security requirements imposed under that statutory scheme, including the maintenance of "effective control against diversion of particular controlled substances into other than legitimate medical, scientific, and industrial channels." 21 U.S.C. § 823(b)(1). They must "design and operate a system to disclose to the registrant suspicious orders of controlled substances" and inform the Field Division Office of the DEA of suspicious orders

when discovered by the registrant. 21 C.F.R. § 1301.74(b).

150. Failure to maintain effective controls against diversion is inconsistent with the public interest as that term is used in 21 U.S.C. §§ 823 and 824 and may result in the revocation of the registrant's DEA Certificate of Registration or registration with the State.

151. Federal law also imposes a duty on Defendants to comply with applicable state and local law. 21 U.S.C. § 823(b)(2).

152. Dispensers are required by Arkansas law to hold a permit issued by the State Board of Pharmacy to sell prescription drugs. Ark. Code Ann. §§ 20-64-504; 17-92-404; Arkansas State Board of Pharmacy Rules, 04-00-0011 (Rev. 05/2014). Under Arkansas law, pharmacy registrants are required to provide "diversion prevention and detection tools" and develop policies and procedures to prevent and detect diversion. Arkansas State Board of Pharmacy Rules, 04-00-0015(b), (c) (Rev. 05/2014). Because pharmacies themselves are registrants under the Arkansas law, the duty to prevent diversion lies with the pharmacy entity, not just the individual pharmacist alone. Arkansas State Board of Pharmacy Rules, 04-00-0015(a) (Rev. 05/2014) ("The permit holder and the pharmacist in charge are jointly responsible for the security and accountability of all controlled drugs stored in and ordered by a pharmacy.").

153. Likewise, the Arkansas Department of Health mandates that "all Practitioners shall provide effective controls and procedures to guard against theft and diversion of controlled substances," and "practitioners" include physicians, pharmacies, manufacturers, wholesalers, and distributors. Arkansas Department of Health Rules and Regulations Pertaining to Controlled Substances, Sec. III, A (Dec. 1, 2014).

154. The DEA, among others, has provided extensive guidance to pharmacies concerning their duties to the public. The guidance advises pharmacies how to identify suspicious

orders and other evidence of diversion.

155. Suspicious pharmacy orders include orders of unusually large size, orders that are disproportionately large in comparison to the population of a community served by the pharmacy, orders that deviate from a normal pattern, and orders of unusual frequency and duration, among others. *See* 21 C.F.R. § 1301.74(b).

156. Additional types of suspicious orders include: (1) prescriptions written by a doctor who writes significantly more prescriptions (or in larger quantities or higher doses) for controlled substances compared to other practitioners in the area; (2) prescriptions which should last for a month in legitimate use, but are being refilled on a shorter basis; (3) prescriptions for antagonistic drugs, such as depressants and stimulants, at the same time; (4) prescriptions that look "too good" or where the prescriber's handwriting is too legible; (5) prescriptions with quantities or doses that differ from usual medical usage; (6) prescriptions that do not comply with standard abbreviations and contain no abbreviations; (7) photocopied prescriptions; or, (8) prescriptions containing different handwriting. Most of the time, these attributes are not difficult to detect and should be easily recognizable by pharmacies.

157. Suspicious pharmacy orders are red flags for, if not direct evidence of, diversion, and pharmacies are obligated not to fill prescriptions until all red flags of diversion are resolved.

158. Other signs of diversion can be observed through data gathered, consolidated, and analyzed by the online pharmacies themselves. That data allows them to observe patterns or instances of dispensing that are potentially suspicious of oversupply in particular stores or geographic areas or of prescribers or facilities that seem to engage in improper prescribing.

159. Despite their obligations under Arkansas law to provide controls against diversion and to dispense opioids only pursuant to valid prescriptions issued for a legitimate medical

purpose, Defendants dispensed 2,189,807,406 morphine milligram equivalents ("MMEs") (the standard measure used when measuring quantities of opioids of different strengths) of opioids into Arkansas, often without adequate due diligence to ensure that the prescriptions involved were valid and not likely to be diverted.[40]

160. Upon information and belief, Defendants also failed to adequately use data available to them to identify doctors who were writing suspicious numbers of prescriptions or prescriptions of suspicious amounts of opioids or to adequately use data available to them to do statistical analysis to prevent the filling of prescriptions that were illegally diverted or otherwise contributed to the opioid crisis.

161. Upon information and belief, Defendants failed to analyze: (a) the number of opioid prescriptions filled in a geographical area relative to the population of the community; (b) the increase in opioid sales relative to past years; (c) the number of opioid prescriptions filled relative to other drugs; and, (d) the increase in annual opioid sales relative to the increase in annual sales of other drugs.

162. Upon information and belief, Defendants failed to conduct adequate internal or external audits of their opioid sales to identify patterns regarding prescriptions that should not have been filled or to create policies accordingly, or if they conducted such audits, they failed to take any meaningful action as a result.

163. The State's claims are based on Defendants' duties, their conduct in establishing dispensing policies and procedures, their failure to make use of the data they had regarding the dispensing of prescriptions, and their own failures to properly train their employees regarding their duties imposed by Arkansas and federal law.

[40] *2018 Annual Report*: *Prescription Drug Monitoring Program*, ARK. DEP'T OF HEALTH (2018), https://www.healthy.arkansas.gov/images/uploads/pdf/2018_Annual_Report_09_09_19.pdf.

164. These laws and the related regulations are intended to create a closed system for the delivery of controlled substances and prevent the distribution of controlled substances outside of the system. Defendants have a duty to ensure that their pharmacies operate appropriately within the closed system to prevent diversion of dangerous drugs.

C. Defendants Were Aware of the Opioid Epidemic.

165. PBM Defendants have access to detailed data regarding the volume, nature, and dosage of prescription opioids. They also have data regarding medical conditions for which opioids are prescribed, the medical providers who are prescribing opioids, and the volume of opioids dispensed by patient and geographical location.

166. In addition, Defendants track the number of opioids that move through their own mail-order pharmacies.

167. Defendants were, or should have been, fully aware that the quantity of opioids being distributed was untenable and in many areas was so high that illegal diversion was the only logical explanation, yet they did not take meaningful action to investigate or to ensure that they were complying with their duties and obligations under the law with regard to controlled substances.

168. As a result of their data tracking and analyzing efforts, Defendants knew for decades that dangerous amounts of opioids were being dispensed in communities across the country.

169. Defendants knew or reasonably should have known about the ongoing opioid crisis and the devastating consequences of oversupply and diversion of prescription opioids, including the increased rates of opioid use disorder and opioid overdoses in the community.

170. Rather than using this knowledge to benefit the health and safety of consumers, Defendants failed to take any action to prevent diversion and opioid related harms in Arkansas.

Instead, Defendants granted the most dangerous opioids unrestricted, preferred formulary status because it was more profitable to them to do so.

D. Defendants' Facilitation and Encouragement of the Use of Opioids Created a Public Health Crisis in Arkansas.

171. Despite their knowledge of the opioid crisis fueled by oversupply and diversion, PBM Defendants encouraged the use of highly addictive opioids through their formulary policies. Defendants placed opioids on preferred formulary tiers without utilization management tools to ensure that opioids would continue to be widely prescribed.

172. Despite their knowledge of the opioid crisis fueled by oversupply and diversion, Defendants never disclosed information regarding widespread misuse, diversion, addiction, and overuse, and failed to warn the State of such risks.

173. Upon information and belief, Defendants failed to take any reasonable actions in response to the opioid crisis because they were incentivized by payments from opioid manufacturers to ensure that opioids would be easy for doctors to prescribe and easy for patients to obtain.

174. By fueling the opioid epidemic, rather than addressing their own data showing overuse, abuse, and addiction to opioids, Defendants contributed to the oversupply of opioids in Arkansas, resulting in a public health crisis and public nuisance.

V. FACTS PERTAINING TO PUNITIVE DAMAGES

175. As set forth above, PBM Defendants acted deliberately to increase sales of, and profits from, opioid drugs. Defendants knew that their actions and inactions were directly resulting in the increased dispensing of highly addictive opioids in numbers far greater than any legitimate medical necessity. Nonetheless, they continued to deliberately act or failed to act to increase the market for their addictive drugs.

176. Defendants knew that large and suspicious quantities of opioids were being poured into communities throughout the United States and in Arkansas, yet, despite this knowledge, took no steps to control the supply of opioids or otherwise prevent diversion. Indeed, as described above, Defendants acted in concert with opioid manufacturers to make opioids readily available.

177. Through their ongoing course of conduct, Defendants knowingly, deliberately, and repeatedly threatened, harmed, and created a risk of harm to public health and safety and caused large-scale economic loss to communities and government liabilities across the country and in Arkansas.

178. As alleged above, Defendants had the ability to implement safeguards to restrict the number of opioids dispensed in the community and to require patients to try safer and less addictive treatment options before being prescribed opioids; however, they failed to implement these safeguards despite knowing that greater numbers of dangerous and addictive opioids would be dispensed as a result.

179. Because it was profitable for Defendants, they continued to grant preferential and unrestricted formulary status to opioids, even after they knew that the number of opioids being dispensed was dangerous and detrimental to society.

180. Defendants knew, or should have known, that implementing the formulary management and safety edits that were already at their disposal could have prevented or significantly lessened the scope of the opioid epidemic nationwide and in Arkansas.

181. Further, Defendants could have worked to abate the harm caused by the opioid epidemic by making treatments more accessible to patients; however, upon information and belief, Defendants, through their policies, practices, and procedures, made it easier for patients to obtain highly addictive and dangerous opioids than to obtain treatment for addiction.

182. Defendants engaged in the conduct alleged herein with a conscious disregard for the rights and safety of other persons even though that conduct had a great probability of causing substantial harm.

183. Defendants were so determined to increase their profits through rebates received by the continued sale of opioids that they simply ignored their own data and other evidence of societal harm.

184. Defendants knew that their actions were injurious but deliberately refused to change their practices because acting to decrease the dispensing of opioids would have decreased their profits.

185. Defendants have knowingly abandoned their duties imposed under Arkansas law and federal law that is incorporated therein and abused the privilege of conducting business in this community.

VI. CLAIMS FOR RELIEF

COUNT 1: Public Nuisance

186. The State repeats and realleges the preceding paragraphs of this Complaint as if fully set forth herein. Ark. R. Civ. P. 10(c).

187. This action is brought by the State to abate the public nuisance created by Defendants.

188. A public nuisance is an unreasonable interference with a right common to the general public.

189. Defendants have contributed to and assisted in creating and maintaining a condition that is harmful to the health of thousands of Arkansas residents and interferes with the enjoyment of life in violation of Arkansas law.

190. Prescription opioid abuse, addiction, morbidity, and mortality are a public nuisance in Arkansas, which, despite the State's efforts, remain unabated. Defendants' unlawful conduct described herein has created these hazards to public health and safety.

191. Defendants knew that opioids were being dispensed into Arkansas in dangerous amounts and were being overutilized, abused, and diverted into illicit drug markets.

192. Defendants knowingly and intentionally designed benefit plans and standard national formularies that would maximize opioid utilization.

193. Defendants knowingly, intentionally, recklessly, and negligently failed to manage these plans to minimize the use and abuse of opioids.

194. Defendants knowingly and intentionally chose to include opioids on their formularies that they knew were highly addictive and dangerous. Defendants did not install reasonable controls in the form of quantity limits, prior authorization requirements, or MME daily limits.

195. Defendants knowingly and intentionally chose to include opioids that were easier to misuse.

196. Defendants knowingly and intentionally made it more expensive or more difficult to obtain known, efficacious non-opioid medications for pain. To date, dozens of non-narcotic pain treatments are not covered by PBM baseline national formularies. This led directly to the increased sale and use of opioids.

197. Defendants knowingly and intentionally chose not to include certain medications that would prevent overdoses or made them more difficult or expensive to obtain.

198. Defendants chose (and continue to choose) not to cover or, alternatively, to create barriers to accessing drugs typically used to treat Opioid Use Disorder ("OUD") such as naloxone,

methadone, buprenorphine, and naltrexone.

199. PBM Defendants conduct substantially contributed to the creation and maintenance of a public nuisance by facilitating and encouraging the use of dangerously addictive opioids, by colluding with manufacturers to place opioid drugs on formularies with preferred status, declining to impose limits on their approval for use in exchange for payments and fees from manufacturers, assisting in promoting and failing to disclose the real risks and appropriate limits on the use of opioids, and failing to use the wealth of data available to them to identify and address signs of over-prescribing, illegitimate and dangerous use of opioids, misuse, abuse, and diversion. Their conduct caused prescriptions and sales of opioids to skyrocket and failed to limit their use even as evidence of the epidemic mounted, including in Arkansas, flooding the State with opioids, and facilitating and encouraging the flow and diversion of opioids into an illegal, secondary market, resulting in devastating consequences to the State and the residents of Arkansas.

200. Defendants knew, or should have known, that their intentional, unreasonable, and unlawful conduct would cause, and has caused, opioids to be used and possessed illegally and that their conduct has produced an ongoing nuisance that has had, and will continue to have, a detrimental effect upon the public health, welfare, safety, peace, comfort, and convenience of the State and its residents.

201. At all times relevant to the ongoing opioid epidemic, Defendants had the power to limit the sale of opioids that were less effective, more addictive, and more easily diverted. Defendants had the ability to install preauthorization requirements for opioid prescriptions for chronic pain when other non-opioid options were available. Defendants could have responded favorably to direct requests from governmental payors attempting to control opioid flow and offer non-opioid options. Defendants could have provided patients easier access to less addictive, less

dangerous drugs and treatment drugs. Defendants could have monitored and modified patients' usage. Defendants could have and should have imposed stricter quantity limits, refill limitations, or preauthorization requirements. Defendants chose not to employ any of these options, choosing profits over safety.

202. Defendants created and maintained a public nuisance by colluding with manufacturers to make opioids more available, by ignoring evidence of addiction and misuse found in their own claims data, and by failing to maintain effective controls against diversion, leading to the oversupply of opioids in Arkansas. Defendants' actions interfered with the public health, welfare, and safety in Arkansas, and the State and its residents have a common right to be free from such conduct that creates a disturbance and reasonable apprehension of danger to person or property.

203. Defendants' conduct has created an ongoing, significant, unlawful, and unreasonable interference with rights common to the general public, including the public health, welfare, safety, peace, comfort, and convenience of the State and its residents. Restatement (Second) of Torts § 821B; *see also City of Ft. Smith v. W. Hide & Fur Co.*, 153 Ark. 99, 239 S.W. 724, 725 (1922) (defining a public nuisance as, among other things, "that which affects the people and is a violation of a public right…by doing some act which tends to a common injury or by the omitting of that which it is the duty of the person to do.") (quoting *Town of Lonoke v. Chicago, R.I. & P.R. Co.*, 92 Ark. 546, 123 S.W. 395, 398 (1909)); *Ex parte Foote*, 70 Ark. 12, 65 S.W. 706, 707–08 (1901) (defining public nuisance as something "so extensive in its consequences as to have common effect upon many" and as arising from "improper, indecent, or unlawful conduct").

204. The interference is unreasonable because Defendants' nuisance-creating conduct:

a. Involves a significant interference with the public health, the public safety, the public peace, the public comfort, and the public convenience;

b. At all relevant times was and is proscribed by state and federal laws and regulations; and,

c. Is of a continuing nature and, as Defendants know, has had and is continuing to have a significant effect upon rights common to the general public, including the public health, the public safety, the public peace, the public comfort, and the public convenience.

205. The significant interference with rights common to the general public is described in detail throughout this Complaint and includes:

a. The creation and fostering of an illegal, secondary market for prescription opioids;

b. A staggering increase in opioid abuse, addiction, overdose, injuries, and deaths;

c. Infants being born addicted to opioids due to prenatal exposure, causing severe withdrawal symptoms and lasting developmental impacts;

d. Employers losing the value of productive and healthy employees; and

e. Increased costs and expenses for the State relating to healthcare services, law enforcement, the criminal justice system, social services, and education systems.

206. Defendants intentionally, unreasonably, and unlawfully pushed as many opioids onto the market as possible, fueling addiction to and diversion of these powerful narcotics, resulting in increased addiction and abuse, an elevated level of crime, death, and injuries to the residents of Arkansas and direct costs to the State.

207. Defendants are liable for creating the public nuisance because the intentional and

unreasonable and unlawful conduct of Defendants was a substantial factor in producing the public nuisance and harm to the State.

208. In their role as dispensers of opioids in Arkansas, Defendants violated Arkansas law, including, but not limited to, Ark. Code Ann. § 17-92-113(b) and the Rules Pertaining to Arkansas Prescription Drug Monitoring Program, Sec. II, IV (a)–(c) (Dec. 28, 2023).

209. Defendants' unlawful and unreasonable nuisance-creating conduct includes violating Arkansas statutes and regulations, including the controlled substance laws, by dispensing opioids without maintaining effective controls against diversion, including, but not limited to, failing to utilize their own data and the data available to them to detect or guard against diversion.

210. Defendants' intentional and unreasonable nuisance-creating conduct, includes:

a. Facilitating the increased use of opioids by giving opioids preferred formulary status in exchange for payments from opioid manufacturers;

b. Failing to impose limits on approval for the use of opioids in exchange for payments from opioid manufacturers;

c. Increasing the number of opioid prescriptions;

d. Ignoring the evidence of addiction and abuse found in its own claims data; and,

e. Failing to maintain effective controls against the diversion of opioids.

211. At all times relevant to the ongoing opioid epidemic, Defendants knew, or should have known, that increasing the availability of opioids would increase the number of opioids that would be abused, misused, and diverted into the illegal, secondary market and would be obtained by persons with criminal purposes.

212. Defendants knew that opioids were dangerous because they were defined under

state and federal law as substances posing a high potential for abuse and addiction.

213. Opioids are akin to medical grade heroin. Defendants' intentional, unlawful, wrongful, and unreasonable conduct of pushing as many opioids onto the market as possible led directly to the public nuisance and harm to the State, which is to be expected when medical grade heroin in the form of prescription opioids flood the community and are diverted into an illegal, secondary market.

214. It was reasonably foreseeable that Defendants' actions and omissions would result in the public nuisance and harm to the State described herein.

215. Defendants acted to make opioids more available in the marketplace, and Defendants have a special position within the closed system of opioid distribution. Without Defendants' actions, opioid use would not have become so widespread, and the enormous public health hazard of prescription opioid and heroin overdose, abuse, and addiction that now exists would have been averted.

216. Defendants' conduct was, and continues to be, a substantial factor causing the ongoing, persistent public nuisance and the harm described herein to the State. Given their gatekeeper position in the prescription drug marketplace, PBMs have always been uniquely positioned to abate the opioid crisis.

217. PBM Defendants knew, or should have known, that their intentional, unreasonable, and unlawful conduct would cause, and has caused, opioids to be used and possessed illegally and that their conduct created an ongoing, persistent public nuisance that endangers the health and safety of the State and negatively impacts the State's ability to provide essential services.

218. The public nuisance created by Defendants' intentional and persistent course of conduct has directly and proximately caused and continues to cause significant economic harm to

the State that includes, but is not limited to:

a. Responding to opioid-related drug overdoses and deaths;

b. Allocating resources for the disease of addiction and other diseases related to long-term opioid use;

c. Allocating resources for child abuse and neglect resulting from opioid abuse;

d. Allocating resources for crime associated with illegal drug use and opioid sales; and,

e. Addressing related blight, vagrancy, property damage, and property crime.

219. Defendants' actions foreseeably created a new secondary market for opioids—providing both the supply of narcotics to sell and creating the demand by causing an increase in the number of individuals suffering from opioid use disorder. The result of Defendants' conduct was not only an explosion of prescription opioids on the black market but also a marked increase in the availability of heroin and synthetic opioids.

220. The results of Defendants' conduct included the diversion of opioids into the secondary, criminal market and the increase in opioid use and opioid use disorder placed unnecessary and excessive demands on the medical, public health, and financial resources of the State.

221. Defendants' misconduct alleged in this case does not concern a discrete event or emergency the State would reasonably expect to occur and is not part of the normal and expected costs of the State.

222. Public resources are being unreasonably consumed in efforts to address the opioid epidemic, including expenditures for special public service programs, thereby eliminating

available resources that would otherwise be used to serve the public at large in the State.

223. The public nuisance created by Defendants' actions is substantial and unreasonable.

224. As a result of the public nuisance, the State has sustained, and continues to sustain, harm by spending a substantial amount of State resources trying to fix the harms caused by Defendants' nuisance-causing activity, including, but not limited to, the costs of hospital services, healthcare, emergency medical services, social services, prevention, treatment, education, intervention, and overhead expenses.

225. The public nuisance created, perpetuated, and maintained by Defendants can be abated and further recurrence of such harm can be abated.

226. Defendants' misconduct alleged in this case is ongoing and persistent, as is the nuisance to which they substantially contributed.

227. Defendants should be required to pay for the harm the State has suffered and will suffer because of the public nuisance that Defendants created.

228. Defendants' intentional, unlawful, and persistent course of conduct, as alleged herein, created an ongoing, conscious, and deliberate nuisance that is continuing and recurring to this day.

229. Defendants' conscious and deliberate acts have caused long-lasting and permanent harm to the State.

230. The State seeks to abate the nuisance created by Defendants' unreasonable, unlawful, intentional, ongoing, continuing, and persistent actions and Defendants' omissions and unreasonable interference with rights common to the general public.

231. The State has suffered, and will continue to suffer, unique harms as described in this Complaint.

232. The State is asserting its own rights and interests, and its claims are not based upon or derivative of the rights of others.

233. Defendants' tortious conduct was a substantial factor in creating a public nuisance and causing harm to the State.

234. Defendants acted recklessly, negligently and carelessly, in breach of their duties to maintain effective controls against diversion, thereby creating an unreasonable risk of harm.

235. Defendants acted with malice, actual or implied, because Defendants acted with a conscious disregard for the rights and safety of other persons, and said actions had a great probability of causing substantial harm.

236. The damages available to the State include, among other things, abatement costs to stop the rise of damages from an ongoing and persistent public nuisance.

237. The State seeks to abate the nuisance created by Defendants' unreasonable, unlawful, intentional, ongoing, continuing, and persistent interference with a right common to the public.

238. The public nuisance created by Defendants' actions is foreseeable, substantial, and unreasonable. It has caused and continues to cause significant harm to the community, and the harm inflicted outweighs any offsetting benefit. The staggering rates of opioid and heroin use resulting from Defendants' abdication of their gate-keeping duties, have caused harm to the entire community as set forth in Section I.A., *supra*.

239. Even those State residents who have never taken opioids have suffered from the public nuisance arising from Defendants' abdication of their gate-keeper duties. Many residents have endured both the emotional and financial costs of caring for loved ones addicted to or injured by opioids, and the loss of companionship, wages, or other support from family members who

have used, abused, become addicted to, overdosed on, or been killed by opioids.

240. More broadly, opioid use and misuse has driven Arkansans' health care costs higher.

241. Employers have lost the value of productive and healthy employees who suffered from the adverse consequences of opioid use.

242. Defendants' conduct created an abundance of drugs available for criminal use and fueled a new wave of addiction, abuse, and injury.

243. Defendants' dereliction of duties and collusion with opioid manufacturers' fraudulent misinformation campaign in which they were pushing dangerous drugs resulted in a diverted supply of narcotics to sell and the ensuing demand of those addicted to opioids to buy them. More pills sold by Defendants led to more addiction, with many addicts turning from prescription pills to heroin. People addicted to opioids frequently require increasing levels of opioids, and many turned to heroin as a foreseeable result.

244. The diversion of opioids into the secondary criminal market and the increased number of individuals who abuse or are addicted to opioids has increased the demands on emergency services and law enforcement in the State.

245. The significant and unreasonable interference with the public rights caused by Defendants' conduct taxed the human, medical, public health, and financial resources of the State.

246. Defendants' conduct has affected and continues to affect a considerable number of people within the State and is likely to continue to cause significant harm to those who take opioids, their families, and the community at large.

247. The health and safety of the citizens of the State, including those who use, have used, or will use opioids, as well as those affected by users of opioids, is a matter of great public

interest and legitimate concern to the State's citizens and residents.

248. The public nuisance created, perpetuated, and maintained by Defendants can be abated, and further recurrence of such harm and inconvenience can be prevented.

249. Defendants created or assisted in the creation of the epidemic of opioid use, abuse, and injury, and are liable for failing to abate it.

250. The State seeks all legal and equitable relief as allowed by law, including among other things, injunctive relief, abatement of the public nuisance, payment to the State of monies necessary to abate the public nuisance, all damages as allowed by law, attorney fees and costs, and pre- and post-judgment interest.

251. The continued tortious conduct by Defendants caused a repeated or continuous injury. The damages have not occurred all at once but have increased as time progresses. The tort is not completed nor have all the damages been incurred. The State has taken efforts to abate the nuisance, but because the wrongdoing and harm are ongoing, the public nuisance remains unabated.

COUNT 2: Negligence

252. The State repeats and realleges the preceding paragraphs of this Complaint as if fully set forth herein. Ark. R. Civ. P. 10(c).

253. Defendants have a duty to the State to employ a reasonable standard of care in their voluntary undertaking of services affected with a significant public interest, to wit, the sale, distribution, dispensing, reimbursement, and promotion of what Defendants knew to be highly addictive, dangerous opioids. This includes a duty to not create a foreseeable risk of harm and a duty to use reasonable care in the services provided.

254. Defendants each owed a duty to the State and to the public health and safety in

Arkansas, because the injury was foreseeable and, in fact, foreseen by Defendants.

255. Reasonably prudent PBMs would have anticipated that the scourge of opioid addiction would wreak havoc on communities. The nature of the services Defendants voluntarily undertook gives rise to a duty to use reasonable care.

256. Society, including the State of Arkansas, expects Defendants to perform the services they offer with reasonable care. For example, society expects that opioid manufacturers will not lie about the addictive properties and dangers of their products; society expects that distributors and dispensers will abide by their statutory obligations, reporting requirements, and professed commitment to public safety; and society expects that PBMs will honor their public statements regarding their commitment to public health and that PBMs will not conspire with manufacturers or construct self-serving plans or formularies.

257. Consistent with societal expectations, the State of Arkansas also reasonably expected that the companies profiting from activity within the State would conduct such activity with reasonable care and would abide by their own repeated affirmations of commitment to public health and safety.

258. The State never could have foreseen the wrongful conduct described herein or protected itself against the harm it has suffered and continues to suffer.

259. Defendants breached their duty by failing to exercise reasonable care or skill with respect to voluntary opioid-related conduct. Working in coordination with opioid manufacturers, Defendants made highly addictive prescription opioids available to the marketplace with the knowledge that they were likely being used for non-medical purposes and posed an inherent danger, especially to patients who were using opioids for chronic pain not associated with active cancer, end-of-life, or palliative care.

260. Defendants knew their breach would cause harm to the State. The use, abuse, and diversion of opioids resulting in addiction, morbidity, and increased mortality in the State was a foreseeable harm of Defendants' breach of their duties.

261. Defendants are and have always been uniquely positioned to abate the crisis they have created. Defendants had superior knowledge of the risks of opioids—which they did not disclose and affirmatively misrepresented. Defendants were in the best position to protect the State from the foreseeable harm resulting from their own misconduct and which the State could not have anticipated.

262. Defendants profited from the oversupply of opioids and the demand created for opioids as a result of the scheme alleged.

263. Defendants were negligent in failing to abide by their duties to conduct themselves with the requisite care and skill and faithfulness in the context of activities and services they voluntarily undertook.

264. Defendants placed their desire for increased profits above their legal duties and enabled, encouraged, and caused the over-use and over-supply of opioids.

265. Defendants are highly sophisticated and knowledgeable actors in the health care marketplace. As such, Defendants were well informed of the highly-addictive nature of prescription opioids and likelihood of foreseeable harm to communities from prescription opioid addiction, oversupply, and diversion. Defendants breached their duties when they failed to act with reasonable care in their respective voluntarily assumed roles, roles which positioned each of the Defendants to help prevent or abate the opioid epidemic had they chosen to use their power for the welfare of Arkansas residents instead of lining their own pockets.

266. A negligent or intentional violation of Defendants' duties poses distinctive and

significant dangers to the State. Given the addictive and dangerous properties of opioids, the illegal opioid market, and criminal activities, which the State must now address, were foreseeable consequences of Defendants' negligence.

267. At all times, Defendants each had the ability and obligation to control opioid access and utilization to avoid the very epidemic that they helped create.

268. As a result of their failures, Defendants caused the State to incur excessive social and economic costs related to responding to the opioid crisis. These costs include, but are not limited to, increased medical and fire services, lost tax revenues, lost productivity, strains on social services, and lost communal benefits of the State's limited and diverted resources.

269. The injuries to the State would not have happened in the ordinary course of events had Defendants exercised the degree of care, prudence, watchfulness, and vigilance commensurate to the dangers involved in the transaction of their business in the promotion, sale, and dispensing of opioids.

270. Defendants' conduct was willful, wanton, malicious, reckless, oppressive, and fraudulent. Here, Defendants were promoting and dispensing dangerous drugs statutorily categorized as posing a high potential for abuse and severe dependence. Thus, Defendants knowingly traded in drugs that presented a high degree of danger if prescribed incorrectly or diverted to other than medical, scientific, or industrial channels.

271. The State seeks all legal and equitable relief as allowed by law, including, among other things, injunctive relief, restitution, disgorgement of profits, compensatory and punitive damages, and all damages allowed by law to be paid by Defendants, attorney fees and costs, and pre- and post-judgment interest.

272. The State has suffered damages as a direct and proximate result of the negligent

failures by Defendants and their employees and agents.

COUNT 3: Unjust Enrichment

273. The State repeats and realleges the preceding paragraphs of this Complaint as if fully set forth herein. Ark. R. Civ. P. 10(c).

274. As a direct and proximate result of the unlawful conduct described herein, Defendants have been and will continue to be unjustly enriched.

275. Defendants have benefited from their unlawful acts by causing millions of illegal and suspicious orders to be distributed and sold in violation of their legal duties. It would be inequitable and not in good conscience for Defendants to retain any ill-gotten gains earned as a result of the conduct alleged herein.

VII. PRAYER FOR RELIEF

276. Based on the unlawful acts described herein, the State of Arkansas respectfully prays:

a. That the acts alleged herein be adjudged and decreed to be unlawful in violation of State statutory and common law and that the Court enter a judgment declaring them to be so;

b. That Defendants be enjoined from, directly or indirectly, failing to comply with state law requiring the monitoring and reporting of suspicious opioid distributions to Arkansas and surrounding areas that are likely to be diverted to Arkansas.

c. That the State recover all measures of damages allowable and that judgment is entered against Defendants in favor of the State;

d. That the State recover the costs and expenses of suit, pre- and post-judgment interest, and reasonable attorneys' fees as provided by law;

e. That Defendants be ordered to pay restitution to the State to the full extent permitted by law;

f. That Defendants be ordered to abate the public nuisance they created in violation of State law;

g. That liability be imposed jointly and severally; and,

h. That the Court order such other and further relief as the Court deems just, necessary, and appropriate.

VIII. JURY DEMAND

277. The State demands a trial by jury on all claims.

Respectfully Submitted,

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