UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

LONG ISLAND ANESTHESIOLOGISTS PLLC, Plaintiff, vs UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM and MULTIPLAN INC., Defendants.	Index No. 2:22-cv-04040 Hon. Hector Gonzalez **ORAL ARGUMENT REQUESTED**

DEFENDANT UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK'S NOTICE OF MOTION TO DISMISS THE COMPLAINT

PLEASE TAKE NOTICE that Defendant UnitedHealthcare Insurance Company of New York (United), by and through its undersigned counsel, will move the Honorable Hector Gonzalez of the United States District Court of the Eastern District of New York, located at 225 Cadman Plaza East, Brooklyn, NY 11201, at a time and date to be set by the Court, for an Order dismissing with prejudice the Complaint filed by Plaintiff Long Island Anesthesiologists PLLC (LIA) under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim. United also moves the Court to dismiss or, alternatively, stay this action on *Colorado River* abstention grounds in light of LIA's parallel state-court lawsuit raising substantially similar legal issues.

PLEASE TAKE FURTHER NOTICE, that in support of its motion, United relies on its accompanying Memorandum Supporting its Motion to Dismiss, dated October 10, 2022, the exhibits attached the Declaration of Karl Geercken, and all prior papers and proceedings heretofore filed or had in this action.

PLEASE TAKE FURTHER NOTICE, that pursuant to the Court's September 12, 2022 Order, Plaintiff's response, if any, is due on November 7, 2022, and United's reply, if any, is due on November 17, 2022.

United requests oral argument on its motion.

Dated: October 10, 2022

ALSTON & BIRD LLP

/s/ Karl Geercken

Karl Geercken
90 Park Avenue
New York, New York 10016
(212) 210-9400
karl.geercken@alston.com

Brian D. Boone (*pro hac vice* pending)
Emily McGowan (*pro hac vice* pending)
ALSTON & BIRD LLP
101 S. Tryon Street, Suite 4000
Charlotte, NC 28280
(704) 444-1000
brian.boone@alston.com
emily.mcgowan@alston.com

D. Andrew Hatchett (*pro hac vice* pending)
Jordan Edwards (*pro hac vice* pending)
ALSTON & BIRD LLP
1201 W. Peachtree Street
Atlanta, GA 30309
(404) 8811-7000
andrew.hatchett@alston.com
jordan.edwards@alston.com

Attorney for Defendant UnitedHealthcare Insurance Company of New York

CERTIFICATE OF SERVICE

I certify that on October 10, 2022, I electronically filed the foregoing Notice of Motion, Memorandum of Law in Support of the Motion to Dismiss, and Declaration of Karl Geercken with the Clerk of Court using the CM/ECF system.

/s/ Karl Geercken

Karl Geercken
90 Park Avenue
New York, New York 10016
(212) 210-9400

Attorney for Defendant UnitedHealthcare Insurance Company of New York

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UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK'S
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INTRODUCTION

Plaintiff Long Island Anesthesiology PLLC's (LIA's) antitrust claims against UnitedHealthcare Insurance Company of New York (United) and MultiPlan, Inc. (MultiPlan) make no sense. LIA alleges that it was injured in January 2022 when the Empire Plan (the state-sponsored health plan for New York state employees) began applying the federal No Surprises Act, instead of New York's Surprise Bill Law, when reimbursing LIA for out-of-network anesthesiology services. LIA alleges that reimbursement rates under the federal law are lower than prevailing rates under New York's statute. But LIA fails to explain how United or MultiPlan caused that alleged harm. The New York Department of Civil Service (DCS)—not United (the Empire Plan's third-party administrator) or MultiPlan (United's vendor)—sponsors and funds reimbursements under the Empire Plan. DCS (not United or MultiPlan) decided to follow federal law. If LIA is upset about the Empire Plan's decision, it should take that up with DCS.

Which brings us to the first of many problems with LIA's complaint: LIA *has* taken that up with DCS. On March 28, 2022, LIA and other plaintiffs filed a declaratory judgment action in New York state court against DCS, United, and other defendants raising the precise legal question at the center of this case: whether the federal No Surprises Act or the New York Surprise Bill Law governs the Empire Plan's reimbursement of certain out-of-network services. *See* Karl Geercken's October 10, 2022 Declaration, Ex. 1, Complaint, *Wayne Joseph et al. v. Rebecca Corso et al.*, No. 902227-22 (N.Y. Sup. Ct.).[1] In that separate lawsuit (we'll call it the "state action"), DCS and the

[1] Exhibits 1 through 4 to the Geercken Declaration are pleadings in LIA's state action of which this Court can take judicial notice on a motion to dismiss. *See Day v. Distinctive Pers., Inc.*, 656 F. Supp. 2d 331, 332 n.2 (E.D.N.Y. 2009) ("[T]he Court may take judicial notice of documents filed in related litigation by the plaintiff."); *Blue Tree Hotels Inv. (Can.), Ltd. v. Starwood Hotels & Resorts Worldwide, Inc.*, 369 F.3d 212, 217 (2d Cir. 2004) (stating that courts "may also look to public records, including complaints filed in state court, in deciding a motion to dismiss").

New York Department of Financial Services (DFS) have explained that (1) DCS made the decision to follow the federal No Surprises Act and (2) DCS's and DFS's interpretations of New York law are entitled to deference. Geercken Decl., Ex. 3 at 10–12 (DCS and DFS Motion to Dismiss Brief in the state action). Because LIA's antitrust claims depend on the answer to the question at the heart of the state action, this Court should dismiss or stay this case on *Colorado River* abstention grounds to avoid "inconsistent and mutually contradictory determinations" that "would cause friction between state and federal courts." *De Cisneros v. Younger*, 871 F.2d 305, 308 (2d Cir. 1989) (citation omitted). "[T]he interests of comity are best served by waiting for the state court to speak first," which would also "guarantee[] that [this Court] will not misinterpret New York law." *Id.* at 309.

If the Court does not abstain, LIA's claims fail for multiple reasons.

First, as a self-funded plan, the Empire Plan is not subject to the New York Surprise Bill Law but is instead legally required to follow the federal No Surprises Act. Because the Empire Plan is correctly applying the federal law, LIA's state and federal antitrust claims, which are predicated on a misapplication of that law, must be dismissed.

Second, LIA has failed to allege an antitrust injury. "[T]he antitrust laws . . . were enacted for 'the protection of competition, not competitors.'" *Balaklaw v. Lovell*, 14 F.3d 793, 797 (2d Cir. 1994) (quotation omitted). Although dressed in antitrust clothing, LIA has alleged harm only to itself arising from a single health plan's reimbursement decisions—not the sort of harm to the competitive process that the antitrust laws were designed to prevent.

Third, LIA's conspiracy claims (Counts I & IV) are implausible. LIA offers a conclusory allegation that United and MultiPlan conspired but alleges no facts supporting the existence of a conspiracy or explaining what United and MultiPlan even conspired to do. And given that neither

United nor MultiPlan controls the Empire Plan's reimbursement decisions, LIA fails to plausibly allege how a United-MultiPlan conspiracy could have affected LIA's reimbursement rates.

Fourth, LIA's conspiracy claims also fail the rule of reason, which requires LIA to identify an adverse effect on competition in the relevant market. For its conspiracy claims, LIA alleges that the relevant market is the "provision of medically necessary anesthesia services to patients." Compl. ¶ 152. But LIA has not alleged any impact on competition in that market. Nor has it alleged that United or MultiPlan compete in that market. At most, LIA alleges that one of United's sister companies (OptumCare) offers anesthesia services. Compl. ¶¶ 47–55. But OptumCare is not a defendant, and, in any event, LIA does not allege facts establishing that OptumCare has anything approaching the sort of market power required to foreclose competition.

Fifth, LIA's Section 2 claims (Counts II & III) fail because LIA does not plausibly allege that United had monopsony power in a properly defined market. For its Section 2 claims, LIA alleges that "United possesses monopsony power in a market for the *reimbursement* of anesthesia services in the New York metropolitan area." Compl. ¶ 189 (emphasis added). But LIA does not allege that either United or MultiPlan competes in the reimbursement market, let alone that either has the power to control prices or exclude competition.

Sixth, LIA's unjust-enrichment claim (Count V) fails because LIA does not allege that it conferred a benefit on either United or MultiPlan—a required element of a claim for unjust enrichment. *See, e.g.*, *Graham v. Take-Two Interactive Software, Inc.*, 2019 U.S. Dist. LEXIS 206236, at *5–6 (S.D.N.Y. Nov. 25, 2019).

For those reasons and others described below, LIA's complaint should be dismissed.

BACKGROUND

A. DCS, not United or Multiplan, sponsors the Empire Plan and funds reimbursements under the Plan.

United is the third-party administrator for the Empire Plan—the state-sponsored health plan for New York state employees and their families. Compl. ¶ 64. United does not fund reimbursements under the Empire Plan; instead, DCS sponsors and funds the Plan. *Id.* ¶¶ 64–69; *Uddoh v. United Healthcare*, 2017 U.S. Dist. LEXIS 19415, at *9 (E.D.N.Y. Feb. 10, 2017) ("[B]ecause the Empire Plan is self-insured, the Department of Civil Service bears all responsibility for claims and expenses under or against it, for which it receives state funding and makes annual budget requests to the New York State Division of the Budget.").

B. When it comes to the Empire Plan, LIA is an out-of-network provider.

LIA is a private anesthesiology practice that primarily serves patients at Good Samaritan Hospital, including patients covered by the Empire Plan. Compl. ¶¶ 19–24, 78, 172. Healthcare providers are generally classified as either "in-network" or "out-of-network" with respect to a health plan. *Id.* ¶ 32. "In-network" providers negotiate reimbursement rates in advance. *Id.* ¶¶ 33, 34, 37. Providers without a participation agreement are "out-of-network." Even though LIA may provide services at in-network facilities, it has "traditionally chosen to remain out of network." *Id.* ¶ 38. LIA admits that it has chosen to stay out-of-network so that it can capture the Empire Plan's traditionally inflated out-of-network reimbursements. *Id.* ¶¶ 92–93.

C. The Empire Plan is not subject to New York's Surprise Bill Law.

The New York Surprise Bill Law (Financial Services Law §§ 601–08) took effect in March 2015. The Surprise Bill Law prohibits out-of-network providers like LIA from directly billing patients in circumstances where the bill qualifies as a "surprise bill." Compl. ¶ 83. The Surprise Bill Law applies to certain "emergency" services where the patient did not have an opportunity to

select their provider as well as instances where a patient receives care from an out-of-network physician at an in-network facility (such as when LIA provides out-of-network anesthesiology services in connection with a procedure at an in-network facility like Good Samaritan Hospital).

Health plans subject to the Surprise Bill Law must reimburse out-of-network providers at a "reasonable amount." *Id.* ¶ 84. Disputes over what constitutes a reasonable amount may be submitted to a state-established independent dispute resolution (IDR) process. *Id.* ¶ 85. LIA alleges that the state's IDR process generally requires payments at 80% of the usual, customary, and reasonable (UCR) rate in the FAIR Health benchmarking database. *Id.* ¶¶ 87–90.

LIA alleges that "[u]ntil January 2022, the Empire Plan was treated as subject to the Surprise Bill Law by all stakeholders, including the Empire Plan itself." *Id.* ¶ 82. But in a sworn affidavit filed in the pending state action, DCS's Director of the Employee Benefits Division, Daniel Yanulavich, testified that the Empire Plan has historically issued reimbursements at rates 90% of the FAIR Health UCR to "ensure consumer protections"—not because of "a specified legal obligation requiring strict fidelity to the Surprise Bill Law." Ex. 2 ¶ 17 (Aug. 31, 2022 Affidavit of Daniel Yanulavich). In its motion to dismiss in the state action, DCS has explained that New York's Surprise Bill Law does not apply to self-funded plans like the Empire Plan. Ex. 3 at 9.

D. The federal No Surprises Act applies to the Empire Plan.

In December 2020, Congress passed the No Surprises Act (Public Law 116-260), which took effect January 1, 2022. Compl. ¶ 103. Like New York's Surprise Bill Law, the federal No Surprises Act establishes a federal IDR process that governs disputes between health plans and out-of-network providers concerning reimbursement rates for qualifying "surprise" or emergency services. *Id.* ¶ 105. The federal No Surprises Act generally applies to all health plans, unless there is a "specified state law" that governs the plan. *Id.* ¶¶ 106–09. LIA alleges that New York's Surprise Bill Law is a "specified state law" that governs the Empire Plan. DCS disagrees and has

argued that New York's Surprise Bill Law does not apply to the Empire Plan and that, instead, the Empire Plan is subject to the federal law. Ex. 3 at 9–12.

LIA alleges that the federal IDR process sets reimbursement rates based on the Qualifying Payment Amount (QPA), defined as the health plan's median in-network rates for the same service in a similar geographic area. Compl. ¶ 115. LIA alleges that "[i]n virtually all circumstances, the QPA is significantly less than the FAIR Health-determined UCR amount." *Id.* ¶ 116.

E. The Empire Plan follows federal law.

Since January 1, 2022, when the federal No Surprises Act became effective, the Empire Plan has followed the federal statute. Compl. ¶¶ 95–100. LIA alleges that the Empire Plan's decision to follow the federal law was made "at United's insistence" or "at United's behest" (*id.* ¶¶ 4, 96, 101), and that the decision was "wrong." *Id.* ¶¶ 101, 102, 117. But LIA does not allege that United had actual authority or control over that decision.

After the Empire Plan insisted that it was subject to the federal law, LIA invoked the federal IDR process under a reservation of rights. *Id.* ¶ 118. LIA then "started receiving written communications from MultiPlan" which "identif[ied] itself as working with United[]" and offered to pay the QPA to resolve billing disputes. *Id.* ¶ 123–25. Over time, LIA alleges that it "started receiving more notices from MultiPlan as United[]'s representative." *Id.* ¶ 126. LIA complains about the volume of letters from MultiPlan, alleging that it was "impossible to keep up with the flood of correspondence and still keep up with the ability to routinely bill and collect for other anesthesia services." *Id.* ¶ 131. It also complains that some of those letters imposed rushed and unreasonable response deadlines. *Id.* ¶¶ 125–27.

F. LIA has already sued DCS and DFS over the same issues.

Three months before filing this lawsuit, on March 28, 2022, LIA joined other plaintiffs in filing a declaratory judgment action in the New York Supreme Court against the Empire Plan,

DCS, DFS, and United, seeking a declaration that "at all times, the Empire Plan, and its provision of benefits and reimbursement, remain subject to New York insurance law, including the Surprise Bill Law." Geercken Decl., Ex. 1 ¶ 130. While some of the introductory framing is different, most of the factual allegations in LIA's complaint in this case are copied directly from allegations that LIA previously included in its state-court complaint, including at least 42 paragraphs that are copied verbatim.[2]

DCS (on behalf of itself, the Empire Plan, and DFS) has filed a motion to dismiss LIA's complaint, arguing, among other things, that the Surprise Bill Law's plain language does not apply to self-funded plans like the Empire Plan. Geercken Decl., Ex. 3 at 9–12. DCS also argued that it and DFS "are the State agencies charged with interpreting and administering the laws at issue" and that their interpretations are entitled to deference. *Id*. at 10–11. In support of its motion, DCS filed an affidavit from DFS's Deputy Superintendent for Health and an affirmation from DCS's Director of Employee Benefits, both attesting that the New York Surprise Bill Law does not apply to the Empire Plan. *See* Geercken Decl., Ex. 2 ¶¶ 32, 33; Geercken Decl., Ex. 4 ¶ 15 (June 3, 2022 Affirmation of John Powell).

LEGAL STANDARD

"To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). Although "[t]here is no heightened pleading requirement in antitrust cases," *In re Crude Oil Commodity Futures*

[2] The following Paragraphs in LIA's complaint in this case are either verbatim or substantially identical to allegations in LIA's state-court complaint: Paragraphs 65, 66, 67, 68, 70, 71, 72, 73, 74, 75, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 94, 95, 96, 97, 98, 99, 100, 101, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, and 116.

Litig., 913 F. Supp. 2d 41, 54 (S.D.N.Y. 2012), "a plaintiff must do more than cite relevant antitrust language to state a claim for relief." *Wolf Concept S.A.R.L. v. Eber Bros. Wine & Liquor Corp.*, 736 F. Supp. 2d 661, 667 (W.D.N.Y. 2010) (citing *Todd v. Exxon Corp.*, 275 F.3d 191, 198 (2d Cir. 2001)). "A plaintiff must allege sufficient facts to support a cause of action under the antitrust laws. Conclusory allegations that the defendant violated those laws are insufficient." *Id.* at 667–68; *see also Twombly*, 550 U.S. at 555 ("[A] plaintiff's obligation to provide the 'grounds' of his 'entitle[ment] to relief' requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do.").

ARGUMENT

I. LIA'S COMPLAINT SHOULD BE DISMISSED (OR, ALTERNATIVELY, STAYED) UNDER THE *COLORADO RIVER* ABSTENTION DOCTRINE.

Although styled as an antitrust lawsuit, this case presents a threshold legal question of whether the Empire Plan (i) is subject to New York's Surprise Bill Law or (ii) is required to follow the federal No Surprises Act. If the Empire Plan has correctly applied the federal law, then LIA's claims (all of which are predicated on the assumption that the Empire Plan is subject to state law) must be dismissed. But this Court should not reach that threshold question. Instead, the Court should abstain until that threshold question is resolved as part of the previously filed declaratory judgment action that is currently pending before the New York Supreme Court. *See* Geercken Decl., Ex. 1; Geercken Decl., Ex. 3.

In *Colorado River Water Conservation District v. United States*, the Supreme Court held that "considerations of wise judicial administration" and regard for the "conservation of judicial resources and [the] comprehensive disposition of litigation" may justify a federal court's decision to abstain from hearing a federal suit where the same issue is presented in concurrent state proceedings. 424 U.S. 800, 817–18 (1976) (alteration marks in original omitted). Although

"[a]bstention from the exercise of federal jurisdiction is the exception, not the rule" (*id.* at 813), circumstances "do nevertheless exist" where abstention is appropriate. *Id.* at 818. This is one of those circumstances.

Before applying *Colorado River* abstention, the Court must "first make the threshold determination" that the state and federal cases are "parallel." *Allstate Ins. Co. v. Elzanaty*, 916 F. Supp. 2d 273, 287 (E.D.N.Y. 2013). Parallel does not mean "identical." *Bernstein v. Hosiery Mfg. Corp.*, 850 F. Supp. 176, 184 (E.D.N.Y. 1994). Instead, it is enough if "substantially the same parties are contemporaneously litigating substantially the same issues in both forums." *Pappas Harris Capital, LLC v. Bregal Partners, L.P.*, 2021 U.S. Dist. LEXIS 139865, at *8 (S.D.N.Y. July 27, 2021) (quotations and citation omitted). The parallel requirement "is satisfied when the main issue in the case is the subject of pending litigation" (*id.*), or where "there is a substantial likelihood that the state litigation will dispose of *all* claims presented in the federal case." *Allstate*, 916 F. Supp. 2d at 287 (quoting *In re Comverse Tech., Inc.*, 2006 U.S. Dist. LEXIS 80195, at *6 (E.D.N.Y. Nov. 3, 2006)).

The state action and this case qualify as parallel proceedings. LIA and United are both parties to the state and federal actions. In its federal complaint, LIA alleges that, "at United's insistence, the Empire Plan has 'decided'" that the federal No Surprises Act applies to the Plan. *See, e.g.*, Compl. ¶ 96. And the "main issue" in the state action is whether the Empire Plan is subject to the federal No Surprises Act or New York's Surprise Bill Law.

Because the state action is a parallel proceeding, this Court must consider the various factors outlined by the Supreme Court for assessing whether abstention is appropriate. Those factors include "(1) [whether the litigation involves] assumption of jurisdiction over a *res*; (2) [the] inconvenience of the forum; (3) [the] avoidance of piecemeal litigation; (4) [the] order in which

the actions were filed; (5) the law that provides the rule of decision; and (6) [the] protection of the federal plaintiff's rights." *De Cisneros*, 871 F.2d at 307 (citing *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 16 (1983)). "[N]o single factor is necessarily decisive, and . . . the test 'does not rest on a mechanical checklist, but on a careful balancing of the important factors as they apply in a given case.'" *Id.* (quoting *Moses H. Cone*, 460 U.S. at 16).

Among those factors, the need to avoid piecemeal litigation is "[b]y far the most important." *Moses H. Cone*, 460 U.S. at 16; *see also Baker v. Warner/Chappell Music, Inc.*, 2018 U.S. Dist. LEXIS 53479, at *13 (S.D. Fla. Mar. 29, 2018) ("'The single most important factor' in the *Colorado River* analysis is the avoidance of piecemeal litigation." (quoting *Ambrosia Coal & Constr. Co. v. Morales*, 368 F.3d 1320, 1329 (11th Cir. 2004)). Indeed, the need to avoid piecemeal litigation may justify abstention even when all or most of the other relevant factors are neutral or tilt against abstention. *See, e.g.*, *De Cisneros*, 871 F.2d at 307–08 ("The basis of the district court's decision to abstain is the third factor—avoidance of piecemeal litigation."); *Gen. Reinsurance Corp. v. Ciba-Geigy Corp.*, 853 F.2d 78, 81 (2d Cir. 1988); *Lumbermens Mut. Cas. Co. v. Conn. Bank & Tr. Co., N.A.*, 806 F.2d 411, 415 (2d Cir. 1986).

This case presents "[t]he central problem with piecemeal adjudication" because there is a "a potential . . . for inconsistent and mutually contradictory determinations." *De Cisneros*, 871 F.2d at 308 (quotation omitted). Although the most likely outcome is that both courts affirm the Empire Plan's decision to follow the federal law, it would be severely problematic if the two courts resolved the question differently. For instance, consider a scenario where the state court agrees with DCS that the Empire Plan must follow federal law. If this Court disagrees, and simultaneously sustains LIA's antitrust claims, then United could face treble antitrust damages for a reimbursement decision that it is powerless to change and that DCS would continue. That is

precisely the sort of "friction between state and federal courts" that *Colorado River* abstention is designed to avoid. *De Cisneros*, 871 F.2d at 308.

It does not matter that LIA's antitrust claim requires this Court to consider other issues, including injury to competition, market definition and market power, or whether United is a monopsonist, because there is no question that those claims cannot proceed if the Empire Plan is applying the law correctly. "Where the issues in the parallel actions are 'inextricably linked,' as they unequivocally are in this case, 'the risk of piecemeal litigation is real and should be avoided.'" *L. Harbert, Inc. v. Aetna Cas. & Sur. Co.*, 1997 U.S. Dist. LEXIS 13021, at *10 (S.D.N.Y. Aug. 22, 1997) (citation omitted). "[T]he interests of comity are best served by waiting for the state court to speak first," to minimize any risk that this court will "misinterpret New York law." *De Cisneros*, 871 F.2d at 309.

Other *Colorado River* factors also favor abstention. "The fourth factor looks at the chronological order in which the actions were filed." *De Cisneros*, 871 F.2d at 308. Here, LIA's state suit "preceded [this] federal action by three months." *Id.* Courts sometimes look beyond the timing when the federal action is more advanced. But that is not true here. This case is still at the starting line, and substantial resources may be spared by waiting for the state court to reach its decision. In contrast, in the state action, the parties are actively briefing the motion to dismiss, and DCS has presented its arguments for why it has correctly followed the federal law.

The fifth factor, "the law that provides the rule of decision," is at best neutral. Although LIA's antitrust claims raise federal questions, the threshold inquiry about whether the Empire Plan is subject to the New York Surprise Bill Law is uniquely a question of New York law that is best reserved for a New York court in a case involving the state regulators charged with implementing the state laws in question. *See* Geercken Decl., Ex. 3 at 9–12 (offering arguments based on plain-

text interpretation of New York statute); *see also Entergy Nuclear Operations, Inc. v. N.Y. State Dep't of State*, 28 N.Y.3d 279, 289 (N.Y. 2016) ("The construction given statutes and regulations by the agency responsible for their administration, if not irrational or unreasonable, should be upheld and th[e] Court treads gently in second-guessing the experience and expertise of state agencies charged with administering statutes and regulations").

The sixth factor—the protection of the federal plaintiff's rights—is likewise neutral. LIA's rights "will be adequately protected in the state proceedings" because LIA—a plaintiff in that case represented by the same counsel—is able to fairly present the issue to the state court for resolution. *De Cisneros*, 871 F.2d at 309. In any event, there is no prejudice to LIA if it is merely forced to wait on a resolution of the state proceeding before advancing an antitrust claim.

II. LIA'S ANTITRUST CLAIMS FAIL BECAUSE THE EMPIRE PLAN IS NOT SUBJECT TO NEW YORK'S SURPRISE BILL LAW.

If the Court does not abstain, then it must answer the question currently pending before the New York Supreme Court about whether the Empire Plan is subject to New York's Surprise Bill Law or is instead required to follow the federal law. As DCS has explained in its state-court motion to dismiss, which United incorporates in full (*see* Geercken Decl., Ex. 3), the Surprise Bill Law applies only to entities that fall within the definition of "health care plans." NY Fin. Servs. Law § 605. "As a governmental self-funded insurance plan, the Empire Plan fits into none of the five definitions of health care plan set forth in the Surprise Bill Law." Geercken Decl., Ex. 3 at 9–10.

LIA nonetheless contends that the Empire Plan is required to follow the Surprise Bill Law because the law authorizing the Empire Plan to provide benefits directly to plan participants (Civil Service Law § 162) states that the Empire Plan should comply with "applicable insurance law." Civil Service Law § 162(1)(b)(iv); Compl. ¶ 81. But the Surprise Bill Law, by its plain terms, is not an "applicable insurance law." As DCS has explained in the state action, "Civil Service Law

§ 162 does not reference, either directly or indirectly, the Surprise Bill Law, much less mandate that the [E]mpire Plan comply with the Surprise Bill Law." Geercken Decl., Ex. 3 at 9. Moreover, as "the State agenc[y] charged with interpreting and administering the laws at issue in this case, including the Surprise Bill Law," this Court and the New York Supreme Court should defer to DCS's interpretation so long as it "is not irrational or unreasonable." *Kurcsics v. Merchants Mut. Ins. Co.*, 49 N.Y.2d 451, 459 (1980). DCS's interpretation is the opposite of irrational; it is text-based and correct.

III. LIA'S ANTITRUST CLAIMS FAIL BECAUSE LIA DOES NOT PLEAD ANTITRUST INJURY.

If the Court reaches the merits of LIA's antitrust claims, it should dismiss them because LIA does not plead "antitrust injury." *Mahmud v. Kaufmann*, 607 F. Supp. 2d 541, 554 (S.D.N.Y. 2009).

Federal and state antitrust statutes were enacted to protect competition, but "they are not general prohibitions of all types of activity which may result in economic harm to any individual." *Assocs. Cap. Serv. Corp. of New Jersey v. Fairway Private Cars, Inc.*, 590 F. Supp. 10, 13 (E.D.N.Y. 1982). Thus, to state a claim under the antitrust laws, the plaintiff must show that the challenged conduct has resulted in an "antitrust injury"—that is, "injury of the type the antitrust laws were intended to prevent and that flow from that which makes defendants' acts unlawful." *Balaklaw*, 14 F.3d at 797 (quoting *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 489 (1977)). "The antitrust injury requirement obligates a plaintiff to demonstrate . . . that the challenged action has had an *actual* adverse effect on competition as a whole in the relevant market." *Bologna v. Allstate Ins. Co.*, 138 F. Supp. 2d 310, 319 (E.D.N.Y. 2001) (emphasis in the original). It "will not suffice" to sustain an antitrust injury if a plaintiff only "prove[s] it has been harmed as an individual competitor." *Id.* Upholding that pleading requirement helps to ensure that

antitrust laws do not "become a treble-damages sword rather than the shield against competition-destroying conduct that Congress meant them to be." *NicSand, Inc. v. 3M Co.*, 507 F.3d 442, 450 (6th Cir. 2007).

LIA alleges that the Empire Plan, "at United's insistence," decided that it is no longer governed by the New York Surprise Bill Law and was instead "governed by the federal No Surprises Act." Compl. ¶ 96. According to LIA, following the federal law allowed the Empire Plan to reimburse for anesthesiology services using the federal QPA, rather than the UCR rate, which in turn negatively affected LIA's revenue. *Id.* ¶¶ 94–95, 134–35. The problem is that LIA "does not assert any facts whatsoever from which an injury *to competition* in the market as a whole can be inferred." *S.O. Textiles Co. v. A & E Prods. Grp.*, 18 F. Supp. 2d 232, 243 (E.D.N.Y. 1998) (emphasis added). Instead, LIA alleges only an injury to itself, which "will not suffice." *Bologna*, 138 F. Supp. 2d at 319.

"Antitrust law in the healthcare setting focuses on protecting patients from prices that are too high." *Anesthesia Assocs. of Ann Arbor, PLLC v. Blue Cross Blue Shield of Mich.*, 2021 U.S. Dist. LEXIS 174021, at *21 (E.D. Mich. Sept. 14, 2021). Although LIA alleges that the relevant market is "the provision of medically necessary anesthesia services to patients" (Compl. ¶ 152), "[f]rom the consumers' point of view, nothing about the market has changed." *Balaklaw*, 14 F.3d at 798. This case resembles *Anesthesia Associates of Ann Arbor*, where an anesthesiology practice alleged that the state's largest insurance provider (Blue Cross Blue Shield of Michigan) conspired with a hospital system to reduce the reimbursement rates for anesthesiology services. 2021 U.S. Dist. LEXIS 174021, at *1–2. The court dismissed the plaintiff's antitrust claims, observing that "[i]t is not altogether clear . . . how insisting on low reimbursement rates results in a cognizable antitrust injury . . . ." *Id.* at *25. The same is true here. There is not a single allegation indicating

that consumers are, or will soon be, forced to pay more for anesthesiology services because of the challenged reimbursements. On the contrary, it is far more plausible that consumer costs will increase if their health plans are required to remit inflated reimbursements to out-of-network physicians.

LIA also fails to allege that consumers lack access to medically necessary anesthesia services or that the quality of care has declined. *See Mahmud*, 607 F. Supp. 2d at 556 (finding no antitrust injury where the was no indication that patients "received inferior emergency cardiac care because of defendants' actions" nor that "the price of emergency cardiac care services has increased" due to defendants' actions); *Mathews v. Lancaster Gen. Hosp.*, 883 F. Supp. 1016, 1045 (E.D. Pa. 1995), *aff'd*, 87 F.3d 624 (3d Cir. 1996) (finding no antitrust injury and holding that "[f]rom the standpoint of the consumer, there [was] no meaningful change in the market" where "orthopedic services [were] still readily available from a large . . . number of providers"). At most, LIA offers speculative allegations of what *might* happen if the Empire Plan continues applying the federal QPA, alleging that some anesthesiologists "*will be* forced to go out of business or dramatically curtail their services" or "*will be* severely hampered in their ability to recruit and retain" physicians. Compl. ¶¶ 135–37 (emphasis added). Those allegations are "too speculative to satisfy the pleading-stage inquiry for antitrust standing." *Anesthesia Assocs.*, 2021 U.S. Dist. LEXIS 174021, at *36 (rejecting allegations that reduced reimbursement rates would drive anesthesiologist out of business). Without concrete factual allegations, it is implausible that a single health plan's decision to follow the federal reimbursement methodology for a limited category of "surprise" bills would drive an entire sector of medical services out of business.

And perhaps most important, LIA's complaint is devoid of any allegations suggesting that anesthesiologists are unable to compete. Although LIA alleges that its individual reimbursement

rates have fallen, "[f]rom the standpoint of the providers of anesthesiology services, the market remains . . . unaltered." *Balaklaw*, 14 F.3d at 799. LIA and other anesthesiologists are free to negotiate a participation agreement with the Empire Plan, and they are likewise free to compete for admitting privileges at Good Samaritan Hospital and other hospitals. There is no "foreclosure of competition" in the relevant market for the provision of anesthesiology services, "and consequently, [there is] no antitrust injury." *Id.*; *see also Korshin v. Benedictine Hosp.*, 34 F. Supp. 2d 133, 138 (N.D.N.Y. 1999) (holding that anesthesiologist did not allege antitrust injury where there were "no indications that [the plaintiff] and other anesthesiologists [were] excluded, or substantially limited, in the broader market for employment"). "Without any allegation as to how market-wide competition will be affected, the complaint fails to allege a claim on which relief may be granted." *Korshin*, 34 F. Supp. 2d at 138–39.

IV. LIA FAILS TO ALLEGE A PLAUSIBLE AGREEMENT TO SUPPORT ITS ANTITRUST CONSPIRACY CLAIMS (COUNTS I AND IV).

Defendants charged with violating Sherman Act Section 1 or the Donnelly Act[3] "are entitled to know how they are alleged to have conspired, with whom, and for what purpose." *In re SSA Bonds Antitrust Litig.*, 2020 U.S. Dist. LEXIS 54000, at *22 (S.D.N.Y. Mar. 18, 2020). To satisfy that requirement, a plaintiff must, as a threshold matter, "allege enough facts to support the inference that a conspiracy actually existed." *Mayor & Council of Balt. v. Citigroup, Inc.*, 709 F.3d 129, 136 (2d Cir. 2013); *see also Twombly*, 550 U.S. at 555–56 (antitrust allegations must contain "enough factual matter (taken as true) to suggest that an agreement was made"). That requires factual allegations showing "a unity of purpose, common design and understanding, or a meeting

[3] LIA's Donnelly Act claims rise and fall with its Sherman Act claims because "[t]he standard for a well-pleaded Donnelly Act claim is the same as a claim under Section 1 of the Sherman Act." *Nat'l Gear & Piston, Inc. v. Cummins Power Sys., LLC*, 861 F. Supp. 2d 344, 370 (S.D.N.Y. 2012).

of the minds in an unlawful agreement." *In re Aluminum Warehousing Antitrust Litig.*, 2014 U.S. Dist. LEXIS 121435, at *99 (S.D.N.Y. Aug. 29, 2014). LIA's conspiracy claims fail to satisfy that threshold pleading requirement.

LIA alleges, in conclusory fashion, that there was a "contract, combination, or conspiracy between United and MultiPlan." Compl. ¶ 175. But that allegation constitutes precisely the sort of "labels and conclusions, and a formulaic recitation of the elements of a cause of action" that the Supreme Court has said "will not do." *Twombly*, 550 U.S. at 555; *see also In re SSA Bonds Antitrust Litig.*, 2020 U.S. Dist. LEXIS 54000, at *24 ("A barebones statement of conspiracy without supporting facts is not enough to survive a motion to dismiss."). LIA fails to allege "how [United and MultiPlan] are alleged to have conspired . . . and for what purpose." *Id.* at *22. At most, LIA alleges that United "enlisted MultiPlan to assist it" in communicating with providers. Compl. ¶ 4; *see also id.* ¶ 134 ("United, with the assistance of MultiPlan"), ¶ 141 ("United, aided by MultiPlan"). And then it separately complains that MultiPlan's communications imposed unreasonable demands. *Id.* ¶¶ 125–27. But those allegations do not establish the existence of a conspiracy.

Whatever conspiracy LIA believes existed between United and MultiPlan is, in any event, implausible absent allegations that United or MultiPlan caused the injury for which LIA complains—lower reimbursement rates. LIA's allegations show that the Empire Plan determined that it was subject to the federal No Surprises Act (Compl. ¶¶ 95–100), and the federal IDR process established the QPA-based reimbursement amount. *Id*. ¶ 115. Although LIA alleges that MultiPlan communicated those rates in written settlement offers, it acknowledges that MultiPlan lacked authority to modify the offered amount. *Id.* ¶¶ 126–29. At most, the allegations show that United and MultiPlan adhered to a policy decision made by the Empire Plan. But adherence to a policy,

"without additional factual allegations," is insufficient to adequately allege a conspiracy. *See Relevent Sports, LLC v. Fédération Internationale De Football Ass'n*, 551 F. Supp. 3d 120, 135 (S.D.N.Y. 2021).

Although LIA alleges that the Empire Plan followed the federal law "at United's behest" (Compl. ¶¶ 4, 96, 101), it makes no attempt to connect United's purported recommendation to the alleged conspiracy with MultiPlan. And even if it did, LIA cannot dispute that the Empire Plan had ultimate authority over the decision. An antitrust claim cannot be predicated on a mere recommendation. *Mathews*, 883 F. Supp. at 1038–39, 1042 (holding that plaintiff failed to support "an essential substantive element of a Sherman Act section one claim" where "although [the defendants] had recommended" the complained-of decision, they had no independent authority to make the decision).

V. LIA'S CONSPIRACY CLAIMS (COUNTS I AND IV) DO NOT SATISFY THE RULE OF REASON.

LIA also fails to allege that the unspecified agreement between United and MultiPlan "constituted an unreasonable restraint." *Relevent Sports*, 551 F. Supp. 3d at 128. "Under Section 1, some restraints on trade, such as horizontal agreements to fix prices, are unlawful per se, while others must be evaluated under the so called 'rule of reason.'" *MacDermid Printing Sols. LLC v. Cortron Corp.*, 833 F.3d 172, 181–82 (2d Cir. 2016). LIA's allegations do not describe a horizontal agreement among competitors or any other sort of agreement that could be deemed "'so plainly anticompetitive' that a court can presume them to be unreasonable without further analysis." *Ross v. Am. Express Co.*, 35 F. Supp. 3d 407, 454 (S.D.N.Y. 2014) (citing *Broadcast Music, Inc. v. CBS, Inc.*, 441 U.S. 1, 8 (1979)). Instead, LIA's Section 1 claim must be evaluated under the rule of reason. *Relevent Sports*, 551 F. Supp. 3d at 128. At the motion to dismiss stage, the rule of reason inquiry requires the plaintiff to "identify the relevant market affected by the challenged conduct

and allege an actual adverse effect on competition in the identified market." *Id.* LIA fails to plead facts that satisfy that test.

To identify the relevant market, a plaintiff must allege "both a product market and a geographic market." *Integrated Sys. & Power, Inc. v. Honeywell Int'l, Inc.*, 713 F. Supp. 2d 286, 298 (S.D.N.Y. 2010). For purposes of its Section 1 claim, LIA alleges that the "relevant product market at issue here is the provision of medically necessary anesthesia services to patients." Compl. ¶ 152. That product-market definition fails because LIA makes no attempt to plead it with reference to economic factors, including the rule of reasonable interchangeability and cross-elasticity of demand. *Integrated Sys. & Power*, 713 F. Supp. 2d at 298 ("Dismissal is appropriate where the alleged product market is defined without 'reference to the rule of reasonable interchangeability and cross-elasticity of demand.'").

LIA's geographic market is also defective. "Courts generally measure a market's geographic scope, the 'area of effective competition,' by determining the area in which the seller operates and where consumers can turn, as a practical matter, for supply of the relevant product." *Concord Assocs., L.P. v. Ent. Props. Tr.*, 2013 U.S. Dist. LEXIS 186964, at *45 (S.D.N.Y. Sept. 18, 2013). LIA defines the relevant geographic market as "no larger than the New York metropolitan area, including New York City, Nassau, Suffolk, and Westchester Counties." Compl. ¶ 162. In support, LIA alleges that "most patients are willing to travel, under the best of circumstances, only about 30 minutes for health care services." *Id.* ¶ 161. But LIA fails to allege why the market should be limited to an obscurely drawn "New York metropolitan area" when LIA provides services throughout the state. *See id.* ¶¶ 24 ("In addition to its diverse practice at Good Samaritan [hospital in West Islip, New York] LI Anesthesia additionally provides anesthesia services at physician offices and surgery centers around New York and Long Island."). More

importantly, LIA fails to explain why Empire Plan members, who are likewise located throughout the state, would turn only to the New York metropolitan area for alternative sources of medically necessary anesthesiology services. *See* Compl. ¶¶ 64, 68 ("Many New York state residents are covered by the Empire Plan."). LIA's attempt to constrict the market to the New York metropolitan area is arbitrary and inconsistent with economic realities. *See, e.g.*, *Mathias v. Daily News, L.P.*, 152 F. Supp. 2d 465, 483 (S.D.N.Y. 2001) (dismissing Sherman Act Section 1 claim where plaintiff's allegations concerning the geographic market were contradictory, specifically where it advanced a narrow "tri-state area" market while simultaneously alleging facts suggesting a broader, U.S. market).

LIA's antitrust claims under Section 1 are also deficient because LIA does not sufficiently plead that the "alleged restraint harmed competition in [the] proposed market." *Mooney v. AXA Advisors, L.L.C.*, 19 F. Supp. 3d 486, 502 (S.D.N.Y. 2014). A plaintiff may plead harm to competition by plausibly alleging an actual adverse effect on competition or "indirectly by establishing that [Defendants] had sufficient market power to cause an adverse effect on competition." *Id.* LIA's allegations fail to satisfy either approach.

First, LIA fails to plead any actual harm to competition "such as increases in price or decreases in output or quality." *U.S. Elecs. v. Directed Elecs.*, 2007 U.S. Dist. LEXIS 118438, at *15 (S.D.N.Y. Apr. 10, 2007). LIA's allegations that anesthesia practices "*will be* forced to go out of business" or "*will be* severely hampered in their ability to recruit and retain" physicians (Compl. ¶¶ 135–37) are mere speculation about what *may* happen in the future. But "[t]o prove an *actual* adverse effect on price, a plaintiff must show just that—that prices actually increased." *MacDermid Printing Sols.*, 833 F.3d at 184. The same would also be true if the plaintiff wishes to show a decrease in output or quality. *Id*. LIA, however, offers no allegations suggesting that even

one anesthesiologist has closed its doors or stopped practicing because the Empire Plan is following federal law. *See Ulrich v. Moody's Corp.*, 2014 U.S. Dist. LEXIS 145898, at *91 (S.D.N.Y. Mar. 31, 2014) (dismissing plaintiff's Section 1 claim where plaintiff asserted that the "alleged agreement has harmed competition . . . generally, but fail[ed] to back up [the] assertion with any facts").

Second, LIA's allegations are insufficient to establish a harm to competition indirectly because LIA has failed to plead facts showing that Defendants have "sufficient market power to cause an adverse effect on competition" in the proposed market.[4] *Mooney*, 19 F. Supp. 3d at 502. LIA defines the relevant market for purposes of its Section 1 claim as the "provision of medically necessary anesthesia services to patients." Compl. ¶ 152. But neither United nor MultiPlan participates in the market for the provision of medically necessary anesthesiology services, so neither could possibly have market power to restrain competition in that market. *See Ross*, 35 F. Supp. 3d at 455. ("To prevail under the rule of reason analysis, plaintiffs must show that the defendant conspirators have 'market power' in a particular market for goods or services.").

Instead, LIA appears primed to argue that United has market power because a sister company (OptumCare) owns and operates medical practices that employee anesthesiologists. Compl. ¶¶ 39–55. But LIA pleads no facts that would justify disregarding the corporate distinction between United and OptumCare. In *Wisconsin v. Indivior Inc. (In re Suboxone (Buprenorphine Hydrochloride & Naloxone) Antitrust Litig.)*, the Eastern District of Pennsylvania considered and rejected a similar attempt by a plaintiff to impute a sister company's market power to a defendant.

[4] "Market power is defined as the ability to raise price significantly above the competitive level without losing all of one's business and may be shown by evidence of specific conduct indicating the defendant's power to control prices or exclude competition or by evidence of market share." *U.S. Elecs.*, 2007 U.S. Dist. LEXIS 118438, at *17–18 (citations and internal marks omitted).

2017 U.S. Dist. LEXIS 171322, at *31 (E.D. Pa. Oct. 16, 2017). The court reasoned that the complaint did "not contain a single allegation from which [it could] reasonably infer that [one company] exercised any control or pervasive domination over [its sister company]." *Id.* The court held that "[a]bsent such control, or at least some showing that the companies were alter egos, [one sister company's] market power cannot be attributed to [the other]." *Id.* at *31–32. The same is true here. OptumCare is neither a parent nor subsidiary of United, and LIA does not allege that United exercised any control over OptumCare or vice versa. The two entities are related only because both share the same ultimate parent. *See* Compl. ¶ 45. That is not enough. *See In re Suboxone*, 2017 U.S. Dist. LEXIS 171322, at *31.

And yet, even if OptumCare's employment of anesthesiologists were considered, LIA's allegations do not show that OptumCare has sufficient market power to satisfy the rule of reason. LIA alleges that OptumCare employs roughly 50 anesthesiologists in the New York metropolitan area (Compl. ¶ 54), but never specifies what that equates to from a market share perspective. There is a good reason LIA is silent on that score. The U.S. Bureau of Labor Statistics suggests that there are nearly 3,000 anesthesiologists in New York. *See* U.S. BUREAU OF LABOR STATISTICS, *Occupational Employment and Wages, May 2021, 29-1211, Anesthesiologists*, https://www.bls.gov/oes/current/oes291211.htm (last visited Sept. 26, 2022).[5] The New York State Society of Anesthesiologists states that it represents "approximately 4,300 New York anesthesiologists." The New York State Society of Anesthesiologists, Inc., *What is the NYSSA?*,

[5] The Court can judicially notice U.S. Bureau of Labor statistics. *See, e.g.*, *Mathews v. ADM Milling Co.*, 2019 U.S. Dist. LEXIS 97564, at *10 (W.D.N.Y. June 11, 2019) ("As the statistical evidence from the Bureau of Labor offered by Plaintiff comes from the official website of the U.S. Department of Labor, the Court could take judicial notice of it.").

https://www.nyssa-pga.org/ (last visited Sept. 26, 2022). If those estimates are accurate, then OptumCare's market share may be as little as 1% (or less).

The Supreme Court has concluded that a defendant with a 30% share of the market lacks sufficient market power for an antitrust violation. *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 26–27 (1984). It goes without saying that a market share below 1% is insufficient. *See Bookhouse of Stuyvesant Plaza, Inc. v. Amazon.com, Inc.*, 985 F. Supp. 2d 612, 622 (S.D.N.Y. 2013) (dismissing Sherman Act Section 1 claim because defendant's market share was only 36%). But this Court doesn't need to resolve OptumCare's exact market share on this motion to dismiss. It is enough that LIA has failed to allege facts to establish showing that OptumCare has market power. Merely alleging that OptumCare employs 50 anesthesiologists in not enough.

VI. LIA FAILS TO ALLEGE PLAUSIBLE SECTION 2 MONOPSONY CLAIMS (COUNTS II AND III).

Through Counts II and III, LIA presses claims under Sherman Act Section 2 for monopsonization (Count II) and attempted monoposonization (Count III). The Supreme Court has described a monopsony as the "mirror image" of a monopoly—but from the "buy side of the market" instead of the "sell side." *Weyerhaeuser Co. v. Ross-Simmons Hardwood Lumber Co.*, 549 U.S. 312, 320–21 (2007). "The kinship between monopoly and monopsony suggests that similar legal standards should apply to claims of monopolization and to claims of monopsonization." *Id.* at 322.

Because LIA has alleged that prices were *too low*, instead of too high, LIA must establish a claim for predatory pricing. *See Atl. Richfield Co. v. USA Petroleum Co.*, 495 U.S. 328, 340 (1990) ("Low prices benefit consumers regardless of how those prices are set, and so long as they are above predatory levels, they do not threaten competition."); *see also Kartell v. Blue Shield*, 749 F.2d 922, 931 (1st Cir. 1984) ("[T]he Congress that enacted the Sherman Act saw it as a way

of protecting consumers against prices that were too *high*, not too low."). Predatory pricing schemes "are rarely tried, and even more rarely successful." *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 589 (1986). That is because, to succeed, a predatory seller must sell its product below marginal costs for long enough "to drive competitors out of business" only to raise prices to supracompetitive levels once competition is vanquished. *Weyerhaeuser*, 549 U.S. at 318; *see also Matsushita*, 475 U.S. at 589 ("The success of any predatory scheme depends on *maintaining* monopoly power for long enough both to recoup the predator's losses and to harvest some additional gain.").

LIA has alleged none of the elements required for a predatory-pricing claim—including that United's reduced reimbursement rates required it to incur a short-term loss with a "dangerous probability of recouping its investment" by raising costs after driving away competition. *Brooke Grp. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 222–24 (1993); *see also Anesthesia Assocs. of Ann Arbor*, 2021 U.S. Dist. LEXIS 174021, at *27–28 (rejecting predatory-bidding theory because plaintiff "does not plausibly plead that low reimbursement rates incur short-term losses for Defendant"); *Weyerhaeuser*, 549 U.S. at 323 ("A predatory-bidding scheme requires a buyer of inputs to suffer losses today on the chance that it will reap supracompetitive profits in the future.").

But there is an even more fundamental problem with LIA's claim. Because LIA is asserting a "monopsony" claim instead of a "monopoly" claim, the predatory theory must be reversed. The Supreme Court has held that predatory behavior by a monopsonist requires allegations that the defendant *overpaid* for the good or service—not that it paid too little. *Weyerhaeuser*, 549 U.S. at 323–24. Relying on *Weyerhaeuser*, courts have rejected predatory monopsony theories on allegations resembling those here, including in cases by anesthesiologists complaining about

reduced reimbursements. In *Anesthesia Associates of Ann Arbor*, the court dismissed an anesthesiology practice's monopsony claim, observing that the plaintiff had mixed up the standards and inappropriately alleged that the defendant "[was] using its buying power to keep the price of inputs—anesthesia services—*down*" instead of overpaying to disrupt competition. 2021 U.S. Dist. LEXIS 174021, at *27. For the same reasons, LIA's monopsony claim makes no sense and does not resemble any liability theory ever recognized by the Supreme Court.

LIA's monopsony claim also fails because LIA fails to allege facts establishing "the possession of [monopsony] power in the relevant market." *Sitts v. Dairy Farmers of Am., Inc.*, 417 F. Supp. 3d 433, 476 (D. Vt. 2019) (quoting *PepsiCo, Inc. v. Coca-Cola Co.*, 315 F.3d 101, 105 (2d Cir. 2002)) (alterations in original). For its Section 1 claims, LIA defined the relevant market as the market for "the provision of medically necessary anesthesia services to patients" (Compl. ¶ 152) in "the New York metropolitan area" (Compl. ¶ 162). But for its Section 2 claims, LIA abandons its service-provider market definition and, instead, asserts that "United possesses monopsony power in the market for the *reimbursement* of anesthesia services in the New York metropolitan area." Compl. ¶ 189 (emphasis added). LIA's allegations fail to show that United has monopsony power in that new "reimbursement" market for several reasons.

First, other than a single conclusory allegation parroting the elements of its Section 2 claims, LIA fails to allege facts to support a "reimbursement" product market. The reimbursement market is not set forth in LIA's "summary of antitrust allegations" or the "relevant product market" sections of its complaint (Compl. ¶¶ 152–59), nor are there any other places in the complaint where LIA attempts to define a reimbursement market with reference to economic considerations. *Chapman v. N.Y. State Div. for Youth*, 546 F.3d 230, 238 (2d Cir. 2008) ("Where the plaintiff fails to define its proposed relevant market with reference to the rule of reasonable interchangeability

and cross-elasticity of demand . . . , the relevant market is legally insufficient and a motion to dismiss may be granted.").

Second, as with its "provision of medically necessary anesthesiology services" market, LIA fails to justify its decision to restrict the geographic scope of its reimbursement market to the New York metropolitan area. When describing the healthcare-provider for its Section 1 claims, LIA at least tried to link the geographic boundaries to the distance that patients are willing to travel for medical care. But that limitation does not work for a reimbursement market. The Empire Plan provides reimbursements statewide and payors from outside New York routinely reimburse for anesthesia services provided in the state. LIA offers no reason the market should be limited to the area where LIA practices. *Discon Inc. v. NYNEX Corp.*, 86 F. Supp. 2d 154, 162 (W.D.N.Y. 2000) ("The Supreme Court has expressly held that political boundaries, such as state and municipal boundaries, cannot be used artificially to circumscribe a relevant market, because relevant markets are defined in terms of economic realities."). LIA's geographic market definition should be rejected because it is "arbitrary, irrational and not supported by competent [allegations]." *Id.*

Third, LIA cannot show that United has market power in a reimbursement market because it does not allege that United competes in that market. The reimbursements at issue are funded by DCS, the Empire Plan's sponsor. Compl. ¶ 4. LIA alleges that United serves as the "program administrator," but does not allege that it reimburses LIA for the services at-issue in this case. Compl. ¶¶ 1, 13, 64, 67, 171. Absent allegations showing that United is responsible for setting the rates and funding the reimbursements that LIA is challenging, the Section 2 claims must be dismissed. *See Discon, Inc. v. NYNEX Corp.*, 93 F.3d 1055, 1062 (2d Cir. 1996) ("Discon's claim of monopolization must fail, since it is axiomatic that a firm cannot monopolize a market in which it does not compete.").

Fourth, LIA's allegations are insufficient to show that United has monopsony power even if we accept LIA's arbitrary market definition. LIA clutters its complaint with statistics without linking those statistics to its defined market. For example, LIA alleges that "UnitedHealthcare" (which is not limited to the named defendant entity) has a 26% share among "health care insurers (all products)" in the "New York-Newark-Jersey City, NY-NJ-PA Metropolitan Statistical Area" (Compl. ¶¶ 62, 170); a 66% share in that same area "[f]or point-of-service products" (*id.*); and a 50% share "of commercial insurers in the New York City market (defined as Suffolk, Nassau, Queens, Kings, Richmond, New York, Bronx, Westchester, Putnam, and Rockland Counties" (*id.* ¶ 63). But LIA never explains which, if any, of those statistics matters to the analysis. None appears tethered to the named United entity, the market for the "reimbursement of anesthesia services" (as opposed to the general commercial insurance market), or the precise geographic boundaries selected by LIA.

Finally, even if LIA's statistics were on point, "[a] high market share alone . . . is insufficient to infer . . . market power if other characteristics of the product market, such as low barriers to entry, high cross elasticity of demand, or technological developments in the industry, interfere with the [buyer's] control of prices." *Kaufman v. Time Warner*, 836 F.3d 137, 143 (2d Cir. 2016). Here, LIA concedes that the reimbursement rates the Empire Plan charges will ultimately be dictated by the IDR process (whether state or federal). Although there is a legal dispute about which law controls, LIA offers no allegations that United has control over prices. *See, e.g.*, *Crossword Magazine v. Times Books*, 1997 U.S. Dist. LEXIS 21606, at *7–8 (E.D.N.Y. May 5, 1997) (dismissing complaint where plaintiff "pleaded no facts indicating that [defendant] has the power to fix prices or exclude competition in the alleged relevant market").

VII. LIA'S UNJUST ENRICHMENT CLAIM FAILS FOR MYRIAD REASONS.

LIA's unjust enrichment claim (Compl. ¶¶ 204–09) fails for three independent reasons. *First*, courts hold that unjust enrichment claims do "not comply with the relevant pleading standards" where, as here, the plaintiff "plead[s] federal antitrust claims and the [alleged] factual foundation for them, and then merely allege[s] that those claims are also actionable as unjust enrichment." *Mosaic Health Inc. v. Sanofi-Aventis U.S., LLC*, 2022 U.S. Dist. LEXIS 159137, at *23 (W.D.N.Y. Sept. 2, 2022). That is all that LIA does here.

Second, the unjust-enrichment claim is "unnecessary and duplicative" because it will "rise and fall with [LIA's antitrust] claims." *In re Novartis & Par Antitrust Litig.*, 2019 U.S. Dist. LEXIS 138133, at *25 (S.D.N.Y. Aug. 14, 2019); *see also Koenig v. Boulder Brands, Inc.*, 995 F. Supp. 2d 274, 291 (S.D.N.Y. 2014).

Third, LIA does not plead that it conferred a benefit on United or Multiplan, a necessary element of unjust enrichment. *Prescient Acquisition Grp., Inc. v. MJ Publ'g Tr.*, 2006 U.S. Dist. LEXIS 52879, at *14 (S.D.N.Y. July 31, 2006) ("To establish a viable cause of action for unjust enrichment . . . in New York, a plaintiff must allege that it '(1) conferred a benefit upon the defendant and (2) that the defendant will obtain such benefit without adequately compensating the plaintiff therefor.'"). At most, LIA alleges that "Defendants were enriched by receiving fees and retaining reimbursement." Compl. ¶ 205. But LIA does not allege that it paid any fee to United, or that United was entitled to any undistributed reimbursement payments. On the contrary, LIA provided anesthesiology services to the Empire Plan's members (not to United), and the payments it received were funded by the Empire Plan (not United).

CONCLUSION

For the foregoing reasons, the Court should dismiss LIA's Complaint with prejudice.

Dated: October 10, 2022

ALSTON & BIRD LLP

/s/ Karl Geercken

Karl Geercken
90 Park Avenue
New York, New York 10016
(212) 210-9400
karl.geercken@alston.com

Brian D. Boone (*pro hac vice* pending)
Emily McGowan (*pro hac vice* pending)
ALSTON & BIRD LLP
101 S. Tryon Street, Suite 4000
Charlotte, NC 28280
(704) 444-1000
brian.boone@alston.com
emily.mcgowan@alston.com

D. Andrew Hatchett (*pro hac vice* pending)
Jordan Edwards (*pro hac vice* pending)
ALSTON & BIRD LLP
1201 W. Peachtree Street
Atlanta, GA 30309
(404) 8811-7000
andrew.hatchett@alston.com
jordan.edwards@alston.com

Attorney for Defendant UnitedHealthcare Insurance Company of New York

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

LONG ISLAND ANESTHESIOLOGISTS PLLC, Plaintiff, vs UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM and MULTIPLAN INC., Defendants.	Index No. 2:22-cv-04040 Hon. Hector Gonzalez

DECLARATION OF KARL GEERCKEN

I, KARL GEERCKEN, hereby declare, pursuant to 28 U.S.C. § 1746, under penalty of perjury that the following is true and correct:

1. I am a partner with the law firm of Alston & Bird LLP. I represent UnitedHealthcare Insurance Company of New York ("United") in the above-captioned case.

2. I submit this declaration in support of United's Motion to Dismiss.

3. I have personal knowledge of the matters set forth herein and could and would competently testify thereto if called to do so.

4. Attached as Exhibits to this Declaration are true and correct copies of the following documents cited in United's Memorandum Supporting its Motion to Dismiss, all of which are public filings submitted in *Wayne Joseph et al. v. Rebecca Corso et al.*, No. 902227-22 (N.Y. Sup. Ct.):

Exhibit	Description
1	Complaint, *Wayne Joseph et al. v. Rebecca Corso et al.*, No. 902227-22 (N.Y. Sup. Ct. Mar. 28, 2022), Dkt. No. 2.

Exhibit	Description
2	Affidavit of Daniel Yanulavich, *Wayne Joseph et al. v. Rebecca Corso et al.*, No. 902227-22 (N.Y. Sup. Ct. Aug. 31, 2022), Dkt. No. 72.
3	Memorandum of Law in Support of Defendants' Motion to Dismiss, *Wayne Joseph et al. v. Rebecca Corso et al.*, No. 902227-22 (N.Y. Sup. Ct. Aug. 31, 2022), Dkt. No. 69.
4	Affirmation of John Powell, *Wayne Joseph et al. v. Rebecca Corso et al.*, No. 902227-22 (N.Y. Sup. Ct. June 3, 2022), Dkt. No. 70.

Dated: October 10, 2022
New York, New York

/s/ Karl Geercken
Karl Geercken

EXHIBIT 1

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ALBANY

Index No. _____/2022

WAYNE JOSEPH; THOMAS COTTONE, SONYA HWANG COTTONE: LORETTA POST; LONG ISLAND ANESTHESIOLOGISTS, PLLC; LONG ISLAND ANESTHESIA PHYSICIANS, LLP.; NEW YORK CARDIOVASCULAR ANESTHESIOLOGISTS, P.C.; SUFFOLK ANESTHESIOLOGY ASSOCIATES, P.C.; ADVANCED PLASTIC SURGERY OF LONG ISLAND, PLLC.; DA MEDICAL SERVICES PLLC; DA SILVA PLASTIC & RECONSTRUCTIVE SURGERY, P.C.; HAND ASSOCIATES OF LONG ISLAND, P.C.; ISLANDWIDE SURGICAL, P.C.; K. JACOB COHEN-KASHI, M.D. & LAWRENCE C. LIN, MD, PLLC; LISA CORRENTE, M.D., P.C.; LONG ISLAND NEUROSURGICAL & PAIN SPECIALISTS, PLLC; LONG ISLAND THORACIC SURGERY, P.C.; MONTAUK MEDICAL ASSOCIATES PLLC.; PERFORMANCE MEDICAL PRACTICE PLLC; SAGTIKOS MEDICAL SERVICES, P.C.; SPINE MEDICAL SERVICES, PLLC; and UNITED MEDICAL MONITORING, P.C.,

Plaintiffs,

vs

REBECCA CORSO, as Acting Commissioner, NEW YORK STATE DEPARTMENT OF CIVIL SERVICE; UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM; and ADRIENNE A. HARRIS, as Superintendent, NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES,

Defendants.

COMPLAINT

Plaintiffs, Wayne Joseph, Thomas Cottone, Sonya Hwang Cottone, Loretta Post,; Long Island Anesthesiologists, PLLC; Long Island Anesthesia Physicians, LLP.; New York Cardiovascular Anesthesiologists, P.C.; Suffolk Anesthesiology Associates, P.C.; Advanced

Plastic Surgery of Long Island, PLLC.; DA Medical Services PLLC; Da Silva Plastic & Reconstructive Surgery, P.C.; Hand Surgery Associates of Long Island, P.C.; Islandwide Surgical, P.C.; K. Jacob Cohen-Kashi, M.D. & Lawrence C. Lin, MD, PLLC; Lisa Corrente, M.D., P.C.; Long Island Neurosurgical & Pain Specialists, PLLC.; Long Island Thoracic Surgery, P.C.; Montauk Medical Associates PLLC; Performance Medical Practice PLLC; Sagtikos Medical Services, P.C.; Spine Medical Services, PLLC; and United Medical Monitoring, P.C., by their attorneys, Harris Beach PLLC, for their Complaint against the Defendants, Rebecca Corso, as Acting Commissioner, New York State Department Of Civil Service; UnitedHealthcare Insurance Company Of New York Inc., as Program Administrator, The Empire Plan Medical/Surgical Program; and Adrienne A. Harris, as Superintendent, New York State Department of Financial Services, allege as follows:

PRELIMINARY STATEMENT

1. As the health benefit plan for New York public employees and their dependents, the Empire Plan is one of the largest health plans in New York, with over 1.2 million enrollees. It funds and provides health benefits directly to those enrollees, using UnitedHealthcare as its Medical/Surgical Program plan administrator. The state agency responsible for overseeing the Plan is the Department of Civil Service. Put simply, the Empire Plan plays a vital role in ensuring the health, safety, and well-being of the hundreds of thousands of New Yorkers who protect us, teach us, move us, lead us, and keep the Empire State running. Particularly during these last two years of a global pandemic, the Empire Plan is a cornerstone of New York's health care system.

2. The Legislature first permitted the Empire Plan to provide health benefits directly to enrollees using the state's funds in 2010. At the same time, the Legislature through Civil Service Law § 162 directed the Plan to comply with all New York insurance laws and be subject to state

regulation, which currently is provided by the Department of Financial Services. In the Legislature's view, the state regulation mandated by Civil Service Law § 162 is vital to ensure that New York public employees and their dependents receive the high-quality health care they so justly deserve.

3. Since inception, the Empire Plan has been designed to provide its enrollees with broad access to the best physicians this state has to offer, regardless of whether those physicians are in the Plan's network, or out-of-network. Historically, the Empire Plan has reimbursed out-of-network physicians at the Usual, Customary, and Reasonable (UCR) rates, approximating those set by the state-sanctioned FAIR Health© benchmarking database. The Empire Plan also reimbursed in full covered services provided by out-of-network radiologists, anesthesiologists, and pathologists at in-network hospitals.

4. This broad coverage was furthered in March 2015 when the New York Emergency Medical Services and Surprise Bills Act (the "Surprise Bill Law") became effective.[1] The Surprise Bill Law applies to all fully insured health coverage in New York and, through Civil Service Law § 162, to the Empire Plan.

5. Accordingly, out-of-network physicians had the ability, for interactions that met the surprise bill or emergency services criteria, to submit a reimbursement dispute to a state independent dispute resolution (IDR) entity, which was required to consider the FAIR Health benchmarking database when determining the reasonable fee. This ensured that out-of-network physicians were regularly reimbursed near the UCR rate.

[1] Financial Services Law §§ 601-08.

6. In December 2020, Congress enacted the No Surprises Act,[2] which took effect on January 1, 2022. The Act establishes a federal IDR process to determine the out-of-network rate in certain circumstances when a "specified state law" does not apply. New York's Surprise Bill Law constitutes a "specified state law" under the No Surprises Act because, for health plans and circumstances governed by it, the Surprise Bill Law has a method for determining the fairness of amounts payable to out-of-network physicians.

7. Thus, health plans and circumstances covered by the Surprise Bill Law, that Surprise Bill Law, and not the No Surprises Act, governs the reimbursement of out-of-network physicians. The Department of Financial Services itself has recognized this in its Circular Letter No. 10.[3]

8. Starting in January 2022, however, the Empire Plan unilaterally determined itself no longer subject to New York insurance law or Department of Financial Services' regulation. Consequently, the Empire Plan considers itself no longer obligated to reimburse out-of-network physicians at the long-standing UCR rates used in New York. As a result, starting in 2022, Empire Plan unilaterally cut reimbursement to out-of-network physicians by more than 80%.

9. Historically, when a state-regulated health plan failed to reimburse an out-of-network physician at the proper UCR rate, the physician could file a complaint with the Department of Financial Services. If a surprise or emergency services bill was involved, the physician could also submit the dispute as a New York IDR per the Surprise Bill Law.

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[2] Consolidated Appropriations Act, 2021 (Public Law 116-260; Division BB, § 109).

[3] "Since New York has a specified state law, the New York IDR process will continue to apply to out-of-network emergency services and surprise bills."

10. Since January, however, the Empire Plan has responded to Department of Financial Services' complaints made by out-of-network physicians by contending that it is no longer subject to that agency's regulation. The Empire Plan also has responded to New York IDR proceedings by contending its reimbursements are no longer reviewable on the state level.

11. The Empire Plan also is attempting to persuade the federal Centers for Medicare and Medicare Services that it is not legally subject to the Surprise Bill Law and, therefore, the No Surprises Act exclusively applies to its out-of-network reimbursement procedures.

12. As we explain in detail below, the Empire Plan cannot prevail in these efforts to override Civil Service Law § 162 by unilaterally declaring itself no longer subject to state law or regulation. Civil Service Law § 162 specifically and unambiguously mandates that the Empire Plan's actions "shall be subject to review by the superintendent of financial services for the purposes of ensuring compliance with applicable insurance law and any and all associated insurance rules and regulations as noted in this subdivision" (*id.*).

13. Accordingly, the Empire Plan's actions are illegal and must cease immediately. The Empire Plan also must comply with Civil Service Law § 162 by confirming it remains subject to state insurance law and Department of Financial Services' regulation, including the Surprise Bill Law.

14. Judicial intervention here is sorely needed because the Empire Plan's illegal actions are causing substantial and irreparable harm. If these actions do not immediately cease, thousands of high-quality, well-respected out of network physician practices that provide medically necessary surgical and specialty medical services to Plan enrollees will go out of business or drastically curtail their services. Those that survive in the short run will be severely hampered in

their ability to recruit and retain high quality recently trained physicians or acquire new medical equipment and information systems, causing New York to lose its' status as a center for high-quality, innovative medical care. The current accessibility of quality medical care available to Empire Plan's 1.2 million enrollees will be severely impacted, and irreparably so for those patients that require such care now.

15. Empire Plan's actions will disrupt longstanding relationships that its enrollees have with their chosen out-of-network physicians. In many instances, these physicians have treated enrollees' and their families for years and have managed their unique medical conditions. All of this will be lost due to Empire Plan's unilateral actions, thereby jeopardizing the health and well-being of New York's public employees and their dependents, as well as the New York health system generally, during these very stressful times.

16. Additionally, the Empire Plan's illegal actions will directly and significantly impact the availability of emergency medical services at hospitals throughout the state. Many hospitals depend on out-of-network physicians to "take call" and come into hospitals in order to provide emergency care. Right now, many of the specialists in the state who provide such emergency care are out-of-network. Thus, Empire Plan's actions will cause Plan enrollees, and patients in this state as a whole, to lose access to life-saving emergency treatment.

17. For years, a major selling point of public employment in New York has been the Empire Plan's out-of-network benefit, giving enrollees a wide option of high-quality physicians to choose from. Unfortunately, if the Empire Plan's actions are allowed go unchecked, this sadly will no longer be the case.

18. For all these reasons, this Court should grant the requested declaratory judgment that the Empire Plan's unilateral attempt to override Civil Service Law § 162 is illegal, improper, and contrary to law. This Court should also permanently enjoin Defendants from contending to any person or agency that the Empire Plan is not subject to state law or Department of Financial Services regulation and award such other relief that the Court deems proper, including an award of attorneys' fees to Plaintiffs under the Equal Access to Justice Act (CPLR Article 86).

PARTIES

19. Plaintiff Wayne Joseph is an enrollee of the Empire Plan. He resides at 329 Archer Street, Freeport, New York 11520.

20. Plaintiff Thomas Cottone is an enrollee of the Empire Plan. He resides at 1 Evans Lane, Setauket, New York 11733.

21. Plaintiff Sonya Hwang Cottone is an enrollee of the Empire Plan. She resides at 1 Evans Lane, Setauket, New York 11733.

22. Plaintiff Loretta Post is an enrollee of the Empire Plan. She resides at 740 East Broadway, Apt #5A, Long Beach, New York 11561.

23. Plaintiff Long Island Anesthesiologists, PLLC is a New York professional medical limited liability company with an address of 1000 Montauk Highway, West Islip, New York 11795.

24. Plaintiff Long Island Anesthesia Physicians, LLP. is a New York professional medical limited liability company with an address of 333 Route 25A, Suite 225, Rocky Point, New York 11778.

25. Plaintiff New York Cardiovascular Anesthesiologists, P.C. is a New York professional medical corporation with an address of 100 Port Washington Boulevard, Roslyn, New York 11576.

26. Plaintiff Suffolk Anesthesiology Associates, P.C. is a New York professional medical corporation with an address of 50 Route 25A, Smithtown, New York 11787.

27. Plaintiff Advanced Plastic Surgery of Long Island, PLLC is a New York professional medical limited liability company with an address of 1800 Merrick Road, Merrick, New York 11566.

28. Plaintiff DA Medical Services PLLC is a New York professional medical limited liability company with an address of 160 East 56th Street, New York, New York 10022.

29. Plaintiff Da Silva Plastic & Reconstructive Surgery, P.C. is a New York professional medical corporation with an address of 3072 East Jericho Turnpike, Suite 202, East Northport, New York 11731.

30. Plaintiff Hand Surgery Associates of Long Island, P.C. is a New York professional medical corporation with an address at 166 East Main Street, Huntington, New York 11743.

31. Plaintiff Islandwide Surgical, P.C. is a New York professional medical corporation, with an address of 1129 Northern Boulevard, Manhasset, New York 11030.

32. Plaintiff K. Jacob Cohen-Kashi, M.D. & Lawrence C. Lin, MD, PLLC is a New York professional medical limited liability company, with an address of 935 Northern Boulevard, Great Neck, New York 11024.

33. Plaintiff Lisa Corrente, M.D., P.C. is a New York professional medical corporation with an address of 160 East 56th Street, 4th Floor, New York, New York 10022.

34. Plaintiff Long Island Neurosurgical & Pain Specialists, PLLC is a New York professional medical limited liability company, with an address of 1175 Montauk Highway, Suite 6, West Islip, New York 11795.

35. Plaintiff Long Island Thoracic Surgery, P.C. is a New York professional medical corporation, with an address of 444 Merrick Road, Suite 380, Lynbrook, New York 11563.

36. Plaintiff Montauk Medical Associates PLLC. is a New York professional medical limited liability company with an address of P.O. Box 129, Old Westbury, New York 11568.

37. Plaintiff Performance Medical Practice PLLC is a New York professional medical limited liability company with an address of 141 East 56th Street, New York, New York 10022.

38. Plaintiff Sagtikos Medical Services, P.C. is a New York professional medical corporation with an address of 1175 Montauk Highway, Suite 6, West Islip, New York 11795.

39. Plaintiff Spine Medical Services, PLLC is a New York professional medical limited liability company with an address of 140 Adams Avenue, Suite B-13, Hauppauge, New York 11788.

40. Plaintiff United Medical Monitoring P.C. is a New York professional medical corporation with an address of 50 Rose Place, Garden City Park, New York 11040.

41. The above Plaintiff physician practices all provide medically necessary, covered medical services to Empire Plan enrollees.

42. The above Plaintiff physician practice are either out of network for the Empire Plan or have physicians as employees or equity owners who are out of network for the Empire Plan.

43. Defendant Rebecca Corso is Acting Commissioner of the New York State Department of Civil Service. She is also Acting President of the New York State Civil Service Commission.

44. The main office of the New York Department of Civil Service is located at the Alfred E. Smith State Office Building, Albany, New York 12239.

45. Defendant UnitedHealthcare Insurance Company of New York Inc. is the Program Administrator of The Empire Plan Medical/Surgical Program.

46. UnitedHealthcare's New York office is located at 1 Pennsylvania Plaza, New York, New York 10119.

47. Adrienne A. Harris is the Superintendent of the New York State Department of Financial Services.

48. The main office of the New York State Department of Financial Services is One State Street, New York, New York 10004.

FACTS COMMON TO ALL CAUSES OF ACTION

49. Plaintiffs repeat and re-allege the allegations set forth above as if more fully set forth herein.

NYSHIP

50. For decades, state and local government employees in New York have received health coverage through the New York State Health Insurance Program, known as NYSHIP.

51. NYSHIP is a comprehensive health insurance program for New York State public employees that consists of (a) The Empire Plan and (b) NYSHIP-approved health maintenance organizations (HMOs).

52. Currently, NYSHIP protects over 1.2 million State and local government employees, retirees, and their families. It is one of the largest employer-sponsored group health insurance programs in the United States. Approximately 800 local government employers currently offer NYSHIP's Empire Plan to their employees.

53. The Civil Service Law places responsibility for overseeing NYSHIP with the State Department of Civil Service (Civil Service Law §§ 160-79). Section 161 provides, in relevant part, that the Department of Civil Service is "hereby authorized and directed to establish a health benefit plan for state officers and employees and their dependents . . . which, subject to the conditions and limitations contained in this article, and in the regulations of the [Department of Civil Service], will provide for group hospitalization, surgical and medical insurance against the financial costs of hospitalization, surgery, medical treatment and care, and may include, among other things prescribed drugs, medicines, prosthetic appliances, hospital in-patient and out-patient service benefits and medical expense indemnity benefits" (Civil Service Law § 161[1]).

54. Initially, NYSHIP provided health coverage for state and local government employees in New York by purchasing health insurance contracts from heavily state regulated, not-for-profit medical indemnity companies (Civil Service Law § 162[1]).

Civil Service Law § 162

55. In 2010, however the State Legislature granted the Department of Civil Service the authority to do what private sector employers were able to do: "provide health benefits directly to plan participants" using the State's own funds rather than purchasing insurance (Civil Service Law § 162[1][a]).

56. The Legislature did, however, put some important limits on the direct provision of health benefits under Civil Service Law § 162.

57. For example, NYSHIP had to ensure that it provided all health coverage and benefits mandated by state insurance law, rule, or regulation. Civil Service Law § 162(1)(b)(i) provides that "[a]ny and all health insurance coverage mandated by any law, rule or regulation, including but not limited to coverage mandated pursuant to article forty-three of the insurance law, applicable to contracts for health insurance entered into under this section shall be provided in a manner assuring uninterrupted continuance of coverage for all covered persons. For the purposes of this paragraph 'coverage' shall include but shall not be limited to all benefits, services, rights, privileges and guarantees allowed by law" (*id.*).

58. Second, the Legislature stipulated that, if NYSHIP provided direct health benefits rather than purchase insurance, it still would be subject to, and required to comply with, the full range of New York insurance law and regulations (Civil Service Law § 162[1][b][iv]). The statute states: "the provision of direct benefits as per this subdivision shall be subject to review by the superintendent of financial services for the purposes of ensuring compliance with applicable insurance law and any and all associated insurance rules and regulations as noted in this subdivision" (*id.*).

The Empire Plan

59. Based on this statutory authority, NYSHIP created the Empire Plan, which pays for covered hospital services, physicians' bills, prescription drugs and other covered medical expenses of eligible public employees and their dependents. The Empire Plan has contracted with UnitedHealthcare Insurance Company of New York to administer its Medical/Surgical Program.

60. Many New York state residents are covered by the Empire Plan. This is because the Plan covers not only New York state employees and their residents, but also employees and dependents of state-related entities, municipalities (county, town, city, and village), school districts, and special purpose government districts.

61. Historically, the Empire Plan granted its enrollees the freedom to not only receive coverage from participating, in-network physicians, but also from non-participating, out-of-network physicians, such as the Plaintiff physician practices here. This was designed to ensure that New York's public employees had broad access to the finest physicians in the state, regardless of whether those physicians were in network with the Empire Plan or out of network.

62. This "freedom of choice" to obtain covered care from any physician, including out-of-network physicians, has long been a major feature of the Empire Plan and a significant benefit for public employees.

63. Historically, the Empire Plan reimbursed out-of-network physicians for providing covered medical services to Plan enrollees at amounts approximating the usual, customary, and reasonable (UCR) rate for the medical services in the geographic area where the services are provided. (2018 Empire Plan Certificate at 44). A true and correct copy of Empire Plan's 2018 certificate is annexed to this Complaint as Exhibit A and incorporated by reference herein.

64. The UCR rate used by the Empire Plan for out-of-network reimbursement is determined using the benchmarking databases maintained by FAIR Health, established in October 2009 as part of the settlement of an investigation by the Attorney General into conflicts of interest involving UnitedHealthcare[4] involving the adjudication of claims. FAIR Health was formed to create an independent, trusted and transparent source of data to support claims adjudication and to meet the healthcare cost and utilization information needs of all participants in the healthcare community (https://www.fairhealth.org/mission-origin [accessed Mar 13, 2022]).

65. While Empire Plan's standard out-of-network reimbursement rates were based on the FAIR Health-determined UCR, covered services provided by out-of-network radiologists, anesthesiologists, or pathologists at an in-network hospital were reimbursed in full by the Empire Plan. The certificate provides: "If [enrollee] receive[s] anesthesia, radiology or pathology services in connection with covered inpatient or outpatient Hospital services at an Empire Plan Network Hospital and The Empire Plan provides [enrollee's] Primary Coverage, covered charges billed separately by the anesthesiologist, radiologist or pathologist will be paid in full by the Medical/ Surgical Program" (2018 Empire Plan Certificate at 63).

66. As a result of these provisions, Empire Plan enrollees had broad access to the finest out-of-network specialty physicians in the country. They were protected against the large balance bills and surprise bills that many other patients faced when they didn't have the protections that the Empire Plan enrollees had.

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[4] To settle allegations of misconduct with regard to its operation of the Ingenix benchmarking database, UnitedHealthcare contributed $50 million to the creation of FAIR Health Attorney General Cuomo Announces Historic Nationwide Reform Of Consumer Reimbursement System For Out-Of-Network Health Care Charges | New York State Attorney General (ny.gov) [accessed Mar 13, 2022]).

New York Surprise Bill Law

67. This access was furthered in March 2015 when the New York Surprise Bill Law ((Financial Services Law §§ 601-08) became effective. Through Civil Service Law § 162, the Surprise Bill Law also applies to the Empire Plan (Civil Service Law § 162[1][b][iv]).

68. Until January 2022, the Empire Plan was treated as subject to the Surprise Bill Law by all stakeholders, including the Empire Plan itself, the Department of Financial Services, state independent dispute resolution agencies, and out-of-network providers.

69. For example, for each year until 2022, Empire Plan issued Out-of-Network Disclosures to its enrollees, among other things, these Disclosures state: "The Emergency Medical Services and Surprise Bills law requires The Empire Plan to provide information regarding your out-of-network reimbursement, including details on referrals, costs, coverage and surprise bills. . . . [T]he law protects patients from being responsible for paying the full charge for surprise bills and generally applies only to services provided within New York State" (Empire Plan Out-of-Network Disclosures 2020 at 1). A true and correct copy of the Empire Plan Out-of-Network Disclosures for 2020 are annexed to this Complaint as Exhibit B and are incorporated by reference into the Complaint herein.

70. Under the Surprise Bill Law, out-of-network providers, such as the Plaintiff physician practices here, were prohibited from billing patients if the bill would meet the Law's definition of a "Surprise Bill" or was a bill for "Emergency Services" (Financial Services Law § 606[a]).

71. The Empire Plan and other health plans subject to the Surprise Bill Law are required under the Law to reimburse the out-of-network physicians at a "reasonable amount" for their

covered medical services (Financial Services Law §§ 607[a][3] [surprise bills], 605[a][1] [emergency services bills]).

72. Then, if a dispute exists between the health plan and the out-of-network physician as to what is "reasonable reimbursement" for the covered medical services at issues, either party may submit the dispute to the independent dispute resolution (IDR) process established by the Surprise Bill Law (Financial Services Law §§ 607[a][4] [surprise bills], 605[a][2] [emergency services bills]).

73. A qualified independent dispute resolution (IDR) entity then reviews the disputed bills code-by-code and selects either the out-of-network physician's fee or the health plan's payment amount as the "reasonable fee for the services rendered" (Financial Services Law §§ 607[a][6] [surprise bills], 605[a][4] [emergency services bills]).

74. In making its determination as to the reasonable fee for the services rendered, the Surprise Bill Law requires the IDR entity to consider all relevant factors, including "the usual and customary cost of the service" (Financial Services Law § 604[f]).

75. The Department of Financial Service's regulations regarding enforcement of the Surprise Bill Law define "usual and customary cost," as set forth in Financial Services Law § 604(f), as "the 80th percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent, which is not affiliated with a health care plan" (23 NYCRR §400.2[w]).

76. Based on this regulation, the IDR entities use the FAIR Health database when selecting the reasonable fee on a code-by-code basis for the services rendered during the Surprise Bill Law dispute resolution process.

77. Accordingly, at least for those circumstances constituting a surprise bill or an emergency services bill, out-of-network physicians, such as the Plaintiff physician practices, had a remedy if Empire Plan fails to reimburse them near the UCR for covered medical services. Indeed, the Surprise Bill Law in New York has been very effective at protecting consumers from surprise medical bills while allowing for reasonable and fair reimbursement for physicians that see Empire Plan enrollees, thereby securing the continued access of Empire Plan enrollees to their chosen providers regardless of network status.

78. Based on this, up until January 2022, the Empire Plan regularly reimbursed Plaintiff physician practices for covered medical services provided to Plan enrollees at or near the UCR rate.

79. Indeed, the Surprise Bill Law has been publicly lauded for preserving the economic health of high-quality physician practices while also protecting patients against personal liability for unexpected medical bills.[5]

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[5] https://www.dfs.ny.gov/reports_and_publications/press_releases/pr1909173 (accessed Mar. 18, 2022).

No Surprises Act

80. In December 2020, the United States Congress enacted the No Surprises Act, which was signed into law as part of the Consolidated Appropriations Act of 2021 (Public Law 116-260; Division BB § 109) on December 27, 2020. It took effect on January 1, 2022.

81. No Surprises Act § 103 amends 42 U.S.C. §§ 300gg *et seq*. to establish an IDR process for non-emergency services performed by non-participating physicians at in-network hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers and out-of-network emergency services in the emergency department of a hospital or independent freestanding emergency department

82. The No Surprises Act provides that the federal IDR process will apply and may be used by physicians and health plans to determine the out-of-network rate for emergency services in the emergency department of a hospital or independent freestanding emergency department and non-emergency items and services furnished by non-participating providers during a visit to a participating health care facility when a "specified state law" does not apply (42 U.S.C. § 300gg-111).

83. Under 42 U.S.C. § 300gg-111(a)(3)(I), a "specified state law" is a state law that provides for a method of determining the total amount payable in the case of an insured receiving an item or service from a non-participating provider at a participating facility or emergency services in the emergency department of a hospital or independent freestanding emergency department (42 U.S.C. § 300gg-111[a][3][I]).

84. For a state law to determine the amount upon which cost-sharing is based and the out-of-network rate, the state law must apply to: [a] the plan, issuer, or coverage involved; [b] the

non-participating provider or non-participating emergency facility involved; and [c] the item or service involved. (42 U.S.C. § 300gg-111).

85. When a state has a specified state law, that state law and state IDR process, rather than the federal IDR process, will apply and the amount upon which cost-sharing is based and the out-of-network rate for emergency and non-emergency services subject to surprise billing protections are calculated based on such specified state law (*id.*).

86. The No Surprise Act specifically deferred to state law, when there was one, precisely because its drafters recognized that states have differing and unique health care systems and applicable state laws might therefore be more effective than a one-size-fits-all federal law. This is particularly apt here, given that New York since 2015 has had one of the most, complex, robust, and sophisticated surprise bill laws in the country.

87. Accordingly, in New York, the provisions of the Surprise Billing Law constitutes a "specified state law" under the No Surprises Act, because, for health plans and circumstances governed by it, the Surprise Bill Law has a method for determining the total amount payable—the health plan pays what it determines to be a reasonable amount, and then either the health plan or the out-of-network physician can submit the matter to IDR, which will determine the reasonable payment amount using the Financial Services Law §§ 600-08.

88. Thus, even after the No Surprises Act took effect this January, for health plans and circumstances covered by the Surprise Bill Law, that Law, and not the federal No Surprises Act, governs the reimbursement of out-of-network physicians.

89. Indeed, the Department of Financial Services recognized this when it issued Circular Letter No. 10, in December 2021. In this Letter, the Department of Financial Services

stated: "New York has an IDR process that applies to out-of-network emergency services, including inpatient services that follow an emergency room visit, in hospital facilities, and surprise bills in participating hospitals or ambulatory surgical centers and for services referred by a participating physician. The IDR process requires issuers, physicians, hospitals and ambulatory surgical centers, and providers to whom the patient was referred by their participating physician, to ensure that the insured incurs no greater out-of-pocket costs for emergency services and surprise bills than the insured would have incurred with an in-network provider. **Since New York has a specified state law, the New York IDR process will continue to apply to out-of-network emergency services and surprise bills**" (New York State Department of Financial Services, Circular Letter 10 [2021]). A true and correct copy of this Circular Letter is annexed as Exhibit C and incorporated by reference in the Complaint herein.

90. Moreover, through the Circular Letter, the Department of Financial Services actually broadened the coverage of the Surprise Bill Law to cover more scenarios, rather than have those scenarios default to the No Surprises Act.

91. Following this provision, virtually all health plans subject to New York regulation recognize that the New York IDR process continues to apply to out-of-network emergency services and surprise bills since the No Surprises Act became effective January 1, 2022.

92. The New York IDR process is preferable for out-of-network physicians over the federal IDR process, because the New York process is independent and fair, focusing on the FAIR Health-determined UCR rate, while the federal IDR process focuses on the Qualifying Payment Amount (QPA), which is biased as solely determined by the health plan, and is based on its median in-network rates for the same service in a similar geographic area (42 U.S.C. § 300gg-111[a][3][E]), 111[c][5][C][i][I]).

In virtually all circumstances, the QPA is significantly less than the FAIR Health-determined UCR amount. Indeed, use of and reliance on the QPA has been roundly criticized in the health care industry (Don't skew surprise-billing regulations in health plans' favor | American Medical Association (ama-assn.org) [accessed Mar. 13, 2022]). One federal court has even invalidated parts of the No Surprises Act regulations for being improperly too reliant on the QPA (Memorandum Opinion and Order [Dkt Entry 113], *Texas Med. Ass'n v. United States Dep't of Health & Human Servs.*, 6:21-cv-00425-JDK [ED Tex Feb. 23, 2022]).

Empire Plan's Illegal Actions

93. Unfortunately, and to the great detriment of Empire Plan's 1.2 million enrollees as well as the Plaintiff physician practices, the Empire Plan has not recognized that the New York IDR process continues to apply to out-of-network emergency services and surprise bills since the No Surprises Act became effective January 1, 2022.

94. Since January 1, 2022, the Plaintiff physician practices – and other out-of-network physicians – have been reimbursed by the Empire Plan for providing medically necessary, covered services at amounts dramatically less than provided for in the Empire Plan. The reimbursement from Empire Plan to these physicians is in most cases **more than 80% less** than what they were reimbursed for the services in December 2021.

95. The Empire Plan's explanation for this dramatic lowering of reimbursement is that it has "determined" that the Plan no longer be subject to New York insurance laws or be subject to regulation by the Department of Financial Services.

96. Rather, the Empire Plan has "decided" that it will be treated like a non-governmental self-funded employee health plan, which are not subject to New York insurance laws or regulation by State's Department of Financial Services. The New York Surprise Bill Law does not apply to non-governmental self-funded employee health plans; the out-of-network reimbursement procedures for those plans are governed by the federal No Surprises Act.

97. Consequently, the Empire Plan is taking the position that it is no longer obligated to reimburse out-of-network physicians, including the Plaintiff physician practices, at the FAIR Health-determined UCR rates set forth in its plan certificates.

98. In ordinary circumstances, when a New York regulated health plan fails to reimburse an out-of-network physician at the proper rate, the physician can file a complaint with the Department of Finance Services, and, if a surprise or emergency services bill is involved, submit the dispute to New York IDR.

99. However, both avenues of redress would be unavailable if the Empire Plan is not subject to New York insurance law (including the Surprise Bill Law) or Department of Financial Services regulation.

100. And, indeed, since January, the Empire Plan has responded to complaints made to the Department of Financial Services by Plaintiff physician practices by contending that it is no longer subject to regulation by that agency.

101. Likewise, since January, the Empire Plan has responded to New York IDR proceedings initiated by Plaintiff physician practices by contending that because it is no longer subject to New York insurance laws, its reimbursements are no longer reviewable in New York IDR.

102. Empire Plan has also taken the extraordinary step of communicating with the federal Centers for Medicare and Medicare Services (CMS) to persuade CMS to find – wrongly – that the Empire Plan is not legally subject to the New York Surprise Bill Law and, therefore, the No Surprises Act applies to its out-of-network reimbursement procedures.

103. However, the Empire Plan cannot prevail in its effort to be treated like a non-governmental self-funded employee health plan not subject to New York insurance laws or Department of Financial Services regulation, because neither the New York State Department of Civil Services, nor UnitedHealthcare, have the legal ability to override Civil Service Law § 162 by opting out or declaring the Empire Plan no longer subject to New York insurance laws or Department of Financial Services regulation.

104. As alleged above, Civil Service Law § 162(1)(b)(iv) requires that the Empire Plan's actions in providing benefits – such as reimbursement for covered medical services -- at all times "shall be subject to review by the superintendent of financial services for the purposes of ensuring compliance with applicable insurance law and any and all associated insurance rules and regulations as noted in this subdivision" (*id.*).

105. Similarly, Civil Service Law § 162(1)(b)(i) requires that the Empire Plan provides that "[a]ny and all health insurance coverage mandated by any law, rule or regulation, including but not limited to coverage mandated pursuant to article forty-three of the insurance law, applicable to contracts for health insurance" under New York law. The statute goes on to state that "[f]or the purposes of this paragraph 'coverage' shall include but shall not be limited to all benefits, services, rights, privileges and guarantees allowed by law" (*id.*).

106. Thus, Civil Service Law § 162 requires that the Empire Plan be subject to New York insurance laws – including the Surprise Bill Law – and the regulation of the Department of Financial Services. Neither the Department of Civil Service nor UnitedHealthcare can change this; only the Legislature can, with the Governor's approval.

107. For these reasons, all actions taken by the Empire Plan since January 2022 that refuse to recognize the authority of New York insurance law or Department of Financial Services regulation are incorrect, improper, and illegal.

The Irreparable Harm Caused by Empire Plan's Illegal Actions

108. Empire Plan's illegal actions have caused significant, irreparable harm. The sudden, precipitous decrease in reimbursement – to less than 20% of what it was in December 2021 – is devastating to many out-of-network physician practices, particularly given skyrocketing expenses due to inflation and the uncertain economic climate. As a result, many of these practices will be forced to go out of business or dramatically curtail their services.

109. Those out-of-network physician practices that survive in the short run will be severely hampered in their ability to recruit and retain high quality recently trained physicians or acquire new medical equipment and information systems.

110. Since these out-of-network physician practices provide medically necessary surgical and specialty medical services to Plan's 1.2 million enrollees, the enrollees' access to his high-quality care will be severely restricted, if not eliminated. Quality of care will decline. New York will lose its status as a center for high-quality, innovative medical care.

111. Empire Plan's actions will disrupt longstanding relationships that its enrollees have with out-of-network physicians. These physicians intimately know the enrollees' unique medical

conditions and how best to treat them. All this will be lost, jeopardizing the health and well-being New York's public employees and their dependents during these very stressful times.

112. Additionally, the Empire Plan's illegal actions will directly and significantly affect the availability of emergency medical services at hospitals throughout the state. Many hospitals depend on out-of-network physicians to provide emergency care. With less access to out-of-network physicians as a result of Empire Plan's actions, Plan enrollees will lose access to life-saving emergency treatment.

113. Taken as a whole, the consequences that Empire Plan enrollees will suffer at the hands of the Plan include the loss of continuity of medical care, significant delays in the provision of care due to the lack of or restricted access to out-of-network physicians, potential exposures to surprise and balance bills, and significant increases in adverse health outcomes, including serious illness and the potential loss of life.

114. The utter tragedy here is that all this can be avoided simply by maintaining state regulation over the Empire Plan, as *state law requires.* This simple act will compel Empire Plan to honor its commitments and be subject to insurance law and regulations that have been the cornerstone of New York's health system for over a decade. Empire Plan should not be permitted to put some nebulous money savings over the life and health of 1.2 million New York public employees and their dependents.

115. For years, a major selling point of public employment in New York has been the Empire Plan's out-of-network benefit, giving enrollees a wide option of high-quality physicians to choose from. Unfortunately, if the Empire Plan's actions are allowed go unchecked, this sadly will no longer be the case.

FIRST CAUSE OF ACTION

116. Plaintiffs repeat and re-allege the allegations set forth above as if more fully set forth herein.

117. Since as early as January 1, 2022, Defendants have taken the position that the Empire Plan is no longer subject to New York state insurance law, including the Surprise Bill Law, as well as Department of Financial Services regulation.

118. Defendants have taken this position in communications with one or more of the Plaintiffs, with other physicians in New York who are out of network with the Empire Plan, with representatives of the federal Centers for Medicare & Medicaid Services, with representatives of representatives of the Department of Civil Service, with representatives of Department of Financial Services, and with state IDR entities, among others.

119. Defendants' position that the Empire Plan is no longer subject to state insurance law as well as Department of Financial Services regulations, and their communications of that policy, have directly and irreparably harmed Plaintiffs and other Empire Plan enrollees and out-of-network physicians because it has enabled the Empire Plan to dramatically reduce its reimbursement for medically necessary, covered treatment provided to Plan enrollees by more than than 80% since December 2021.

120. If these actions do not immediately cease, thousands of high-quality, well-respected out of network physician practices – providing medically necessary surgical and specialty medical services to Plan enrollees – will go out of business or drastically curtail their services. Those that survive in the short run will be severely hampered in their ability to recruit and retain high quality recently trained physicians or acquire new medical equipment and information systems, causing

New York to lose its' status as a center for high-quality, innovative medical care. The quality of medical care available to Empire Plan's 1.2 million enrollees will significantly decline.

121. Empire Plan's actions will disrupt longstanding relationships that its enrollees have with out-of-network physicians. These physicians intimately know the enrollees' unique medical conditions and how best to treat them. All this will be lost, jeopardizing the health and well-being New York's public employees and their dependents during these very stressful times.

122. Additionally, the Empire Plan's illegal actions will directly and significantly affect the availability of emergency medical services at hospitals throughout the state. Many hospitals depend on out-of-network physicians to provide emergency care. With less access to out-of-network physicians as a result of Empire Plan's actions, Plan enrollees will lose access to life-saving emergency treatment.

123. Taken as a whole, the consequences that Empire Plan enrollees will suffer at the hands of the Plan include the loss of continuity of medical care, significant delays in the provision of care due to the lack of or restricted access to out-of-network physicians, and significant increases in in adverse health outcomes, including serious illness and the potential loss of life.

124. Additionally, Defendants' position has irreparably harmed the Plaintiff physician practices and other physicians out of network with the Empire Plan by eliminating the ability of those physicians to challenge Defendants' reimbursement procedure and level complaints to the Department of Financial Services or the state IDR process.

125. Defendants' position that the Empire Plan is no longer subject to state insurance law as well as Department of Financial Services regulations is directly contrary to, and in violation of Civil Service Law § 162.

126. Defendants have not ceased in taking and advocating this position after its illegality has been called to their attention.

127. By reason of the foregoing, a dispute exists between the parties.

128. Plaintiffs have no adequate remedy at law.

129. Plaintiffs have not sought this or similar relief in this or any other Court.

130. By reason of all of the foregoing, Plaintiffs are entitled to a judgment from this Court pursuant to CPLR 3001 declaring that: (a) Civil Service Law § 162 requires that, at all times, the Empire Plan, and its provision of benefits and reimbursement, remain subject to New York insurance law, including the Surprise Bill Law, and regulation by the Department of Financial Services; (b) Civil Service Law § 162 and the Surprise Bill Law require that the state IDR process be available to resolve disputes between the Empire Plan and out-of-network physicians concerning situations that qualify as emergency medical services or surprise bills under Surprise Bill Law; (c) Defendants' position that the Empire Plan is no longer subject to the provisions of New York insurance law (including the Surprise Bill Law), state IDR procedures, and Department of Financial Services regulation violates and is contrary to the provisions of Civil Service Law § 162, which is valid and effective; and (d) Defendants' communications with one or more of the Plaintiffs, with other physicians in New York who are out of network for the Empire Plan, with representatives of the federal Centers for Medicare & Medicaid Services, with representatives of representatives of the Department of Civil Service, with representatives of Department of Financial Services, and with state IDR entities, among others, that they no longer are subject to the provisions of New York insurance law (including the Surprise Bill Law), state IDR procedures, and

Department of Financial Services regulation violates and is contrary to the provisions of Civil Service Law § 162, which is valid and effective .

131. Plaintiffs are entitled to such other and further relief that the Court deems just, proper, and equitable including, but not limited to the costs, disbursements, and other allowances of this action, as well as an award of attorney's fees under the Equal Access to Justice Act (CPLR Article 86).

SECOND CAUSE OF ACTION

132. Plaintiffs repeat and re-allege the allegations set forth above as if more fully set forth herein.

133. Since as early as January 1, 2022, Defendants have taken the position that the Empire Plan is no longer subject to New York state insurance law, including the Surprise Bill Law, as well as Department of Financial Services regulation.

134. Defendants have taken this position in communications with one or more of the Plaintiffs, with other physicians in New York who are out of network with the Empire Plan, with representatives of the federal Centers for Medicare & Medicaid Services, with representatives of representatives of the Department of Civil Service, with representatives of Department of Financial Services, and with state IDR entities, among others.

135. Defendants' position is wrong on the law. Civil Service Law § 162 mandates that the Empire Plan be subject to New York law and regulation. Defendants cannot override or avoid the application of this clearly applicable law.

136. By reason of the foregoing, Plaintiffs are likely to succeed on the merits of their claims.

137. Moreover, Defendants' position that the Empire Plan is no longer subject to state insurance law as well as Department of Financial Services regulations, and their communications of that policy, have directly and irreparably harmed Plaintiffs, Empire Plan enrollees in general, and o physicians out-of-network with the Empire Plan.

138. This is because, if the Empire Plans' actions do not immediately cease, thousands of high-quality, well-respected out of network physician practices – providing medically necessary surgical and specialty medical services to Plan enrollees – will go out of business or drastically curtail their services. Those that survive in the short run will be severely hampered in their ability to recruit and retain high quality recently trained physicians or acquire new medical equipment and information systems, causing New York to lose its' status as a center for high-quality, innovative medical care. The quality of medical care available to Empire Plan's 1.2 million enrollees will significantly decline.

139. Empire Plan's actions will disrupt longstanding relationships that its enrollees have with out-of-network physicians. These physicians intimately know the enrollees' unique medical conditions and how best to treat them. All this will be lost, jeopardizing the health and well-being New York's public employees and their dependents during these very stressful times.

140. Additionally, the Empire Plan's illegal actions will directly and significantly affect the availability of emergency medical services at hospitals throughout the state. Many hospitals depend on out-of-network physicians to provide emergency care. With less access to out-of-

network physicians as a result of Empire Plan's actions, Plan enrollees will lose access to life-saving emergency treatment.

141. Taken as a whole, the consequences that Empire Plan enrollees will suffer at the hands of the Plan include the loss of continuity of medical care, significant delays in the provision of care due to the lack of or restricted access to out-of-network physicians, and significant increases in in adverse health outcomes, including serious illness and the potential loss of life.

142. Additionally, Defendants' position has irreparably harmed the Plaintiff physician practices and other physicians out of network with the Empire Plan by eliminating the ability of those physicians to challenge Defendants' reimbursement procedure and level complaints to the Department of Financial Services or the state IDR process.

143. By reason of all the foregoing Plaintiffs will be irreparably harmed without the issuance of an injunction.

144. The utter tragedy here is that all this can be avoided simply by maintaining state regulation over the Empire Plan, as *state law requires.* This simple act will compel Empire Plan to honor its commitments and be subject to insurance law and regulations that have been the cornerstone of New York's health system for over a decade. Empire Plan should not be permitted to put some nebulous money savings over the life and health of 1.2 million New York public employees and their dependents.

145. By reason of the foregoing, the balance of equities favors Plaintiffs.

146. Further, the public interest will be served by the requested injunction in that it will preserve the health and welfare of the 1.2 million New York public employees and the their dependents.

147. Defendants have not ceased in taking and advocating their illegal position after its illegality has been called to their attention.

148. Plaintiffs have no adequate remedy at law.

149. Plaintiff have not sought this or similar relief in this or any other Court.

150. By reason of all of the foregoing, Plaintiffs are entitled to a judgment from this Court permanently enjoining Defendants from (a) denying Plaintiff physician practices, and other physicians out-of-network with the Empire Plan, from access to the Department of Financial Services complaint procedures by reason of Defendants' assertion that the Empire Plan is no longer subject to the provisions of New York insurance law and Department of Financial Services regulation; (b) denying Plaintiff physician practices, and other physicians out-of-network with the Empire Plan, from access to the state IDR process to resolve disputes between the Empire Plan and out-of-network physicians concerning situations that qualify as emergency medical services or surprise bills under Surprise Bill Law by reason of Defendants' assertion that the Empire Plan is no longer subject to the provisions of New York insurance law and Department of Financial Services regulation; (c) communicating with one or more of the Plaintiffs, with other physicians in New York who are out-of-network for the Empire Plan, with representatives of the federal Centers for Medicare & Medicaid Services, with representatives of representatives of the Department of Civil Service, with representatives of Department of Financial Services, and with state IDR entities, among others, that they no longer are subject to the provisions of New York insurance law (including the Surprise Bill Law), state IDR procedures, and Department of Financial Services regulation violates and is contrary to the provisions of Civil Service Law § 162..

151. Plaintiffs are entitled to such other and further relief that the Court deems just, proper, and equitable including, but not limited to the costs, disbursements, and other allowances of this action, as well as an award of attorney's fees under the Equal Access to Justice Act (CPLR Article 86).

WHEREFORE, Plaintiffs, Wayne Joseph; Thomas Cottone; Sonya Hwang Cottone; Loretta Post; Long Island Anesthesiologists, PLLC; Long Island Anesthesia Physicians, LLP.; New York Cardiovascular Anesthesiologists, P.C.; Suffolk Anesthesiology Associates, P.C.; Advanced Plastic Surgery of Long Island, PLLC.; DA Medical Services PLLC; Da Silva Plastic & Reconstructive Surgery, P.C.; Hand Surgery Associates of Long Island, P.C.; Islandwide Surgical, P.C.; K. Jacob Cohen-Kashi, M.D. & Lawrence C. Lin, MD, PLLC; Lisa Corrente, M.D., P.C.; Long Island Neurosurgical & Pain Specialists, PLLC.; Long Island Thoracic Surgery, P.C.; Montauk Medical Associates PLLC; Performance Medical Practice, PLLC; Sagtikos Medical Services, P.C.; Spine Medical Services, PLLC; and United Medical Monitoring, P.C., demand judgment against the Defendants, Rebecca Corso, as Acting Commissioner, New York State Department of Civil Service; UnitedHealthcare Insurance Company of New York Inc., as Program Administrator, The Empire Plan Medical/Surgical Program; and Adrienne A. Harris, as Superintendent, New York State Department of Financial Services, as follows:

A. On the first cause of action, declaring pursuant to CPLR 3001 that (i) Civil Service Law § 162 requires that, at all times, the Empire Plan, and its provision of benefits and reimbursement, remain subject to New York insurance law, including the Surprise Bill Law, and regulation by the Department of Financial Services; (ii) Civil Service Law § 162 and the Surprise Bill Law require that the state IDR process be available to resolve disputes between the Empire Plan and out-of-network physicians concerning situations that qualify

as emergency medical services or surprise bills under Surprise Bill Law; (iii) Defendants' position that the Empire Plan is no longer subject to the provisions of New York insurance law (including the Surprise Bill Law), state IDR procedures, and Department of Financial Services regulation violates and is contrary to the provisions of Civil Service Law § 162, which is valid and effective; and (iv) Defendants' communications with one or more of the Plaintiffs, with other physicians in New York who are out of network WITH the Empire Plan, with representatives of the federal Centers for Medicare & Medicaid Services, with representatives of representatives of the Department of Civil Service, with representatives of Department of Financial Services, and with state IDR entities, among others, that they no longer are subject to the provisions of New York insurance law (including the Surprise Bill Law), state IDR procedures, and Department of Financial Services regulation violates and is contrary to the provisions of Civil Service Law § 162, which is valid and effective .

B. On the second cause of action, permanently enjoining Defendants from (i) denying Plaintiff physician practices, and other physicians out of-network with the Empire Plan, from access to the Department of Financial Services complaint procedures by reason of Defendants' assertion that the Empire Plan is no longer subject to the provisions of New York insurance law and Department of Financial Services regulation; (ii) denying Plaintiff physician practices, and other physicians out-of-network with the Empire Plan, from access to the state IDR process to resolve disputes between the Empire Plan and out-of-network physicians concerning situations that qualify as emergency medical services or surprise bills under Surprise Bill Law by reason of Defendants' assertion that the Empire Plan is no longer subject to the provisions of New York insurance law and Department of Financial Services regulation; and (iii) communicating with one or more of the Plaintiffs, with other physicians in New York who are out of network for the Empire Plan, with representatives

of the federal Centers for Medicare & Medicaid Services, with representatives of representatives of the Department of Civil Service, with representatives of Department of Financial Services, and with state IDR entities, among others, that they no longer are subject to the provisions of New York insurance law (including the Surprise Bill Law), state IDR procedures, and Department of Financial Services regulation violates and is contrary to the provisions of Civil Service Law § 162.

C. Such other and further relief that the Court deems just, proper, and equitable including, but not limited to the incidental damages caused Plaintiffs by reason of Defendants' actions, and the costs, disbursements, and other allowances of this action, as well as an award of attorney's fees under the Equal Access to Justice Act (CPLR Article 86).

Dated: Uniondale, New York
March 28, 2022

Respectfully submitted,

HARRIS BEACH PLLC

By: _____

Roy W. Breitenbach
Jack M. Martins
Daniel S. Hallak

The Omni
333 Earle Ovington Blvd, Suite 901
Uniondale, New York 11553
Phone: 516.880.8484
Fax: 516.880.8483

677 Broadway, Suite 1101
Albany, New York 12207
Phone: 518.427.9700
Fax: 518.427.0235

Attorneys for Plaintiffs

TO: REBECCA CORSO
Acting Commissioner
New York State Department of Civil Service
Alfred E. Smith State Office Building
Albany, New York 12239

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC.
Program Administrator
The Empire Plan Medical/Surgical Program
1 Pennsylvania Plaza
New York, New York 10119

ADRIENNE A. HARRIS
Superintendent
New York State Department of Financial Services
One State Street
New York, New York 10004

LETITIA JAMES
Attorney General
New York State Department of Law
The Capitol
Albany, New York 12224

EXHIBIT 2

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ALBANY

WAYNE JOSEPH; THOMAS COTTONE, SONYA HWANG COTTONE; LORETTA POST; LONG ISLAND ANESTHESIOLOGISTS, PLLC; LONG ISLAND ANESTHESIA PHYSICIANS, LLP; NEW YORK CARDIOVASCULAR ANESTHESIOLOGISTS, P.C.; SUFFOLK ANESTHESIOLOGY ASSOCIATES, P.C.; ADVANCED PLASTIC SURGERY OF LONG ISLAND, PLLC; DA MEDICAL SERVICES PLLC; DA SILVA PLASTIC & RECONSTRUCTIVE SURGERY, P.C.; HAND ASSOCIATES OF LONG ISLAND, P.C.; ISLANDWIDE SURGICAL, P.C.; K. JACOB COHEN-KASHI, M.D. & LAWRENCE C. LIN, MD, PLLC; LISA CORRENTE, M.D., P.C.; LONG ISLAND NEUROSURGICAL & PAIN SPECIALISTS, PLLC; LONG ISLAND THORACIC SURGERY, P.C.; MONTAUK MEDICAL ASSOCIATES PLLC.; PERFORMANCE MEDICAL PRACTICE PLLC; SAGTIKOS MEDICAL SERVICES, P.C.; SPINE MEDICAL SERVICES, PLLC; and UNITED MEDICAL MONITORING, P.C.,

Plaintiffs,

-against-

REBECCA CORSO, as Acting Commissioner, NEW YORK STATE DEPARTMENT OF CIVIL SERVICE; UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM; and ADRIENNE A. HARRIS, as Superintendent, NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES,

Respondents/Defendants.

AFFIDAVIT
Index No. 902227-22

STATE OF NEW YORK)
COUNTY OF ALBANY) ss.:

DANIEL YANULAVICH, being duly sworn, deposes and says:

1. I am employed at the New York State Department of Civil Service ("DCS") as the Director of the Employee Benefits Division. I have been employed at DCS since 2015. The Employee Benefits Division administers the New York State Health Insurance Program ("NYSHIP"), one of the largest public employer health insurance programs in the nation, covering 1.2 million State and local government employees, retirees, and their families. In my capacity as the Director of the Employee Benefits Division, I am fully familiar with the practices, procedures and policy determinations related to the administration of NYSHIP and the Empire Plan.

2. As a comprehensive health insurance program for New York State public employees, NYSHIP is comprised of The Empire Plan and NYSHIP-approved Health Maintenance Organizations (HMOs). NYSHIP was established in 1957 for State employees and in 1958, became available to local governments and school districts.

3. In 1986, NYSHIP established The Empire Plan. In 2010, Ch.56 of the Laws of 2010 amended the Civil Service Law and established that NYSHIP could elect to provide benefits directly to the plan participants, as opposed to purchasing a fully insured contract. Presently, The Empire Plan is a governmental self-funded health insurance plan subject to the Civil Service Law and specific provisions of the Insurance Law, as dictated by the Civil Service Law.

4. The Empire Plan is NYSHIP's unique health insurance plan designed exclusively for New York State's public employees and employers. The Empire Plan pays for covered

hospital services, physicians' bills, prescription drugs and other covered medical expenses. Enrollees have the freedom to choose participating providers and pay only a copayment or choose non-participating providers and pay a higher share of the cost.

5. NYSHIP's self-funded construct is codified in the Civil Service Law (CSL). In pertinent part, CSL § 162 permits the President (head of the NY Civil Service Commission) to provide the health benefits directly to plan participants (self-funding), as opposed to purchasing a fully insured contract.

6. CSL 162(1)(b)(i) requires that the provision of health insurance coverages mandated by law, rule, or regulation, including the coverages mandated under Insurance law Article 43, shall be provided in a manner assuring uninterrupted continuance of coverage for all covered persons. Coverage is defined to include, but not be limited to, all benefits, services, rights, privileges and guarantees allowed by law. CSL 162(1)(b)(ii) provides that plan participants shall be afforded the internal and external review rights under Insurance Law Article 49. These two provisions are collectively referred to as consumer protections.

7. CSL §162(1)(b)(iv) provides that if the President elects to provide benefits directly to plan participants, this shall not constitute the doing of insurance business under Insurance Law Article 11. This section further provides that the provision of direct benefits shall be subject to review by the superintendent of financial services for the purpose of ensuring compliance with applicable Insurance Law and any associated insurance rules and regulations.

8. Similarly, Insurance Law §1101(b)(6) provides that the election by the President of the Civil Service Commission to provide health benefits directly to New York state health

benefit plan participants shall not constitute the doing of insurance business within the meaning of article eleven of the Insurance Law.

9. As discussed above, the Empire Plan, provided through NYSHIP, is governed by the specific consumer protection provisions of the Insurance Law and associated statutes, rules, and regulations, as set forth in CSL §162. The statutes clearly delineate that NYSHIP is not to be considered an insurance business, such as those supervised and regulated by DFS.

10. These clear delineations reflect the legislature's intent to make NYSHIP a novel self-funded entity, separate and distinct from the insurance businesses subject to the supervision and regulatory oversight that Plaintiffs reference.

11. The role of DFS, relative to NYSHIP, as defined in CSL §162, involves the review of the self-funded plan, in order to ensure compliance with the insurance laws, regulations and statutes that are noted within CSL §162, namely the consumer protection statutes.

12. New York enacted "surprise bill" consumer protections on March 15, 2015, through the New York Surprise Bill Law. The purpose of the law is to limit consumer exposure to unforeseen balance bills from emergencies and occasions where an out-of-network provider treated them without explicit permission at a network hospital or in a network provider's office. Subsequently, New York expanded the Surprise Bill Law's applicability to out-of-network provider services performed in an inpatient hospital setting when a patient was admitted through the Emergency Department.

13. To protect its members from being balance billed by out-of-network providers, under the Surprise Bill Law the Empire Plan has, since 2015, paid the Usual and Customary Rate

(UCR) at the 90th percentile. If a provider wanted to dispute the payment amount, they had the option of filing a dispute through NYS DFS, who would then assign the case for submission to an Independent Dispute Resolution Entity (IDRE) to arbitrate. As part of their determination, the IDRE considered additional provider factors including the 80th percentile of FAIR Health© UCR as a starting benchmark amount. However, since the Empire Plan out-of-network benefit design utilizes the 90th percentile of FAIR Health as the basis for UCR, few providers brought cases to the IDRE.

14. As noted above, CSL 162 requires compliance with health insurance mandates under Section 43 and 49 of Insurance Law and requires that any and all health insurance coverage mandated by any law, rule or regulation applicable to contracts for health insurance entered into under this section shall be provided in a manner assuring uninterrupted continuance of coverage for all covered persons. Coverage is defined to include all benefits, services, rights, privileges, and guarantees allowed by law.

15. Plaintiffs cite these provisions in support of the contention that the Empire Plan is mandated to follow the independent dispute resolution ("IDR") process of Financial Services Law, Article 6.

16. While Civil Service Law §162 requires that the Empire Plan provide consumer protections equivalent to applicable laws, rules or regulations which apply to contracts for health insurance, it does not specify how those protections are achieved.

17. Civil Service Law §162 also does not specifically compel compliance with the Surprise Bill Law. Thus, to the extent that the Empire Plan previously submitted out-of-network billing disputes to the State IDR process, this was done in recognition of the need to provide

consumer protections in the absence of any alternate means of providing those protections. It was not the consequence of a specified legal obligation requiring strict fidelity to the Surprise Bill Law.

18. If the Empire Plan initially paid the par median rate prior to the enactment of the NSA, members' out of pocket costs would have been dramatically higher than what is required under collective bargaining and the Empire Plan insurance certificate.

19. The Surprise Bill Law applies to health care plans, defined as "insurers licensed to write accident and health insurance pursuant to Article thirty-two of the insurance law, a corporation organized pursuant to Article 43 of the insurance law, a municipal cooperative health benefit plan certified pursuant to Article 47 of the insurance law, a health maintenance organization certified pursuant to Article 44 of the public health law, or a student health plan established or maintained pursuant to section 1124 of the insurance law." NY Fin. Serv. Law 603 (c).

20. Currently, the President, as allowed under Civil Service Law §162, has selected an ASO[1]/self-funded plan as the health insurance plan type for its employees. There can be no dispute that the Surprise Bill Law definition does not include ASO plans, and NYS Insurance law does not in general extend to ASO plans.

21. The No Surprises Act ("NSA") was enacted in December 2020, to address surprise medical bills and like the New York Surprise Bill Law, limits the amount an insured patient will pay for emergency services furnished by an out-of-network provider and for certain

1 ASO – Administrative Services Only: a benefit plan in which the employer funds the benefits rather than an insurance company, this is sometimes referred to generally as a self-funded plan.

non-emergency services furnished by an out-of-network provider at an in-network facility. The NSA also addresses the payment of these out-of-network providers by group health plans or health insurance issuers. In particular, the NSA establishes an initial payment rate that plans and issuers are to pay out-of-network providers, known as Qualifying Payment Amount (QPA). The QPA is equal to the median contracted/participating rate for a region. With the enactment of the NSA, the federal government defined initial payment rates for facility-based services for different plan types.

22. In states with an All-Payer Model Agreement or specified state law, the out-of-network rate is the rate provided by the Model Agreement or state law. § 300gg-111(a)(3)(K). In states without a Model Agreement or specified state law, the out-of-network rate is either the amount agreed to by the insurer and the out-of-network provider or an amount determined through an IDR process.

23. Plaintiffs properly note that upon the enactment of the NY Surprise Bill Law, there was an available New York process for adjudicating disputed out-of-network surprise medical bills. However, as discussed, the Empire Plan is not bound to the State process in the manner asserted by plaintiffs. Indeed, plaintiffs' reference to the definition of "specified state law," as set forth in the statute, is incomplete. The statute instructs that:

> The term "specified State law" means, with respect to a State, an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, *a State law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively* ***(to the extent such State law applies to such plan, coverage, or issuer, subject to section 1144 of title 29)*** in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility (42 U.S.C. § 300gg-111)(a)(3)(I) (Emphasis

added).

24. The qualifying language highlighted above recognizes that given the existence of differing and unique healthcare systems, available state processes may yet be inapplicable to a specific plan. Accordingly, the Empire Plan is not precluded from the Federal NSA because the Empire Plan is not mandated to submit to the specified state law available in New York.

25. To protect the consumer, as required by both New York State and the Empire Plan's licensing agreement with DFS as an ASO plan, and to prevent plan members from being balanced billed by providers, the Empire Plan exercised its option as an ASO to utilize the NSA.

26. The NSA defines initial payment rates for facility-based services for different plan types. Because New York State law does not define an initial payment amount, The Empire Plan can determine that the reasonable amount is equivalent to the Qualifying Payment Amount (QPA), which is equal to the median contracted/participating rate for a region. The Empire Plan implemented the use of the QPA for Surprise bills effective on January 1, 2022, with the start of the NSA.[2]

27. The NSA defines the QPA as the median of the contracted rates recognized by the plan or issuer; the median rate paid to network providers (par median rate) is presently one factor that federal IDREs can consider when reviewing disputes. Par median is also the QPA or the initial payment made to providers in the case of a surprise bill. The 2022 QPA is based on the

2 HR 133-1557, TITLE I, SEC. 102. ("No Surprises Act," p. 1576)

2019 median rate for the same or similar item increased by the combined annual percentage increase in CPI-U. [3]

28. Under both the state law and the NSA, the consumer is protected, as their liability will be held only to any applicable Empire Plan network level copayment. The provider is prohibited by law from balance billing the member beyond their network copayment. For example, under the NSA, medical care including anesthesiology, pathology, radiology, and neonatology, care provided by assistant surgeons, hospitalists, intensivists, and diagnostic services rendered at an in-network facility are automatically considered surprise bills by the health plan. This is beneficial, since the in-network cost sharing (which for the Empire Plan is zero or a copayment) is always assessed in the case of a surprise bill.

29. The NSA similarly protects insureds from Air Ambulance bills, in that they too are always considered a surprise bill. Plan members are held harmless for any amounts that exceed the insured's in-network cost-sharing for out-of-network air ambulance services if the insured has coverage for in-network air ambulance services. 42 U.S.C. § 300gg-112(a).

30. The Empire plan enjoys a robust network of physician and medical services statewide, including the region and specialties implicated by the instant plaintiffs. It is notable that providers who are not contracted with the Empire Plan, are in many instances contracted with UnitedHealthcare's commercial book of business. Such is the case with many of the plaintiff physicians, who remain out-of-network and willingly refuse to negotiate with the

3 HR 133-1557 TITLE I, SEC. 103 (p.1582).

Empire Plan. This is no coincidence given the Empire Plan's generous out-of-network reimbursement formula.

31. Empire Plan payments to network providers are typically 120 percent to 300 percent of what Medicare pays. The Empire Plan utilizes the 90th percentile of FAIR Health, based on agreements with state employee unions, which results in payments that are, on average, 540 percent of what Medicare pays. Recent negotiations with the Civil Service Employees Association (CSEA) culminated in an agreement to cease using FAIR Health and instead base out-of-network reimbursement on 275 percent of the Medicare fee schedule, effective July 1, 2023. This is notable, inasmuch as outliers, for services such as anesthesiology, charge upward of 3,000 percent of what Medicare pays.

32. While the attraction of the Empire Plan's generous out-of-network benefit design is understandable, the continued stewardship of the plan in a fiscally responsible manner dictates that the Empire Plan should not be made to continue to subsidize these physician practices to the degree now demanded.

33. It is respectfully submitted that the Surprise Bill Law does not specifically apply to the Empire Plan, nor does the law specifically mention the Empire Plan. Civil Service Law dictates that the Empire Plan follow consumer protections afforded by the Financial Services Law, which it does. As a self-funded health plan, it is within the right of the Empire Plan to determine that a reasonable reimbursement rate to out-of-network providers in the case of a surprise bill is the QPA. The Empire Plan has made the decision to adopt the NSA framework in the interest of its members, who will benefit from reduced premiums, and the New York State taxpayer, who pays a significant percentage of the plan costs.

WHEREFORE, it is respectfully requested that this Court issue an Order dismissing Plaintiffs' claims in their entirety, together with such other and further relief as this Court may deem just and proper and equitable.

DATED: Albany, New York
August 31, 2022

DANIEL YANULAVICH
Director, Employee Benefits Division
NYS Department of Civil Service

Sworn to before me this 31st
day of August, 2022

Notary Public

JEFFREY M. BRAUDE
Notary Public, State of New York
Qualified in Albany Co. No. 02BR6140609
Commission Expires Jan. 30, 20 26

EXHIBIT 3

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ALBANY

WAYNE JOSEPH; THOMAS COTTONE, SONYA HWANG COTTONE: LORETTA POST; LONG ISLAND ANESTHESIOLOGISTS, PLLC; LONG ISLAND ANESTHESIA PHYSICIANS, LLP; NEW YORK CARDIOVASCULAR ANESTHESIOLOGISTS, P.C.; SUFFOLK ANESTHESIOLOGY ASSOCIATES, P.C.; ADVANCED PLASTIC SURGERY OF LONG ISLAND, PLLC; DA MEDICAL SERVICES PLLC; DA SILVA PLASTIC & RECONSTRUCTIVE SURGERY, P.C.; HAND ASSOCIATES OF LONG ISLAND, P.C.; ISLANDWIDE SURGICAL, P.C.; K. JACOB COHEN-KASHI, M.D. & LAWRENCE C. LIN, MD, PLLC; LISA CORRENTE, M.D., P.C.; LONG ISLAND NEUROSURGICAL & PAIN SPECIALISTS, PLLC; LONG ISLAND THORACIC SURGERY, P.C.; MONTAUK MEDICAL ASSOCIATES PLLC.; PERFORMANCE MEDICAL PRACTICE PLLC; SAGTIKOS MEDICAL SERVICES, P.C.; SPINE MEDICAL SERVICES, PLLC; and UNITED MEDICAL MONITORING, P.C.,

Plaintiffs,

-against-

REBECCA CORSO, as Acting Commissioner, NEW YORK STATE DEPARTMENT OF CIVIL SERVICE; UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM; and ADRIENNE A. HARRIS, as Superintendent, NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES,

Respondents/Defendants.

Index No. 902227-22

MEMORANDUM OF LAW
IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS

LETITIA JAMES
Attorney General of the State of New York
Attorney for Defendants
The Capitol
Albany, New York 12224-0341

William A. Scott
Assistant Attorney General, of Counsel
Telephone: (518) 776-2255
Fax: (518) 915-7740 (Not for service of papers)

Date: August 31, 2022

Table of Contents

PRELIMINARY STATEMENT

Defendants Rebecca Corso, as Acting Commissioner, New York State Department of Civil Service (collectively, "Civil Service"), and Adrienne A. Harris, as Superintendent, New York State Department of Financial Services (collectively, "DFS"), submit this memorandum of law, along with the accompanying Affirmation of John Powell ("Powell Aff.") and Affidavit of Daniel Yanulavich ("Yanulavich Aff.") in support of their Motion to Dismiss.

Plaintiffs, who consist of out-of-network medical providers and a small handful of Empire Plan members, incorrectly assert that all claims for payment by out-of-network providers are subject to New York's independent dispute resolution system. Plaintiffs' claim is premised upon an inaccurate reading of New York's Civil Service Law, the New York State Surprise Bill Law, and the Federal No Surprises Act. As Plaintiffs fail to state a cause of action, and as their arguments present no questions of fact, their claims must be dismissed.

STATEMENT OF FACTS/PROCEDURAL HISTORY

The New York State Health Insurance Program ("NYSHIP") has provided New York State public employees with health insurance benefits since 1957. *See* Yanulavich Aff. at ¶¶2-3. NYSHIP initially established the Empire Plan in 1985, but its current incarnation came to be when the Civil Service Law was amended in 2010. *See* Yanulavich Aff. at ¶3. At that time, the head of the Civil Service Commission, as the President of NYSHIP, was given the authority to provide benefits directly to New York State public employees through the Empire Plan as a governmental self-funded insurance plan. *See* Yanulavich Aff. at ¶3. The Empire Plan is a unique health insurance plan subject to the Civil Service Law and specific provisions of the Insurance Law, as dictated by the Civil Service Law. *See* Yanulavich Aff. at ¶¶5-10. Empire Plan members, including

the individual Plaintiffs, enjoy access to a robust network of in-plan healthcare providers. *See* Yanulavich Aff. at ¶30.

DFS, as relevant to this case, is charged with supervising and regulating the activities of 94 health insurers. Powell Aff. at ¶¶3-4. While DFS has broad regulatory authority over insurance companies and other entities, its authority is not unlimited, and generally does not extend to self-funded health plans. Powell Aff. at ¶4. As the Empire Plan is a self-funded health plan, DFS has oversight over some, but not all facets, of the Empire Plan's functioning, pursuant to the Civil Service Law. Powell Aff. at ¶¶5-7.

DFS has oversight over New York's independent dispute resolution process ("state IDR process"). Powell Aff. at ¶10. As described in greater detail below and in the Powell Aff., the state IDR process was created to provide a mechanism for resolving payment disputes between out-of-network providers and insurers. Powell Aff. at ¶10.

Plaintiffs Wayne Joseph, Thomas Cottone, Sonya Hwang Cottone, and Loretta Post are individuals who are members of the Empire Plan. Plaintiffs Long Island Anesthesia Physicians, LLP; New York Cardiovascular Anesthesiologists, P.C.; Suffolk Anesthesiology Associates, P.C.; Advanced Plastic Surgery Of Long Island, PLLC; DA Medical Services PLLC; Da Silva Plastic & Reconstructive Surgery, P.C.; Hand Associates Of Long Island, P.C.; Islandwide Surgical, P.C.; K. Jacob Cohen-Kashi, M.D. & Lawrence C. Lin, Md, PLLC; Lisa Corrente, M.D., P.C.; Long Island Neurosurgical & Pain Specialists, PLLC; Long Island Thoracic Surgery, P.C.; Montauk Medical Associates PLLC.; Performance Medical Practice PLLC; Sagtikos Medical Services, P.C.; Spine Medical Services, PLLC; and United Medical Monitoring, P.C. are all health care providers who do not participate in the Empire Plan (collectively, "the out-of-network providers").

Plaintiffs challenge the Empire Plan's position that it is not subject to New York Financial Services Law ("NY Fin. Servs. Law") Article 6 ("Surprise Bill Law"), and, by extension, is not required to participate in the state IDR process. NYSCEF Doc. 2 at ¶18.

I. The Surprise Bill Law

New York enacted the Surprise Bill Law in 2015. NY Fin. Servs. Law §601, *et. seq*. The Surprise Bill Law was enacted to protect patients from having to pay for unexpected medical costs associated with emergency care, or for a surprise bill for services provided by an out-of-network provider while the patient is being treated at an in-plan hospital or ambulatory surgical center, or for services of an out-of-network provider when the patient is referred by an in-network physician. NY Fin. Servs. Law §§601, 603. Accordingly, the Surprise Bill Law ensures that patients are not compelled to pay excessive bills from out-of-network providers for "emergency services" or "surprise bills." NY Fin. Servs. Law §603(b), (h).

The Surprise Bill Law also required DFS to establish the state IDR process whereby out-of-network providers could submit their disputed bills for resolution. NY Fin. Servs. Law §§601, 605, 607; 23 NYCRR §400.0, *et seq*. The state IDR process is available only for emergency medical bills, surprise bills, and bills associated with continuing medical care flowing from an emergency medical bill. NY Fin. Servs. Law §§605, 607; 23 NYCRR §400.0, *et seq*. The state IDR process, and the Surprise Bill Law as a whole, are not applicable to bills incurred by members who affirmatively choose to receive care from out-of-network providers. NY Fin. Servs. Law §603(h).

The Surprise Bill Law also only applies to "healthcare plans," which it defines as:

> an insurer licensed to write accident and health insurance pursuant to article thirty-two of the insurance law; a corporation organized

> pursuant to article forty-three of the insurance law; a municipal cooperative health benefit plan certified pursuant to article forty-seven of the insurance law; a health maintenance organization certified pursuant to article forty-four of the public health law; or a student health plan established or maintained pursuant to section one thousand one hundred twenty-four of the insurance law.

NY Fin. Servs. Law §603(c).

The Empire Plan is not subject to the Surprise Bill Law because it is not a healthcare plan as that term is defined by the Surprise Bill Law. *See* Yanulavich Aff. at ¶¶17-20, 23-24; Powell Aff. at ¶15. The Empire Plan is a governmental self-funded health insurance plan, and the Surprise Bill Law does not include self-funded plans in its definition of "healthcare plans." *See* Yanulavich Aff. at ¶¶17-20, 23-24; Powell Aff. at ¶15. Nonetheless, between 2015 and December 31, 2021, the Empire Plan took part in the state IDR process created by the Surprise Bill Law for the benefit and protection of its members as no comparable process existed at that time. *See* Yanulavich Aff. at ¶13; Powell Aff. at ¶11.

II. The No Surprises Act

On January 1, 2022, the federal No Surprises Act ("NSA") became effective. Public Law 116-260, Division BB §109; 42 USC §300gg-111. The NSA, as with the Surprise Bill Law, was created to ensure that patients are not billed for emergency medical services or non-emergency services performed by out-of-network providers at in-network hospitals or facilities. 42 USC §300gg-111(a)(1). The NSA was not enacted to supplant comparable state laws but applies in any instances where there is not an already applicable state law. 42 USC §300gg-111(a)(3)(I); Powell Aff. at ¶¶12-13.

The NSA, like the Surprise Bill Law, creates a dispute resolution process whereby out-of-network providers can submit their contested bills for payment ("federal IDR process"). 42 USC

§§300gg-111(c)(2). Because the Surprise Bill Law is not applicable to the Empire Plan, when the NSA came into effect, the Empire Plan was able to utilize the federal IDR process provided for under the NSA. 42 USC §300gg-111(c); *see* Yanulavich Aff. At ¶24; Powell Aff. at ¶15. As with the Surprise Bill Law, the NSA does not apply to circumstances where a patient affirmatively seeks non-emergency treatment from an out-of-network provider when in-plan providers are available. 42 USC §§300gg-111 (a)(1), 300gg-111(a)(3).

The federal IDR process accounts for different factors than the state IDR process for valuing medical services provided by out-of-network providers. While the state IDR process permits consideration of, among other factors, the usual, customary, and reasonable ("UCR") rate for medical services, the federal IDR process bars the UCR from consideration and instead considers, among other factors, the qualifying payment amount ("QPA").[1] 42 USC §§300gg-111(c)(5)(C); NY Fin. Servs. Law §604. However, as noted by Plaintiffs, at least one federal court has directed that the QPA not be given undue weight in the federal IDR process. NYSCEF Doc. 18 at pg. 14.

III. Plaintiffs' Claims

Plaintiffs' complaint is that the out-of-network providers believe that they will derive less profit if compelled to use the federal IDR process instead of the state IDR process for Empire Plan members. In an attempt to avoid this potential loss of profits, Plaintiffs filed the complaint in this matter ("Complaint") on March 28, 2022, seeking a declaration from this Court that the Empire Plan is generally subject to New York's Insurance Law and specifically subject to the Surprise Bill Law. NYSCEF Doc. 2 at ¶¶130, 150.

[1] As of April 9, 2022, Part AA of Chapter 57 of the Laws of 2022 amended the New York Financial Services Law to allow the state IDR process to consider the median in-network rate as a factor, which is the same as the QPA.

Plaintiffs argue that Civil Service Law §162 mandates that the Empire Plan is "always" subject to every provision of the New York insurance law and to DFS oversight. NYSCEF Doc. 2 at ¶¶2, 8, 18; NYSCEF Doc. 18 at pg. 5. By extension, Plaintiffs claim, the Empire Plan is subject to the Surprise Bill Law and to the state IDR process. NYSCEF Doc. 2 at ¶106. However, Civil Service Law §162 has no such requirement and the Empire Plan, as a self-funded health insurance plan, cannot be compelled to participate in the State IDR process provided for in the Surprise Bill Law.

Plaintiffs also sought, and were denied, a preliminary injunction to compel the Empire Plan to submit to the state IDR process. NYSCEF Doc. 11-18. The Court denied this request due to Plaintiffs' failure to establish irreparable harm. NYSCEF Doc. 63.

As Plaintiffs' Complaint fails to state a cause of action, and as there are no questions of fact, Defendants now move to dismiss the Complaint in its entirety.

ARGUMENT

I. STANDARD OF REVIEW

Pursuant to CPLR § 3001, "[t]he supreme court may render a declaratory judgment… as to the rights and other legal relations of the parties to a justiciable controversy." CPLR § 3001. "The sole issue presented in determining a pre-answer motion to dismiss a declaratory judgment action is whether the plaintiff has set forth a cause of action for declaratory relief, without consideration as to whether [the party] will succeed on the merits of the action." *Salvador v. Town of Queensbury*, 162 A.D.3d 1359, 1360 (3d Dep't 2018) (citing *Hallack v. State of New York*, 32 N.Y.2d 599, 603 (1973)); *see also Staver Co. v. Skrobisch*, 144 A.D.2d 449, 450 (2d Dep't 1988). However, a court may reach "the merits of a properly pleaded cause of action for a declaratory judgment action upon a motion to dismiss for failure to state a cause of action where 'no questions of fact are presented [by the controversy].'" *Bregman v. E. Ramapo Cent. Sch. Dist.*, 122 A.D.3d 656, 658 (2d Dep't 2014) (quoting *Matter of Tilcon N.Y., Inc. v. Town of Poughkeepsie*, 87 A.D.3d 1148, 1150 (2011)). Where no question of material fact is presented, a declaration in Defendants' favor is appropriately granted. *Matter of Tilcon*, 87 A.D.3d at 1150 (citing *Hoffman v. City of Syracuse*, 2 N.Y.2d 484, 487 (1957)).[2]

The issues presented by the Complaint relate solely to the interpretation of statutes, particularly Civil Service Law §162, the Surprise Bill Law, and the NSA. The parties' respective positions as to the interpretation of those laws is clear, and no questions of fact exist that must be resolved before the Court can dispose of the case on the merits. Given this, and as the Complaint

[2] Accordingly, while Defendants ask that the Complaint be dismissed, if the Court deems it appropriate, Defendants seek, as alternative to dismissal of the complaint, a declaration that Plaintiffs are not entitled to any of the relief sought in the Complaint.

fails to state a cause of action upon which relief can be granted, the matter must be dismissed in its entirety.

II. PLAINTIFFS' GENERAL ALLEGATIONS REGARDING THE APPLICABILITY OF NEW YORK'S INSURANCE LAWS DOES NOT STATE A CAUSE OF ACTION

A complaint must do more than assert in conclusory fashion that the elements of a cause of action are met, and instead must allege sufficient facts supporting those elements. *See, e.g.*, *Maas v. Cornell Univ.*, 94 N.Y.2d 87, 91 (1999). "[C]onclusory averments of wrongdoing are insufficient to sustain a complaint unless supported by allegations of ultimate facts." *Muka v. Greene County*, 101 A.D.2d 965, 965 (3d Dep't 1984) (citing *Melito v. Interboro-Mutual Indem. Ins. Co.*, 73 A.D.2d 819, 820 (4th Dep't 1979)). If a complaint fails to "state the essential facts constituting the material elements of any cause of action," it must be dismissed. *Prof'l Health Services v. City of New York*, 34 A.D.2d 918 (1st Dep't 1970).

Plaintiffs allege that, after the NSA was enacted, "the Empire Plan unilaterally determined itself no longer subject to New York insurance law[3] or Department of Financial Services' regulation." NYSCEF Doc. 2 at ¶8. Except for the Surprise Bill Law, Plaintiffs point to no other law, rule, or regulation that the Empire Plan has indicated it will not comply with. In the absence of anything more than conclusory allegations and arguments about the general applicability of New York's insurance laws, Plaintiffs fail to state a cause of action, and any request for a declaration that the Empire Plan is generally subject to New York's insurance laws must be denied.

[3] The improper nature of Plaintiffs' claim is highlighted by their reference to "New York insurance law." New York's laws governing insurance are spread across multiple different groups of statutes and regulations. As discussed in greater detail below, the Empire Plan is specifically excepted from several of the statutes that govern more traditional insurers, and Plaintiffs make no allegation as to what provision or provisions of these laws the Empire Plan has supposedly indicated that it is not subject to. Even further, Plaintiffs make no allegation that the Empire Plan indicated that it is not subject to some provision of the "insurance law" that would confer standing on any of the Plaintiffs.

III. THE EMPIRE PLAN IS NOT SUBJECT TO THE SURPRISE BILL LAW

Plaintiffs' case is premised on the belief that Civil Service Law §162 subjects the Empire Plan to the Surprise Bill Law. It does not. Civil Service Law §162 also does not state, as alleged by Plaintiffs, that the Empire Plan is subject to every provision of New York's laws regulating insurance, nor does it mandate that the Empire Plan fall under DFS's regulatory oversight in all circumstances. Instead, the Civil Service Law requires only that the Empire Plan comply with Articles 43 and 49 of the Insurance Law, neither of which is applicable here, and requires that the Empire Plan ensure that its members have uninterrupted coverage and receive appropriate consumer protections.[4] *See* Yanulavich Aff. at ¶¶16-17; Powell Aff. at ¶¶6-7. Civil Service Law §162 does not reference, either directly or indirectly, the Surprise Bill Law, much less mandate that the Empire Plan comply with the Surprise Bill Law.

Plaintiffs also cannot rely on the Surprise Bill Law itself to support their claims. The Surprise Bill Law does not govern self-funded insurance plans and applies only to "health care plans." NY Fin. Servs. Law §605. Under the Surprise Bill Law, health care plans are: 1) an insurer licensed to write accident and health insurance pursuant to Article 32 of the Insurance Law; 2) a corporation organized pursuant to Insurance Law Article 43; 3) a municipal cooperative health benefit plan certified pursuant to Insurance Law Article 47; 4) a health maintenance organization certified pursuant to Public Health Law Article 44; or 5) a student health plan established or maintained pursuant to Insurance Law §1124. NY Fin. Servs. Law §603(c). As a governmental self-funded insurance plan, the Empire Plan fits into none of the

[4] In short, Article 43 concerns the scope of insurance coverage to be provided to participants, while Article 49 concerns the rights of a member to challenge and appeal an adverse decision by a health plan. Neither article concerns reimbursements to out-of-network providers for emergency or surprise bills.

five definitions of a health care plan set forth in the Surprise Bill Law. *See* Yanulavich Aff. at ¶¶19-20.

Each statute referenced in the Surprise Bill Law concerns different entities that are authorized to conduct an insurance business in New York. Insurance Law Article 32 concerns commercial insurers that are authorized to write life, accident, or health insurance in New York. NY Insurance Law §3201, *et seq*. Insurance Law Article 43 governs "Non-Profit Medical and Dental Indemnity, or Health and Hospital Service Companies." NY Insurance Law §4301, *et seq*. Public Health Law Article 44 relates to health maintenance organizations, which are defined as groups that enter "into an arrangement, agreement or plan … [to] provide or offer, a comprehensive health services plan." NY Public Health Law §4401 (1). Insurance Law Article 47 relates to health plans "established or maintained by two or more municipal corporations." NY Insurance Law §4702(e). Lastly, Insurance Law §1124 relates to health insurance provided by an "institution of higher education." NY Insurance Law §1124.

The Empire Plan fits none of these descriptions. As specifically set forth in Civil Service Law §162, the Empire Plan is only a governmental self-funded health plan. NY Civil Service Law §162(1)(a). The Civil Service Law specifically notes that the Empire Plan's provision of health benefits "shall not constitute the doing of insurance business within the meaning of article eleven of the insurance law." NY Civil Service Law §162(1)(b)(iv). The Insurance Law contains a similar provision that states that the Empire Plan "shall not constitute the doing of insurance business within the meaning of article eleven of the insurance law." NY Insurance Law §1101(b)(6).

DFS and Civil Service are the State agencies charged with interpreting and administering

the laws at issue in this case, including the Surprise Bill Law. "Where the interpretation of a statute or its application involves knowledge and understanding of underlying operational practices or entails an evaluation of factual data and inferences to be drawn therefrom the courts regularly defer to the governmental agency charged with the responsibility for administration of the statute." *Kurcsics v. Merchants Mut. Ins. Co.*, 49 NY2d 451, 459 (1980); *see also Peyton v. New York City Board of Standards and Appeals*, 36 NY3d 271, 280 (2020). So long as the agency's "interpretation is not irrational or unreasonable" the agency's interpretation should be upheld. *Kurcsics*, 49 NY2d at 459.

In their Complaint, Plaintiffs refer to DFS Insurance Circular Letter No. 10 ("CL 10"). A copy of this letter is attached as Ex. A to the Powell Affidavit. Plaintiffs inaccurately allege that this circular letter is applicable to self-funded plans like the Empire Plan. NYSCEF Doc. 2 at ¶¶7, 89-90. The Circular Letter was issued to provide guidance regarding the interplay of the Surprise Bill Law and the NSA. Powell Aff. ¶15. It states that it is intended "to provide guidance to insurers authorized to write accident and health insurance in New York State, Article 43 corporations, health maintenance organizations, student health plans certified pursuant to Insurance Law §1124, municipal cooperative health benefit plans, and prepaid health services plans . . . and health care providers. . ." regarding the NSA. Powell Aff. at ¶¶14-15. It is not directed to self-funded insurance plans, such as the Empire Plan. Powell Aff. at ¶15. It also does not state that DFS's position is that the Surprise Bill Law applies to the Empire Plan or similarly situated self-funded plans. Powell Affidavit at ¶15. DFS's position that Civil Service Law § 162 does not expressly require that the Empire Plan must use the state IDR system is neither irrational nor unreasonable, and the Court should defer to that interpretation. Civil Service's

position that the Surprise Bill Law does not apply to the Empire Plan is also not irrational or unreasonable and is entitled to deference.

As the Surprise Bill Law does not apply to self-funded insurance plans, the Empire Plan cannot be compelled to participate in its IDR process, and Plaintiffs' request for a declaration to the contrary must be denied and the Complaint dismissed in its entirety.

CONCLUSION

Because Plaintiffs cannot establish that they are entitled to the relief sought, their claims must be dismissed.

Dated: Albany, New York
August 31, 2022

LETITIA JAMES
Attorney General of the State of New York
Attorney for Defendants Rebecca Corso, as Acting Commissioner, New York State Department of Civil Service and Adrienne A. Harris, as Superintendent, New York State Department of Financial Services
The Capitol
Albany, New York 12224-0341

By: /s/ *William A. Scott*
WILLIAM A. SCOTT
Assistant Attorney General, of Counsel
Telephone: (518) 776-2622
Fax: (518) 915-7738 (Not for service of papers)

TO: All Counsel of Record by NYSCEF

EXHIBIT 4

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ALBANY

WAYNE JOSEPH; THOMAS COTTONE, SONYA HWANG COTTONE: LORETTA POST; LONG ISLAND ANESTHESIOLOGISTS, PLLC; LONG ISLAND ANESTHESIA PHYSICIANS, LLP; NEW YORK CARDIOVASCULAR ANESTHESIOLOGISTS, P.C.; SUFFOLK ANESTHESIOLOGY ASSOCIATES, P.C.; ADVANCED PLASTIC SURGERY OF LONG ISLAND, PLLC; DA MEDICAL SERVICES PLLC; DA SILVA PLASTIC & RECONSTRUCTIVE SURGERY, P.C.; HAND ASSOCIATES OF LONG ISLAND, P.C.; ISLANDWIDE SURGICAL, P.C.; K. JACOB COHEN-KASHI, M.D. & LAWRENCE C. LIN, MD, PLLC; LISA CORRENTE, M.D., P.C.; LONG ISLAND NEUROSURGICAL & PAIN SPECIALISTS, PLLC; LONG ISLAND THORACIC SURGERY, P.C.; MONTAUK MEDICAL ASSOCIATES PLLC.; PERFORMANCE MEDICAL PRACTICE PLLC; SAGTIKOS MEDICAL SERVICES, P.C.; SPINE MEDICAL SERVICES, PLLC; and UNITED MEDICAL MONITORING, P.C.,

Plaintiffs,

-against-

REBECCA CORSO, as Acting Commissioner, NEW YORK STATE DEPARTMENT OF CIVIL SERVICE; UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK INC., as Program Administrator, THE EMPIRE PLAN MEDICAL/SURGICAL PROGRAM; and ADRIENNE A. HARRIS, as Superintendent, NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES,

Respondents/Defendants.

AFFIRMATION
Index No. 902227-22

JOHN POWELL, an attorney admitted to practice in the State of New York, affirms the following under penalty of perjury pursuant to CPLR 2106:

1. I am employed at the New York State Department of Financial Services ("DFS")

as Deputy Superintendent for Health. I have worked at DFS since 2007.

2. My responsibilities as Deputy Superintendent for Health include overseeing all workings of DFS's Health Bureau ("Health Bureau"), such as the drafting of health insurance legislation, issuance of health insurance regulations, review and approval of health insurance rates, review and approval of health insurance policy forms, and co-management of the state independent dispute resolution process used in the case of surprise bills and bills for emergency services.

3. DFS supervises and regulates the activities of nearly 3,000 financial institutions with assets totaling more than $8.4 trillion as of December 31, 2021. The institutions regulated by DFS include more than 1,700 insurance companies with assets of more than $5.5 trillion, including 866 property/casualty insurance companies, 131 life insurance companies, and 94 health insurers and managed care organizations. DFS also regulates more than 1,200 banking and other financial institutions with assets totaling more than $2.9 trillion, including 388 financial services companies, 159 state-chartered banks, 73 foreign branches, 10 foreign agencies, 29 virtual currency companies, 21 credit rating agencies, and 16 credit unions.

4. While DFS does regulate 94 health insurers and managed care organizations, it does not generally regulate self-funded health plans, in other words, plans under which medical expenses are paid for directly by an employer or a union, rather than by purchasing a health insurance policy from a health insurer.

5. The Empire Plan is a self-funded health plan and is not an insurer. Indeed, Insurance Law § 1101(b)(6) states that the provision of the Empire Plan "shall not constitute the doing of insurance business within the meaning of article eleven of the insurance law."

6. However, the Empire Plan is not like other self-funded plans because Civil Service

Law § 162 expressly subjects the Empire Plan to certain provisions of the Insurance Law and Financial Services Law. Civil Service Law § 162(1)(b)(i) requires that the Empire Plan's provision of health insurance coverages mandated by law, rule, or regulation, including the coverages mandated under Insurance Law Article 43, shall be provided in a manner assuring uninterrupted continuance of coverage for all covered persons. "Coverage" is defined to include, but not be limited to, all benefits, services, rights, privileges, and guarantees allowed by law. Civil Service Law § 162(1)(b)(ii) further provides that plan participants shall be afforded all the internal and external review rights described in Insurance Law Article 49. For the purposes of this Affirmation, these two provisions are collectively referred to as "consumer protections." Therefore, the Empire Plan must provide its members with consumer protections.

7. One type of consumer protection that the Empire Plan must provide is to ensure that, when a patient has no real choice but to use an out-of-network provider, the patient is charged no more than the in-network cost-sharing for the service in question. New York State has a law that provides such protection, namely, Financial Services Law Article 6 (Emergency Medical Services and Surprise Bills) ("Article 6"), which was enacted in 2014 and took effect on March 31, 2015. Article 6 considers a patient to have no real choice but to use an out-of-network provider in two circumstances: when emergency medical services, including inpatient services following an emergency admission, are provided and when a patient receives a surprise bill.

8. Financial Services Law § 603(b) defines "emergency services" to mean, "with respect to an emergency condition: (1) a medical screening examination as required under section 1867 of the social security act, 42 U.S.C. § 1395dd, which is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency

department to evaluate such emergency condition; and (2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the social security act, 42 U.S.C. § 1395dd, to stabilize the patient."

9. Financial Services Law § 603(h) defines a "surprise bill," in relevant part, as "a bill for health care services, other than emergency services, received by: (1) an insured for services rendered by a non-participating provider at a participating hospital or ambulatory surgical center, where a participating provider is unavailable or a non-participating provider renders services without the insured's knowledge, or unforeseen medical services arise at the time the health care services are rendered; provided, however that a surprise bill shall not mean a bill received for health care services when a participating provider is available and the insured has elected to obtain services from a non-participating provider; or (2) an insured for services rendered by a non-participating provider, where the services were referred by a participating physician to a non-participating provider without explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the health care plan."

10. Where there are emergency services or a surprise bill, within the meaning of Article 6, the out-of-network provider will no doubt want an insurer to pay more than what the insurer would have paid an in-network provider (known as the "in-network rate") [1] for the services rendered to a patient. To deal with this situation, Article 6 provides for an independent dispute resolution ("IDR") system so that the insurer and the provider can resolve their dispute without

[1] The in-network rate is the reimbursement amount contractually agreed upon by the insurer and the provider for rendering particular medical services to patients. Out-of-network providers, on the other hand, do not have such contracts with an insurer, and therefore generally charge higher reimbursement rates than in-network providers.

involving the patient. Part 400 of 23 NYCRR sets forth the rules governing New York's IDR process ("state IDR process"). The state IDR process requires insurers and providers, including hospitals and ambulatory surgical centers, to ensure that the insured incurs no greater out-of-pocket costs for emergency services and surprise bills than the insured would have incurred with an in-network provider.

11. From March 31, 2015 to January 1, 2022, there was no federal equivalent to Article 6 and the state IDR process. On December 27, 2020, however, the federal No Surprises Act ("NSA") was signed into law and took effect on January 1, 2022. Like Article 6, the NSA is designed to ensure that, when a patient has no real choice but to use an out-of-network provider, the patient is charged no more than the in-network cost-sharing for the service in question. Thus, the NSA states that providers may not bill and may not hold insureds liable for payment amounts that are more than the in-network cost-sharing requirement for out-of-network emergency services and for non-emergency services performed by non-participating providers at participating facilities. In addition, the NSA amended 42 U.S.C. § 300gg *et seq.* to establish an IDR process ("federal IDR process") to resolve provider-insurer disputes over fees for non-emergency services performed by non-participating providers at in-network hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers and out-of-network emergency services in the emergency department of a hospital or independent freestanding emergency department.

12. 42 U.S.C. § 300gg-111(a)(1)(C)(iii) and (b)(1)(B) and regulations promulgated thereunder provide that an insured's cost-sharing for emergency services in the emergency department of a hospital or independent freestanding emergency department, and for nonemergency services furnished by a non-participating provider at a participating facility, must

be calculated based on one of the following amounts: an amount determined by an applicable All-Payer Model Agreement under federal Social Security Act § 1115A; if there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; or if there is no such applicable All-Payer Model Agreement or specified state law, the lesser of the billed charge or the plan's or insurer's median contracted rate, the latter referred to as the "qualifying payment amount."

13. The NSA defines a "specified state law" as a state law that provides for a method of determining the total amount payable in the case of an insured receiving a service from a non-participating provider at a participating facility or emergency services. 42 U.S.C. § 300gg-111(a)(3)(I). The state law must apply to: (1) the plan, insurer, or coverage; (2) the non-participating provider or facility; and (3) the service. When a state has a specified state law, the state law and the state IDR process will apply and determine the amount paid by the insurer. 45 C.F.R. 149.30.

14. On December 17, 2021, DFS issued Insurance Circular Letter No. 10 (2021) ("CL 10"), which explains in relevant part that since New York has a "specified state law" (i.e., Financial Services Law Article 6), the state IDR process, rather than the federal IDR process, will continue to apply to out-of-network emergency services and surprise bills. A copy of CL 10 is annexed hereto as Exhibit A. CL 10 also explained that where the federal IDR process would provide greater protections to insureds than the state IDR process, DFS would apply federal standards to the state IDR process. After CL 10 was issued, the New York State legislature, in Part AA of Chapter 57 of the Laws of 2022, amended Article 6 to add to the state IDR process protections provided under the federal IDR process that were not previously included in the state IDR process.

15. CL 10 was addressed to all insurers authorized to write accident and health insurance in New York State, Insurance Law Article 43 corporations, health maintenance organizations, student health plans certified pursuant to Insurance Law § 1124, municipal cooperative health benefit plans, prepaid health services plans, and health care providers. However, it was not addressed to self-funded plans such as the Empire Plan. Although Civil Service Law § 162 requires the Empire Plan to provide its members with consumer protections, it does not expressly state that the Empire Plan must use the state IDR system to provide those consumer protections. DFS defers to the Department of Civil Service as to how it interprets the Civil Service Law.

Dated: June 3, 2022

JOHN POWELL